Executive Summary: Interventions with Special Relevance for the Family First Prevention Services Act (FFPSA) (Second Edition)

Executive Summary

Family First Prevention Services Act

The passage of a new federal law, *the Family First Prevention Services Act (P.L. 115-123),* affords opportunities to use research-based interventions to help children safely avoid placement in foster care by meeting key service and treatment needs of children and their parents. Three major categories of services are eligible for reimbursement for up to 12 months under the new law:

1. Mental health services for children and parents
2. Substance abuse prevention and treatment services for children and parents
3. In-home parent skill-based programs:
   - Parenting skills training
   - Parent education
   - Individual and family counseling

The law includes Kinship Navigator programs, but as a separate provision with its own timeline.

FFPSA supports funding for services "directly related to the safety, well-being or permanence of the child or to prevent the child from entering foster care" (p. 170) that can be provided to:

- Infants, children, youth, pregnant and parenting youth, birth parents, kinship caregivers providing temporary or permanent care for children
- Children who are at risk of entering out-of-home care but who can stay safely with parents or kinship caregivers. This also includes children whose adoption or guardianship is at risk of disruption/dissolution.
- Children multiple times if they are identified as a "candidate"/at risk of out of home multiple times.
- Families regardless of their income (in contrast to current requirements).[1]

Evidence Standards

The levels of evidence for interventions (Promising, Supported and Well-supported) are currently being clarified by the Federal government but are similar in many ways to the California Evidence Based Clearinghouse for Child Welfare (CEBC) criteria, with three major exceptions: (1) an RCT study is *not* required; (2) publication in a peer review journal is *not* required (at least at this time); and (3) a book, program manual or some other form of documentation is required.[2] See Table E1 for a comparison of the current evidence criteria for FFPSA and CEBC.

[1] FFPSA law, pp. 170-173. Retrieved from https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf

[2] For example, the language in the FFPSA uses the CEBC's language but allows for other available writings: "The practice has a book, manual, or other available writings that specify the components of the practice protocol and describe how to administer the practice." The CEBC uses the concept of "other available writings" to include programs that do not have a formal book or manual, but have written training materials available that specify the components of the practice protocol and describe how to administer the practice (Personal Communication, Jennifer A. Rolls Reutz, May 15, 2018). See: https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf

Table E1. A Comparison of the Criteria for FFPSA and CEBC

Family First Prevention Services Act (FFPSA)[a]	California Evidence-Based Clearinghouse (CEBC)[b]
General Requirements: In order for an intervention to be reimbursed by FFPSA it must: (i) have a book, manual or other available writings that specify the components of the practice protocol, and describe how to administer the practice. (ii) there is no empirical basis is suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it. (iii) if multiple outcome studies have been conducted, the overall weight of evidence supports the benefits of the practice (iv) outcome measures are reliable and valid, and are administered consistently and accurately across all those receiving the practice. (v) there are no case data suggesting a risk of harm that was probably caused by the treatment that was severe or frequent. (p. 171) (vi) been published in "government reports and peer-reviewed journal articles that assess effectiveness (i.e., impact) using quantitative methods." (See https://www.federalregister.gov/d/2018-13420, p. 9.) FFPSA also requires that ▪ The practice be provided in an agency context and with a "trauma-informed approach and trauma-specific interventions" (p. 171) ▪ Study must be rated by some kind of "an independent systematic review" (p. 172) ▪ Study must have targeted one of the FFPSA "target outcomes;" conducted in the U.S., U.K., Canada, New Zealand, or Australia; and published/prepared in English during or after 1990. (See https://www.federalregister.gov/d/2018-13420, pp. 9.-10.) ▪ The "meaningful positive significant effect" on the study FFPSA target outcome "…will be defined using conventional standards of statistical significance (i.e., two-tailed hypothesis test and a specified alpha level of p<.05)." (See https://www.federalregister.gov/d/2018-13420, p. 11.)	**General Requirements:** In order for an intervention to be rated by CEBC it must: a. Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects. b. If multiple outcome studies have been conducted, the overall weight of evidence supports the benefit of the practice. c. There are no case data suggesting a risk of harm that: (a) was probably caused by the treatment and (b) the harm was severe or frequent. d. There is no legal or empirical basis suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it. e. The practice has a book, manual, and/or other available writings that specify the components of the practice protocol and describe how to administer it. (See http://www.cebc4cw.org/ratings/)
Well-Supported: A practice shall be considered to be a 'well- supported practice' if: (I) the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least two studies that— (aa) were rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed; (bb) were rigorous random-controlled trials (or, if not available, studies using a rigorous quasi-experimental research design); and (cc) were carried out in a usual care or practice setting; and (II) at least one of the studies described in sub clause (I) established that the practice has a sustained effect (when compared to a control group) for at least 1 year beyond the end of treatment. (pp. 172-173) [I.e. at least one 12 month follow-up study is required.]	**Well-Supported:** • At least 2 rigorous randomized controlled trials (RCTs) in different usual care or practice settings have found the practice to be superior to an appropriate comparison practice. • In at least one of these RCTs, the practice has shown to have a sustained effect of at least one year beyond the end of treatment, when compared to a control group.

Family First Prevention Services Act (FFPSA)[a]	California Evidence-Based Clearinghouse (CEBC)[b]
Supported: (I) the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least one study that— (aa) was rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed; (bb) was a rigorous random-controlled trial (or, if not available, a study using a rigorous quasi-experimental research design); and (cc) was carried out in a usual care or practice setting; and (II) the study described in sub-clause (I) established that the practice has a sustained effect (when com-pared to a control group) for at least 6 months beyond the end of the treatment (p. 172) [I.e. at least one 6 month follow-up study is required.]	Supported: • At least one rigorous RCT in a usual care or practice setting has found the practice to be superior to an appropriate comparison practice. • In that RCT, the practice has shown to have a sustained effect of at least six months beyond the end of treatment, when compared to a control group.
Promising: The practice is superior to a comparison practice "using conventional standards of statistical significance in terms of demonstrated meaningful improvements in validated measure of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being, as established by the results or outcomes of at least one study that: (I) that was rated by an independent systematic review for the quality of the study design and execution, and determined to be well-designed and well-executed; and (II) utilized some form of control (e.g., untreated group, placebo group, wait list study) (III) the evaluation was carried out in a "usual care or practice setting." (p. 172)	Promising:[c] • At least one study utilizing some form of control (e.g., untreated group, placebo group, matched wait list) that has established the practice's benefit over the comparison, or found it to be equal to or better than an appropriate comparison practice.

[a] See the final FFPSA bill at https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf

[b] The CEBC criteria are described here: http://www.cebc4cw.org/files/OverviewOfTheCEBCScientificRatingScale.pdf CEBC uses two rating scales – one for strength of the research evidence supporting a practice or program; and a second rating of the tools used for screening or assessment. See http://www.cebc4cw.org/ratings/

[c] Note that the research support for the CEBC "promising" level varies substantially. For example, some interventions have high quality comparison-group studies that are not randomized or have RCTs with no follow-up, while others barely meet the "control group" requirement (Personal Communication, Jennifer A. Rolls Reutz, May 30, 2018)

Interventions Reviewed and Sources

Based on a review of the literature, the following interventions are highlighted as effective or relevant for potential reimbursement under FFPSA. For each intervention, the following information is provided (when available): intervention summary, consumer age range, problem areas addressed, number of sessions, duration of treatment, cost, cost savings, benefit-cost ratio, and the availability of a manual. Due to the importance of the Title IV-E Waiver program, we also designate which of these interventions were being implemented by a jurisdiction as part of their Waiver, as of 2015,[3] and how each of these interventions was

[3] Pecora, P.J., O'Brien, K. & Maher, E. (2015). *Levels of research evidence and benefit-cost data for Title IV-E waiver interventions: A Casey research brief. (Third Edition)* Seattle: Casey Family Programs. Available at: http://www.casey.org/media/Title-IV_E-Waiver-Interventions-Research-Brief.pdf

rated according to the established criteria of the California Evidence-Based Clearinghouse for Child Welfare (CEBC), using the three levels of effectiveness for the CEBC classification system as described in the table above:[4]

1. Well-supported by Research Evidence
2. Supported by Research Evidence
3. Promising Research Evidence

As noted in the table above, in order for an intervention to be rated by the CEBC for any level, it must (a) Have a book or manual that describes how to administer it; (b) Meet the requirements for inclusion in one of the CEBC topic areas; (c) Outcomes of the research must be published in a peer review journal; and (d) Outcome measures are reliable/valid and administered consistently and accurately.[5]

Interventions listed on the CEBC were included if: they were rated 1, 2 or 3; there was a response and details provided by the developer; there was a book or manual; and, in the case of substance abuse and mental health treatment, the treatment provided was delivered by a qualified clinician in either individual or group format; and, in the case of *in-home* parenting services, the intervention did not require a group component. Parent training or skill-building interventions, even if they were group-based, were included in the mental health treatment FFPSA program category if they helped improve some aspect of a caregiver's emotional or behavioral health. While most evidence-based interventions last 6-8 months, a number last longer than 12 months. Strictly applying the 12 month time limit in the FFPSA legislation would result in well-researched programs like Nurse Family Partnership and promising programs such as Parents as Teachers being excluded from the catalog. However, while FFPSA may pay for up to 12 months of a longer term intervention, states can likely elect to use Medicaid, state or other funding to continue the service beyond 12 months; hence, we have included interventions that extend beyond 12 months in the catalog. The duration information then indicates if the FFPSA funding would "time out" before that intervention was fully delivered.

Some relevant interventions were not included in the CEBC, but were selected for inclusion here based on ratings from the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP), which uses a four level system (where the quality of research studies is rated on a 4-point scale)[6], the "BLUEPRINTS" intervention registry (which uses a three level system of promising, model and model plus),[7] or the Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs Guide (which uses a three level system of harmful, promising and effective).[8] For some of the interventions included in these sources, the information was not obtained directly from the developer but from published manuals, reports, journal articles or book chapters. With this exception, all the other criteria used to select interventions from the CEBC were applied to these clearinghouses.

Interventions that were not able to be rated due to a lack of evaluation data are listed in a companion document, as some of these interventions warrant further evaluation so that they might qualify. In some cases, the evidence base for the effectiveness of a particular intervention within a child welfare environment is sparse. In this case we rely on the research evidence indicating that the intervention is effective for a particular problem, or area of functioning that children and

[4] See http://www.cebc4cw.org/. For more complete definitions, see http://www.cebc4cw.org/ratings/scientific-rating-scale/.
[5] See http://www.cebc4cw.org/files/OverviewOfTheCEBCScientificRatingScale.pdf
[6] Note that the NREPP contractor and review criteria/process may be undergoing change. See https://nrepp.samhsa.gov/landing.aspx
[7] See Center for the Study and Prevention of Violence's http://www.blueprintsprograms.com/
[8] See OJJDP's https://www.ojjdp.gov/mpg/

their caregivers typically have in child welfare, and various meta-analyses that have reported intervention effect sizes.[9] In addition, to help describe the evidence base or other aspects of the interventions with scant material, a wide range of other websites were reviewed. Note that Multisystemic Therapy for Substance Abuse (MST-SA), Structural Family Therapy (SFT) and Trauma Systems Therapy (TST), despite their use by child welfare programs in New York City and elsewhere, were not included in this catalog as these interventions are not rated by the CEBC or Blueprints; and the NREPP site was taken down at the time this catalog was being revised. We will rate these interventions in a later edition of this catalog.

In addition, in contrast to Family Spirit and some other culturally competent interventions, the in-home and group-based versions of the Positive Indian Parenting Program have not been evaluated sufficiently to be rated by one of the Clearinghouses. Until more evaluation data can be gathered by NICWA, the law allows for a request to be made to the Secretary of HHS to waive those aspects of the law, via guidance, per the provision allowing for cultural and tribal specific needs.

Interventions Summary

On pages xii-xv, we provide a condensed table that lists each of the interventions in the catalog by program category and level of evidence (Table E4). In order for states, counties, and tribal nations to make well-informed intervention-selection decisions, better understanding where and how these interventions have been tested, used, spread, or discontinued across child-serving and family-serving systems is also important. In the months ahead, we will also be adding effect-size data for more interventions because of its value in estimating the expected impact of the intervention outcomes of interest.

In examining that summary table, even without applying the less stringent FFPSA criteria to the interventions, we see that there are sizable numbers of interventions that meet the standards for each level for each program area. There are not, however, as many interventions that are rated by the CEBC or other ranking system at a *Well-supported* level. (See Table E2 below.) This highest evidence level is important because 50 percent of the state intervention funding for FFPSA-eligible interventions must be spent on *Well-supported* interventions, but using criteria that is slightly less stringent than CEBC, as discussed earlier.

[9] For examples of meta-analyses reporting intervention effect sizes, see Lee, B. R., Bright, C. L., Svoboda, D. V., Fakunmoju, S., & Barth, R. P. (2011). Outcomes of group care for youth: A review of comparative studies. *Research on Social Work Practice, 21*(2), 177-189. doi:10.1177/1049731510386243 Leenarts, L.E.W., Diehle, J., Doreleijers, T.A.H., Jansma, E.P., & Lindauer, R.J.L., (2012). Evidence-based treatments for children with trauma-related psychopathology as a result of childhood maltreatment: A systematic review. *European Child Adolesc Psychiatry* 22:269-283.

Table E2. Summary Table of Interventions Classified as Well-Supported in Terms of Evidence Level
(N=40)

FFPSA Intervention Areas	Number of Interventions Ranked as Well-supported According to the CEBC or Other Ranking System
▪ Mental health services for children and parents	29
▪ Substance abuse prevention and treatment services for children and parents	4
▪ In-home parent skill-based programs: ▪ Parenting skills training and Parent education[a] ▪ Individual and family counseling	 5 2

[a] A clear definition of each program type and how they differ from each other has not yet been issued by the Federal Government in relation to FFPSA. Therefore, we grouped interventions that might qualify for one or both these program types together.

Table E2 needs to be viewed with caution as Casey Family Programs, the CEBC staff, Abt Associates (the organization that ACYF has contracted with to act as the FFPSA Clearinghouse), and others are just now beginning to review the research literature for interventions to see how they would be rated if the current FFPSA research evidence criteria remain unchanged. Many experts are reluctant to devote a large amount of staff time or other resources to that effort since we need to know what kinds of research reports or data summaries can be used to determine what rating the intervention should receive. FFPSA does *not* require a Randomized Control Trial (RCT) or publication in a peer-review journal, which should result in a larger number of interventions qualifying for the upper evidence levels than what we show in this catalog. For example, in a special review described next, 26 interventions which are currently classified at a lower level using the CEBC, NREPP, or BLUEPRINTS rating criteria should be determined to be at the *Well-supported* level using FFPSA criteria (see Table E3.) ***Combining Tables E2 and E3, a total of 66 interventions relevant to child welfare should be classified as Well-Supported.***

Interventions that Should be Rated as Well-Supported Under the Most Recent FFPSA Standards

The levels of evidence that will be used to rate interventions for reimbursement under Family First as Promising, Supported and Well-supported are currently being clarified by the Federal government, and new parameters were recently released for comment by ACYF. All the FFPSA evidence criteria released thus far are similar in many ways to the California Evidence Based Clearinghouse for Child Welfare (CEBC) criteria, with six major exceptions:

1. A RCT study is *not* required
2. Publication in a peer review journal is *not* necessary
3. Study must have targeted one of the FFPSA "target outcomes;" conducted in the U.S., U.K., Canada, New Zealand, or Australia;
4. The study report must have been published in English
5. The study conducted or summarized during or after 1990. (See https://www.federalregister.gov/d/2018-13420, pp. 9.-10.)
6. The "meaningful positive significant effect" on the study FFPSA target outcome "…will be defined using conventional standards of statistical significance (i.e., two-tailed hypothesis test and a specified alpha level of p<.05)." (See https://www.federalregister.gov/d/2018-13420, p. 11.)

Review Process

The Casey Family Programs review team from Research Services examined all 45 "Supported" interventions in the first edition of the Catalog in relation to all the specific rating criteria published to date about the FFPSA interventions. We also paid special attention to the following:

- Study sample size.
- The drop-out/attrition rates as the study proceeded, including the response rate for the follow-up studies. The study might be disqualified if these drop-out/attrition rates are too high – especially if there was differential attrition across the treatment and comparison groups.
- Use of valid assessment measures.

If the information gathered showed that the intervention had evidence that would qualify it for the *Well-Supported level,* that was recorded, along with a brief summary of why – along with the articles supporting that evidence level. We also confirmed that there were at least two qualifying studies for every outcome highlighted for that intervention (as distinct from a situation where each study found a different outcome).

If the initial set of evidence was insufficient to qualify for *Well-Supported*, we contacted the intervention developer for additional studies and technical reports that might help their intervention qualify for the highest level possible. The 27 interventions with evidence that should qualify them for the *Well-Supported* level under FFPSA are listed in Table E.2, along with their target outcomes. The studies that provided the most direct evidence are footnoted for each intervention.

Conclusions

In sum, although further direction from the Children's Bureau is forthcoming, the information in this document provides a conservative approach regarding interventions that may be covered under FFPSA. In other words, if an intervention is designated as promising, supported, or well-supported in this document, it is likely to have the same or higher evidence standard under FFPSA. Until further direction is provided, this catalog offers a rough estimate as to what interventions are likely to be covered under FFPSA.

Table E3. Relevant Interventions Rated as Supported Using CEBC Criteria that Could Be Classified as Well-Supported Under FFPSA Rating Criteria
(N = 26)[10]

Mental Health Services for Children and Parents
1. Blues Program[1] (Depressive symptoms, lower risk for onset of major depression - i.e. risk of future depressive episodes)
2. Building Confidence[2] (Child and adolescent anxiety)
3. Chicago Parent Program[3] (Parent self-efficacy, corporal punishment, consistent discipline, positive parenting, and child behavior problems)
4. Cognitive Behavioral Therapy (CBT) for Child & Adolescent Depression[4] (Child and adolescent depression)
5. Cognitive Behavioral Therapy (CBT) - Group Therapy for Children with Anxiety[5] (Child anxiety)
6. Cognitive Behavioral Therapy (CBT) - Parent Counseling for Young Children with Anxiety[6] (Child anxiety)
7. Dialectical Behavior Therapy (DBT)[7] (Reducing self-harm; suicide attempts in highly suicidal self-harming adolescents; non-suicidal self-injury; depression; and improved general functioning among people with borderline personality disorder)
8. Families and Schools Together (FAST)[8] (Youth aggressive/externalizing behavior, academic performance)
9. Family-Focused Treatment for Adolescents (FFT-A)[9] (Manic symptoms in youth with bipolar disorder)
10. Interpersonal Psychotherapy-Adolescent Skills Training (IPT-AST)[10] (Child and adolescent depression, overall functioning)
11. Wraparound Services[11] (Reduced recidivism in terms of juvenile justice offenses, improved overall youth functioning, placement in least restrictive settings, including achieving legal permanency)
Substance Abuse Prevention and Treatment Services for Children and Parents

[10]*Source*: Compiled by Olivia Thai, Danielle Roy, Jessica Elm and Peter J. Pecora, Research Services, Casey Family Programs. Note that the table lists target outcomes where 2 or more separate studies found positive effects for that outcome, with at least one study finding positive results at a 12 month or longer follow-up.

12. Buprenorphine Maintenance Treatment for Opioid Use Disorder[12] (Opioid use)
13. Assertive Continuing Care (ACC)[13] (Substance abuse)
14. Adolescent Community Reinforcement Approach (A-CRA)[14] (Substance abuse)
15. Adolescent Coping with Depression (CWD-A)[15] (Depression)
16. Brief Marijuana Dependence Counseling (BMDC)[16] (Marijuana use)
17. Ecologically Based Family Therapy (EBFT)[17] (Substance abuse)
18. Functional Family Therapy (FFT) for adolescents with SUDs[18] (Substance abuse)
19. Helping Women Recover & Beyond Trauma (HWR/BT)[19] (Substance abuse among women)
20. Interim Methadone Maintenance (IM) for opioid use[20] (Opioid use)
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education
21. Family Spirit (for American Indian/Alaskan Native parents)[21] (Mothers' knowledge of and involvement in child care, maternal parenting skills)
22. Home Instruction for Parents of Preschool Youngsters (HIPPY)[22] (Child school performance)
23. SafeCare[23] (Re-referral to CPS for child neglect or physical abuse)
In-Home Parent Skill-Based Programs: Individual and Family Counseling
24. Child-Parent Psychotherapy[24] (Secure and disorganized attachment)
25. Functional Family Therapy (FFT)[25] (Family functioning, youth emotional and behavior improvement, child out-of-home placement prevention, and delinquent behavior recidivism/arrests)
26. Homebuilders[26] (Family functioning improvement to prevent child out-of-home placement)
27. Parenting with Love and Limits[27] (Child emotional and behavior health problems)

In Table E.4 the interventions in the catalog are listed by their FFPSA program area and evidence level.

Table E.4: Interventions Summary by Program Areas Listed in P.L. 115-123

Mental Health Services for Children and Parents (Total: 81)		
Well-supported (sub-total: 29):	*Supported (sub-total: 23):*	*Promising (sub-total: 29):*
▪ Acceptance and Commitment Therapy (ACT) for Adults ▪ Acceptance and Commitment Therapy (ACT) for adults with anxiety ▪ Acceptance and Commitment Therapy (ACT) for adults with schizophrenia and psychosis ▪ Acceptance and Commitment Therapy (ACT) for children with anxiety ▪ Acceptance and Commitment Therapy (ACT) for children with depression ▪ Aggression Replacement Training® (ART) ▪ Attachment and Biobehavioral Catch Up (ABC) ▪ Child and Family Traumatic Stress Intervention (CFTSI) ▪ Cognitive Behavioral Therapy (CBT) ▪ Cognitive Behavioral Therapy (CBT) for Adult Anxiety ▪ Cognitive Behavioral Therapy (CBT) for Adult Depression ▪ Cognitive Behavioral Therapy (CBT) for Adult Posttraumatic Stress Disorder (PTSD) ▪ Cognitive Behavioral Therapy (CBT) for Adult Schizophrenia and Psychosis ▪ Cognitive Behavioral Therapy (CBT) for Children with Anxiety ▪ Cognitive Behavioral Therapy (CBT) for Children with Trauma	▪ Accelerated Resolution Therapy ▪ Blues Program ▪ Building Confidence ▪ Chicago Parent Program (CPP) ▪ Childhaven Childhood Trauma Treatment ▪ Cognitive Behavioral Therapy (CBT) for Child and Adolescent Depression ▪ Cognitive Behavioral Therapy (CBT) – Group Therapy for Children with Anxiety ▪ Cognitive Behavioral Therapy (CBT) – Parent counseling for young children with anxiety ▪ Collaborative & Proactive Solutions ▪ Collaborative Problem-Solving ▪ Common Sense Parenting (CSP) ▪ Community Reinforcement + Vouchers Approach (CRA + Vouchers) ▪ Dialectical Behavior Therapy (DBT) ▪ Dialectical Behavior Therapy (DBT) for Adolescent Self-Harming Behavior ▪ Families and Schools Together (FAST) ▪ Family-Focused Treatment for Adolescents (FFT-A) ▪ Interpersonal Psychotherapy-Adolescent Skills Training (IPT-AST) ▪ Multi-Family Psychoeducational Psychotherapy (MF-PEP) ▪ New Beginnings (for children of divorce)	▪ 1-2-3 Magic ▪ ACTION (youth group treatment for depression) ▪ Adolescent Coping with Depression (CWD-A) ▪ Behavioral Activation Treatment for Depression (BATD) ▪ Brief Eclectic Psychotherapy for PTSD (BEPP) ▪ C.A.T. Project ▪ Child-Centered Play Therapy (CCPT) ▪ *CICC's Effective Black Parenting Program (EBPP)* ▪ Cognitive Behavioral Analysis System of Psychotherapy (CBASP) ▪ Cognitive-Behavioral Coping-Skills Training ▪ Cognitive Processing Therapy (CPT) ▪ Combined Parent-Child Cognitive-Behavioral Therapy (CPC-CBT) ▪ Cool Kids ▪ Defiant Children: A Clinician's Manual for Assessment and Parent Training (The Barkley Method of Behavioral Parent Training) ▪ Exchange Parent Aide ▪ Fairy Tale Model (Treating Problem Behaviors: A Trauma-Informed Approach) ▪ Family Connections ▪ Helping the Noncompliant Child ▪ Interpersonal Psychotherapy for Depressed Adolescents (IPT-A) ▪ Life Space Crisis Intervention (LSCI)

Mental Health Services for Children and Parents (Total: 81)		
Well-supported (sub-total: 29):	*Supported (sub-total: 23):*	*Promising (sub-total: 29):*
▪ Cognitive Behavioral Therapy (CBT) – Individual Therapy for Children with Anxiety ▪ Cognitive Therapy (CT) ▪ Coping Cat ▪ Coping Power Program ▪ Eye movement desensitization and reprocessing (EMDR) for Adult PTSD ▪ Eye movement desensitization and reprocessing (EMDR) for Children ▪ GenerationPMTO (Group Delivery Format) ▪ Mindfulness-Based Cognitive Therapy (MBCT) for Adults ▪ Multidimensional Family Therapy (MDFT) ▪ Parent Child Interaction Therapy (PCIT) ▪ Problem Solving Skills Training for Children ▪ Prolonged Exposure Therapy for Adolescents (PE-A) ▪ Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) ▪ Triple P – Positive Parenting Program – Level 4 Individual for Child Disruptive Behavior	▪ Positive Peer Culture (PPC) ▪ Primary and Secondary Control Enhancement Training (PASCET) ▪ Problematic Sexual Behavior- (PSB-CBT-S)- for School Age Children ▪ Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) for Sexual Behavior Problems in Children	▪ Mindfulness-Based Cognitive Therapy for Children (MBCT-C) ▪ Nurturing Parenting Program for Parents and their School-age Children 5 to 12 Years ▪ Parents Anonymous ▪ Play and Learning Strategies–Infant Program ▪ Solution-Based Casework (SBC) ▪ Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) ▪ Structured Sensory Intervention for Traumatized Children, Adolescents and Parents (SITCAP-ART) ▪ Trauma and Grief Component Therapy for Adolescents (TGCT-A) ▪ Wraparound

Substance Abuse Prevention and Treatment for Children and Parents (Total: 26)		
Well-supported (sub-total: 4): ▪ Communities that Care for Substance Abuse Prevention ▪ Motivational Interviewing ▪ Multidimensional Family Therapy (MDFT) ▪ PROSPER	*Supported (sub-total: 15):* ▪ Adaptive Stepped Care ▪ Adolescent Community Reinforcement ▪ Approach/Assertive Continuing Care (A-CRA/ACC) ▪ Adolescent Coping with Depression (CWD-A) ▪ Adolescent-focused Family Behavior Therapy ▪ Adult-focused Family Behavior Therapy ▪ Brief Marijuana Dependence Counseling (BMDC) ▪ Brief Strategic Family Therapy ▪ Buprenorphine (or buprenorphine/naloxone) maintenance treatment for opioid use disorder ▪ Ecologically Based Family Therapy ▪ Families Facing the Future ▪ Functional Family Therapy (FFT) for adolescents with substance use disorder ▪ Helping Women Recover & Beyond Trauma (HWR/BT) [Substance Abuse Treatment (Adult)] ▪ Injectable naltrexone for opiates ▪ Intermittent methadone maintenance	*Promising (sub-total: 7):* ▪ Alcohol Behavioral Couple Therapy ▪ C.A.R.E.S. (Coordination, Advocacy, Resources, Education and Support) ▪ Cognitive-Behavioral Coping-Skills Therapy for alcohol or drug use disorders ▪ Matrix Model Intensive Outpatient program ▪ Seeking Safety ▪ Sobriety Treatment and Recovery Teams (START) ▪ 12-Step Facilitation Therapy for Substance Abuse (TSF)
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education (Total: 17)		
Well-supported (sub-total: 5): ▪ Family Connects ▪ Healthy Families America (HFA) ▪ Minding the Baby® (MTB) ▪ Nurse Family Partnership (NFP) ▪ The Incredible Years	*Supported (sub-total: 5):* ▪ AVANCE Parent-Child Education Program ▪ Home Instruction for Parents of Preschool Youngsters (HIPPY) ▪ SafeCare ▪ Tuning In To Kids (TIK) ▪ Tuning In To Teens (TINT)	*Promising (sub-total: 7):* ▪ All Babies Cry (ABC) ▪ Circle of Security-Home Visiting-4 (COS-HV4) ▪ Collaborative Problem Solving (CPS) ▪ Early Head Start-Home Visiting (EHS-HV) ▪ GenerationPMTO (individual delivery format) ▪ Infant Health and Development Program (IHDP) ▪ Parents as Teachers (PAT)

In-Home Parent Skill-Based Programs: Individual and Family Counseling (Total: 23)		
Well-supported (sub-total: 2): ▪ Attachment-Based Family Therapy (ABFT) ▪ The Family Check-up (FCU)	*Supported (sub-total: 7):* ▪ Child-Parent Psychotherapy (CPP) ▪ Child Parent Relationship Therapy (CPRT) ▪ Functional Family Therapy (FFT) ▪ Intensive Family Preservation Services (HOMEBUILDERS®) ▪ Multisystemic Therapy (MST) ▪ Parenting with Love and Limits (PLL) ▪ Strengthening Families for Parents and Youth 10–14	*Promising (sub-total: 14):* ▪ Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT) ▪ Child FIRST (Child and Family Interagency, Resource, Support, and Training) ▪ Cue-Centered Treatment (CCT) ▪ Domestic Abuse Intervention Project - The Duluth Model (DAIP) ▪ Early Pathways Program (EPP) ▪ Families First ▪ Family Centered Treatment ▪ Multisystemic Therapy Building Stronger Families (MST-BSF) ▪ Parent Child Assistance Program (PCAP) ▪ Promoting First Relationships (PFR) ▪ Risk Reduction through Family Therapy (RRFT) ▪ Step-by-Step Parenting Program© ▪ Trauma Affect Regulation: Guide for Education and Therapy for Adolescents (TARGET-A) ▪ Wraparound (in-home parent support focus)

[1] Studies that help Blues Program meet FFPSA evidence criteria include:

- Stice, E., Rohde, P., Seeley, J. R., & Gau, J. M. (2008). Brief cognitive-behavioral depression prevention program for high-risk adolescents outperforms two alternative interventions: A randomized efficacy trial. Journal of Consulting and Clinical Psychology, 76(4), 595-606.
- Rohde, P., Stice, E., Shaw, H., & Briere, F. N. (2014). Indicated cognitive behavioral group depression prevention compared to bibliotherapy and brochure control: Acute effects of an effectiveness trial with adolescents. Journal of Consulting and Clinical Psychology, 82 (1), 65-74.
- Stice, E., Rohde, P., Gau, J. M., & Wade, E. (2010). Efficacy trial of a brief cognitive-behavioral depression prevention program for high-risk adolescents: Effects at 1- and 2-year follow-up. Journal of Consulting and Clinical Psychology, 78(6), 856-867.
- Rohde, P., Stice, E., Shaw, H., & Gau, J. M. (2015). Effectiveness Trial of an Indicated Cognitive-Behavioral Group Adolescent Depression Prevention Program versus Bibliotherapy and Brochure Control at 1- and 2-Year Follow-Up. Journal of Consulting and Clinical Psychology, 83(4), 736–747. http://doi.org/10.1037/ccp0000022

[2] Studies that help Building Confidence meet FFPSA evidence criteria include two main studies with sample sizes less than 50 but with 40 or more children:

- Wood, J. J., Piacentini, J. C., Southam-Gerow, M., Chu, B. C., & Sigman, M. (2006). Family cognitive behavioral therapy for child anxiety disorders. *Journal of the American Academy of Child & Adolescent Psychiatry,* 45(3), 314-321.
- Chiu, Angela W., Langer, David A., McLeod, Bryce D., Har, Kim, Drahota, Amy, Galla, Brian M., . . . Wood, Jeffrey J. (2013). Effectiveness of Modular CBT for Child anxiety in elementary schools. *School Psychology Quarterly*, 28(2), 141-153.
- Wood, Jeffrey J., McLeod, Bryce D., Piacentini, John C., & Sigman, Marian. (2009). One-year follow-up of family versus child cbt for anxiety disorders: exploring the roles of child age and parental intrusiveness. *Child Psychiatry and Human Development,* 40(2), 301-316.
- Galla, Brian M., Wood, Jeffrey J., Chiu, Angela W., Langer, David A., Jacobs, Jeffrey, Ifekwunigwe, Muriel, & Larkins, Clare. (2012). One year follow-up to modular cognitive behavioral therapy for the treatment of pediatric anxiety disorders in an elementary school setting. *Child Psychiatry and Human Development,* 43(2), 219-226.

[3] Studies that help Chicago Parent Program meet FFPSA evidence criteria include:

- Gross, D., Garvey, C., Julion, W., Fogg, L., Tucker, S., & Mokros, H. (2009). Efficacy of the Chicago Parent Program with Low-Income African American and Latino parents of young children. *Prevention Science: The Official Journal of the Society for Prevention Research,* 10(1), 54–65. http://doi.org/10.1007/s11121-008-0116-7
- Breitenstein, S. M., Gross, D., Fogg, L., Ridge, A., Garvey, C., Julion, W., & Tucker, S. (2012). The Chicago Parent Program: Comparing 1-Year outcomes for African American and Latino parents of young children. *Research in Nursing & Health*, 35(5), 475–489. http://doi.org/10.1002/nur.21489
- Additional research may be found at: http://www.chicagoparentprogram.org/our-research

[4] Studies that help CBT for Child & Adolescent Depression meet FFPSA evidence criteria include:

- Brent, D., Holder, D., Kolko, D., Birmaher, B., Baugher, M., Roth, C., . . . Johnson, B. (1997). A Clinical psychotherapy trial for adolescent depression comparing cognitive, family, and supportive therapy. *Archives of General Psychiatry*, 54(9), 877-885.
- Clarke, Gregory, DeBar, Lynn L., Pearson, John A., Dickerson, John F., Lynch, Frances L., Gullion, Christina M., & Leo, Michael C. (2016). Cognitive behavioral therapy in primary care for youth declining antidepressants: A randomized trial. *Pediatrics*, 137(5), 1.
- Brent, Kolko, Birmaher, Baugher, Bridge, Roth, & Holder. (1998). Predictors of Treatment efficacy in a clinical trial of three psychosocial treatments for adolescent depression. *Journal of the American Academy of Child & Adolescent Psychiatry*, 37(9), 906-914.
- Reinecke, Ryan, & Dubois. (1998). Cognitive-Behavioral Therapy of depression and depressive symptoms during adolescence: A review and meta-analysis. *Journal of the American Academy of Child & Adolescent Psychiatry*, 37(1), 26-34.
- A cost-benefit analysis conducted by the Washington State Institute for Public Policy may be found here: http://www.wsipp.wa.gov/BenefitCost/Program/542

[5] Studies that help CBT Group Therapy for Children with Anxiety meet FFPSA evidence criteria include:

- Barrett, P. (1998). Evaluation of cognitive-behavioral group treatments for childhood anxiety disorders. *Journal of Clinical Child Psychology*, 27(4), 459-468.
- Wergeland, Fjermestad, Marin, Haugland, Bjaastad, Oeding, . . . Heiervang. (2014). An effectiveness study of individual vs. group cognitive behavioral therapy for anxiety disorders in youth. *Behaviour Research and Therapy*, 57(1), 1-12.
- Hudson, Rapee, Deveney, Schniering, Lyneham, & Bovopoulos. (2009). Cognitive-behavioral treatment versus an active control for children and adolescents with anxiety disorders: A randomized trial. Journal of the American Academy of Child & Adolescent Psychiatry, 48(5), 533-544.
- Lau, Chan, Li, & Au. (2010). Effectiveness of group cognitive-behavioral treatment for childhood anxiety in community clinics. *Behaviour Research and Therapy*, 48(11), 1067-1077.
- A cost-benefit analysis conducted by the Washington State Institute of Public Policy may be found here: http://www.wsipp.wa.gov/BenefitCost/Program/66

[6] Studies that help CBT Parent Counseling for Young Children with Anxiety meet FFPSA evidence criteria include:

- Waters, Ford, Wharton, & Cobham. (2009). Cognitive-behavioural therapy for young children with anxiety disorders: Comparison of a Child Parent condition versus a Parent Only condition. *Behaviour Research and Therapy*, 47(8), 654-662.
- Rapee, R., Kennedy, S., Ingram, M., Edwards, S., & Sweeney, L. (2010). Altering the trajectory of anxiety in at-risk young children. *American Journal of Psychiatry*, 167(12), 1518-1525.
- Kennedy, Rapee, & Edwards. (2009). A selective intervention program for inhibited preschool-aged children of parents with an anxiety disorder: effects on current anxiety disorders and temperament. *Journal of the American Academy of Child & Adolescent Psychiatry*, 48(6), 602-609.

[7] Studies that help Dialectical Behavior Therapy (DBT) meet FFPSA evidence criteria include:

- Mccauley, E., Berk, M., Asarnow, J., Adrian, M., Cohen, J., Korslund, K., . . . Linehan, M. (2018). Efficacy of Dialectical Behavior Therapy for adolescents at high risk for suicide: A randomized clinical trial. *JAMA Psychiatry*, 20 June 2018.
- Linehan, M., Comtois, K., Murray, A., Brown, M., Gallop, R., Heard, H., . . . Lindenboim, N. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry*, 63(7), 757-766.
- Neacsiu, Lungu, Harned, Rizvi, & Linehan. (2014). Impact of dialectical behavior therapy versus community treatment by experts on emotional experience, expression, and acceptance in borderline personality disorder. *Behaviour Research and Therapy*, 53(1), 47-54.
- Linehan, M., Armstrong, H., Suarez, A., Allmon, D., & Heard, H. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, 48(12), 1060-1064.
- Additional research on Dialectical Behavior Therapy may be found here: https://behavioraltech.org/research/evidence/#domains

[8] Studies that help Families and Schools Together (FAST) meet FFPSA evidence criteria include:

- Kratochwill, T.R., McDonald, L., Levin, J.R., Young Bear-Tibbetts, H., & Demaray, M.K. (2004). Families and Schools Together: An Experimental analysis of a parent-mediated multi-family group program for american Indian children. *Journal of School Psychology*, 42(5), 359-383.
- McDonald, Lynn, Moberg, D. Paul, Brown, Roger, Rodriguez-Espiricueta, Ismael, Flores, Nydia I., Burke, Melissa P., & Coover, Gail. (2006). After-school multifamily groups: A randomized controlled trial involving low-income, urban, Latino children. *Children & Schools,* 28(1), 25-34.
- Kratochwill, Mcdonald, Levin, Scalia, & Coover. (2009). Families And Schools Together: An experimental study of multi-family support groups for children at risk. *Journal of School Psychology,* 47(4), 245-265.
- Additional research on FAST may be found here: https://www.familiesandschools.org/why-fast-works/ And a cost-benefit analysis from the Washington State Institute for Public Policy may be found here: http://www.wsipp.wa.gov/BenefitCost/ProgramPdf/150/Families-and-Schools-Together-FAST

[9] Studies that help Family-Focused Treatment for Adolescents (FFT-A) meet FFPSA evidence criteria include:

- Miklowitz, D., Schneck, C., George, E., Taylor, D., Sugar, C., Birmaher, B., . . . Axelson, D. (2014). Pharmacotherapy and Family-Focused Treatment for Adolescents With Bipolar I and II Disorders: A 2-Year Randomized Trial. American Journal of Psychiatry, 171(6), 658-667.
- Miklowitz, Axelson, George, Taylor, Schneck, Sullivan, . . . Birmaher. (2009). Expressed Emotion Moderates the Effects of Family-Focused Treatment for Bipolar Adolescents. Journal of the American Academy of Child & Adolescent Psychiatry, 48(6), 643-651.
- Miklowitz, George, Axelson, Kim, Birmaher, Schneck, . . . Brent. (2004). Family-focused treatment for adolescents with bipolar disorder. Journal of Affective Disorders, 82(S), S113-S128.

[10] Studies that help Interpersonal Psychotherapy-Adolescent Skills Training (IPA-AST) meet FFPSA evidence criteria include:

- Young, J., Jones, J., Sbrilli, M., Benas, J., Spiro, C., Haimm, C., . . . Gillham, J. (2018). Long-term effects from a school-based trial comparing Interpersonal Psychotherapy-Adolescent Skills Training to group counseling. *Journal of Clinical Child & Adolescent Psychology,* 1-10.
- Young, Jami F., Mufson, Laura, & Davies, Mark. (2006). Efficacy of Interpersonal Psychotherapy-Adolescent Skills Training: An indicated preventive intervention for depression. *Journal of Child Psychology and Psychiatry,* 47(12), 1254-1262.
- Young, J., Mufson, L., & Gallop, R. (2010). Preventing depression: A randomized trial of interpersonal psychotherapy-adolescent skills training. *Depression and Anxiety*, 27(5), 426-433.
- Mufson, & Fairbanks. (1996). Interpersonal Psychotherapy for Depressed Adolescents: A one-year naturalistic follow-up study. *Journal of the American Academy of Child & Adolescent Psychiatry,* 35(9), 1145-1155.
- Mufson, L., Weissman, M., Moreau, D., & Garfinkel, R. (1999). Efficacy of Interpersonal Psychotherapy for depressed adolescents. *Archives of General Psychiatry*, 56(6), 573-579.

[11] Studies that help Wraparound meet FFPSA evidence criteria include:

1. Carney, M. M., & Butell, F. (2003). Reducing juvenile recidivism: Evaluating the wraparound services model. *Research on Social Work Practice, 13*(5), 551-568. doi:10.1177/1049731503253364

2. Clark, H. B., Lee, B., Prange, M. E., & McDonald, B. A. (1996). Children lost within the foster care system: Can wraparound service strategies improve placement outcomes? *Journal of Child and Family Studies, 5*(1), 39-54. doi:10.1007/BF02234677
3. Grimes, K.E., Schulz, M.F., Cohen, S.A., Mullin, B.O., Lehar, S.E., & Tien, S. (2011) Pursuing cost-effectiveness in mental health service delivery for youth with complex needs. *J Ment Health Policy Econ.*14(2):73-83. PMID: 21881163.
4. Jeong, S., Lee, B. H., & Martin, J. H. (2014). Evaluating the effectiveness of a special needs diversionary program in reducing reoffending among mentally ill youthful offenders. *International Journal of Offender Therapy and Comparative Criminology*, 58(9), 1058–1080. doi:10.1177/0306624x13492403
5. Mears, S. L., Yaffe, J., & Harris, N. J. (2009). Evaluation of Wraparound services for severely emotionally disturbed youths. *Research on Social Work Practice, 19,* 678-685. doi:10.1177/1049731508329385
6. Pullman, M. D., Kerbs, J., Koroloff, N., Veach-White, E., Gaylor, R., & Sieler, D. (2006). Juvenile offenders with mental health needs: Reducing recidivism using Wraparound. *Crime and Delinquency, 52*(3), 375-397. doi:10.1177/0011128705278632
7. Rast, J., Bruns, E. J., Brown, E. C., Peterson, C. R., & Mears, S. L. (2008). *Outcomes of the wraparound process for children involved in the child welfare system: Results of a matched comparison study.* Manuscript submitted for publication.

[12] Studies that help Buprenorphine Maintenance Treatment for Opioid Use Disorder meet the FFPSA evidence criteria include:

- Johnson, R., Jaffe, J., & Fudala, P. (1992). A Controlled Trial of Buprenorphine Treatment for Opioid Dependence. JAMA, 267(20), 2750-2755.
- D'Onofrio, G., Chawarski, M., O'Connor, C., Pantalon, P., Busch, G., Owens, M., . . . Fiellin, H. (2017). Emergency Department-Initiated Buprenorphine for Opioid Dependence with Continuation in Primary Care: Outcomes During and After Intervention. Journal of General Internal Medicine, 32(6), 660-666.
- O'connor, Oliveto, Shi, Triffleman, Carroll, Kosten, . . . Schottenfeld. (1998). A randomized trial of buprenorphine maintenance for heroin dependence in a primary care clinic for substance users versus a methadone clinic. The American Journal of Medicine, 105(2), 100-105.
- Johnson, Eissenberg, Stitzer, Strain, Liebson, & Bigelow. (1995). A placebo controlled clinical trial of buprenorphine as a treatment for opioid dependence. Drug and Alcohol Dependence, 40(1), 17-25.
- Knudsen, Ducharme, & Roman. (2006). Early adoption of buprenorphine in substance abuse treatment centers: Data from the private and public sectors. Journal of Substance Abuse Treatment, 30(4), 363-373.

[13] Studies that help Assertive Continuing Care (ACC) meet FFPSA evidence criteria include:

- Godley, Mark D., Godley, Susan H., Dennis, Michael L., Funk, Rodney R., Passetti, Lora L., Petry, Nancy M., & Nezu, Arthur M. (2014). A Randomized Trial of Assertive Continuing Care and Contingency Management for Adolescents With Substance Use Disorders. Journal of Consulting and Clinical Psychology, 82(1), 40-51.
- Garner, Bryan R., Godley, Mark D., Funk, Rodney R., Dennis, Michael L., Godley, Susan H., & Shaffer, Howard J. (2007). The Impact of Continuing Care Adherence on Environmental Risks, Substance Use, and Substance-Related Problems Following Adolescent Residential Treatment. Psychology of Addictive Behaviors, 21(4), 488-497.
- Godley, Mark D., Godley, Susan H., Dennis, Michael L., Funk, Rodney R., & Passetti, Lora L. (2007). The effect of assertive continuing care on continuing care linkage, adherence and abstinence following residential treatment for adolescents with substance use disorders. Addiction, 102(1), 81-93.

[14] Studies that help Adolescent Community Reinforcement Approach (A-CRA) meet FFPSA evidence criteria include:

- Dennis, Godley, Diamond, Tims, Babor, Donaldson, . . . Funk. (2004). The Cannabis Youth Treatment (CYT) Study: Main findings from two randomized trials. Journal of Substance Abuse Treatment, 27(3), 197-213.
- Hunter, B. D., Godley, S. H., Hesson-McInnis, M. S., & Roozen, H. G. (2014). Longitudinal change mechanisms for substance use and illegal activity for adolescents in treatment. Psychology of Addictive Behaviors, 28(2), 507-515.
- Slesnick, Prestopnik, Meyers, & Glassman. (2007). Treatment outcome for street-living, homeless youth. Addictive Behaviors, 32(6), 1237-1251.

[15] Studies that help Adolescent Coping with Depression (CWD-A) meet FFPSA evidence criteria include:

- Lewinsohn, Clarke, Hops, & Andrews. (1990). Cognitive-behavioral treatment for depressed adolescents. Behavior Therapy, 21(4), 385-401.

- Clarke, Rohde, Lewinsohn, Hops, & Seeley. (1999). Cognitive-Behavioral Treatment of Adolescent Depression: Efficacy of Acute Group Treatment and Booster Sessions. Journal of the American Academy of Child & Adolescent Psychiatry, 38(3), 272-279.
- Clarke, G., Hornbrook, Lynch, Polen, Gale, Beardslee, . . . Seeley. (2001). A Randomized Trial of a Group Cognitive Intervention for Preventing Depression in Adolescent Offspring of Depressed Parents. Archives of General Psychiatry, 58(12), 1127-1134.
- Clarke, Hornbrook, Lynch, Polen, Gale, O'connor, . . . Debar. (2002). Group Cognitive-Behavioral Treatment for Depressed Adolescent Offspring of Depressed Parents in a Health Maintenance Organization. Journal of the American Academy of Child & Adolescent Psychiatry, 41(3), 305-313.

[16] Studies that help Brief Marijuana Dependence Counseling (BMDC) meet FFPSA evidence criteria include:

- Babor, Thomas F. (2004). Brief treatments for cannabis dependence: Findings from a randomized multisite trial. *Journal of Consulting and Clinical Psycholo*gy, 72(3), 455-466.
- Litt, M., Kadden, R., Kabela-Cormier, E., & Petry, N. (2008). Coping skills training and contingency management treatments for marijuana dependence: Exploring mechanisms of behavior change. *Addiction*, 103(4), 638-648.
- The BMDC program manual may be found here: https://www.integration.samhsa.gov/clinical-practice/sbirt/brief_counseling_for_marijuana_dependence.pdf and a cost-benefit analysis conducted by the Washington State Institute for Public Policy may be found here: http://www.wsipp.wa.gov/BenefitCost/ProgramPdf/306/Brief-Marijuana-Dependence-Counseling

[17] Studies that help Ecologically Based Family Therapy (EBFT) meet FFPSA evidence criteria include:

- Slesnick, & Prestopnik. (2005). Ecologically based family therapy outcome with substance abusing runaway adolescents. *Journal of Adolescence,* 28(2), 277-298.
- Slesnick, N., & Prestopnik, J. (2009). Comparison of family therapy outcome with alcohol-abusing, runaway adolescents. *Journal of Marital and Family Therapy*, 35(3), 255-277.

[18] Studies that help Functional Family Therapy (FFT) for adolescents with SUDs meet the FFPSA evidence criteria include:

- Waldron, H. B., Slesnick, N., Brody, J. L., Peterson, T. R., & Turner, C. W. (2001). Treatment outcomes for adolescent substance abuse at 4- and 7-month assessments, *Journal of Consulting and Clinical Psychology, 69*(5), 802-813.
- Slesnick, N., & Prestopnik, J. (2009). Comparison of family therapy outcome with alcohol-abusing, runaway adolescents. *Journal of Marital & Family Therapy, 35*(3), 255-277.
- Slesnick, N., & Prestopnik, J. (2004). Office versus home-based family therapy for runaway, alcohol abusing adolescents: Examination of factors associated with treatment attendance. *Alcoholism Treatment Quarterly, 22*(2), 3-19.
- Alexander J. F., & Parsons, B. V. (1973). Short-term behavioral intervention with delinquent families: Impact on family process and recidivism. *Journal of Abnormal Psychology, 81*(3), 219-225.
- Parsons, B., & Alexander, J. (1973). Short-term family intervention: A therapy outcome study. *Journal of Consulting and Clinical Psychology, 41*(2), 195-201.
- Alexander, J., Barton, C., Schiavo, R., & Parsons, B. (1976). Systems-behavioral intervention with families of delinquents: Therapist characteristics, family behavior, and outcome. *Journal of Consulting and Clinical Psychology, 44*(4), 656-664.
- Klein, N., Alexander, J., & Parsons, B. (1977). Impact of family systems intervention on recidivism and sibling delinquency: A model of primary prevention and program evaluation. *Journal of Consulting and Clinical Psychology, 45*(3), 469-474.
- Friedman, A. (1989). Family therapy vs. parent groups: Effects on adolescent drug abusers. *American Journal of Family Therapy, 17*(4), 335-347.
- Rohde, P., Waldron, H. B., Turner, C. W., Brody, J., & Jorgensen, J. (2014). Sequenced Versus Coordinated Treatment for Adolescents With Comorbid Depressive and Substance Use Disorders. *Journal Of Consulting & Clinical Psychology*, *82*(2), 342-348. doi:10.1037/a0035808

[19] Studies that help Helping Women Recover & Beyond Trauma (HWR/BT) for substance abuse treatment in women meet the FFPSA evidence criteria include:

- Messina, N., Grella, C. E., Cartier, J., & Torres, S. (2010). A randomized experimental study of gender-responsive substance abuse treatment for women in prison. *Journal of Substance Abuse Treatment, 38*(2), 97–107.
- Messina, N., Calhoun, S., & Warda, U. (2012). Gender responsive drug court treatment: A randomized controlled trial. *Criminal Justice and Behavior, 9*(12), 1539-1558.
- Covington, S., Burke, C., Keaton, S., & Norcott, C. (2008). Evaluation of a trauma-informed and gender-responsive intervention for women in drug treatment. *Journal of Psychoactive Drugs, SARC Supplement 5,* 387-398.

- Saxena, P., Messina, N., & Grella, C. E., (2014). Who benefits from gender responsive treatment. Accounting for abuse history on longitudinal outcomes for women in prison. *Criminal Justice and Behavior, 41*(4), 417–432.

[20] Studies that help Interim Methadone Maintenance for Opioid use (IMM) meet the FFPSA evidence criteria include:

- Schwartz, R. P., Highfield, D. A., Jaffe, J. H., Brady, J. V., Butler, C. B., Rouse, C. O., ... & Breteler, M. M. (2006). A randomized controlled trial of interim methadone maintenance. *Archives of General Psychiatry*, *63*(1), 102-109.
- Schwartz, R. P., Kelly, S. M., O'grady, K. E., Gandhi, D., & Jaffe, J. H. (2012). Randomized trial of standard methadone treatment compared to initiating methadone without counseling: 12-month findings. *Addiction*, *107*(5), 943-952.
- Schwartz, R. P., Kelly, S. M., O'Grady, K. E., Gandhi, D., & Jaffe, J. H. (2011). Interim methadone treatment compared to standard methadone treatment: 4-month findings. *Journal of substance abuse treatment*, *41*(1), 21-29.
- Schwartz, R. P., Kelly, S. M., O'grady, K. E., Gandhi, D., & Jaffe, J. H. (2012). Randomized trial of standard methadone treatment compared to initiating methadone without counseling: 12-month findings. *Addiction*, *107*(5), 943-952.
- Gruber, V. A., Delucchi, K. L., Kielstein, A., & Batki, S. L. (2008). A randomized trial of 6-month methadone maintenance with standard or minimal counseling versus 21-day methadone detoxification. *Drug and alcohol dependence*, *94*(1-3), 199-206.
- Schwartz, R. P., Jaffe, J. H., O'Grady, K. E., Kinlock, T. W., Gordon, M. S., Kelly, S. M., ... & Ahmed, A. (2009). Interim methadone treatment: impact on arrests. *Drug and Alcohol Dependence*, *103*(3), 148-154.
- Schwartz, R. P., Kelly, S. M., Mitchell, S. G., Gryczynski, J., O'Grady, K. E., Gandhi, D., & ... Jaffe, J. H. (2017). Patient-centered methadone treatment: a randomized clinical trial. *Addiction*, *112*(3), 454-464. doi:10.1111/add.13622
- Yancovitz, S. K., Des Jarlais, D. C., Peskoe Peyser, N., Drew, E., Friedmann, P., Trigg, H. L., & Robinson, J. W. (1991). A Randomized Trial of an Interim Methadone Maintenance Clinic. *American Journal Of Public Health*, *81*(9), 1185-1191.
- Gryczynski, J., Schwartz, R., O'Grady, K., & Jaffe, J. (2009). Treatment Entry among Individuals on a Waiting List for Methadone Maintenance. *American Journal Of Drug & Alcohol Abuse*, *35*(5), 290-294. doi:10.1080/00952990902968577
- Interim methadone maintenance therapy makes a difference. (2006). *Inpharma Weekly*, (1529), 8.

[21]Studies that help Family Spirit meet the FFPSA evidence criteria include these below:

- Barlow A, Varipatis-Baker E, Speakman K, et al. Home-visiting intervention to improve child care among American Indian adolescent mothers: A randomized trial. *Arch Pediatr Adolesc Med*. 2006; 160(11):1101-1107.
- Barlow, A., Mullany, B., Neault, N., et al. (2015). Paraprofessional Delivered, Home-Visiting Intervention for American Indian Teen Mothers and Children: Three-Year Outcomes from a Randomized Controlled Trial. *American Journal of Psychiatry*, 172(2), 154-162. doi: 10.1176/appi.ajp.2014.14030332.
- Walkup J.T., Barlow, A., Mullany, B.C., et al. (2009). Randomized controlled trial of a paraprofessional-delivered in-home intervention for young reservation-based American Indian mothers. *J Am Acad Child Adolesc Psychiatry,* 48(6), 591-601.

[22] Studies that help Home Instruction for Parents of Preschool Youngsters (HIPPY) meet the FFPSA evidence criteria include:

- Baker, A. J. L., Piotrkowski, C. S., & Brooks-Gunn, J. (1998). The effects of the Home Instruction Program for Preschool Youngsters (HIPPY) on children's school performance at the end of the program and one year later. *Early Childhood Research Quarterly, 13*(4), 571-588.
- Brown, A., & Lee, J. (2014). School performance in elementary, middle, and high school: A comparison of children based on HIPPY participation during the preschool years. *School Community, 24*(2), 83-106.
- Nievar, M. A., Jacobson, A., Chen, Q., Johnson, U., & Dier, S. (2011). Impact of HIPPY on home learning environments of Latino families. *Early Childhood Research Quarterly, 26,* 268-277.
- Barhava-Monteith, G., Harre, N., & Field, J. (1999). A promising start: An evaluation of the HIPPY program in New Zealand. *Early Child Development and Care, 159*, 145-157.
- Bradley, R. H., & Gilkey, B. (2002). The impact of the Home Instructional Program for Preschool Youngsters (HIPPY) on school performance in 3rd and 6th Grades. *Early Education and Development, 13*(3), 301-311.

- Brown, A. L. (2013). The impact of early intervention on the school readiness of children born to teenage mothers. *Journal of Early Childhood Research.* Advance online publication. doi: 10.1177/1476718X13479048

[23]Studies that help SafeCare meet the FFPSA evidence criteria:

- Justice Research Center (July 2009) Parenting with Love and Limits Research Outcome – 2009-2010
- Karam, E. A., Sterrett, E. M., & Kiaer, L. (2015). The integration of family and group therapy as an alternative to juvenile incarceration: A quasi-experimental evaluation using parenting with love and limits. *Family Process*, *56*,
- Sterrett-Hong, E. M., Karam, E., & Kiaer, L. (2017). Statewide implementation of Parenting with Love and Limits (PLL) among youth with co-existing emotional and behavioral problems to reduce return to service rates and treatment costs. *Administration and Policy in Mental Health and Mental Health Services Research*, 44(5):792-809, doi:10.1007/s10488-016-0788-4.

[24] Studies that help Child-Parent Psychotherapy (CPP) meet the FFPSA evidence criteria include:

- Cicchetti, D., Rogosh, F. A., & Toth, S. L. (2006). Fostering secure attachment in infants in maltreating families through preventive interventions. *Development and Psychopathology, 18*, 623-649.
- Cicchetti, D., Toth, S. L., & Rogosch, F. A. (1999). The efficacy of Toddler-Parent psychotherapy to increase attachment security in off-spring of depressed mothers. *Attachment & Human Development, 1*(1), 34-66.
- Lieberman, A. F., Ghosh Ippen, C., & Van Horn, P. (2006). Child-Parent Psychotherapy: 6-month follow-up of a randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*(8), 913-918. doi:10.1097.01.chi.0000222784.03735.92
- Lieberman, A. F., Van Horn, P., & Ghosh Ippen, C. (2005). Toward evidence-based treatment: Child-Parent Psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*(12), 1241-1448.
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[25] Studies that help Functional Family Therapy (FFT) meet the FFPSA evidence criteria for the outcomes listed in the table include those below. Also see https://www.fftllc.com/documents/FFT-CW-Model-Effectiveness.pdf

- Baglivio, M. T., Jackowski, K., Greenwald, M. A. and Howell, J. C. (2014), Serious, Violent, and Chronic Juvenile Offenders. Criminology & Public Policy, 13: 83-116. doi:10.1111/1745-9133.12064
- Barnoski, R. (2004, January). *Outcome Evaluation of Washington State's Research-Based Programs for Juvenile Offenders* (Document No. 04-01-1201). Olympia: Washington State Institute for Public Policy.
- Barton, C., Alexander, J. F., Waldron, H., Turner, C. W., & Warburton, J. (1985). Generalizing treatment effects of Functional Family Therapy: Three replications. American Journal of Family Therapy, 13(3), 16–26.
- Darnell, A.J., & Schuler, M.S. (2015). Quasi-experimental study of Functional Family Therapy effectiveness for juvenile justice aftercare in a racially and ethnically diverse community sample. *Children and Youth Services Review, 50*, 75-82.
- Gordon, D. A., Graves, K., & Arbuthnot, J. (1995). The effect of Functional Family Therapy for delinquents on adult criminal behavior. Criminal Justice and Behavior, 22(1), 60–73.
- Hansson, K., Cederblad, M., & Hook, B. (2000). Functional family therapy: A method for treating juvenile delinquents. Socialvetenskaplig tidskrift, 3, 231-243. [Being translated into English.]
- Hansson, K., Johansson, Drott-Englén, & Benderix (2004). Functional Family Therapy in child psychiatric practice. *Nordisk Psykologi*, 56, 4, 304–320. [Being translated into English.]
- Kerig, P. K., & Alexander, J. F. (2012). Family Matters: Integrating Trauma Treatment into Functional Family Therapy for Traumatized Delinquent Youth. *Journal of Child & Adolescent Trauma*, *5*(3), 205-223. doi:10.1080/19361521.2012.697103
- Rohde, P., Waldron, H., Turner, C., Brody, J., & Jorgensen, J. (2014). Sequenced versus coordinated treatment for adolescents with comorbid depressive and substance use disorders. *Journal Of Consulting And Clinical Psychology,* 82(2):342-8. doi: 10.1037/a0035808
- Sexton, T., & Turner, C. W. (2010). The effectiveness of functional family therapy for youth with behavioral problems in a community practice setting. *Journal Of Family Psychology*, *24*(3), 339-348. doi:10.1037/a0019406

- Stanton, M.D., & Shadish, W.R. (1997). Outcome, attrition, and family-couples treatment for drug abuse: A meta-analysis and review of the controlled, comparative studies. *Psychological Bulletin*.122, 170–191.
- Stout, B.D & Holleran, D. (2013). The impact of evidence-based practices on requests for out-of-home placements in the context of system reform. *Journal of Child and Family Studies*, 22:311–321 DOI 10.1007/s10826-012-9580-6
- Waldron, H. B., Slesnick, N., Brody, J. L., Turner, C. W., & Peterson, T. R. (2001). Treatment outcomes for adolescent substance abuse at 4- and 7- month assessments. *Journal of Consulting and Clinical Psychology*, 69, 802-813.

[26] Studies that help HOMEBUILDERS meet the FFPSA evidence criteria are documented in these two meta-analyses:

- Walton, E. (1998). In-home family focused reunification: A six-year follow-up of a successful experiment. *Social Work Research, 22*(4), 205-214.
- Fraser, M. W., Walton, E., Lewis, R. E., Pecora, P. J., & Walton, W. K. (1996). An experiment in family reunification: Correlates of outcomes at one-year follow-up. *Children and Youth Services Review, 18*(4/5), 335-361.
- Forrester, D., Copello, A., Waissbein, C., & Pokhrel, S. (2008). Evaluation of an intensive family preservation service for families affected by parental substance misuse. *Child Abuse Review*, *17*(6), 410-426.
- Department for Community Based Services. (2008) Kentucky's Family Preservation Program: Comprehensive Program Evaluation. (DCBS).
- Stuva, D., Ringle, J. L., Thompson, R. W., Chmelka, B., Juliano, N., & Bohn, K. (2016). In-Home Family Services: Providing Lasting Results to Crisis Helpline Callers. *American Journal Of Family Therapy*, *44*(5), 245-254. doi:10.1080/01926187.2016.1223566
- Al, C. M. W., Stams, G. J. J. M., Bek, M. S., Damen, E. M., Asscher, J. J., & van der Laan, P. H. (2012). A meta-analysis of intensive family preservation programs: Placement prevention and improvement of family functioning. *Children and Youth Services Review*, *34*(8), 1472–1479. doi:10.1016/j.childyouth.2012.04.002
- Schweitzer, D. D., Pecora, P. J., Nelson, K., Walters, B., & Blythe, B. J. (2015). Building the evidence base for intensive family preservation services. *Journal of Public Child Welfare*, *9*(5), 423–443. doi:10.1080/15548732.2015.1090363

[27] Studies that help Building Confidence meet FFPSA evidence criteria include:

- Justice Research Center (July 2009) Parenting with Love and Limits Research Outcome – 2009-2010
- Karam, E. A., Sterrett, E. M., & Kiaer, L. (2015). The integration of family and group therapy as an alternative to juvenile incarceration: A quasi-experimental evaluation using parenting with love and limits. *Family Process*, *56*,
- Sterrett-Hong, E. M., Karam, E., & Kiaer, L. (2017). Statewide implementation of Parenting with Love and Limits (PLL) among youth with co-existing emotional and behavioral problems to reduce return to service rates and treatment costs . *Administration and Policy in Mental Health and Mental Health Services Research*, 44(5):792-809, doi:10.1007/s10488-016-0788-4.
- Winokur-Early, K, Chapman, S. F., & Hand, G. A. (2013). Family-focused juvenile reentry services: A quasi-experimental design evaluation of recidivism outcomes. *Journal of Juvenile Justice, 2*(2), 1–22.

Interventions with Special Relevance for the Family First Prevention Services Act (FFPSA) (Second Edition)

Executive Summary

Family First Prevention Services Act

The passage of a new federal law, *the Family First Prevention Services Act (P.L. 115-123),* affords opportunities to use research-based interventions to help children safely avoid placement in foster care by meeting key service and treatment needs of children and their parents. Three major categories of services are eligible for reimbursement for up to 12 months under the new law:

1. Mental health services for children and parents
2. Substance abuse prevention and treatment services for children and parents
3. In-home parent skill-based programs:
   - Parenting skills training
   - Parent education
   - Individual and family counseling

The law includes Kinship Navigator programs, but as a separate provision with its own timeline.

FFPSA supports funding for services "directly related to the safety, well-being or permanence of the child or to prevent the child from entering foster care" (p. 170) that can be provided to:

- Infants, children, youth, pregnant and parenting youth, birth parents, kinship caregivers providing temporary or permanent care for children
- Children who are at risk of entering out-of-home care but who can stay safely with parents or kinship caregivers. This also includes children whose adoption or guardianship is at risk of disruption/dissolution.
- Children multiple times if they are identified as a "candidate"/at risk of out of home multiple times.
- Families regardless of their income (in contrast to current requirements).[1]

Evidence Standards

The levels of evidence for interventions (Promising, Supported and Well-supported) are currently being clarified by the Federal government but are similar in many ways to the California Evidence Based Clearinghouse for Child Welfare (CEBC) criteria, with three major exceptions: (1) an RCT study is *not* required; (2) publication in a peer review journal is *not* required (at this time); and (3) a book, program manual or some other form of documentation is required.[2] See Table E1 for a comparison of the current evidence criteria for FFPSA and CEBC.

[1] FFPSA law, pp. 170-173. Retrieved from https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf

[2] For example, the language in the FFPSA uses the CEBC's language but allows for other available writings: "The practice has a book, manual, or other available writings that specify the components of the practice protocol and describe how to administer the practice." The CEBC uses the concept of "other available writings" to include programs that do not have a formal book or manual, but have written training materials available that specify the components of the practice protocol and describe how to administer the practice (Personal Communication, Jennifer A. Rolls Reutz, May 15, 2018). See: https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf

Table E1. A Comparison of the Criteria for FFPSA and CEBC

Family First Prevention Services Act (FFPSA)[a]	California Evidence-Based Clearinghouse (CEBC)[b]
General Requirements: In order for an intervention to be reimbursed by FFPSA it must: (i) have a book, manual or other available writings that specify the components of the practice protocol, and describe how to administer the practice. (ii) there is no empirical basis is suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it. (iii) if multiple outcome studies have been conducted, the overall weight of evidence supports the benefits of the practice (iv) outcome measures are reliable and valid, and are administered consistently and accurately across all those receiving the practice. (v) there are no case data suggesting a risk of harm that was probably caused by the treatment that was severe or frequent. (p. 171) (vi) been published in "government reports and peer-reviewed journal articles that assess effectiveness (i.e., impact) using quantitative methods." (See https://www.federalregister.gov/d/2018-13420, p. 9.) FFPSA also requires that ▪ The practice be provided in an agency context and with a "trauma-informed approach and trauma-specific interventions" (p. 171) ▪ Study must be rated by some kind of "an independent systematic review" (p. 172) ▪ Study must have targeted one of the FFPSA "target outcomes;" conducted in the U.S., U.K., Canada, New Zealand, or Australia; and published/prepared in English during or after 1990. (See https://www.federalregister.gov/d/2018-13420, pp. 9.-10.) ▪ The "meaningful positive significant effect" on the study FFPSA target outcome "…will be defined using conventional standards of statistical significance (i.e., two-tailed hypothesis test and a specified alpha level of p<.05)." (See https://www.federalregister.gov/d/2018-13420, p. 11.)	**General Requirements:** In order for an intervention to be rated by CEBC it must: a. Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects. b. If multiple outcome studies have been conducted, the overall weight of evidence supports the benefit of the practice. c. There are no case data suggesting a risk of harm that: (a) was probably caused by the treatment and (b) the harm was severe or frequent. d. There is no legal or empirical basis suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it. e. The practice has a book, manual, and/or other available writings that specify the components of the practice protocol and describe how to administer it. (See http://www.cebc4cw.org/ratings/)
Well-Supported: A practice shall be considered to be a 'well- supported practice' if: (I) the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least two studies that— (aa) were rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed; (bb) were rigorous random-controlled trials (or, if not available, studies using a rigorous quasi-experimental research design); and (cc) were carried out in a usual care or practice setting; and (II) at least one of the studies described in sub clause (I) established that the practice has a sustained effect (when compared to a control group) for at least 1 year beyond the end of treatment. (pp. 172-173) [I.e. at least one 12 month follow-up study is required.]	**Well-Supported:** • At least 2 rigorous randomized controlled trials (RCTs) in different usual care or practice settings have found the practice to be superior to an appropriate comparison practice. • In at least one of these RCTs, the practice has shown to have a sustained effect of at least one year beyond the end of treatment, when compared to a control group.

Family First Prevention Services Act (FFPSA)[a]	California Evidence-Based Clearinghouse (CEBC)[b]
Supported: (I) the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least one study that— (aa) was rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed; (bb) was a rigorous random-controlled trial (or, if not available, a study using a rigorous quasi-experimental research design); and (cc) was carried out in a usual care or practice setting; and (II) the study described in sub-clause (I) established that the practice has a sustained effect (when com-pared to a control group) for at least 6 months beyond the end of the treatment (p. 172) [I.e. at least one 6 month follow-up study is required.]	Supported: • At least one rigorous RCT in a usual care or practice setting has found the practice to be superior to an appropriate comparison practice. • In that RCT, the practice has shown to have a sustained effect of at least six months beyond the end of treatment, when compared to a control group.
Promising: The practice is superior to a comparison practice "using conventional standards of statistical significance in terms of demonstrated meaningful improvements in validated measure of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being, as established by the results or outcomes of at least one study that: (I) that was rated by an independent systematic review for the quality of the study design and execution, and determined to be well-designed and well-executed; and (II) utilized some form of control (e.g., untreated group, placebo group, wait list study) (III) the evaluation was carried out in a "usual care or practice setting." (p. 172)	Promising:[c] • At least one study utilizing some form of control (e.g., untreated group, placebo group, matched wait list) that has established the practice's benefit over the comparison, or found it to be equal to or better than an appropriate comparison practice.

[a] See the final FFPSA bill at https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf

[b] The CEBC criteria are described here: http://www.cebc4cw.org/files/OverviewOfTheCEBCScientificRatingScale.pdf CEBC uses two rating scales – one for strength of the research evidence supporting a practice or program; and a second rating of the tools used for screening or assessment. See http://www.cebc4cw.org/ratings/

[c] Note that the research support for the CEBC "promising" level varies substantially. For example, some interventions have high quality comparison-group studies that are not randomized or have RCTs with no follow-up, while others barely meet the "control group" requirement (Personal Communication, Jennifer A. Rolls Reutz, May 30, 2018)

Interventions Reviewed and Sources

Based on a review of the literature, the following interventions are highlighted as effective or relevant for potential reimbursement under FFPSA. For each intervention, the following information is provided (when available): intervention summary, consumer age range, problem areas addressed, number of sessions, duration of treatment, cost, cost savings, benefit-cost ratio, and the availability of a manual. Due to the importance of the Title IV-E Waiver program, we also designate which of these interventions were being implemented by a jurisdiction as part of their Waiver, as of 2015,[3] and how each of these interventions was rated according to the established criteria of the California Evidence-Based Clearinghouse for Child Welfare (CEBC), using the three levels of effectiveness for the CEBC classification system as described in the table above:[4]

1. Well-supported by Research Evidence

[3] Pecora, P.J., O'Brien, K. & Maher, E. (2015). *Levels of research evidence and benefit-cost data for Title IV-E waiver interventions: A Casey research brief. (Third Edition)* Seattle: Casey Family Programs. Available at: http://www.casey.org/media/Title-IV_E-Waiver-Interventions-Research-Brief.pdf

[4] See http://www.cebc4cw.org/. For more complete definitions, see http://www.cebc4cw.org/ratings/scientific-rating-scale/.

2. Supported by Research Evidence
3. Promising Research Evidence

As noted in the table above, in order for an intervention to be rated by the CEBC for any level, it must (a) Have a book or manual that describes how to administer it; (b) Meet the requirements for inclusion in one of the CEBC topic areas; (c) Outcomes of the research must be published in a peer review journal; and (d) Outcome measures are reliable/valid and administered consistently and accurately.[5]

Interventions listed on the CEBC were included if: they were rated 1, 2 or 3; there was a response and details provided by the developer; there was a book or manual; and, in the case of substance abuse and mental health treatment, the treatment provided was delivered by a qualified clinician in either individual or group format; and, in the case of *in-home* parenting services, the intervention did not require a group component. Parent training or skill-building interventions, even if they were group-based, were included in the mental health treatment FFPSA program category if they helped improve some aspect of a caregiver's emotional or behavioral health. While most evidence-based interventions last 6-8 months, a number last longer than 12 months. Strictly applying the 12 month time limit in the FFPSA legislation would result in well-researched programs like Nurse Family Partnership and promising programs such as Parents as Teachers being excluded from the catalog. However, while FFPSA may pay for up to 12 months of a longer term intervention, states can likely elect to use Medicaid, state or other funding to continue the service beyond 12 months; hence, we have included interventions that extend beyond 12 months in the catalog. The duration information then indicates if the FFPSA funding would "time out" before that intervention was fully delivered.

Some relevant interventions were not included in the CEBC, but were selected for inclusion here based on ratings from the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP), which uses a four level system (where the quality of research studies is rated on a 4-point scale)[6], the "BLUEPRINTS" intervention registry (which uses a three level system of promising, model and model plus),[7] or the Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs Guide (which uses a three level system of harmful, promising and effective).[8] For some of the interventions included in these sources, the information was not obtained directly from the developer but from published manuals, reports, journal articles or book chapters. With this exception, all the other criteria used to select interventions from the CEBC were applied to these clearinghouses.

Interventions that were not able to be rated due to a lack of evaluation data are listed in a companion document, as some of these interventions warrant further evaluation so that they might qualify. In some cases, the evidence base for the effectiveness of a particular intervention within a child welfare environment is sparse. In this case we rely on the research evidence indicating that the intervention is effective for a particular problem, or area of functioning that children and their caregivers typically have in child welfare, and various meta-analyses that have reported intervention effect sizes.[9] In addition, to help describe the evidence base or other aspects of the interventions with scant material, a wide range of other websites were reviewed. Note that Multisystemic Therapy for Substance Abuse (MST-SA), Structural Family Therapy (SFT) and Trauma Systems Therapy (TST), despite their use by child welfare programs in New York City and

[5] See http://www.cebc4cw.org/files/OverviewOfTheCEBCScientificRatingScale.pdf
[6] Note that the NREPP contractor and review criteria/process may be undergoing change. See https://nrepp.samhsa.gov/landing.aspx
[7] See Center for the Study and Prevention of Violence's http://www.blueprintsprograms.com/
[8] See OJJDP's https://www.ojjdp.gov/mpg/
[9] For examples of meta-analyses reporting intervention effect sizes, see Lee, B. R., Bright, C. L., Svoboda, D. V., Fakunmoju, S., & Barth, R. P. (2011). Outcomes of group care for youth: A review of comparative studies. *Research on Social Work Practice, 21*(2), 177-189. doi:10.1177/1049731510386243 Leenarts, L.E.W., Diehle, J., Doreleijers, T.A.H., Jansma, E.P., & Lindauer, R.J.L., (2012). Evidence-based treatments for children with trauma-related psychopathology as a result of childhood maltreatment: A systematic review. *European Child Adolesc Psychiatry* 22:269-283.

elsewhere, were not included in this catalog as these interventions are not rated by the CEBC or Blueprints; and the NREPP site was taken down at the time this catalog was being revised. We will rate these interventions in a later edition of this catalog.

In addition, in contrast to Family Spirit and some other culturally competent interventions, the in-home and group-based versions of the Positive Indian Parenting Program have not been evaluated sufficiently to be rated by one of the Clearinghouses. Until more evaluation data can be gathered by NICWA, the law allows for a request to be made to the Secretary of HHS to waive those aspects of the law, via guidance, per the provision allowing for cultural and tribal specific needs.

Interventions Summary

On pages xii-xv, we provide a condensed table that lists each of the interventions in the catalog by program category and level of evidence (Table E4). In order for states, counties, and tribal nations to make well-informed intervention-selection decisions, better understanding where and how these interventions have been tested, used, spread, or discontinued across child-serving and family-serving systems is also important. In the months ahead, we will also be adding effect-size data for more interventions because of its value in estimating the expected impact of the intervention outcomes of interest.

In examining that summary table, even without applying the less stringent FFPSA criteria to the interventions, we see that there are sizable numbers of interventions that meet the standards for each level for each program area. There are not, however, as many interventions that are rated by the CEBC or other ranking system at a *Well-supported* level. (See Table E2 below.) This highest evidence level is important because 50 percent of the state intervention funding for FFPSA-eligible interventions must be spent on *Well-supported* interventions, but using criteria that is slightly less stringent than CEBC, as discussed earlier.

Table E2. Summary Table of Interventions Classified as Well-Supported in Terms of Evidence Level
(N=40)

FFPSA Intervention Areas	Number of Interventions Ranked as Well-supported According to the CEBC or Other Ranking System
▪ Mental health services for children and parents	29
▪ Substance abuse prevention and treatment services for children and parents	4

▪ In-home parent skill-based programs:
  ▪ Parenting skills training and Parent education[a]
  ▪ Individual and family counseling
	
	5
	2

[a] A clear definition of each program type and how they differ from each other has not yet been issued by the Federal Government in relation to FFPSA. Therefore, we grouped interventions that might qualify for one or both these program types together.

Table E2 needs to be viewed with caution as Casey Family Programs, the CEBC staff, Abt Associates (the organization that ACYF has contracted with to act as the FFPSA Clearinghouse), and others are just now beginning to review the research literature for interventions to see how they would be rated if the current FFPSA research evidence criteria remain unchanged. Many experts are reluctant to devote a large amount of staff time or other resources to that effort since we need to know what kinds of research reports or data summaries can be used to determine what rating the intervention should receive. FFPSA does *not* require a Randomized Control Trial (RCT) or publication in a peer-review journal, which should result in a larger number of interventions qualifying for the upper evidence

levels than what we show in this catalog. For example, in a special review described next, 26 interventions which are currently classified at a lower level using the CEBC, NREPP, or BLUEPRINTS rating criteria should be determined to be at the *Well-supported* level using FFPSA criteria (see Table E3.) ***Combining Tables E2 and E3, a total of 67 interventions relevant to child welfare should be classified as Well-Supported.***

Interventions that Should be Rated as Well-Supported Under the Most Recent FFPSA Standards

The levels of evidence that will be used to rate interventions for reimbursement under Family First as Promising, Supported and Well-supported are currently being clarified by the Federal government, and new parameters were recently released for comment by ACYF. All the FFPSA evidence criteria released thus far are similar in many ways to the California Evidence Based Clearinghouse for Child Welfare (CEBC) criteria, with six major exceptions:

1. A RCT study is *not* required
2. Publication in a peer review journal is *not* necessary
3. Study must have targeted one of the FFPSA "target outcomes;" conducted in the U.S., U.K., Canada, New Zealand, or Australia;
4. The study report must have been published in English
5. The study conducted or summarized during or after 1990. (See https://www.federalregister.gov/d/2018-13420, pp. 9.-10.)
6. The "meaningful positive significant effect" on the study FFPSA target outcome "…will be defined using conventional standards of statistical significance (i.e., two-tailed hypothesis test and a specified alpha level of p<.05)." (See https://www.federalregister.gov/d/2018-13420, p. 11.)

Review Process

The Casey Family Programs review team from Research Services examined all 45 "Supported" interventions in the first edition of the Catalog in relation to all the specific rating criteria published to date about the FFPSA interventions. We also paid special attention to the following:

- Study sample size.
- The drop-out/attrition rates as the study proceeded, including the response rate for the follow-up studies. The study might be disqualified if these drop-out/attrition rates are too high – especially if there was differential attrition across the treatment and comparison groups.
- Use of valid assessment measures.

If the information gathered showed that the intervention had evidence that would qualify it for the *Well-Supported level,* that was recorded, along with a brief summary of why – along with the articles supporting that evidence level. We also confirmed that there were at least two qualifying studies for every outcome highlighted for that intervention (as distinct from a situation where each study found a different outcome).

If the initial set of evidence was insufficient to qualify for *Well-Supported*, we contacted the intervention developer for additional studies and technical reports that might help their intervention qualify for the highest level possible. The 27 interventions with evidence that should qualify them for the *Well-Supported* level under FFPSA are listed in Table E.2, along with their target outcomes. The studies that provided the most direct evidence are footnoted for each intervention.

Conclusions

In sum, although further direction from the Children's Bureau is forthcoming, the information in this document provides a conservative approach regarding interventions that may be covered under FFPSA. In other words, if an intervention is designated as promising, supported, or well-supported in this document, it is

likely to have the same or higher evidence standard under FFPSA. Until further direction is provided, this catalog offers a rough estimate as to what interventions are likely to be covered under FFPSA.

Table E3. Relevant Interventions Rated as Supported Using CEBC Criteria that Could Be Classified as Well-Supported Under FFPSA Rating Criteria
(N = 27)[10]

Mental Health Services for Children and Parents
1. Blues Program[1] (Depressive symptoms, lower risk for onset of major depression - i.e. risk of future depressive episodes)
2. Building Confidence[2] (Child and adolescent anxiety)
3. Chicago Parent Program[3] (Parent self-efficacy, corporal punishment, consistent discipline, positive parenting, and child behavior problems)
4. Cognitive Behavioral Therapy (CBT) for Child & Adolescent Depression[4] (Child and adolescent depression)
5. Cognitive Behavioral Therapy (CBT) - Group Therapy for Children with Anxiety[5] (Child anxiety)
6. Cognitive Behavioral Therapy (CBT) - Parent Counseling for Young Children with Anxiety[6] (Child anxiety)
7. Dialectical Behavior Therapy (DBT)[7] (Reducing self-harm; suicide attempts in highly suicidal self-harming adolescents; non-suicidal self-injury; depression; and improved general functioning among people with borderline personality disorder)
8. Families and Schools Together (FAST)[8] (Youth aggressive/externalizing behavior, academic performance)
9. Family-Focused Treatment for Adolescents (FFT-A)[9] (Manic symptoms in youth with bipolar disorder)
10. Interpersonal Psychotherapy-Adolescent Skills Training (IPT-AST)[10] (Child and adolescent depression, overall functioning)
11. Wraparound[11] (Reduced recidivism in terms of juvenile justice offenses, improved overall youth functioning, placement in least restrictive settings, including achieving legal permanency)
Substance Abuse Prevention and Treatment Services for Children and Parents
12. Buprenorphine Maintenance Treatment for Opioid Use Disorder[12] (Opioid use)

[10]*Source*: Compiled by Olivia Thai, Danielle Roy, Jessica Elm and Peter J. Pecora, Research Services, Casey Family Programs. Note that the table lists target outcomes where 2 or more separate studies found positive effects for that outcome, with at least one study finding positive results at a 12 month or longer follow-up.

13. Assertive Continuing Care (ACC)[13] (Substance abuse)
14. Adolescent Community Reinforcement Approach (A-CRA)[14] (Substance abuse)
15. Adolescent Coping with Depression (CWD-A)[15] (Depression)
16. Brief Marijuana Dependence Counseling (BMDC)[16] (Marijuana use)
17. Ecologically Based Family Therapy (EBFT)[17] (Substance abuse)
18. Functional Family Therapy (FFT) for adolescents with SUDs[18] (Substance abuse)
19. Helping Women Recover & Beyond Trauma (HWR/BT)[19] (Substance abuse among women)
20. Interim Methadone Maintenance (IM) for opioid use[20] (Opioid use)
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education
21. Family Spirit (for American Indian/Alaskan Native parents)[21] (Mothers' knowledge of and involvement in child care, maternal parenting skills)
22. Home Instruction for Parents of Preschool Youngsters (HIPPY)[22] (Child school performance)
23. SafeCare[23] (Re-referral to CPS for child neglect or physical abuse)
In-Home Parent Skill-Based Programs: Individual and Family Counseling
24. Child-Parent Psychotherapy[24] (Secure and disorganized attachment)
25. Functional Family Therapy (FFT)[25] (Family functioning, youth emotional and behavior improvement, child out-of-home placement prevention, and delinquent behavior recidivism/arrests)
26. Homebuilders[26] (Family functioning improvement to prevent child out-of-home placement)
27. Parenting with Love and Limits[27] (Child emotional and behavior health problems)

In Table E.4 the interventions in the catalog are listed by their FFPSA program area and evidence level.

Table E.4: Interventions Summary by Program Areas Listed in P.L. 115-123

Mental Health Services for Children and Parents (Total: 80)		
Well-supported (sub-total: 29):	*Supported (sub-total: 22):*	*Promising (sub-total: 29):*
▪ Acceptance and Commitment Therapy (ACT) for Adults ▪ Acceptance and Commitment Therapy (ACT) for adults with anxiety ▪ Acceptance and Commitment Therapy (ACT) for adults with schizophrenia and psychosis ▪ Acceptance and Commitment Therapy (ACT) for children with anxiety ▪ Acceptance and Commitment Therapy (ACT) for children with depression ▪ Aggression Replacement Training® (ART) ▪ Attachment and Biobehavioral Catch Up (ABC) ▪ Child and Family Traumatic Stress Intervention (CFTSI) ▪ Cognitive Behavioral Therapy (CBT) ▪ Cognitive Behavioral Therapy (CBT) for Adult Anxiety ▪ Cognitive Behavioral Therapy (CBT) for Adult Depression ▪ Cognitive Behavioral Therapy (CBT) for Adult Posttraumatic Stress Disorder (PTSD) ▪ Cognitive Behavioral Therapy (CBT) for Adult Schizophrenia and Psychosis ▪ Cognitive Behavioral Therapy (CBT) for Children with Anxiety ▪ Cognitive Behavioral Therapy (CBT) for Children with Trauma ▪ Cognitive Behavioral Therapy (CBT) – Individual Therapy for Children with Anxiety	▪ Accelerated Resolution Therapy ▪ Blues Program ▪ Building Confidence ▪ Chicago Parent Program (CPP) ▪ Childhaven Childhood Trauma Treatment ▪ Cognitive Behavioral Therapy (CBT) for Child and Adolescent Depression ▪ Cognitive Behavioral Therapy (CBT) – Group Therapy for Children with Anxiety ▪ Cognitive Behavioral Therapy (CBT) – Parent counseling for young children with anxiety ▪ Collaborative & Proactive Solutions ▪ Common Sense Parenting (CSP) ▪ Community Reinforcement + Vouchers Approach (CRA + Vouchers) ▪ Dialectical Behavior Therapy (DBT) ▪ Dialectical Behavior Therapy (DBT) for Adolescent Self-Harming Behavior ▪ Families and Schools Together (FAST) ▪ Family-Focused Treatment for Adolescents (FFT-A) ▪ Interpersonal Psychotherapy-Adolescent Skills Training (IPT-AST) ▪ Multi-Family Psychoeducational Psychotherapy (MF-PEP) ▪ New Beginnings (for children of divorce) ▪ Positive Peer Culture (PPC) ▪ Primary and Secondary Control Enhancement Training (PASCET)	▪ 1-2-3 Magic ▪ ACTION (youth group treatment for depression) ▪ Adolescent Coping with Depression (CWD-A) ▪ Behavioral Activation Treatment for Depression (BATD) ▪ Brief Eclectic Psychotherapy for PTSD (BEPP) ▪ C.A.T. Project ▪ Child-Centered Play Therapy (CCPT) ▪ *CICC's Effective Black Parenting Program (EBPP)* ▪ Cognitive Behavioral Analysis System of Psychotherapy (CBASP) ▪ Cognitive-Behavioral Coping-Skills Training ▪ Cognitive Processing Therapy (CPT) ▪ Combined Parent-Child Cognitive-Behavioral Therapy (CPC-CBT) ▪ Cool Kids ▪ Defiant Children: A Clinician's Manual for Assessment and Parent Training (The Barkley Method of Behavioral Parent Training) ▪ Exchange Parent Aide ▪ Fairy Tale Model (Treating Problem Behaviors: A Trauma-Informed Approach) ▪ Family Connections ▪ Helping the Noncompliant Child ▪ Interpersonal Psychotherapy for Depressed Adolescents (IPT-A) ▪ Life Space Crisis Intervention (LSCI) ▪ Mindfulness-Based Cognitive Therapy for Children (MBCT-C)

Mental Health Services for Children and Parents (Total: 80)		
Well-supported (sub-total: 29):	*Supported (sub-total: 22):*	*Promising (sub-total: 29):*
▪ Cognitive Therapy (CT) ▪ Coping Cat ▪ Coping Power Program ▪ Eye movement desensitization and reprocessing (EMDR) for Adult PTSD ▪ Eye movement desensitization and reprocessing (EMDR) for Children ▪ GenerationPMTO (Group Delivery Format) ▪ Mindfulness-Based Cognitive Therapy (MBCT) for Adults ▪ Multidimensional Family Therapy (MDFT) ▪ Parent Child Interaction Therapy (PCIT) ▪ Problem Solving Skills Training for Children ▪ Prolonged Exposure Therapy for Adolescents (PE-A) ▪ Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) ▪ Triple P – Positive Parenting Program – Level 4 Individual for Child Disruptive Behavior	▪ Problematic Sexual Behavior- (PSB-CBT-S)- for School Age Children ▪ Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) for Sexual Behavior Problems in Children	▪ Nurturing Parenting Program for Parents and their School-age Children 5 to 12 Years ▪ Parents Anonymous ▪ Play and Learning Strategies–Infant Program ▪ Solution-Based Casework (SBC) ▪ Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) ▪ Structured Sensory Intervention for Traumatized Children, Adolescents and Parents (SITCAP-ART) ▪ Trauma and Grief Component Therapy for Adolescents (TGCT-A) ▪ Wraparound

Substance Abuse Prevention and Treatment for Children and Parents (Total: 26)		
Well-supported (sub-total: 4): ▪ Communities that Care for Substance Abuse Prevention ▪ Motivational Interviewing ▪ Multidimensional Family Therapy (MDFT) ▪ PROSPER	*Supported (sub-total: 15):* ▪ Adaptive Stepped Care ▪ Adolescent Community Reinforcement ▪ Approach/Assertive Continuing Care (A-CRA/ACC) ▪ Adolescent Coping with Depression (CWD-A) ▪ Adolescent-focused Family Behavior Therapy ▪ Adult-focused Family Behavior Therapy ▪ Brief Marijuana Dependence Counseling (BMDC) ▪ Brief Strategic Family Therapy ▪ Buprenorphine (or buprenorphine/naloxone) maintenance treatment for opioid use disorder ▪ Ecologically Based Family Therapy ▪ Families Facing the Future ▪ Functional Family Therapy (FFT) for adolescents with substance use disorder ▪ Helping Women Recover & Beyond Trauma (HWR/BT) [Substance Abuse Treatment (Adult)] ▪ Injectable naltrexone for opiates ▪ Intermittent methadone maintenance	*Promising (sub-total: 7):* ▪ Alcohol Behavioral Couple Therapy ▪ C.A.R.E.S. (Coordination, Advocacy, Resources, Education and Support) ▪ Cognitive-Behavioral Coping-Skills Therapy for alcohol or drug use disorders ▪ Matrix Model Intensive Outpatient program ▪ Seeking Safety ▪ Sobriety Treatment and Recovery Teams (START) ▪ 12-Step Facilitation Therapy for Substance Abuse (TSF)
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education (Total: 17)		
Well-supported (sub-total: 5): ▪ Family Connects ▪ Healthy Families America (HFA) ▪ Minding the Baby® (MTB) ▪ Nurse Family Partnership (NFP) ▪ The Incredible Years	*Supported (sub-total: 5):* ▪ AVANCE Parent-Child Education Program ▪ Home Instruction for Parents of Preschool Youngsters (HIPPY) ▪ SafeCare ▪ Tuning In To Kids (TIK) ▪ Tuning In To Teens (TINT)	*Promising (sub-total: 7):* ▪ All Babies Cry (ABC) ▪ Circle of Security-Home Visiting-4 (COS-HV4) ▪ Collaborative Problem Solving (CPS) ▪ Early Head Start-Home Visiting (EHS-HV) ▪ GenerationPMTO (individual delivery format) ▪ Infant Health and Development Program (IHDP) ▪ Parents as Teachers (PAT)

In-Home Parent Skill-Based Programs: Individual and Family Counseling (Total: 23)		
Well-supported (sub-total: 2): ▪ Attachment-Based Family Therapy (ABFT) ▪ The Family Check-up (FCU)	*Supported (sub-total: 7):* ▪ Child-Parent Psychotherapy (CPP) ▪ Child Parent Relationship Therapy (CPRT) ▪ Functional Family Therapy (FFT) ▪ Intensive Family Preservation Services (HOMEBUILDERS®) ▪ Multisystemic Therapy (MST) ▪ Parenting with Love and Limits (PLL) ▪ Strengthening Families for Parents and Youth 10–14	*Promising (sub-total: 14):* ▪ Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT) ▪ Child FIRST (Child and Family Interagency, Resource, Support, and Training) ▪ Cue-Centered Treatment (CCT) ▪ Domestic Abuse Intervention Project - The Duluth Model (DAIP) ▪ Early Pathways Program (EPP) ▪ Families First ▪ Family Centered Treatment ▪ Multisystemic Therapy Building Stronger Families (MST-BSF) ▪ Parent Child Assistance Program (PCAP) ▪ Promoting First Relationships (PFR) ▪ Risk Reduction through Family Therapy (RRFT) ▪ Step-by-Step Parenting Program© ▪ Trauma Affect Regulation: Guide for Education and Therapy for Adolescents (TARGET-A) ▪ Wraparound (in-home parent support focus)

Interventions with Special Relevance for the Family First Prevention Services Act (FFPSA)[11]

Introduction

Family First Prevention Services Act

The passage of a new federal law, *the Family First Prevention Services Act (P.L. 115-123),* affords opportunities to use research-based interventions to help children safely avoid placement in foster care by meeting key service and treatment needs of children and their parents. Three major categories of services are eligible for reimbursement for up to 12 months under the new law:

- Mental health services for children and parents
- Substance abuse prevention and treatment services for children and parent
- In-home parent skill-based programs:
  - Parenting skills training
  - Parent education
  - Individual and family counseling

FFPSA provides federal funds for up to 12 months of services to prevent children from entering or re-entering foster care. Many aspects of the new law are being clarified but described below are some of the reasons why children and their families would be covered:

- Infants, children, youth, pregnant and parenting youth, other birth parents, kinship caregivers providing temporary or permanent care for children
- Services "directly related to the safety, well-being or permanence of the child or to prevent the child from entering foster care" (p. 170)
- Children who are at risk of entering out-of-home care but who can stay safely with parents or kinship caregivers. This also includes children whose adoption or guardianship is at risk of disruption/dissolution.
- Can receive services more than once if child is again identified as a "candidate"/at risk of out of home care but for the services.
- Not dependent upon family income like federal foster care is.[12]

The levels of evidence for interventions (Promising, Supported and Well-supported) are being clarified by the Federal government but are similar in many ways to the California Evidence Based Clearinghouse for Child Welfare (CEBC) criteria, with three major exceptions: (1) an RCT study is *not* required, (2) publication in a peer review journal is *not* necessary (at least at this time); and (3) a program manual *is* required.[13] To receive federal funding for these areas, FFPSA will require 50 percent of interventions to be evidence-based. To facilitate this a ranking system a clearinghouse will be established. An important requirement for the interventions relates to having evidence of their ability to achieve certain kinds of child welfare outcomes:

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[11] Compiled by the Casey Family Programs Research Services and Knowledge Management teams as part of a project to help public child welfare agencies and their community partners' better match child and family needs with effective services. For more information, please contact Research Services at ResearchTeam@casey.org or Knowledge Management at KMresources@casey.org. This interventions catalog builds on material compiled from English, D., Pecora, P.J., Goodman, D., Wackerman, J. & Rebbe, R. (2018). *Interventions with special relevance for child welfare, with age range, treatment duration, effect sizes and cost data*. Seattle, WA: Casey Family Programs. We thank the staff of the California Evidence Based Clearinghouse for Child Welfare and the Washington State Institute for Public Policy for their excellent and timely work in reviewing numerous interventions.

[12] FFPSA law, pp. 170-173. Retrieved from https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf

[13] See: https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf

> HHS must, directly or through grants, contracts or interagency agreements, evaluate research on the promising, supported, or Well-supported practices and programs, including culturally specific, or location- or population-based adaptations, to identify and establish a public clearinghouse of the promising, supported, or Well-supported practices. The clearinghouse must include specific information on whether the promising, supported, or Well-supported practice has been shown to prevent child abuse and neglect or reduce the likelihood of foster care placement by supporting birth families and kinship families and improving targeted supports for pregnant and parenting youth and their children.[14]

Interventions Reviewed and Sources

Based on a review of the literature and selected conversations with experts from the U.S. and overseas, the following interventions are highlighted as effective or relevant for potential reimbursement under FFPSA. For each intervention, the following information is provided: summary of the intervention, client age range, problem areas addressed, number of sessions, the length of treatment, effect sizes, cost, cost savings, benefit cost ratio, and availability of a manual. Because of the importance of the Title IV-E Waiver program, we also designate which of these interventions were being implemented by a jurisdiction as part of their Waiver, as of 2015,[15] and how each of these interventions was rated according to the established criteria of the California Evidence-Based Clearinghouse for Child Welfare (CEBC), using the three highest levels of effectiveness for the CEBC classification system:[16]

1. *Well-supported by Research Evidence:* At least 2 rigorous randomized controlled trials (RCTs) in different usual care or practice settings have found the practice to be superior to an appropriate comparison practice. In at least one of these RCTs, the practice has shown to have a sustained effect of at least one year beyond the end of treatment, when compared to a control group.
2. *Supported by Research Evidence*: At least one RCT in usual care or a practice setting that has found the practice to be superior to an appropriate comparison practice. In that RCT, the practice has shown to have a sustained effect of at least six months beyond the end of treatment, when compared to a control group.
3. *Promising Research Evidence:* At least one study utilizing some form of comparison (e.g., untreated group, placebo group, matched wait list) [that has] established the practice's benefit over the control, or found it to be comparable to a practice rated 3 or higher on the CEBC, or superior to an appropriate comparison practice.

Note that In order for an intervention to be rated by the CEBC for any level, it must (a) Have a book or manual that describes how to administer it; (b) Meet the requirements for inclusion in one of the CEBC topic areas; (c) Outcomes of the research must be published in a peer review journal; and (d) Outcome measures are reliable/valid and administered consistently and accurately.[17]

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[14] U.S. DHHS. (April 12, 2018*). INFORMATION MEMORANDUM: NEW LEGISLATION – Public Law 115-123, the Family First Prevention Services Act within Division E, Title VII of the Bipartisan Budget Act of 2018.* Log No: ACYF-CB-IM-18-02. Attachment B: Time-Limited Foster Care Prevention Program and Services. Washington, D.C.: Author, p. 6.

[15] Pecora, P.J., O'Brien, K. & Maher, E. (2015). *Levels of research evidence and benefit-cost data for Title IV-E waiver interventions: A Casey research brief. (Third Edition)* Seattle: Casey Family Programs. Available at: http://www.casey.org/media/Title-IV_E-Waiver-Interventions-Research-Brief.pdf http://www.casey.org/media/Title-IV_E-Waiver-Interventions-Research-Brief.pdf http://www.casey.org/media/Title-IV_E-Waiver-Interventions-Research-Brief.pdf http://www.casey.org/media/Title-IV_E-Waiver-Interventions-Research-Brief.pdf

[16] See http://www.cebc4cw.org/. And for more complete definitions, see http://www.cebc4cw.org/ratings/scientific-rating-scale/.

[17] See http://www.cebc4cw.org/files/OverviewOfTheCEBCScientificRatingScale.pdf

Interventions listed on the CEBC were included if: they were rated 1, 2 or 3; there was a response and details provided by the developer; there was a book or manual; and, in the case of substance abuse and mental health treatment, the treatment provided was delivered by a qualified clinician in either individual or group format; and, in the case of in-home parenting services, the intervention did not require a group component. Parent training or skill-building interventions, even if they were group-based, were included in the mental health treatment FFPSA program category if they helped improve some aspect of a caregiver's emotional or behavioral health. Strictly applying the 12 month time limit in the FFPSA legislation would result in well-researched programs like Nurse Family Partnership and promising programs such as Parents as Teachers being excluded from the catalog. Because we believe that FFPSA will pay for up to 12 months of a longer term intervention and states can then elect to use Medicaid, state or other funding to continue the service, we have included interventions that often do extend beyond 12 months in the catalog. The duration information then indicates if the FFPSA funding would "time out" before that intervention was fully delivered.

When not rated by the CEBC, for some interventions we based our selection on ratings from the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP), which uses a four level system (where the quality of research studies is rated on a 4-point scale,[18] the "BLUEPRINTS" intervention registry (which uses a three level system of promising, model and model plus),[19] or the Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs Guide (which uses a three level system of harmful, promising and effective).[20] The NREPP site lists over 560 programs, so we prioritized including the 215 *"effective"* programs in the "newly reviewed group" (reviewed since 2015 with new criteria), rather than the programs in the legacy group. All of the interventions rated as *Promising* or above on the Blueprints site were included if they fit one of the FFPSA program categories. For the Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs Guide we focused on FFPSA-relevant interventions among those rated as *Effective*.

In addition, where multiple studies of the intervention have been reviewed as part of either the Cochrane or Campbell reviews to examine their overall effectiveness (e.g., effect sizes), the summary results for those reviews are reported.[21] For some interventions in these sources, the information was not obtained directly from the developer but from published manuals, reports and journal articles or book chapters. With this exception, all the other criteria used to selected interventions from the CEBC were applied with these clearinghouses. Interventions that were not able to be rated due to a lack of evaluation data are listed in a companion document as some of these deserve further evaluation so they might qualify.

In some cases, the evidence base for the effectiveness of a particular intervention within a child welfare environment is sparse. In this case we rely on the research evidence indicating that the intervention is effective for a particular problem, or area of functioning that children and their caregivers typically have in child welfare, and various meta-analyses that have reported intervention effect sizes.[22] For example, many youth in out-of-home care suffer from depression[23]

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[18] Note that the NREPP contractor and review criteria/process may be undergoing change. See https://nrepp.samhsa.gov/landing.aspx

[19] See Center for the Study and Prevention of Violence's http://www.blueprintsprograms.com/

[20] See OJJDP's https://www.ojjdp.gov/mpg/

[21] See https://www.campbellcollaboration.org/ and http://www.DBT library.com/

[22] For examples of meta-analyses reporting intervention effect sizes, see Lee, B. R., Bright, C. L., Svoboda, D. V., Fakunmoju, S., & Barth, R. P. (2011). Outcomes of group care for youth: A review of comparative studies. *Research on Social Work Practice, 21*(2), 177-189. doi:10.1177/1049731510386243 Leenarts, L.E.W., Diehle, J., Doreleijers, T.A.H., Jansma, E.P., & Lindauer, R.J.L., (2012). Evidence-based treatments for children with trauma-related psychopathology as a result of childhood maltreatment: a systematic review. *European Child Adolesc Psychiatry* 22:269-283.

[23] Griffin, G., McClelland, G., Holzberg, M., Stolbach, B., Maj, N. & Kisiel, C. (2011). Addressing the impact of trauma before diagnosing mental illness in child welfare. *Child Welfare,* 90, 69-89. Turney, K. & Wildeman, C. (2016). Mental and physical health of children in foster care. *Pediatrics*, 138(5), 1-11. e20161118

and yet relatively few intervention trials have focused on these youth. In addition, based on a 2016 Cochrane review of studies from around the world, the effects of Cognitive Behavioral Treatment (CBT), Interpersonal Therapy and Third Wave CBT were positive but more consistent results are needed:

> Overall the results show small positive benefits of depression prevention, for both the primary outcomes of self-rated depressive symptoms post-intervention and depression diagnosis up to 12 months (but not beyond). Estimates of numbers needed to treat to benefit (NNTB = 11) compare well with other public health interventions. However, the evidence was of moderate to low quality using the GRADE framework and the results were heterogeneous.[24]

Similarly, many youth in care also suffer from post-traumatic stress disorder (PTSD), and the evaluation research for common interventions for PTSD such as CBT, exposure-based, psychodynamic, narrative, supportive counselling, and Eye Movement Desensitization and Reprocessing (EMDR) needs to be bolstered, according to a 2012 Cochrane review of US and other literature:

> The psychological therapy for which there was the best evidence of effectiveness was CBT. Improvement was significantly better for up to a year following treatment…There is evidence for the effectiveness of psychological therapies, particularly CBT, for treating PTSD in children and adolescents for up to a month following treatment. [Overall] at this stage, there is no clear evidence for the effectiveness of one psychological therapy compared to others. There is also not enough evidence to conclude that children and adolescents with particular types of trauma are more or less likely to respond to psychological therapies than others. The findings of this review are limited by the potential for methodological biases, and the small number and generally small size of identified studies. In addition, there was evidence of substantial heterogeneity in some analyses which could not be explained by subgroup or sensitivity analyses.[25]

Similarly, many *caregivers* of youth in care also suffer from PTSD, and the evaluation research for common interventions for PTSD such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Eye Movement Desensitization and Reprocessing (EMDR) for adults needs to be bolstered, according to a 2013 Cochrane review of US and other literature:

> The evidence for each of the comparisons made in this review was assessed as very low quality. This evidence showed that individual TFCBT and EMDR did better than waitlist/usual care in reducing clinician-assessed PTSD symptoms. There was evidence that individual TFCBT, EMDR and non-TFCBT are equally effective immediately post-treatment in the treatment of PTSD. There was some evidence that TFCBT and EMDR are superior to non-TFCBT between one to four months following treatment, and also that individual TFCBT, EMDR and non-TFCBT are more effective than other therapies. There was evidence of greater drop-out in active treatment groups. Although a substantial number of studies were included in the review, the conclusions are compromised by methodological issues evident in some. Sample sizes were small, and it is apparent that many of the studies were underpowered. There were limited follow-up data, which compromises conclusions regarding the long-term effects of psychological treatment.[26]

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[24] http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD003380.pub4/epdf/standard, p. 4.

[25] Gillies D, Taylor F, Gray C, O'Brien L, D'Abrew N. (2012). *Psychological therapies for the treatment of post-traumatic stress disorder in children and adolescents. Cochrane Database of Systematic Reviews 2012, Issue 12. Art. No.: CD006726. DOI: 10.1002/14651858.CD006726.pub2.* Retrieved from http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD006726.pub2/full, p. 1.

[26] Cochrane Database of Systematic Reviews Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults (Review) Bisson JI, Roberts NP, Andrew M, Cooper R, Lewis C Bisson JI, Roberts NP, Andrew M, Cooper R, & Lewis C. (2013). *Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults*. Cochrane Database of Systematic Reviews 2013, Issue 12. Art. No.: CD003388. DOI: 10.1002/14651858.CD003388.pub4. Retrieved from http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD003388.pub4/epdf/standard, p. 2.

Child welfare agencies have been criticized for over-prescribing group-based parenting programs or using programs with insufficient research evidence,[27] but for parents who truly need them, some high quality programs have significant positive effects according to a 2012 Campbell collaborative review:

> We included 48 studies that involved 4937 participants and covered three types of programmes: behavioural, cognitive-behavioural and multimodal. Overall, we found that group-based parenting programmes led to statistically significant short-term improvements in depression (standardised mean difference (SMD) -0.17, 95% confidence interval (CI) -0.28 to -0.07), anxiety (SMD -0.22, 95% CI -0.43 to -0.01), stress (SMD -0.29, 95% CI -0.42 to -0.15), anger (SMD -0.60, 95% CI -1.00 to -0.20), guilt (SMD -0.79, 95% CI -1.18 to -0.41), confidence (SMD -0.34, 95% CI -0.51 to -0.17) and satisfaction with the partner relationship (SMD -0.28, 95% CI -0.47 to -0.09). However, only stress and confidence continued to be statistically significant at six month follow-up, and none were significant at one year. There was no evidence of any effect on self-esteem (SMD -0.01, 95% CI -0.45 to 0.42). None of the trials reported on aggression or adverse effects. The limited data that explicitly focused on outcomes for fathers showed a statistically significant short-term improvement in paternal stress (SMD -0.43, 95% CI -0.79 to -0.06). We were unable to combine data for other outcomes and individual study results were inconclusive in terms of any effect on depressive symptoms, confidence or partner satisfaction.[28] [Bold formatting added.]

Some interventions were exclusively school-based and even though they were geared to prevent youth substance abuse or acting-out behavior, we did not include them until further federal guidance is issued [e.g., Adlerian Play Therapy, American Indian Life Skills (AILS), Cognitive Behavioral Intervention for Trauma in Schools (CBITS), Positive Action Project Towards No Drug Abuse, Promoting Alternative Thinking Strategies (PATHS)].

Listed below are the clearinghouses and intervention-focused websites we reviewed:

• Child Welfare: California Evidence Based Clearinghouse for Child Welfare • Children & Families: Promising Practices Network • Education: What Works Clearinghouse • Evidence-based Policy: Coalition for Evidence-Based Policy • Delinquency: OJJDP Model Programs Guide • Home Visiting: HomVEE - Home Visiting Evidence of Effectiveness	• Mental Health & Substance Abuse: National Registry of Evidence-Based Programs and Practices • State Implementation & Scaling up Evidence-based Practices Center: www.scalingup.org • Trauma: National Child Traumatic Stress Network • Youth Development, Youth Mental Health and Violence Prevention: Blueprints for Healthy Youth Development[29]

[27] Barth, R. P. (2012). Progress in developing responsive parenting programs for child welfare-involved infants: Commentary on Spieker, Oxford, Kelly, Nelson, and Fleming. *Child Maltreatment, 17*, 287-290. doi: 10.1177/1077559512466586.

[28] Barlow, J., Smailagic, N., Huband, N., Roloff, V., & Bennett, C. (2012). *Group-based parent training programmes for improving parental psychosocial health.* Campbell Systematic Reviews 2012:15 DOI: 10.4073/csr.2012.15, p. 7. Retrieved from https://www.campbellcollaboration.org/library/group-training-programmes-improving-parental-psychosocial-health.html

[29] This site includes 1,000 tested programs in the following areas: (1) Behavior, (2) Education, (3), Emotional Well-Being, (4) Physical Health, and (5) Positive Relationships. Also see: Blueprints Program Criteria for Selection

The table below describes the evidence rating of the primary clearinghouses used for this document (other than the CEBC).

SAMHSA National Registry of Evidence-based Programs and Practices (NREPP) Criteria for Each Level	Blueprints for Healthy Youth Development Intervention Registry Criteria for Each Level[30]	Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs Guide Criteria for Each Level
Inconclusive: Programs may be classified as inconclusive for two reasons. First, the evaluation evidence has insufficient methodological rigor to determine the impact of the program. Second, the size of the short-term effect could not be calculated. *Ineffective:* The evaluation evidence has sufficient methodological rigor, but there is little to no short-term effect. More specifically, the short-term effect does not favor the intervention group and the size of the effect is negligible. Occasionally, the evidence indicates that there is a *negative* short-term effect. In these cases, the short-term effect harms the intervention group and the size of the effect is substantial. *Promising:* The evaluation evidence has sufficient methodological rigor, and the short-term effect on this outcome is likely to be favorable. More specifically, the short-term effect favors the intervention group and the size of the effect is likely to be substantial. *Effective:* The evaluation evidence has strong methodological rigor, and the short-term effect on this outcome is favorable. More specifically, the short-term effect favors the intervention group and the size of the effect is substantial. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a	*Promising programs*: meet the following standards: • Intervention specificity: The program description clearly identifies the outcome the program is designed to change, the specific risk and/or protective factors targeted to produce this change in outcome, the population for which it is intended, and how the components of the intervention work to produce this change. • Evaluation quality: The evaluation trials produce valid and reliable findings. This requires a minimum of (a) one high quality randomized control trial or (b) two high quality quasi-experimental evaluations. • Intervention impact: The preponderance of evidence from the high quality evaluations indicates significant positive change in intended outcomes that can be attributed to the program and there is no evidence of harmful effects. • Dissemination readiness: The program is currently available for dissemination and has the necessary organizational capability, manuals, training, technical assistance and other support required for implementation with fidelity in communities and public service systems. European programs have not undergone the Blueprints certification process to determine dissemination readiness. *Model programs*: meet these additional standards: • Evaluation Quality: A minimum of (a) two high quality randomized control trials or (b) one high quality randomized control trial plus one high quality quasi-experimental evaluation.	The Office of Juvenile Justice and Delinquency Prevention's (OJJDP's) Model Programs Guide (MPG) contains information about evidence-based juvenile justice and youth prevention, intervention, and reentry programs. It is a resource for practitioners and communities about what works, what is promising, and what does not work in juvenile justice, delinquency prevention, and child protection and safety. MPG uses expert study reviewers and CrimeSolutions.gov's program review process, scoring instrument, and evidence ratings. The two sites also share a common database of juvenile-related programs. Three levels are used: *Ineffective*, *Promising* and *Effective*.

[30] Blueprints criteria are defined here: http://www.blueprintsprograms.com/criteria

SAMHSA National Registry of Evidence-based Programs and Practices (NREPP) Criteria for Each Level	Blueprints for Healthy Youth Development Intervention Registry Criteria for Each Level[30]	Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs Guide Criteria for Each Level
program's conceptual framework. For more information on the ratings, see the review process. Beginning September 2015 and continuing through June 2019, NREPP staff will re-review programs that were reviewed under the previous criteria.[31] The re-reviewed programs can be found in the general registry of programs.	• Positive intervention impact is sustained for a minimum of 12 months after the program intervention ends. *Model Plus programs*: meet one additional standard: • Independent Replication: In at least one high quality study demonstrating desired outcomes, authorship, data collection, and analysis has been conducted by a researcher who is neither a current or past member of the program developer's research team and who has no financial interest in the program.	

Intervention Cost and Cost Savings

We draw heavily from the Washington State Institute for Public Policy (WSIPP) for cost estimates around program costs, monetary benefits, and cost-benefit ratios, when available. [32] These costs are estimated and adjusted to be specific to Washington State, based on state wage, child welfare, and other state-specific data. Nonetheless, we believe these Washington State cost estimates provide a helpful guide to a program's effectiveness. The user of this information will need to determine how these costs and benefits may, or may not, apply in another state. Details on the three cost figures, as reported from WSIPP, can be found from WSIPP's technical documentation:[33]

When we cite the WSIPP cost figures we present them in this manner:

- Cost: $267
- Savings: $6,787
- B-C: $26.46

The program *costs*, if derived from the WSIPP Cost-Benefit analyses, were calculated using a variety of methods. If available, average program costs were collected directly from the operating agency. If not, and program resource needs were available from the published evaluations, these were converted to unit costs with available data, such as relevant personnel salaries. Otherwise, when available, we obtained program costs directly from program Web sites or through personal communication. These costs are the direct costs of implementing the program per participant, family, or child.

[31] For the new SAMHSA NREPP review criteria, see: https://nrepp.samhsa.gov/reviews_open.aspx

[32] See http://www.wsipp.wa.gov/BenefitCost The information is drawn primarily from these reports:

- Washington State Institute for Public Policy (2017a). *Adult mental health.* Retrieved from http://www.wsipp.wa.gov/BenefitCost/Pdf/8/WSIPP_BenefitCost_Adult-Mental-Health
- Washington State Institute for Public Policy (2017b). *Children's mental health.* Retrieved from http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health
- Washington State Institute for Public Policy (2017c*). Child welfare.* Retrieved from http://www.wsipp.wa.gov/BenefitCost/Pdf/3/WSIPP_BenefitCost_Child-Welfare
- Washington State Institute for Public Policy (2017d*). Substance use disorders*. Retrieved from http://www.wsipp.wa.gov/BenefitCost/Pdf/7/WSIPP_BenefitCost_Substance-Use-Disorders

[33] http://www.wsipp.wa.gov/TechnicalDocumentation/WsippBenefitCostTechnicalDocumentation.pdf

Cost savings or loss, if reported from WSIPP, are the life cycle benefits (direct and indirect) minus net program costs (program costs compared to the alternative) in present value. These are the expected returns over time per participant. If cost savings were derived from a source other than WSIPP, we recommend going to the original source document to see how the cost savings were calculated as there are different definitions and methodologies used. If reported as a loss (in red with accounting parentheses), it is because the costs, compared to the alternative, exceed any observed or anticipated benefits.

The ***benefit-to-cost ratio*** is the life cycle program benefits divided by the net program cost of producing the outcomes. This ratio is another way of presenting the same information and represents the monetary gain (or loss) for every dollar spent over the life cycle. Occasionally the costs for an intervention compared to the alternative will exceed the savings it generates, and those figures are presented in red font and in parentheses:

- Cost: $1,979
- Loss: ($4,046)
- B-C: ($0.17)

Note that in the example above, the B-C ratio is a negative $.17 cents. That means for every dollar spent, society will lose an additional .17 cents from the program investment. If, for example, the benefit cost ratio is not in red, as below, the B-C ratio would be interpreted as recouping $.16 cents for every dollar spent, because there were positive societal benefits, just not enough in relationship to the program costs relative to the alternative.

- Cost: $1,979
- Loss: $1,703
- B-C: $0.16

Please note, that the B-C ratio uses cost estimates NOT reported in our tables below to calculate the B-C ratio. That is, rather than using the per participant program cost, the B-C ratio uses the program cost, as compared to the alternative, which we do not report in these tables. We report the per participant program cost instead, because we believe this is more useful information to jurisdictions who want to know how much a program might cost to implement on a per person basis, regardless of the alternative. (To locate the per participant annual program cost in the WSIPP materials, after clicking on the program name in their benefit-cost results tables, scroll to the table titled, "Detailed Annual Cost Estimates Per Participant" and find the "Program costs" under the "Annual Cost" column. Please note the year for which the program cost is valid for.)

For some interventions, the developer websites were consulted and additional cost per client and cost-savings information is provided. If cost savings or benefit-to-cost ratios are reported from a source other than WSIPP, we recommend going to the original source document to see how the ratio was calculated as definitions and methodologies may vary. An important task for each jurisdiction is to distinguish which interventions could be paid for by Medicaid or behavioral health systems versus federal or state child welfare funds. In a few areas, we included what services or other supports might be needed to help a youth "step down" into a less restrictive form of care. For example, in juvenile probation in Los Angeles, Functional Family Therapy (FFT) is an important intervention while the youth is placed but also for helping the entire family when the youth returns home.

Cautions and Limitations: What this Document Does Not Include or Address

As mentioned earlier, there are a number of FFPSA areas where the federal government needs to issue more specific definitions and guidance. For example, we were not able to differentiate between *parenting skills training* and *parent education* interventions, so we included what are believed to be programs that qualified for one or both of these program types in the ***in-home parent skill-based programs*** category. What qualifies as a "manual" or adequate research

evidence in terms of a quasi-experimental design is not clear. Finally, effect size data for most interventions are limited and will be added in subsequent editions of this catalog. We also recommend the reader go to the registries or program website for more information.

To keep the document length and scope of the project manageable we were not able to present areas of information that other sites such as the CEBC, NREPP, NIRN and developer websites may provide, such as:

- Qualifications of staff required to provide program (e.g., paraprofessional, BA, undifferentiated master's degree, masters in psychology or social work)
- How staff are trained, certified and re-certified
- Implementation process, including time requirements
- Management information system requirements to store therapist fidelity data, if necessary
- Typical funding sources

We did not include interventions designed to prevent or treat domestic violence, although a 2016 Campbell review of US and international studies found two quality studies with 12 month follow-ups that showed significant effects for reduced minor physical abuse for brief but intensive advocacy interventions (less than 12 hours) with shelter services; and that an antenatal care program for pregnant women showed reduced emotional abuse at 12-month follow-up compared to no care or usual care.[34] We have included some but not all of the many group-based parenting interventions that are designed to improve parenting and reduce child behavior problems. Finally, as mentioned earlier, there are many interventions that are important for achieving good results in child welfare that do not meet the FFPSA funding criteria for some reason, including a lack of research evidence (e.g., Positive Indian Parenting Program). That does not mean that child welfare agencies should not invest in those programs.

Next Steps

In summary, although further direction from the Children's Bureau is forthcoming, the information in this document provides a conservative approach to what will be covered under FFPSA. In other words, if an intervention is designated as promising, supported or well-supported in this document, it is likely to have the same or higher evidence standard under FFPSA. Until further direction is provided, the summary provided here offers a rough-guide to what will be covered under FFPSA. In order for states, counties and tribes to make well-informed intervention selection decisions, better understanding of where and how these interventions have been tested, used, scaled up or discontinued across child and family-serving systems is also important. In addition, as the Children's Bureau research evidence standards and other aspects of the law are clarified further, and the ACYF FFPSA Interventions Clearinghouse contractor (Abt Associates) completes their intervention reviews, it will be possible to construct a catalog of programs that more precisely fit each of FFPSA evidence levels.

[34]Low to very low quality evidence from two intensive advocacy trials (12 hours plus duration) showed reduced severe physical abuse in women leaving a shelter at 24 months (OR 0.39, 95% CI 0.20 to 0.77; NNT = 8), but not at 12 or 36 months. See Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse, pp. 8-9.

Interventions Catalog

Section I: Interventions that Appear to Qualify Under the FFPSA Criteria of *Well-supported*

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health for Caregivers or Children						
Acceptance and Commitment Therapy (ACT) for Adults A contextually focused form of cognitive behavioral psychotherapy that uses mindfulness and behavioral activation to increase a client's psychological flexibility—his/her ability to engage in values-based, positive behaviors while experiencing difficult thoughts, emotions, or sensations. ACT establishes this through six core processes: Acceptance of private experiences; cognitive defusion (i.e., alter the undesirable functions of thoughts and other private events); being present, a perspective-taking sense of self; identification of values; and commitment to action.	Adults with depression; has also been used with adults with a variety of other mental health disorders and behavioral problems	Delivered to clients in one-on-one sessions and in small groups. Number, frequency, and length of the sessions and overall duration of the intervention varies depending on the needs of the client or treatment provider.	1 (Well-supported)	Cost: $367 Savings: $6,901 B-C: N/A[28, 29]	No official manual, but resources are available[30]	
Acceptance and Commitment Therapy (ACT) for children with anxiety ACT aims to increase client acceptance of negative thoughts and feelings and to reduce the negative behavioral impact of anxiety. Acceptance and Commitment Therapy relies on six core processes of change: (1) acceptance; (2) learning to view thoughts as hypotheses rather than facts, (3) being present, (4) viewing the self as context for experience, (5) identifying core values, and (6) acting based on those values. These core principles are applied through various exercises and through homework.	Children with anxiety	Delivered to clients in one-on-one sessions and in small groups. In the single study reported here, the treatment was delivered in 10 group sessions with parents present at all sessions.[31]	1 (Well-supported)	Cost: $660 Savings: $6,901 B-C: N/A	No official manual, but resources are available[32]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health for Caregivers or Children						
Acceptance and Commitment Therapy (ACT) for adults with anxiety Aims to increase client acceptance of negative thoughts and feelings and to reduce the negative behavioral impact of anxiety. Acceptance and Commitment Therapy relies on six core processes of change: (1) acceptance; (2) learning to view thoughts as hypotheses rather than facts, (3) being present, (4) viewing the self as context for experience, (5) identifying core values, and (6) acting based on those values. These core principles are applied through various exercises and through homework.[33]	Adults with anxiety	One-on-one sessions and in small groups. Number, frequency, and length of the sessions and overall duration varies.	1 (Well-supported)	Cost: $1,319 (2015) Savings: $20,562 B-C: $48.55[34]	No official manual, but resources are available[35]	
Acceptance and Commitment Therapy (ACT) for adults with schizophrenia and psychosis Acceptance and Commitment Therapy for schizophrenia/psychosis aims to increase client acceptance of psychotic symptoms (such as hallucinations and delusions) and reduce the negative behavioral impact of psychosis. (See the catalog entry above for the six core processes of change.)[36]	Adults with schizophrenia and psychosis	One-on-one sessions and in small groups. Number, frequency, and length of the sessions and overall duration varies.	1 (Well-supported)	Cost: $693 Savings: $498 B-C: $1.71[37]	No official manual, but resources are available[38]	
Acceptance and Commitment Therapy (ACT) for children with depression Acceptance and Commitment Therapy (ACT) for depression aims to increase client acceptance of negative thoughts and feelings and to reduce the negative behavioral impact of depression. (See the catalog entry above for the six core processes of change.)	Children with depression	One-on-one sessions and in small groups. Number, frequency, and length of the sessions and overall duration varies.	1 (Well-supported)	Cost: $1,417 Loss: ($755) B-C: ($0.26)[39]	No official manual, but resources are available[40]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health for Caregivers or Children						
Aggression Replacement Training® (ART®) This is a cognitive-behavioral intervention to help children and adolescents improve social skill competence and moral reasoning, better manage anger, and reduce aggressive behavior. The program specifically targets chronically aggressive children and adolescents ages 12–17. The intervention training is divided into three components: social skills training, anger-control training, and training in moral reasoning. Clients attend a one-hour session in each of these components each week. Incremental learning, reinforcement techniques, and guided group discussions enhance skill acquisition, and reinforce the lessons in the curriculum.[41]	Ages 12–17. Chronic aggression	10 weeks (30 sessions)	1 (Well-supported)	Cost: $1,449 (for youth in state juvenile justice institutions)[42] Savings: $4,865 B-C: $4.03[43]	Yes[44]	
Attachment and Biobehavioral Catch Up (ABC)[45] ABC intends to increase caregiver nurturance, sensitivity, and delight; child attachment security and child behavioral and biological regulation. It intends to decrease frightening behaviors and disorganized attachment. Utilizes parent coaches. This program is typically conducted in: Adoptive Homes, Birth Family Homes and Foster/Kinship Care	Ages 0–2 for children who have experienced early adversity	Ten weekly one-hour sessions Duration: 10 weeks	1 (Well-supported)	$1,300-$1,600 per family. 2–3 day staff training is required.[46]	Yes	
Child and Family Traumatic Stress Intervention (CFTSI)[47] Focuses on 2 key risk factors (poor social or familial support, and poor coping skills in the aftermath of potentially traumatic events) with the primary goal of preventing the development of PTSD. CFTSI seeks to reduce these risks in two ways: (1) by increasing communication between the affected child and his caregivers about feelings, symptoms, and behaviors, with	Ages 7–18; both males and females; for parents and children who may have complex trauma histories	4 sessions within 30–45 days of a potentially traumatic event[48]	1 (Well-supported)	N/A[49]	Yes[50]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health for Caregivers or Children						
the aim of increasing the caregivers' support of the child; and (2) by teaching specific behavioral skills to both the caregiver and the child to enhance their ability to cope with traumatic stress reactions.						
Cognitive Behavioral Therapy (CBT) CBT is a time-limited, evidence-based psychotherapy for treating anxiety disorders and major depressive disorders. It is "an intervention for ameliorating distressing feelings, disturbing behavior, and the dysfunctional thoughts from which they spring. Improvements in target symptoms, such as anxiety and depression, are mediated through identifying and disputing the automatic thoughts that generate those feelings. Behavioral techniques, such as skills training and role-playing, are well-established ways of addressing phobias and posttraumatic reactions. These techniques also help patients develop coping mechanisms for managing the thoughts and feelings identified during the intervention."[51]	Ages 13–25 Anxiety, depression, dysfunctional thoughts	12 to 16 weekly sessions	1 (Well-supported) 70% for depression (Cohen's d= .86)[52] Anxiety (Cohen's d= .65)[53] Post-traumatic stress (Cohen's d= .68)[54]	Cost: $1,661 (individual CBT for children with anxiety)[55]	Yes[56]	KY, NV
Cognitive Behavioral Therapy (CBT) for Adult Anxiety Cognitive-behavioral therapies (CBT) include various components, such as cognitive restructuring, behavioral activation, emotion regulation, exposure, communication skills, and problem-solving.	Adults ages 18 and older with anxiety	10–20 weekly sessions[57]	1 (Well-supported)[58]	Cost: $1,458 (2015) Savings: $30,370 B-C: $54.01[59]	Yes[60]	
Cognitive Behavioral Therapy (CBT) for Adult Depression[61] Skills-based, present-focused, and goal-oriented treatment approach that targets the thinking styles and behavioral	Adults (18 and over) diagnosed with a mood disorder, including Unipolar	10–20 therapeutic hours per client[62]	1 (Well-supported) Unadjusted random effects model: -	Cost: $1,231 (2014) Savings: $24,288 B-C: $49.09[63]	Yes[64]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health for Caregivers or Children						
patterns that cause and maintain depression-like behavior and mood.	Major Depressive Disorder (MDD) not otherwise specified, and minor depression.		0.66; Adjusted effect size: -044			
Cognitive Behavioral Therapy (CBT) for Adult Posttraumatic Stress Disorder (PTSD) Treatments in this review include several components, such as psycho-education about posttraumatic stress disorder (PTSD), relaxation and other techniques for managing physiological and emotional stress, exposure (the gradual desensitization to memories of the traumatic event), and cognitive restructuring of inaccurate or unhelpful thoughts.	Adults (18 and over) diagnosed with PTSD	1–45 weekly sessions[65]	1 (Well-supported)[66]	Cost: $1,444 (2014) Savings: $49,184 B-C: $88.11[67]	Yes[68]	
Cognitive Behavioral Therapy (CBT) for Adult Schizophrenia and Psychosis Cognitive behavioral therapy for psychosis (CBTp) includes the application of cognitive strategies focused on changing thoughts to improve feelings and behaviors as well as behavioral techniques most often used to address negative symptoms. CBTp involves teaching patients methods of coping with their symptoms and training in problem solving, social skills and strategies to reduce risk of relapse.	Adults (18 and over) diagnosed with Schizophrenia or Psychosis	12–20 sessions over 4–6 months[69]	1 (Well-supported)[70]	Cost: $1,436 (2014) Savings: $12,221 B-C: $9.39[71]	Yes[72]	
Cognitive Behavioral Therapy (CBT) for Children with Anxiety	Children with anxiety	8–16 weekly sessions[73]	1 (Well-supported)[74]	Cost: $217 (2010)[75]	Yes[76]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health for Caregivers or Children						
These treatments utilize the same principles and techniques as those of other Cognitive Behavior Therapy (CBT) treatments for anxiety (e.g., strategies to control physiological responses to anxiety, cognitive restructuring and self-talk, exposure to feared stimuli, and positive reinforcement). However, they are unique insofar as clients have reduced (if any) face-to-face time with therapists. Clients are supported remotely via email or phone contact. A manual or online program helps to guide progress of the intervention.						
Cognitive Behavioral Therapy (CBT) for Children with Trauma CBT is a skills-based, present-focused, and goal-oriented treatment approach that targets the thinking styles and behavioral patterns that cause and maintain depression-like behavior and mood.[77]	Children ages 3–18[78]	12–18, 30–45 minute sessions[79] Duration: 12-18 weeks	1 (Well-supported)	Cost: $1,037 (2016) Savings: 21,837 B-C: $N/A[80]	Yes	
Cognitive Therapy (CT) A form of psychotherapy proven in numerous clinical trials to be effective for a wide variety of disorders. The therapist and client work together as a team to identify and solve problems. Therapists help clients to overcome their difficulties by changing their thinking, behavior, and emotional responses. *CT* and Cognitive Behavioral Therapy are often used interchangeably. There are, however, numerous subsets of CBT that are narrower in scope than *CT*: e.g., problem-solving therapy, stress-inoculation therapy, motivational interviewing, dialectical behavior therapy, behavioral modification, exposure and response prevention, etc.	Children and adults with a wide range of problems	50-minute weekly sessions Duration: 12 weeks	1 (Well-supported)	N/A	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health for Caregivers or Children						
Coping Cat Individual psychotherapy intervention for children with a range of anxiety difficulties. Includes psychoeducational, exposure therapy, somatic management, cognitive restructuring, problem solving.	Ages 7–13 with version for 13–17 year olds with anxiety	16 weekly group sessions Duration: about 16 weeks	1 (Well-supported)	N/A	Yes[81]	CO
Coping Power Program For high-risk children, it addresses deficits in social cognition, self-regulation, peer relations, and positive parental involvement. The Coping Power Program, which has both a child and parent intervention component, is designed to be presented in an integrated manner. It was designed as a school-based program, but has been adapted for mental health settings.	Ages 7–14	34 group sessions	1 (Well-supported)	Cost: $919 Savings: $1,016 B-C: $1.56[82]	Yes[83]	
Eye movement desensitization and reprocessing (EMDR) for Adult PTSD A psychological treatment commonly used to treat posttraumatic stress disorder. During treatment, clients focus on the traumatic memory for 30 seconds at a time while the therapist provides a stimulus.	Adults with posttraumatic stress disorder (PTSD)	One 50- or 90-minute session per week Duration: 3–12 weeks[84]	1 (Well-supported)[85]	Cost: $974 (2014) Savings: $41,349 B-C: $598.49[86]	Yes[87]	CO
Eye movement desensitization and reprocessing (EMDR) for Children EMDR is based on Adaptive Information Processing theory and involves eight phases of psychotherapy that integrate psychodynamic, cognitive behavioral, interpersonal, experiential, and body-centered therapies[88]	Ages 2–17. Anxiety, behavior problems, fear, phobias, posttraumatic stress and posttraumatic stress disorder (PTSD)	One 50- or 90-minute session per week Duration: 3–12 weeks[89]	1 (Well-supported)[90]	Cost: $886 (2009) Savings: $8,810 B-C: N/A[91]	Yes[92]	CO

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health for Caregivers or Children						
GenerationPMTO (Group Delivery Format) GenerationPMTO was formerly known as Parent Management Training - the Oregon Model (PMTO®). *GenerationPMTO (group delivery format)* is a parent training intervention		10-14 weeks	1 (Well-supported)		Yes	
Mindfulness-Based Cognitive Therapy (MBCT) for Adults Based on Jon Kabat Zinn's Stress Reduction program at the University of Massachusetts Medical Center, which was developed to help people suffering with chronic physical pain and disease. It includes simple meditation techniques to help participants become more aware of their experience in the present moment, by tuning in to moment-to-moment changes in the mind and the body.[93]	Adults who have suffered three or more prior episodes of major depression	Weekly for 2 hours per week Duration: 9–10 weeks	1 (Well-supported)	N/A	Yes	
Multidimensional Family Therapy (MDFT) *has been rated by the CEBC in the areas of Behavioral Management Programs for Adolescents in Child Welfare*.[94] See the Well-supported substance abuse section for more intervention details	Children and adolescents ages 11–18	Duration: 3–4 months for at-risk and early intervention youth and families. 5–6 months for youth with a substance abuse and/or conduct disorder diagnosis.	1 (Well-supported)	Cost data are only available for its usage for treating substance abuse.	Yes[95]	CO
Parent Child Interaction Therapy (PCIT) PCIT has been used with child welfare populations has been successfully tested with the addition of a group	Ages 2–7 years old	Hour-long weekly sessions.	1 (Well-supported)	Cost: $2,240 (2007) Savings: $22,994	Yes[97]	CO, MD, MT, NE, NV, WI

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health for Caregivers or Children						
motivational component to increase engagement and success of the parent. As in standard PCIT, over the course of 12 to 14 sessions, a therapist directly observes a parent and child through a one-way mirror, and provides direct coaching to the parent through a radio earphone. The focus is building the skills of the parent to more positively interact with the child and manage his or her behavior.		Duration: Treatment length varies but averages about 14 weeks		B-C: $15[96]		
Problem Solving Skills Training (PSST) for Children Is aimed at decreasing inappropriate or disruptive behavior in children. The program teaches that problem behaviors arise because children lack constructive ways to deal with thoughts and feelings and instead resort to dysfunctional ones. It is designed to help children learn to slow down, stop and think, and generate multiple solutions to any given problem. The program uses a cognitive-behavioral approach to teach techniques in managing thoughts and feelings, and interacting appropriately with others. Specific techniques include modeling, role-playing, positive reinforcement of appropriate behavior, and teaching alternative behaviors.[98]	Children ages 7–14 with oppositional, aggressive, anti-social behavior	8–14 weekly sessions Duration: up to one year	1 (Well-supported)	N/A	N/A	
Prolonged Exposure Therapy for Adolescents (PE-A) Promote the client's ability to emotionally process their traumatic experiences and consequently diminish posttraumatic stress disorder (PTSD) and other trauma-related symptoms. Clients are encouraged to repeatedly approach situations or activities they are avoiding because they remind them of their trauma (in vivo exposure) as well as to revisit the traumatic memory several times through	Children, adolescents and adults who have experienced a trauma (e.g., sexual assault, car accident, violent crimes, etc.).	8–15 sessions Duration: up to 17 months	1 (Well-supported)	N/A (4-day on-site training costs $1500 per participant for PE Therapy for PTSD[100])	Yes[101]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health for Caregivers or Children						
retelling it (imaginal exposure). Psychoeducation about common reactions to trauma as well as breathing retraining exercises are also included in the treatment.[99]						
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) TF-CBT is a conjoint child and parent psychotherapy approach for children and adolescents who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It has mostly been used and evaluated with youth who were sexually abused or exposed to domestic violence. TF-CBT can also benefit children with depression, anxiety, shame, and/or grief related to their trauma.[102] This psychotherapy model includes parent and child individual and joint sessions in several modules that combine trauma-sensitive interventions with CBT. TF-CBT aims to (1) improve child and parent knowledge and skills related to processing the trauma; (2) manage distressing thoughts, feelings, and behaviors; and (3) enhance safety, parenting skills, and family communication.[103]	Ages 4–18. Anxiety, depression, PTSD	Weekly 60- to 90-minute sessions Duration: 12–16 weeks	1 (Well-supported)	$1,037 (CBT based models for child trauma)[104]	Yes[105]	AR, CO, IN, KY, MD, MT, NV, WI
Triple P – Positive Parenting Program – Level 4 Individual for Child Disruptive Behavior Triple P—Positive Parenting Program (Level 4, self-directed) is an intensive individual-based parenting program for families of children with challenging behavior problems. In the self-directed modality, parents receive a full Level 4 curriculum with a workbook and exercises to complete at their own pace. They are also offered support from a therapist by telephone on a regular basis.	Ages 0–12	10–16 sessions Duration:over 3–4 months[106]	1 (Well-supported)	Cost: $1,792 Savings: $2339 B-C: $3.36[107]	Yes[108]	CO, ME, NE, TX, WA

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
Communities that Care for Substance Abuse Prevention Communities that Care (CTC) is a coalition-based community prevention program that aims to prevent youth problem behaviors including underage drinking, tobacco use, violence, delinquency, school dropout, and substance abuse. CTC works through a community board to assess risk and protective factors among the youth in their community using a population-based survey of young people. The board works to implement tested and effective programs to address the issues and needs that are identified.	0–21[109]		1 (Well-supported)[110]	Cost: $103 (2004) Savings: $2,555 B-C: $5.31[111]	Yes[112]	
Motivational Interviewing *MI* is a client-centered, directive method designed to enhance client motivation for behavior change. It focuses on exploring and resolving ambivalence by increasing intrinsic motivation to change. *MI* can be used by itself, as well as in combination with other treatments. It has been utilized in pretreatment work to engage and motivate clients for other treatment modalities, including substance abuse treatment for adults.	Adults	1–3, 30–50 minute sessions	1 (Well-supported) *Campbell 2011 Review:* Significant short-term effect for decreasing substance abuse at for 1-6 months and for the 7-12 month follow-up periods but not longer than that.[113]	Cost: $263 (2014) Savings: $5,572 B-C: $21.95[114]	Yes[115]	AR, CO, IN, NV
Multidimensional Family Therapy (MDFT) *MDFT* is a family-based treatment system for adolescent substance use, delinquency, and related behavioral and emotional problems. Therapists work simultaneously in four interdependent domains: the adolescent, parent, family, and community. Once a therapeutic alliance is established and	Children and adolescents, ages 11–18	1–3 sessions per week (average of 2) each lasting 45–90 minutes.[117] Duration: 5–6 months	1 (Well-supported) *Campbell 2015 Review:* Small but significant short-term effect was found for decreasing	Cost: $6,168 (2001) Loss: ($5,827) B-C: $0.28[119]	Yes[120]	CO

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
youth and parent motivation is enhanced, the *MDFT* therapist focuses on facilitating behavioral and interactional change. The final stage of *MDFT* works to solidify behavioral and relational changes and launch the family successfully so that treatment gains are maintained.[116]			substance abuse at 6 month and 12 month follow-ups, but less so for the pooled effects across 4 studies.[118]			
PROSPER The PROSPER (PROmoting School-community-university Partnerships to Enhance Resilience) delivery system is a partnership-based prevention model designed to help communities implement effective programs to reduce substance use and problem behaviors in youth. In addition to supporting program delivery, the model includes needs assessments, quality monitoring, sustainability strategies, and evaluation. Communities participating in PROSPER form local teams consisting of staff from the Cooperative Extension System (CES); representatives from the public school system and service providers; youth and parents; and other community stakeholders. University researchers and CES staff partner with the local teams and provide a menu of effective programs, technical assistance, coordination, and other supports. Local teams select and implement a family-based program for students in 6th grade and a school-based program in 7th grade from the menu of effective practices.	10–14[121]		1 (Well-supported)	Cost: $104 Savings: $469 B-C: $1.89[122]	N/A	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education						
Family Connects Family Connects® is a community-wide nurse home visiting program for parents of newborns residing in a given geographic area. It is based on the Durham Connects model piloted in Durham County, N.C.	Parent of children ages 0–2 years	3 to 7 contacts between 3 and 12 weeks after birth[123] Duration: about 8 weeks	1 (Well-supported) Significant reduction in child maltreatment, measured by childhood injuries (*Cohen's d .48-.85*) and substantiated maltreatment reports (*Cohen's d .22-.62*).[124]	$700 per family[125] B/C ratio: $3.02[126]	N/A	
Healthy Families America (HFA) *HFA* is a home visiting program model designed to work with overburdened families who are at-risk for child abuse and neglect and other adverse childhood experiences. It is designed to work with families who may have histories of trauma, intimate partner violence, mental health issues, and/or substance abuse issues.[127]	Pregnant women and women with child ages Birth to 4 years+ *HFA* services are offered voluntarily, intensively, and over the long-term (3 to 5 years after the birth of the baby).[128]	29–43 home visits Duration: about 16 months[129]	1 (Well-supported)	Cost: $5,071 (2016) Loss: ($1,840) B-C: $0.64[130]	Yes[131]	DC
Nurse Family Partnership (NFP)[132] Program provides home visits by registered nurses to first-time, low-income mothers, beginning during pregnancy and continuing through the child's second birthday.	Ages 0-2 and their caregivers: Voluntary First time mothers Low income Enrolled early in pregnancy	Registered nurses visit weekly for the first month after enrollment and then every other week until the baby is born. Visits continue with	1 (Well-supported)	Cost: $5,944 (2015) B-C: $0.81[134]	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education						
		varying frequency until the child is two years old.[133]				
Minding the Baby® (MTB) MTB is an intensive home visiting model for first-time young mothers and their families. The interdisciplinary intervention brings together a home visiting team including a pediatric nurse practitioner and a licensed clinical social worker to promote positive health, mental health, life course, and attachment outcomes in babies, mothers, and their families.[135]	Medically low-risk pregnant women age 14–25	27 months, beginning in second or third trimester of pregnancy.	1 (Well-supported At least 2 RCTs and peer review journal articles. 5 year study underway.[136]	Approximately $10,000–$13,200 per year, per family[137]	Yes[138]	
The Incredible Years A series of three separate, multifaceted, and developmentally based curricula for parents, teachers, and children. This series is designed to promote emotional and social competence; and to prevent, reduce, and treat behavior and emotional problems in young children. The parent, teacher, and child programs can be used separately or in combination. There are treatment versions of the parent and child programs as well as prevention versions for high-risk populations. In-home services delivery is one option.	Ages 4–8 Children with disruptive behavior and emotional problems	Basic Parent Training Program is 14 weeks and 18–20 weeks for treatment. Child Training Program is 18–22 weeks. Child Prevention Program is 20–30 weeks and may be spaced over two years.	1 (Well-supported)	Cost: $2,215 (2013) Savings: $1,039C: 1.79[139]	Yes[140]	CO, WA

In-Home Parent Skill-Based Programs: Individual and Family Counseling						
Attachment-Based Family Therapy (ABFT)[141] Designed to help families strengthen their relationships, solve problems, and regulate emotions. Consists of individual and joint meetings with depressed adolescents and their parents.	Ages 13–18 Depressed adolescents and their families	Weekly sessions Duration: Approximately 12 weeks	1 (Well-supported) ABFT was found to have significant positive impacts on rates of change in adolescents' suicidal thoughts, clinical recovery for suicidal thoughts and depressive symptoms, and treatment retention.[142]	N/A	N/A	
The Family Check-up (FCU) A family-centered intervention that promotes positive family management and addresses child and adolescent adjustment problems. The *FCU* has two phases: (1) An initial assessment and feedback; (2) Parent management training (Everyday Parenting) which focuses on positive behavior support, healthy limit setting, and relationship building.[143]	Parents of children and adolescents	One-hour session every 1–2 weeks. Duration: 1–4 months depending on the individual needs of the family	1 (Well-supported)	Cost: $164 (2013) Loss: ($399) B-C: $(0.20)[144]	Yes[145]	

Section II: Interventions that Appear to Qualify Under the FFPSA Criteria of *Supported*

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
Accelerated Resolution Therapy A brief, exposure-based psychotherapy aimed at treating psychological trauma, depression, anxiety, phobias, obsessive–compulsive disorder, and substance use. The program incorporates specific visualization techniques enhanced through the use of rapid eye movements (similar to the rapid eye movement stage of sleep) and a directive approach that reduces physical and emotional reactions to distressing memories and images stored in the brain.[146]	Adults For psychological trauma, depression, anxiety, phobias, obsessive–compulsive disorder, and substance abuse.	One to five, 60–75 minute sessions. Duration: 2 weeks.	2 (Supported)+ NREPP rating of effective	N/A	Yes	
Blues Program Actively engages high school students with depressive symptoms or at risk of onset of major depression, includes six weekly one-hour group sessions and home practice assignments. Weekly sessions focus on building group rapport and increasing participant involvement in pleasant activities (all sessions), learning and practicing cognitive restructuring techniques (sessions 2–4), and developing response plans to future life stressors (sessions 5–6). In-session exercises require participants to apply skills taught in the program. Home practice assignments are intended to reinforce the skills taught in the sessions and help participants learn how to apply these skills to their daily life.	Ages 15–18	6 weekly group sessions[147]	2 (Supported)[148]	Cost: $114 (2014) Savings: $6144 B-C: $0.24[149]	Yes[150]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
Building Confidence A cognitive-behavioral therapy (CBT) that is provided to school-aged children who demonstrate clinically significant symptoms of a range of anxiety disorders (e.g., separation anxiety disorder). The format consists of individual child therapy combined with parent-training and involvement. Both children and their parents are taught fundamental CBT principles and techniques as well as integrating ways to build confidence through graduated learning and practice of age-appropriate self-independence skills.[151]	Ages: 6 – 11 with anxiety disorder	Weekly 1.5-hour session Duration: 16 weeks	2 (Supported)	N/A	Yes	
Chicago Parent Program (CPP) A parenting-skills training program that aims to prevent or reduce behavior problems in children, ages 2 to 5, by strengthening parenting skills, reducing reliance on harsh and inconsistent discipline methods, and improving parenting confidence. CPP is grounded in social learning theory and the belief that parents can shape their child's behavior and social–emotional well-being through the quality and consistency of their communications and behavioral interactions. Developed in collaboration with an advisory board of African American and Latino parents of young children, the CPP is designed to address the needs of a racially, ethnically, and economically diverse population of parents.	Ages 2–5 with behavior problems	Two trained group leaders deliver the program during weekly 2-hour sessions for 11 weeks, and at a booster session 4 weeks later Duration: 15 weeks	2 (Supported)+ NREPP rating of effective	N/A	Yes (Manual and video vignettes)	
Childhaven Childhood Trauma Treatment Provides therapeutic child care and other optional specialized treatment services in a licensed child-care milieu) setting (therapeutic/treatment to abused,	Children ages 1–5 and their families to help improve relationships and	5.5 hours per day, five days a week, with a	2 (Supported)	N/A	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
neglected, at-risk, and/or drug-affected children. Children are referred by Child Protective Services, Child Welfare Services, Department of Health, or the TANF Program.[152]	parenting skills, enable children to be life-long learners	monthly home visit Duration: Variable				
Cognitive Behavioral Therapy (CBT) for Child and Adolescent Depression This is a developmental adaptation of the classic cognitive therapy model developed by Aaron Beck and colleagues. CBT emphasizes collaborative empiricism, the importance of socializing patients to the cognitive therapy model, and the monitoring and modification of automatic thoughts, assumptions, and beliefs.[153]	Ages 13–25. Depression	12 to 16 weekly sessions	2 (Supported) NREPP rating 3.4–3.7	Cost: $1,245 (2015) Savings: $566 B-C: $0.27[154]	Yes[155]	
Cognitive Behavioral Therapy (CBT) – Group Therapy for Children with Anxiety Treatments usually include multiple components, such as strategies to control physiological responses to anxiety, cognitive restructuring and self-talk, exposure to feared stimuli, and positive reinforcement. This brief therapy can be administered in individual, group, or family format; well-known examples include the Coping Cat and Coping Koala programs.	Children with anxiety	Not available	2 (Supported) Effect size to decrease anxiety: between -.191 and -414 (WSIPP)[156] (CEBC rates non-group work based TF-CBT for children as "Well-Supported")	Cost: $559 (2010) Savings: $6,612 B-C: N/A[157]	N/A	
Cognitive Behavioral Therapy (CBT) – Individual Therapy for Children with Anxiety Treatments usually include multiple components, such as strategies to control physiological responses to anxiety, cognitive restructuring and self-talk, exposure to feared	Children with anxiety	N/A	2 (Supported) Effect size to decrease anxiety: between -.191 and -414[158]	Cost: $1,661 (2010)[159] Savings: $3,554 B-C: $5.55[160]	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
stimuli, and positive reinforcement. This brief therapy can be administered in individual, group, or family format.						
Cognitive Behavioral Therapy (CBT) – Parent counseling for young children with anxiety Uses CBT techniques with a focus on anxiety.	Adults with children with anxiety	N/A	2 (Supported)[161]	Cost: $648 Savings: $2,459 B-C: $ N/A [162]	N/A	
Collaborative & Proactive Solutions A treatment model that is designed to help parents/caregivers and children learn to collaboratively and proactively solve the problems that contribute to the children's challenging behaviors. It is made up of four modules that teach parents: (a) to identify lagging skills and unsolved problems that contribute to oppositional episodes; (b) to prioritize which unsolved problems to focus on first; (c) and how to resolve problems.[163]	Parents of children ages 4–14 to improve family communication, cohesion, and relationships	Weekly 60 minute sessions Duration: 11 weeks on average	2 (Supported)	N/A	Yes	
Common Sense Parenting (CSP) A group-based class for parents led by a credentialed trainer who focuses on teaching practical skills to increase children's positive behavior, decrease negative behavior, and model appropriate alternative behavior. Each class is formatted to include a review of the prior session, instruction of the new skill, modeled examples, skill practice/feedback, and a summary. The goals of *Common Sense Parenting (CSP)* are to (a) Equip parents with a logical method for changing their children's behaviors through teaching positive behaviors, social skills, and methods to reduce stress in crisis situations; and (b)	Parents/caregivers of children ages 6 – 16 to increase children's positive behavior, decrease negative behavior, including delinquent and aggressive behavior	Six weekly, 2-hour sessions Duration: 6 weeks	2 (Supported)	N/A	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
Provide parents with practical strategies for enhancing parent-child communication and building robust family relationships.						
Community Reinforcement + Vouchers Approach (CRA + Vouchers) It has two main components. The Community Reinforcement Approach (CRA) component is an intensive psychosocial therapy emphasizing changes in substance use; vocation; social and recreational practices; and coping skills. The Voucher Approach is a contingency- management intervention where clients earn material incentives for remaining in treatment and sustaining cocaine abstinence verified by urine toxicology testing.[164]	Adults 18+ with diagnosis of cocaine abuse or dependence	60 minute weekly sessions. Duration: for 24 weeks[165]	2 (Supported)	Cost: $2,602 (2013) Savings: $4,165 B-C: $4.45[166]	No, but other instructional materials exist.	
Dialectical Behavior Therapy (DBT) DBT is a mindfulness- and acceptance-based cognitive-behavioral therapy adapted for treating people with severe, complex, hard-to-treat multi-diagnostic conditions, in particular borderline personality disorder (BPD). DBT for Substance Abusers was developed to treat individuals with co-occurring substance use disorders and BPD.[167] DBT was found effective as a precursor for treating trauma in sexually abused young women in TRTG,[168] and for reducing PTSD symptoms.[169]	Ages 13–25. Borderline personality disorder (BPD), self-harm, and substance abuse.[170]	About six months (15–20 sessions), but could be more intensive or as individualized therapy twice a week and group skills sessions five days a week.[171] This could total 52 individualized sessions and 104 group sessions. Duration: 6 or more months	2 (Supported)+ Not CEBC[172]	Cost: $2,148 (2016)[173] $150/ individual session + $60/ group session = for full year intensive, cost could be $14,000. DBT for Youth In Juvenile Justice: B-C: N/A[174]	Yes[175]	KY

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
Dialectical Behavior Therapy (DBT) for Adolescent Self-Harming Behavior A cognitive behavioral treatment originally developed for chronically parasuicidal adults. DBT involves both group skills training and individual psychotherapy and focuses on mindfulness, interpersonal, emotion-regulating, and self-management skills. In studies included in this meta-analysis, DBT was modified to treat adolescents by shortening the treatment length, streamlining and simplifying some lessons, and including parents in some sessions. Studies in this analysis include adolescents in both inpatient and outpatient treatment settings presenting with suicidal ideation, non-suicidal self-harm, and/or prior suicide attempts. Treatment duration ranges from 2–19 weeks, with multiple sessions per week.	Ages 13–21 Self-Harming behavior	2–19 weeks	2 (Supported)+ Not CEBC[176]	Cost: $151 Savings: ($5.00) B-C: $0.97[177]	Yes[178]	
Families and Schools Together (FAST) A 2-year, multifamily group intervention based on social ecological theory, family systems theory, and family stress theory. FAST is designed to build relationships between and within families, schools, and communities (particularly in low-income areas) to increase all children's well-being, especially as they transition into elementary school.[179]	Families with children 0-12 years	2.5 hours weekly for 8 weeks, then monthly for 2 years[180]	2 (Supported)	Cost: $1,694 (2009)[181] Savings: $439 B-C: $1.23[182]	Yes[183]	
Family-Focused Treatment for Adolescents (FFT-A) *FFT-A* is a psychosocial treatment for youth with bipolar disorder, consisting of family psychoeducation, communication enhancement training, and problem-solving skills training. It is given alongside of medications in the period just after an episode of bipolar disorder. The	Ages 9–17	21, 1-hour sessions: 12 weekly, 6	2 (Supported)	N/A	Yes[184]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
clients are the adolescent, mother/father, and where possible, siblings and extended relatives.		biweekly, 3 monthly Duration: 9 months				
Interpersonal Psychotherapy-Adolescent Skills Training (IPT-AST) The group focuses on psychoeducation and general skill-building that can be applied to different relationships within the framework of three interpersonal problem areas: interpersonal role disputes, role transitions, and interpersonal deficits. The psychoeducation component includes defining prevention, educating members about depression, and discussing the relationship between feelings and interpersonal interactions. The interpersonal skill-building component consists of two stages. First, communication and interpersonal strategies are taught through didactics, activities, and role-plays. Once group members understand the skills, they are asked to apply them to different people in their lives, practicing first in group and then at home.	Ages 12–18	Two initial individual sessions and eight weekly 90-minute group sessions. Duration: 10 weeks	2 (Supported)	Not available	Yes[185]	
Multi-Family Psychoeducational Psychotherapy (MF-PEP) *MF-PEP* is a manual-based group treatment for children aged 8-12 with mood disorders (depressive and bipolar spectrum disorders). *MF-PEP* is based on a biopsychosocial framework and utilizes cognitive-behavioral and family-systems based interventions. *MF-PEP* treatment begins and ends with children and parents	Ages 8–12	Eight 90-minute weekly sessions Duration: 8 weeks	2 (Supported)	N/A	Yes[186]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
together; the bulk of each session is run separately for parents and children.						
New Beginnings (for children of divorce) A group and individual Cognitive-Behavioral Treatment-based session program for divorced mothers and their children to promote resilience in children after parental divorce. Groups are led by two master's level clinicians. The intervention focuses on changing aspects of the child's environment that directly involve the child, including increasing effective discipline strategies, increasing mother-child relationship quality and decreasing exposure to interparental conflict. There are two individual phone sessions that are structured, but also allow for tailoring the program to specific needs. Program skills are taught through presentations, role-playing, and videotapes.[187]	Mothers of children 5–18 years Antisocial-aggressive Behavior Close Relationships with Parents Externalizing Internalizing Mental Health - Other Reciprocal Parent-Child Warmth Sexual Risk Behaviors	10 group and 2 individual sessions Duration: 10–15 weeks	2 (Supported)+ Blueprints Model Program for the mother-only program as the mother and child program has not been replicated yet[188]	N/A	Yes	
Positive Peer Culture (PPC) *PPC* is a peer-helping model designed to improve social competence and cultivate strengths in youth. "Care and concern" for others (or "social interest") is the defining element of *PPC*. Rather than demanding obedience to authority or peers, *PPC* demands responsibility, empowering youth to discover their greatness. Caring is made fashionable and any hurting behavior totally unacceptable. *PPC* assumes that as group members learn to trust, respect, and take responsibility for the actions of others, norms can be established. These norms not only extinguish antisocial conduct, but more	Ages 11–22 in private schools, groups homes and residential treatment centers Groups of 8–12	45–90-minute structured group meetings depending on the setting and the participants, ideally 5 times per week Duration: typically 6–9 months.	2 (Supported)	N/A	Yes[190]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
importantly reinforce pro-social attitudes, beliefs, and behaviors. Positive values and behavioral change are achieved through the peer-helping process. Helping others increases self-worth. As one becomes more committed to caring for others, s/he abandons hurtful behaviors.[189]						
Primary and Secondary Control Enhancement Training (PASCET) Structured individual psychotherapy intervention for depression. Treatment sessions and take-home practice assignments are built on research findings concerning cognitive and behavioral features of depression in children and adolescents, and on the two-process model of perceived control and coping.	Ages 8–15 who are depressed	10–15 sessions, 2 individual, 8 group- up to 18 months.	2 (Supported)	N/A	Yes[191]	
Problematic Sexual Behavior- (PSB-CBT-S)- for School Age Children A family-oriented, cognitive-behavioral, psychoeducational, and supportive treatment group designed to reduce or eliminate incidents of sexual behavior problems	Ages 6–12 for children with problematic sexual behavior and who may or may not have a history of trauma	4–5 months	2 (Supported)	N/A	Yes[192]	
Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) for Sexual Behavior Problems in Children *TF-CBT* is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic	For parents and children ages 3–12 with sexual Behavior Problems	12–18 total 30- to 45-minute weekly sessions for child and parent separately plus 30-	2 (Supported)	N/A	Yes[194]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles.[193]		to 45-minute conjoint child-parent sessions towards end of treatment				

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
Adaptive Stepped Care A program for adults with chronic substance use and addiction as an alternative to standard methadone maintenance treatment. It is based on a treatment model that integrates patient–service matching and patient–provider matching along with behavioral contingencies to reinforce treatment adherence within a four-step continuum of counseling treatment intensity. The program's three main components are medication, graded intensities of counseling care, and behavioral contingencies to reinforce the treatment plan. It is delivered by a team that includes a medical doctor, a clinical psychologist, a counseling supervisor, and counseling staff to groups of up to 50 clients. [195]	Adults with opioid, cocaine, sedative and general substance abuse disorders	Duration: TBD	2 (Supported)+ NREP rating of effective	N/A	N/A	
Adolescent Community Reinforcement Approach/Assertive Continuing Care (A-CRA/ACC)	Youth and young adults ages 12 and	Generally includes ten,1-hour	2 (Supported)+	N/A	N/A	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
An outpatient program for youths and young adults between the ages of 12 and 24 who have substance use and co-occurring mental health disorders. A-CRA uses both behavioral and cognitive–behavioral techniques to replace environmental settings and cues that have supported alcohol or drug use with prosocial activities and new social skills that support recovery. A-CRA is the main component within Assertive Continuing Care (ACC), which provides home, school, or other community visits to youths following residential treatment for substance use disorders.[196]	24 with substance use and co-occurring mental health disorders	individual sessions; two 1-hour sessions with parents/caregiver; and two 1-hour sessions with both adolescents and parents/caregivers together Duration: 12 to 14 weeks	NREPP rating of effective			
Adolescent Coping with Depression (CWD-A) A behavioral intervention that seeks to increase the family, social, and educational/vocational reinforcers of an adolescent to support recovery from substance abuse and dependence.	Adolescents aged 12 to 22 with substance abuse issues	3 types of sessions: adolescents alone, caregivers alone, and adolescents and caregivers together.	2 (Supported)	Average cost is between $1,200 - $1,600 per person[197]	Yes[198]	
Adolescent-focused Family Behavior Therapy A comprehensive, outpatient program for managing problem behaviors such as adolescent substance misuse. FBT is based on elements of the community reinforcement approach to substance use, which posits that environmental elements and relationships have a significant role in encouraging and discouraging behaviors. Adolescent-focused FBT is aimed at replacing negative influences (people, places, situations) with positive influences to achieve patient goals. Cognitive and behavioral skills are developed through role play,	With substance abuse and non-cohesive family relations	Begins with 1- to 2-hour sessions twice a week, which are reduced as the adolescent progresses and achieves treatment goals. Duration: typically between 6–12 months.	2 (Supported)+ NREPP rating of effective *Campbell 2015 Review:* Significant effect was found for family functioning but not non-opioid drug abuse at a 12 month follow-up.[200]	N/A	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
therapeutic assignments, and the use of family support systems. Parent participation is integral to treatment so parents attend sessions with their child.[199]						
Adult-focused Family Behavior Therapy Includes more than a dozen treatments including management of emergencies, treatment planning, home safety tours, behavioral goals and rewards, contingency management skills training, communication skills training, child management skills training, job-getting skills training, financial management, self-control, environmental control, home safety and aesthetics tours, and tele-therapy to improve session attendance.	Adults with drug abuse and dependence, as well as other co-existing problems such as depression, family dysfunction, trauma, child maltreatment, noncompliance, employment, HIV/STIs risk behavior, and poor communication skills	1 to 2-hour initial outpatient or home-based sessions once or twice in the first week then fades in frequency depending on multiple factors. Duration: 6–12 months	2 (Supported)	N/A	Yes	
Brief Marijuana Dependence Counseling (BMDC) An intervention designed to treat adults with a diagnosis of cannabis dependence. Using a client-centered approach, BMDC targets a reduction in the frequency of marijuana use, thereby reducing marijuana-related problems and symptoms. BMDC is based on the research protocol used by counselors in the Center for Substance Abuse Treatment's (CSAT's) Marijuana Treatment Project, which was conducted in the late 1990s. BMDC is implemented as a 9-session, multicomponent therapy that includes elements of motivational enhancement therapy (MET), cognitive behavioral therapy (CBT), and case management.	Adults with cannabis dependence	9 sessions Duration: 12 weeks	2 (Supported)+ NREPP rating of effective	Cost: $822 Savings: $7,611 B-C: $14.65[201]	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
Brief Strategic Family Therapy *BSFT* is a brief intervention used to treat adolescent drug use that co-occurs with other problem behaviors. *BSFT* is based on three basic principles: First, *BSFT* is a family systems approach. Second, patterns of interaction in the family influence the behavior of each family member. The role of the *BSFT* counselor is to identify the patterns of family interaction that are associated with the adolescent's behavior problems. Third, plan interventions that carefully target and provide practical ways to change those patterns of interaction that are directly linked to the adolescent's drug use and other problem behaviors.[202]	Parents with adolescents 6-18 with drug use that co-occurs with other problem behaviors such as conduct problems at home and at school, oppositional behavior, delinquency, associating with antisocial peers, aggressive and violent behavior, and risky sexual behavior.	12-17 weekly 60-90 minute sessions (range 8-24 sessions)[203]	2 (Supported)[204]	Cost: $3,200[205]	Yes	
Ecologically Based Family Therapy Addresses multiple ecological systems and originated from the therapeutic work with substance-abusing adolescents who have run away from home. The treatment was developed to address immediate needs, to resolve the crisis of running away, and to facilitate emotional re-connection through communication and problem solving skills among family members. The intervention includes family systems techniques such as reframes, relabels, and relational interpretations; communication skills training; and conflict resolution, but also therapeutic case management in which systems outside the family are directly targeted.[206]	Ages 12–17 with substance abuse issues	12 home-based (or office-based) family therapy sessions and 2–4 individual HIV prevention sessions. Duration: 12-16 weeks	2 (Supported)	N/A	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
Families Facing the Future for parents taking methadone The parent training format combines a peer support and skill training model to teach skills using the "guided participant modeling." Skills are modeled by trainers and other group members, then discussed and practiced by participants. Video-tape is frequently used in modeling the skills or during practice of the skills. The training focuses on affective and cognitive as well as behavioral aspects of performance.[207]	Adults and their children ages 5–14[208]	One, five-hour family retreat and 32 hour-and-a-half groups-based parent training sessions. Sessions are conducted twice a week.[209] Duration: 16 weeks	2 (Supported)	N/A	Yes[210]	
Functional Family Therapy (FFT) for adolescents with substance use disorder FFT is a family intervention program for dysfunctional youth. *FFT* has been applied to a wide range of problem youth and their families in various multi-ethnic, multicultural contexts. While *FFT* targets youth aged 11–18, younger siblings of referred adolescents often become part of the intervention process. *FFT* has been conducted both in clinic settings as an outpatient therapy and as a home-based model.[211]	11–18 year olds with drug or alcohol abuse (but also for conduct disorder and violent acting-out)	8 to 12 one-hour sessions for mild cases and up to 30 sessions of direct service for more difficult situations. Duration: sessions are spread over a three-month period.	2 (Supported) *Campbell 2015 Review:* Mixed effects were found in that cannabis use was reduced at a 4 month follow-up disappears in the longer term.[212]	Cost: $3,134 Savings and B-C: N/A [213]	Yes[214]	CA, MD, NY
Helping Women Recover & Beyond Trauma (HWR/BT) [Substance Abuse Treatment (Adult)] *HWR/BT* is a 29-session intervention that integrates three theories: a theory of addiction, a theory of women's psychological development, and a theory of trauma; and then adds a psychoeducational component that teaches women what trauma is, its process, and its impact. The program model is organized into seven modules. The first four: Self, Relationships, Sexuality, and Spirituality are	Adult women with addictive disorders and a trauma history Opioid drug abuse, positive parenting	1 or 2, 90-minute sessions of Helping Women Recover per week. 1 or 2, 2-hour sessions of Beyond Trauma per week	2 (Supported)	N/A	Yes[216]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
areas that recovering women have identified as triggers for relapse and as necessary for growth and healing. The last three: Violence, Abuse, and Trauma; The Impact of Trauma on Women's Lives; and Healing from Trauma; focus on the trauma with a major emphasis on coping skills, with specific exercises for developing emotional wellness. The program comes with facilitator's manuals, two participant workbooks (A Women's Journal and A Healing Journey), and 3 DVDs. The materials are designed to be user-friendly and self-instructive. A special edition for criminal justice settings has also been developed.[215]		Duration: 29 total sessions, over approximately 4–7 months				
Methadone maintenance for opioid use disorder Methadone is an opiate substitution treatment used to treat opioid dependence. It is a synthetic opioid that blocks the effects of opiates, reduces withdrawal symptoms, and relieves cravings. Methadone is a daily medication dispensed in outpatient clinics that specialize in methadone treatment and is often used in conjunction with behavioral counseling approaches.	Adults with opioid drug abuse	N/A	2 (Supported)+ (Rated as effective by NREPP)[217]	Cost: $3,613 (2012) Savings: $4,488 B-C: $2.19[218]	N/A	
Buprenorphine (or buprenorphine/naloxone) maintenance treatment for opioid use disorder Buprenorphine/buprenorphine/naloxone is an opiate substitution treatment for opioid dependence. It is a daily medication generally provided in addition to counseling therapies. Buprenorphine/buprenorphine/naloxone is a partial agonist that suppresses withdrawal symptoms and blocks the effects of opioids. Two versions of buprenorphine are used in the treatment of opioid	Adults with opioid drug abuse	N/A	2 (Supported)+ (Rated as effective by NREPP)[219]	Cost: $4,431 Loss: ($3,458) B-C: $1.75[220]	N/A	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
dependence. Subutex consists of buprenorphine only while Suboxone is a version of buprenorphine that combines buprenorphine and naloxone. The addition of naloxone reduces the probability of overdose and reduces misuse by producing severe withdrawal effects if taken any way except sublingually. Suboxone is generally given during the maintenance phase and many clinics will only provide take-home doses of Suboxone. Buprenorphine and buprenorphine/naloxone are alternatives to methadone treatments and, unlike methadone, can be prescribed in office-based settings by physicians that have completed a special training.						
Injectable naltrexone for opiates Long-acting injectable naltrexone is used as an alcohol or opiate antagonist to treat alcohol or opiate dependence. Naltrexone is an antagonist that blocks the euphoric effects of alcohol or opiates, and patients do not develop tolerance or experience withdrawal symptoms when they stop taking the drug. It is intended to reduce cravings and prevent relapse.[221]	Adults with opioid drug abuse	N/A	2 (Supported)+ (Not CEBC but reviewed by WSIPP: Effect size: -.566)[222]	Cost: $16,356 (2015) Loss: ($17,409) B-C: ($0.05)[223]	N/A	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education						
AVANCE Parent-Child Education Program AVANCE's philosophy is based on the premise that education must begin in the home and that the parent is the child's first and most important teacher. The PCEP fosters parenting knowledge and skills through a nine-month, intensive bilingual parenting curriculum that aims to have a direct impact on a young child's physical, emotional, social, and cognitive development. Parents/primary caregivers are taught how to make toys out of common household materials and how to use them as tools to teach their children school readiness skills and concepts. Monthly home visits are also conducted to observe parent-child interactions and provide guidance in the home on learning through play. Along with the parenting education component, parents/primary caregivers are supported in meeting their personal growth, developmental and educational goals to foster economic stability. While parents/primary caregivers attend classes, their children under the age of three are provided with early childhood enrichment in a developmentally appropriate classroom setting which aims to build the academic, social, and physical foundation necessary for school readiness.[224] Note that this program appears to require a classroom component, and that portion of the cost may not be reimbursable by FFPSA.	Parents with children from birth to 3, pregnant women and/or partners of pregnant women, especially those with challenges such as poverty; illiteracy; teen parenthood; geographic and social marginalization; and toxic stress	Parent/primary caregiver contacts: Once per week for three hours - Child contacts: Once per week for three hours (early childhood education provided while parents are in class) Parent-Child contacts: Once per month for 30–45 minutes (minimum) in the home	2 (Supported)	N/A	Yes[225]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education						
Home Instruction for Parents of Preschool Youngsters (HIPPY) A home-based and parent-involved school readiness program that helps parents prepare their children ages three to five years old for success in school and beyond. The parent is provided with a set of carefully developed curriculum, books, and materials designed to strengthen their child's cognitive and early literacy skills, as well as their social, emotional, and physical development. The *HIPPY* Curriculum contains 30 weekly activity packets, a set of storybooks, and a set of 20 manipulative shapes for each year. In addition to these basic materials, supplies such as scissors and crayons are provided for each participating family. The program uses trained coordinators and community-based home visitors who go into the home. These coordinators and home visitors role-play the activities with the parents and support each family throughout.	3–5 years old Child development and school readiness, Positive parenting practices	Weekly home visits Duration: A minimum of 30 weeks of interaction with the home visitor- - up to three years total of home visiting services Duration: 30 weeks or more	2 (Supported) Research outcomes: Child development and school readiness, Positive parenting practices	Cost: $2,050 (2016) Cost: $2,050 Loss: ($499) B-C: ($0.88)[226]	Yes[227]	
SafeCare A home-visiting program where parents are taught child behavior management, home safety, and child healthcare skills in order to avoid child maltreatment.	Parents of children under the age of 5 who are at risk of child maltreatment.	Weekly 60 minute home visits Duration:15–20 weeks	2 (Supported)	Cost: $1,950 (2010) Savings: $3,563 B-C: $20.25[228]	Yes[229]	AR, MT, TX, WA

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education						
Tuning In To Kids (TIK) Work with parents and caregivers of young children with disruptive behaviors, can be used as a preventative/early intervention strategy. A parenting program that focuses on emotions and emotion coaching. Note that this program appears to require a classroom component, and that portion of the cost may not be reimbursable by FFPSA.	Ages 1–18	6–10 sessions 2 day, 14 hour training to prepare staff	2 (Supported)	N/A	Yes[230]	
Tuning In To Teens (TINT) Work with parents and caregivers of adolescents with disruptive behaviors, can be used as a preventative/early intervention strategy. A parenting program that focuses on emotions and emotion coaching. New Jersey modified TINT for overlays to help staff work with adoptive and guardian parents. Note that this program appears to require a classroom component, and that portion of the cost may not be reimbursable by FFPSA.	Ages 10–18	6–10 sessions Duration: 6-10 weeks	2 (Supported)	N/A 2 day, 14 hour training to prepare staff	Yes[231]	NJ

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Individual and Family Counseling						
Child Parent Relationship Therapy (CPRT) A brief intervention used to treat adolescent drug use that occurs with other problem behaviors. These co-occurring problem behaviors include conduct problems at home and at school, oppositional behavior, delinquency, associating with antisocial peers, aggressive and violent behavior, and risky sexual behavior.	Ages 12–18 with drug use and other problem behaviors.	12–16 sessions Duration: 12-16 weeks	2 (Supported)	Cost: $545 Savings: -$192 B-C: $0.65[232]	Yes[233]	KY
Child-Parent Psychotherapy (CPP)[234] The aim of this intervention is to support and strengthen the relationship between a child and his or her parent (or caregiver) to help restore child's sense of safety, attachment, and appropriate affect and improve the child's cognitive, behavioral and social function. This program is typically conducted in a(n): Adoptive Home, Birth Family Home, Community Agency, Foster/Kinship Care, Outpatient Clinic or School	Ages 0–5 who have experienced a trauma, and their caregivers to improve secure attachment in the children.	1 to 1.5-hour sessions each week Duration: 52 weeks	2 (Supported)	N/A Training costs available.[235]	Yes[236]	IL, IN, WI
Functional Family Therapy (FFT) FFT is a family counseling intervention targeted toward youth-family conflict areas. While FFT is increasingly being used in child welfare, the vast majority of FFT studies are based on programs targeted toward high risk youth who have had previous contact with the juvenile justice system or who are at risk of delinquency. A clinician meets in the home with the youth and his or her family to progressively build protective factors against delinquency while mitigating risk factors, or to improve parent and youth functioning in child welfare. The intermediate program goals focus on improving interpersonal relationships between family	Ages 11–18. Youth-family conflict areas, such as physical or verbal aggression, and other behavioral or emotional problems	12-14 sessions Duration: 3–4 months[238]	2 (Supported)[239]	Cost: $3,134 Savings: A New Jersey study found cost savings over a multi-year period of FFT implementation.[240]	Yes[241]	CA, MD

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Individual and Family Counseling						
members and then building those skills in extra-family relationships.[237]						
Intensive Family Preservation Services (HOMEBUILDERS®) A prevention intervention that consists of short term, in-home, intensive family-based services targeted at families facing child removal.	Parents of children ages 3–25 who are at risk of child maltreatment or foster care placement due to the behavior of the child.	Duration: 4–6 weeks	2 (Supported)[242]	Cost: $3,547 (2008) Savings: $13,005 B-C: $4.73 [243]	Yes[244]	DC, KY, MD, WA
Multisystemic Therapy (MST)[245] An intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues and their families. The primary goals of MST are to decrease youth criminal behavior and out-of-home placements. The California Evidence Based Clearinghouse for Child Welfare lists three adaptations of MST that have high ratings for research support—MST Child Abuse and Neglect (MST-CAN), and MST for Youth with Problem Sexual Behavior (MST-YPSB).	Ages 12–17, with possible substance abuse issues who are at risk of out-of-home placement due to antisocial or delinquent behaviors and/or youth involved with the juvenile justice system	Weekly sessions, with multiple therapist-family contacts each week, that become less frequent as discharge approaches. Duration: 4 months	2 (Supported) *Campbell 2015 Review:* No significant effects were found for decreasing the need for out-of-home placements.[246]	Cost: $7,076 Savings: $4,824 B-C: $1.62[247]	Yes[248]	CA, CO, MD, NY
Parenting with Love and Limits (PLL) An integrative group and family therapy approach that integrates parenting skills with in home trauma-informed family therapy and child behavioral management with the parents and their kinship network to prevent high risk youth from home removal or to accelerate permanency while preventing re-entry into foster care.	Parents of youth ages 10-18 Family conflict, unresolved trauma, and child behavioral or emotional	6- 20 individual/family counseling sessions (90 minutes on average).[249]	2 (Supported)	Cost: $2,600 per youth[250] *Savings:* $1,197.39 to $2,268.33 per youth	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Individual and Family Counseling						
	problems, juvenile delinquent behavior	Duration: 3-4 months				
Strengthening Families for Parents and Youth 10–14 A family skills training intervention designed to enhance school success and reduce youth substance use and aggression among 10- to 14-year-olds. It is theoretically based on several etiological and intervention models including the biopsychosocial vulnerability, resiliency, and family process models.	Parents and their children ages 10–14 with substance use, aggression and school success issues.	Seven 2-hour group sessions and four optional booster sessions Duration: 11 weeks	2 (Supported)+ (Rated as effective by NREPP)	Cost: $754 (2009) Savings: $4,547 B-C: $6.45[251]	Yes	

Section III: Interventions that Appear to Qualify Under the FFPSA Criteria of *Promising*

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
1-2-3 Magic This is a group format discipline program for parents of children. The program can be used with children with and without cognitive impairments. 1-2-3 Magic divides the parenting responsibilities into three straightforward tasks: controlling negative behavior, encouraging good behavior, and strengthening the child-parent relationship. The program seeks to encourage gentle, but firm, discipline without arguing, yelling, or spanking.[252]	2–12 years of age Behavior problems	1–2, 1.5-hour sessions per week Duration: 4–8 weeks	3 (Promising)	N/A	Yes (plus Spanish)[253]	
ACTION A developmentally sensitive group treatment program for depressed youth that follows a structured therapist's manual and workbook. Each of the 20 group and 2 individual meetings lasts approximately 60 minutes. The child treatment is designed to be fun and engaging while teaching the youngsters a variety of skills and therapeutic concepts that are applied to their depressive symptoms, interpersonal difficulties, and other stressors.	9 to 14-year olds who are depressed	2 one-hour sessions a week, but one session will work if time/transportation is an issue. 20 group meetings and 2 individual meetings Duration: 11 weeks	3 (Promising)	N/A	Yes	
Adolescent Coping with Depression (CWD-A) A cognitive behavioral group intervention that targets specific problems typically experienced by depressed adolescents. Each participant receives a workbook that provides structured learning tasks, short quizzes, and homework forms. To encourage generalization of skills to everyday situations, adolescents are given homework	Ages 13–17. Anxiety, discomfort, irrational/negative thoughts, limited experiences of pleasant activities, poor social skills	16 two-hour sessions for mixed-gender groups of up to 10 adolescents Duration: 8 -16 weeks	3 (Promising) (NREPP ratings: 3.6–3.8)	N/A[255]	Yes[256]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
assignments that are reviewed at the beginning of the subsequent session.[254]						
Behavioral Activation Treatment for Depression (BATD) The BATD program's primary goal is to reduce depressive symptoms. It is aimed at helping clients reconnect with their values across several life areas. It begins with behavioral monitoring of daily activities with an examination of the extent to which the client currently is living according to these values. In moving the client towards this more valued life, *BATD* uses a structured approach aimed at identifying activities that fit within the client's values on a daily basis. The program also uses contracts to recruit social support for these efforts. *BATD* can be conducted individually or in groups. It was designed to be a 10-12 session treatment, but has been shown to be efficacious in shorter durations.	Depressed adults including those with substance abuse problems	30–50-minute weekly sessions Duration: 10–12 weeks	3 (Promising)	N/A	Yes	
Brief Eclectic Psychotherapy for PTSD (BEPP) The 16-session ***Brief Eclectic Psychotherapy for PTSD (BEPP)*** protocol starts with psychoeducation on posttraumatic stress disorder (PTSD). The patient and his/her partner learn to understand the symptoms of PTSD as dysfunctional, and caused by the traumatic event. The patient will then receive 4-6 sessions of relaxation and imaginary exposure, focused on the suppressed intense emotions of sorrow.	Adult patients suffering from posttraumatic stress disorder	45–60-minute weekly sessions Duration: 16 weeks	3 (Promising)	N/A	Yes	
C.A.T. Project The program provides education about anxiety, skills for identifying and managing anxiety, and an approach to face	Youth ages 12–18	Duration: 16 weeks	3 (Promising)	N/A	Yes[257]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
one's fears and develop mastery. This requires exposure tasks.						
Child-Centered Play Therapy (CCPT) A developmentally responsive, play-based mental health intervention for children who are experiencing social, emotional, behavioral, or relational disorders. CCPT uses play and the therapeutic relationship to provide a safe, consistent therapeutic environment in which a child can experience full acceptance, empathy, and understanding from the counselor and process inner experiences and feelings through play and symbols. In CCPT, a child's experience within the counseling relationship is the factor that is most healing and meaningful in creating lasting, positive change. The goal of CCPT is to develop the child's potential to move toward integration and self-enhancing ways of being.[258]	Children ages 3–10 with problems in general functioning, anxiety and disruptive behavior disorders	16–20 weekly, 45-minute individual play sessions[259] Duration: 16–20 weeks	3 (Promising)+ (NREPP rating)	N/A	Yes	
CICC's Effective Black Parenting Program (EBPP) *EBPP* is a parenting skill-building program created specifically for parents of African-American children. It was originally designed as a 15-session program to be used with small groups of parents. A one-day seminar version of the program for large numbers of parents has been created.[260]	For African-American parents/caregivers of children ages 0 – 17 where parental rejection, quality of family relationships, and child behavior outcomes may be present	Weekly three-hour sessions or a one-day 6.5 hours abbreviated seminar version Duration: 1-15 weeks	3 (Promising)	N/A	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
Cognitive Behavioral Analysis System of Psychotherapy (CBASP) Developed solely for the treatment of the chronic depressive adults. Most patients present with maltreatment developmental histories that impede normal cognitive-emotive growth in the ability to related socially with others. Hence, patients begin treatment functioning in a primitive manner meaning their thought and feeling patterns are not very organized, self-centered, and prelogical, and they talk to therapists in a monologic manner. Chronic depression is essentially a chronic mood disorder and does not fit the typical description of major depression that comes and goes as a "thinking disorder."	Chronically depressed adults	Thirty 1-hour weekly sessions Duration: 7–8 months	3 (Promising)	N/A	Yes	
Cognitive Processing Therapy (CPT) Developed originally for use with rape and crime victims, CPT begins with the trauma memory and focuses on feelings, beliefs, and thoughts that directly emanated from the traumatic event. The therapist then helps the clients examine whether the trauma appeared to disrupt or confirm beliefs prior to this experience, and how much the clients have over-generalized (over-accommodated) from the event to their beliefs about themselves and the world. Clients are then taught to challenge their own self-statements using a Socratic style of therapy (leading clients to understand their reasoning processes and beliefs through questions), and to modify their extreme beliefs to bring them into balance. CPT can be conducted individually or in groups where the written trauma account is completed in an individual session.[261]	Older adolescents and adults. Trauma symptoms, including depression, anxiety, guilt/shame, or anger	One-on-one: 1–2 sessions per week totaling 12 sessions (50 minutes per session), Group: weekly 90-minute sessions Duration: about 12 weeks	3 (Promising)	N/A	Yes[262]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
Combined Parent-Child Cognitive-Behavioral Therapy (CPC-CBT) Helps the child heal from the trauma of the physical abuse, empowers and motivates parents to modulate their emotions and use effective non-coercive parenting strategies, and strengthens parent-child relationships while helping families stop the cycle of violence. Program is grounded in cognitive behavioral theory and incorporates elements (e.g., trauma narrative and processing, positive reinforcement, timeout, behavioral contracting) from CBT models for families who have experienced sexual abuse, physical abuse, and/or domestic violence, as well as elements from motivational, family systems, trauma, and developmental theories.	Children ages 3–17 and their parents (or caregivers) in families where parents engage in a continuum of coercive parenting strategies and children may present with PTSD symptoms, depression, behavioral problems and other difficulties	16 individual or group sessions Duration: 16–20 weeks	3 (Promising)	N/A ($2k–$3k per day for training)[263]	Yes[264]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
Defiant Children: A Clinician's Manual for Assessment and Parent Training (The Barkely Method of Behavioral Parent Training) A scientifically based behavioral paradigm and set of methods in which to train parents in the management of defiant/ oppositional defiant disorder (ODD) children. The program involves training parents in 10 steps through weekly sessions that have proven effectiveness in reducing defiance and ODD symptoms in children ages 4-12 years. The manual also provides information on the assessment of these children prior to intervention and with rating scales to use to monitor changes that occur during treatment. The manual further provides the parent handouts that are to be given by the therapist at each step. Therapists are granted limited permission to photocopy the assessment tools and rating scales as well as the parent handouts for use with families undergoing treatment in their practice.	Parents of children ages 4–12	1 hour (individual parent) or 2 hours (group parent) training per week Duration: 10 weeks	3 (Promising)	N/A	Yes	
Exchange Parent Aide Program consists of trained, professionally supervised individuals (volunteer or paid) who provide supportive and educational in-home services to families at risk of child abuse and neglect. Agencies elect to use paid and/or volunteer Parent Aides to provide services based on their community needs and resources. Services are strength-based and family-centered. Auxiliary services enhance service delivery (e.g., group-based parenting classes).	Ages 0–12	1 or 2 home visits per week, lasting 1–2 hours each Duration: 9–12 months	3 (Promising)	N/A	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
Fairy Tale Model (Treating Problem Behaviors: A Trauma-Informed Approach) The Fairy Tale Model is a model of trauma-informed psychotherapy and is so named because it is taught with the telling of a fairy tale, in which each element of the story corresponds to one of the phases in treatment. Following the treatment manual, *Treating Problem Behaviors: A Trauma-Informed Approach*, this phase model of trauma-informed treatment calls for a given phase of treatment to be pursued until the client outcome specified for that phase has been achieved. The treatment manual has scripted interventions for working with teens individually.[265]	Ages 13–18	Varies by client/situation	3 (Promising)	N/A	Yes	
Family Connections Multifaceted, community-based service program that works with families in their homes and in the context of their neighborhoods to help them meet the basic needs of their children and prevent child maltreatment. Individualized family intervention is geared to increase protective factors, decrease risk factors, and target child safety, well-being, and permanency outcomes.	Children 0–17 in families at risk of maltreatment	One hour once per week Duration: 3–4 months, with an optional 90-day extension if needed	3 (Promising)[266]	N/A	Yes	CO, MD
Family Spirit[267] ▪ John's Hopkins Family Spirit Research Findings: https://www.jhsph.edu/research/affiliated-programs/family-spirit/proven-results/research-findings/ ▪ ChildTrends: https://www.childtrends.org/programs/family-spirit	Addresses maternal stress, substance use, depression and behavior problems, while promoting children's earliest social, emotional and behavioral development					

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
▪ Springer: https://link.springer.com/article/10.1007/s11121-012-0277-2						
Helping the Noncompliant Child A skills-training program aimed at teaching parents how to obtain compliance in their children ages 3 to 8 years old. The goal is to improve parent-child interactions in order to reduce the escalation of problems into more serious disorders (e.g., conduct disorder, juvenile delinquency).	Children ages 3–8 with disruptive behavior Together	60-to-90–minute sessions once or Two sessions per week, for a total of 5–14 sessions Duration: 7–14 weeks	3 (Promising)[268]	Cost: $1,612 Savings: $857 B-C: $2.23[269]	Yes[270]	
Interpersonal Psychotherapy for Depressed Adolescents (IPT-A) Interpersonal Psychotherapy (IPT) is a time-limited, manualized psychosocial treatment for depression in adolescents and adults. IPT for adults has been rated by the CEBC in the area of Depression Treatment (Adult). IPT identifies how interpersonal issues are related to the onset or maintenance of depressive symptoms while recognizing the contributions of genetic, biological, and personality factors to vulnerability for depression. Patients work to understand the effects of interpersonal events on their mood and to improve their communication and problem-solving skills in order to increase their effectiveness and satisfaction in current relationships.[271]	Ages 12–18	45–50-minute weekly sessions Duration: 12–16 weeks	3 (Promising)	N/A	Yes	
Life Space Crisis Intervention (LSCI) *LSCI* is an interactive therapeutic strategy for turning crisis situations into learning opportunities for children and youth	Adults working and living with children and youth who	The intervention is intended to be used as needed	3 (Promising)	N/A	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
with chronic patterns of self-defeating behaviors. *LSCI* views problems or stressful incidents as opportunities for learning, growth, insight, and change.	escalate incidents into no-win power struggles, distort reality, are self-abusive, engage in destructive peer relationships, lack social skills, and show little conscience for aggressive behavior	when individuals are in crisis and display disruptive behaviors.				
Mindfulness-Based Cognitive Therapy for Children (MBCT-C) A psychotherapy for anxious or depressed children adapted from MBCT for adults which has been rated by the CEBC in the Depression Treatment (Adult) topic area. The adult and child programs both combine mindfulness-based theory and practices with cognitively oriented interventions. The aim is to improve affective self-regulation through development of mindful attention and decentering from thoughts and emotions. Unlike cognitive therapy, no effort is made to restructure or change existing thoughts and emotions. It includes simple meditation techniques to help participants become more aware of their experience in the present moment, by tuning in to moment-to-moment changes in the mind and the body.[272]	Children 8–12 years old	Weekly therapy sessions lasting 90-minutes, conducted individually or in small groups of 6–8 children Duration: 12 weeks	3 (Promising)	N/A	Yes	
Multisystemic Therapy Building Stronger Families (MST-BSF)[273]	For co-occurring parental substance abuse and child	N/A	3 (Promising) (Not CEBC)	N/A	N/A	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
MST-BSF is an integrated treatment model for the co-occurring problem of parental substance abuse and child maltreatment among CWS involved families.[274]	maltreatment among CWS-involved families.					
Nurturing Parenting Program for Parents and their School-age Children 5 to 12 Years A 15-session program that is group-based, and family-centered. Parents and their children attend separate groups that meet concurrently. Each session is scheduled for 2.5 hours with a 20-minute break in which parents and children get together and have fun. The lessons in the program are based on the known parenting behaviors that contribute to child maltreatment.[275]	Parents of children ages 5-12	2.5 hour sessions Duration: 15 weeks	3 (Promising)	B-C:.87[276]	Yes	
Parents Anonymous A prevention and treatment program for stressed families at risk of becoming involved in the CW system. Addresses a comprehensive list of caregiver issues such as child development, communication skills, positive discipline, parent roles, age appropriate expectations, effecting parenting strategies anger management, mental health, drug/alcohol/safety and self-care through weekly adult support groups.	Ages 0–18. Child, parent, caregivers	Group treatment, groups meet 1.5–2 hour each week. Duration: at least 3–4 months. For CW-involved families, likely 12–18 months	3 (Promising)[277]	N/A (Parent Leader certification = $3k; presume staff certification cost is similar; unable to find cost info for weekly groups)	Yes[278]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
Play and Learning Strategies–Infant Program The *PALS I* curriculum was developed to facilitate parents' mastery of specific skills for interacting with their young children including paying attention to and correctly interpreting babies' signals, responding contingently to signals, and using rich language. It is designed as a preventive intervention program to strengthen the bond between parent and baby and to stimulate early language, cognitive, and social development.	Children 5–15 months and their families	Weekly 90-minute sessions Duration: 11 weeks	3 (Promising)	N/A	Yes	
Solution-Based Casework (SBC) A case management approach to assessment, case planning, and ongoing casework. The approach is designed to help the caseworker focus on the family in order to support the safety and well-being of their children. The goal is to work in partnership with the family to help identify their strengths, focus on everyday life events, and help them build the skills necessary to manage situations that are difficult for them. This approach targets specific everyday events in the life of a family that have caused the family difficulty and represent a situation in which at least one family member cannot reliably maintain the behavior that the family needs to accomplish its goals. The model combines the best of the problem-focused relapse prevention approaches that evolved from work with addiction, violence, and helplessness, with solution-focused models that evolved from family systems casework and therapy.[279]	Children ages 0–17 and their parents/caregivers	Varies according to family needs	3 (Promising)[280]	N/A	Yes	CO

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) Predominantly cognitive – behavioral and Dialectical Behavioral Therapy and Complex Trauma theory. The curriculum also incorporates elements from early versions of Trauma Adaptive Recovery Group Education and Therapy (TARGET)[281] and Trauma and Grief Components Therapy (TGCT).[282] Key components: Mindfulness practice, Problem Solving and Meaning Making, Relationship building/ Communication Skills, Distress Tolerance, and psychoeducation regarding stress, trauma, and triggers.[283]	Ages 12–21 for adolescents with complex trauma. Prevents runaways,	16, 60 minute sessions Duration: 12 or more weeks	3 (Promising)+ rating based on outcome research as no registry recognizes this intervention but it combine effective strategies[284]	N/A	Yes[285]	Yes
Structured Sensory Intervention for Traumatized Children, Adolescents and Parents (SITCAP-ART) *SITCAP-ART* is a comprehensive trauma intervention program, modified from the original *Structured Sensory Intervention for Traumatized Children, Adolescents and Parents (SITCAP)* program. It integrates cognitive strategies with sensory/implicit strategies. When memory cannot be linked linguistically in a contextual framework, it remains at the symbolic level for which there are no words to describe. To retrieve that memory so it can be encoded, given a language, and then integrated into consciousness, it must be retrieved and externalized in its symbolic perceptual (iconic) form.	Ages 12–17, children/ adolescents & parents/caregivers. At-risk or adjudicated youth with a history of trauma and/or loss.	Weekly 1-hour sessions Duration: 8–10 weeks	3 (Promising)	N/A (Training on-site or via TLD Institute trainings – min 2 day training ($300–$900/person)	Yes[286]	
Trauma and Grief Component Therapy for Adolescents (TGCT-A) A manualized group or individual treatment program for trauma-exposed or traumatically bereaved older children and adolescents that may be implemented in school,	Ages 12–20	50–75 minute weekly sessions Duration:for 12–26 weeks[287]	3 (Promising)[288]	N/A	Yes[289]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
community mental health, clinic, or other service settings. The program has been implemented with a wide range of trauma-exposed and traumatically bereaved older child and adolescent populations, in both the United States and international settings. These populations include youth impacted by community violence, traumatic bereavement, natural and man-made disasters, war/ethnic cleansing, domestic violence, witnessing interpersonal violence, medical trauma, serious accidents, physical assaults, gang violence, and terrorist events.						
Wraparound (child treatment focus) Team-based planning process intended to provide individualized and coordinated family-driven care. Wraparound is designed to meet the complex needs of children who are involved with several child and family-serving systems (e.g., mental health, child welfare, juvenile justice, special education, etc.), who are at risk of placement in institutional settings, and who experience emotional, behavioral, or mental health difficulties.	Children age 0–17	Intensive engagement and planning process of 2, 60–90 minute sessions and 2 team sessions in the first month. Duration: About 14 months	3 (Promising)	Yes but varies by the study[290]	Yes	AR, HI, NE, RI, TN

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
C.A.R.E.S. (Coordination, Advocacy, Resources, Education and Support) A community-based prevention and diversion program utilizing Wraparound Family Team Conferencing to successfully engage and serve families who are at risk of child abuse and neglect.[291]	Families at high risk for abuse or neglect with children ages 0–17	Varies by needs of family. Averages 5–10 hours per week, with higher intensity at entry to program Duration: 6 months	3 (Promising)	N/A	Yes	
Treatment For Youth With Substance Abuse						
Seeking Safety (for youth) A present-focused, coping skills therapy to help people attain safety from trauma and/or substance abuse. The treatment is available as a book, providing both client handouts and clinician guidelines. The treatment may be conducted in group or individual format for adolescents (both females, and males) in various settings (e.g., outpatient, inpatient, residential, home care, and schools). *Seeking Safety* consists of 25 topics that can be conducted in any order and number. Examples of topics are Safety, Asking for Help, Setting Boundaries in Relationships, Healthy Relationships, Community Resources, Compassion, Creating Meaning, Discovery, Recovery Thinking, Taking Good Care of Yourself, Commitment, Coping with Triggers, Self-Nurturing, Red and Green Flags, and Life Choices.[292]	Children and adolescents ages: 12–17 with \substance abuse and trauma [Seeking Safety has also been rated by the CEBC in the areas of Substance Abuse Treatment (Adult) and Trauma Treatment.]	• Group intervention (between 2 and 50 participants per group); is also available as an individual intervention. Sessions intensity is flexible: 1 hour once per week, others 1.5 hours twice a week, etc. Duration: 3–6 months	3 (Promising)	Cost: $526 (2013)[293]	Yes[294]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
Treatment for Adults with Substance Abuse						
Alcohol Behavioral Couple Therapy This is an outpatient treatment for individuals with an alcohol use disorder, which includes their intimate partners in the treatment program. ABCT assumes that an individual's alcohol use has an impact on a couple's relationship and that this relationship conflict can similarly affect the individual's alcohol use. Based on social learning theory and the family systems model, ABCT incorporates communication, problem-solving, self-control, and contingency-management skills to maintain abstinence from substance use and promote healthy relationship functioning.	Adults with Alcohol Use and Alcohol Use Disorder	12–20 weekly sessions of up to 90 minutes each, with both the client and intimate partner.[295] Duration: 21 weeks	3 (Promising)+ NREP rating of promising	N/A	Yes	
Cognitive-Behavioral Coping-Skills Therapy for alcohol or drug use disorders Encompasses a variety of interventions that emphasize different targets. The individual and group treatments include motivational interventions, contingency management strategies, and Relapse Prevention and related interventions with a focus on functional analysis.[296]	Adults	Not available	3 (Promising) Not CEBC	Cost: $842 (2013) Savings: $5,572 B-C: $21.95[297]	Not available	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
Matrix Model Intensive Outpatient program The Matrix model is an intensive, outpatient treatment approach for individuals with substance use disorders, which was developed through 30 years of experience in real-world treatment settings. The intervention integrates aspects of several treatment approaches, including cognitive-behavioral therapy, contingency management, motivational interviewing, 12-step facilitation, family involvement, and supportive/person-centered therapy.	Adults	Duration: 16 weeks	3 (Promising)+ NREPP for Stimulant Use	Cost: $1,281 Savings: ($2,748) B-C: ($2.15)[298]	Yes	ME
Seeking Safety (for adults) See the description in the catalog entry above.[299]	Adults with substance abuse and trauma	Group intervention 1-1.5 hour once or twice per week Duration: 3–6 months (See the description in the catalog entry above.)	3 (Promising)	$526 (2013)[300]	Yes[301]	
Sobriety Treatment and Recovery Teams (START) START pairs child protective services workers trained in family engagement with family mentors (peer support employees in long-term recovery) using a system-of-care and team decision-making approach with families, treatment providers, and the courts. Essential elements of the model include quick entry into START services to safely maintain child placement in the home when possible and rapid access to intensive addiction/mental health assessment and treatment. (Note this is a case	Families with at least one child under 6 years of age who are in the child welfare system and have a parent whose substance use is determined to be a primary child safety risk factor	Weekly home visits by CPS caseworker and mentor; addiction and co-occurring MH treatment intensity as determined by assessment; for 14 months,	3 (Promising)	N/A	Yes (Manual is currently in development)	IL, KY, NV

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
management and family support strategy that is designed to accompany SA treatment.)		including at least 6 months of documented sobriety before closing the case				
12-Step Facilitation Therapy for Substance Abuse (TSF) A brief, structured, and manual-driven approach to facilitating early recovery from alcohol abuse, alcoholism, and other drug abuse and addiction problems.	Adults[302]	TSF is implemented with individual clients or groups over 12–15 sessions.[303] The intervention is based on the behavioral, spiritual, and cognitive principles of 12-step fellowships such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA).[304] Duration: 15 weeks	3 (Promising)+ SAMHSA NREPP[305] *Campbell 2017 Review:* Significant effect was found for drug abuse at a 6 month follow-up but not at 12 months.[306]	Cost: $407 (1993) Savings: $5,392 B-C: $N/A[307]	Yes[308]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education						
All Babies Cry (ABC) A strengths-based prevention program that targets the parents of infants, with the goal of reducing incidences of child abuse during the first year of life. Infant crying is the most common precursor to child maltreatment in the first year of life. ABC aims to improve new parents' ability to understand and cope with infant crying. ABC is a multiple-dose intervention intended for use from hospital discharge through the infant's first months of life. The core program components include (1) a short video program for hospital closed-circuit TV systems or classroom introduction; (2) media, including videos, for families to access at home or on mobile platforms; and (3) a booklet with checklists and activities. The components employ positive visual messaging and focus subtly on males (the perpetrators of a majority of pediatric abusive head trauma cases).[309]	Adults to prevent child abuse	Duration: 3–6 months	3 (Promising)+ NREPP rating of promising	N/A	Yes	
Circle of Security-Home Visiting-4 (COS-HV4) *COS-HV4* is a version of Circle of Security that includes a mandatory home visiting component consisting of 4 home visits. One of the special features is use f videotaping parent-child interactions. The protocol focuses on: 1. Teaching caregivers the fundamentals of attachment theory (i.e., children's use of the caregiver as a secure base from which to explore and a safe haven in times of distress) by introducing a user-friendly graphic to the caregivers that they can refer to throughout the program 2. Exploring not only parenting behaviors but also internal working models	Families with children younger than 6 years old in high-risk populations such as child enrolled in Early Head Start, teen moms, or parents with irritable babies	One 3-hour assessment session followed by a 1.5-hour session every two to three weeks Duration: four home visits (after an out-of-home assessment) over a period of three months	3 (Promising)	N/A	Yes[311]	MT

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education						
3. Presenting caregivers with a simple structure for considering the ways in which their internal working models influence their cognitive, affective, and behavioral responses to their children, thus helping caregivers gain awareness and understanding of the non-conscious, problematic responses they sometimes have to their children's needs.[310]						
Collaborative Problem Solving (CPS) *CPS* is an approach to understanding and helping children with behavioral challenges who may carry a variety of psychiatric diagnoses, including oppositional defiant disorder, conduct disorder, attention-deficit/hyperactivity disorder, mood disorders, bipolar disorder, autism spectrum disorders, posttraumatic stress disorder, etc. *CPS* uses a structured problem solving process to help adults pursue their expectations while reducing challenging behavior and building helping relationships and thinking skills. Specifically, the *CPS* approach focuses on teaching the neurocognitive skills that challenging kids lack related to problem solving, flexibility, and frustration tolerance. Unlike traditional models of discipline, this approach avoids the use of power, control, and motivational procedures and instead focuses on teaching at-risk kids the skills they need to succeed. *CPS* provides a common philosophy, language and process with clear guideposts that can be used across settings. In addition, *CPS* operationalizes principles of trauma-informed care.[312]	Parents/caregivers of children ages 3 – 21 and the children themselves regarding parenting skills and child behavior related to oppositional defiant disorder or conduct disorder such as distractibility-hyperactivity and adaptability.	Weekly for 1 hour. Can also be delivered in-home with greater frequency and intensity, such as twice a week for 90 minutes. Parent training group sessions occur once a week for 90 minutes over the course of 4 or 8 weeks. Duration: 4-12 weeks	3 (Promising)	N/A	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education						
Early Head Start-Home Visiting (EHS-HV) Early Head Start–Home Visiting is a comprehensive, two-generation federal initiative aimed at enhancing the development of infants and toddlers while strengthening families. The program is founded on nine principles: (1) high-quality services; (2) activities that promote healthy development and identify atypical development at the earliest stage possible; (3) positive relationships and continuity, with an emphasis on the role of the parent as the child's first, and most important, relationship; (4) activities that offer parents a meaningful and strategic role in the program's vision, services, and governance; (5) inclusion strategies that respect the unique developmental trajectories of young children in the context of a typical setting, including children with disabilities; (6) cultural competence that acknowledges the profound role that culture plays in early development; (7) comprehensiveness, flexibility, and responsiveness of services that allow children and families to move across various program options over time as their life situation demands; (8) transition planning; and (9) collaboration with community partnerships that allow programs to expand their services.[313]	Pregnant women with children ages birth to 3 years[314] Successfully improves: Child development and school readiness, Positive parenting practices, Family economic self-sufficiency, Linkages and referrals[315]	1 weekly 90-minute home visit, 2 group socialization activities per month Duration: at least 1 year	3 (Promising) HOM-VEE report	N/A	N/A	
Infant Health and Development Program (IHDP) The Infant Health and Development Program (IHDP) is an early intervention program for preterm (< 37 weeks gestation), low birthweight (< 2,500 grams) infants that aims to improve children's cognitive and behavioral outcomes. This three-year intervention includes home visits, weekday attendance at an educational child day care program, and bimonthly parent group meetings.	Birth to 35 months	Duration: 3 years, including home visits and weekly educational child day care program	3 (Promising) Not CEBC, research outcomes: Child health, Positive parenting practices[316]	Cost: $13,636 (2016) Loss: ($41,188) B-C: ($0.04)[317]	N/A	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education						
GenerationPMTO (Individual Delivery Format) GenerationPMTO was formerly known as Parent Management Training - the Oregon Model (PMTO®). *GenerationPMTO (Individual Delivery Format)* is a parent training intervention that can be used in family contexts including two biological parents, single-parent, re-partnered, grandparent-led, reunification, and foster families. The intervention can be used as a preventative program and a treatment program. It can be delivered through individual family treatment in agencies or home-based and via telephone/video conference delivery, books, audiotapes and video recordings.[318]	Parents of children ages 2–18	10–25 individual or family sessions Duration: 3–6 months (or longer)[319]	3 (Promising)	Cost: $619 Savings: $5,587 B-C: $9.50[320]	Yes[321]	CO, MD, TX
Parents as Teachers Parents as Teachers is an early childhood parent education, family support and well-being, and school readiness home visiting model based on the premise that "all children will learn, grow, and develop to realize their full potential." Based on theories of human ecology, empowerment, self-efficacy, attribution, and developmental parenting, *Parents as Teachers* involves the training and certification of parent educators who work with families using a comprehensive curriculum. Parent educators work with parents to strengthen protective factors and ensure that young children are healthy, safe, and ready to learn. An agency may choose to use the Parents as Teachers model to focus services primarily on pregnant women and families with children from birth to age 3 or through kindergarten.[322]	Families with an expectant mother or parents of children up to kindergarten entry (usually 5 years)	Duration: home visits of approximately 60 minutes monthly. At least 12 home visits annually to families with one or no high-needs characteristics. At least 24 home visits annually to families with two or more high-needs characteristics. At least 2 years.	3 (Promising)	N/A	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Individual and Family Counseling						
Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT) AF-CBT is designed for families who are referred for problems related to management of anger and/or aggression, including the use of coercion and/or physical force. This includes anger and verbal aggression, family conflict, and behavior problem such as physical threats, and physical abuse.	Children and adolescents ages 5–17 and caregivers who are physically abusive or expose their children to IPAV	20 sessions at about 1–1.5 hours/each Duration: about 12 weeks [323]	3 (Promising)	N/A ($1500 per therapist to be trained.[324]	Not available	
Child FIRST (Child and Family Interagency, Resource, Support, and Training) Child FIRST, is a home-based parent–child intervention. The intervention targets young children with social-emotional problems and aims to decrease emotional and learning problems and child abuse and neglect. The program provides a two-person team of home visitors (a mental health clinician and a care coordinator) to regularly visit the family in their home, provide therapeutic services, and coordination with other services in the community.[325]	Parents with children birth to 4 years or older with difficulties in Maternal health, Child development and school readiness, child maltreatment, linkage to services and referrals[326]	Not available	3 (Promising)+ Blueprints[327]	N/A	N/A	
Cool Kids[328] Utilizes CBT, program that teaches children and their parents how to better manage the child's anxiety. It can be run either individually or in groups and involves the participation of both children and their parents. The program aims to teach clear and practical skills to both the child and parents. Variations of the program also exist for children with comorbid autism, adolescents with comorbid depression, and for delivery in school settings.	Parents and their children ages 7–17	6–10, 1–2 hour sessions (varies by the specific type of Cool Kids program)[329] Duration: 10–12 weeks	3 (Promising)	Average cost of assessment and treatment is $2460 AUD (Australian) manual/workbook required, $20–40. E-learning workshop $600 AUD	Yes[330]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Individual and Family Counseling						
Cue-Centered Treatment (CCT) Combines elements of cognitive behavioral, psychodynamic, expressive and family therapies to address conditions, behaviors, emotions and physiology (consequences of child/youth's trauma exposure)	Youth 8–18 with chronic history of trauma, adversity and ongoing stress	45 minute weekly sessions Duration: 15–18 weeks	3 (Promising)	N/A	Yes[331]	
Domestic Abuse Intervention Project - The Duluth Model (DAIP)[332] Use of a psychoeducational approach in which a feminist philosophy is taught with the assumption that battering occurs as a result of societally sanctioned male dominance and female submissiveness.	Adult perpetrators of domestic or interpersonal violence (IPV)	Weekly sessions Duration: 6 or more months	3 (Promising)[333]	Cost: $1,365 (2011)	Yes[334]	
Early Pathways Program (EPP) Home-based, parent-child therapy program for children with significant behavior and/or emotional problems. Designed specifically for a diverse population of very young children who come from families living in poverty, most of whom meet criteria for a psychiatric diagnosis. Emphasizes psychoeducation, direct clinician modeling to parents and other primary caretakers of effective strategies to strengthen the child's positive behaviors and reduce challenging ones, parent practice of new strategies with clinician feedback, and parent coaching.	Ages 0–6	Weekly sessions Duration: average of 8–12 weeks with booster sessions added as needed	3 (Promising)	N/A Online training for providers is free; a manual costs $55[335]	Yes[336]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Individual and Family Counseling						
Families First In-home intervention that addresses family conflict, parenting skills, child abuse, childhood emotional issues, disruptive behavioral problems including criminal conduct and other-at-risk situations that children, parents and families face. Utilizes the Risk Need and Responsivity Model tailored to family need.	Children and adolescents and family 0–17 (High risk children and families. Can be used with children in their biological, kin, or out-of-home placements.	6–10 hours per week (3–4 home visits) Duration: 10–12 weeks	3 (Promising)	N/A	Yes[337]	IN
Family Centered Treatment[338] FCT is designed to find simple, practical, and common sense solutions for families faced with disruption or dissolution of their family. Critical components of FCT are derivatives of Eco-Structural Family Therapy and Emotionally Focused Therapy	Children 0–17	2 multiple-hour sessions per week Lengthier/more frequent sessions available based on assessed need; 24-hr on call support Duration: 6 months	3 (Promising)	N/A	Yes	IN
Parent Child Assistance Program (PCAP)[339] Helps link women and their families with a comprehensive array of appropriate and available community resources and services, and develop a network of contacts and relationships with client's family and friends, and provide advocacy for other family members as needed. Home visits are provided by paraprofessional client advocates with similar life experiences as the mothers.	Parents of children age 0–3	Visits are weekly for the first six weeks after birth, then bi weekly or more frequently as needed. Duration: 11 to 36 months.	3 (Promising)	Substantial savings[340]	Yes	OK

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Individual and Family Counseling						
Promoting First Relationships (PFR) PFR is a manualized home visiting intervention/prevention program which includes parent training components based on strengths-based practice, practical, and in-depth strategies for promoting secure and healthy relationships between caregivers and young children (birth to 3 years). Features of *PFR* include: (a) Videotaping caregiver-child interactions to provide insight into real-life situations and help the caregiver reflect on the underlying needs of the child and how those needs impact behavior; (b) Giving positive and instructive feedback that builds caregivers' competence with and commitment to their children; and (c) Focusing on the deeper emotional feelings and needs underlying children's distress and behaviors.[341]	Children ages birth to 3 years. Focuses on improving healthy relationships between caregivers and young children	1 hour per week for ten weeks Duration: 10 or more weeks	3 (Promising) Has lowered the rate of foster care placements and increased certain parent attitudes and parenting skills.[342]	N/A	Yes[343]	
Risk Reduction through Family Therapy (RRFT) An integrative, ecologically informed, and exposure-based approach to addressing co-occurring symptoms of PTSD (and other mental health problems), substance use problems, and other risk behaviors often experienced by trauma-exposed adolescents. RRFT is novel in its integration of these components, given that standard care for trauma-exposed youth often entails treatment of substance use problems separate from treatment of other trauma-related psychopathology. RRFT is individualized to the needs, strengths, developmental factors, and cultural background of each adolescent and family.[344]	Trauma-exposed adolescents aged 13–18 years who experience co-occurring trauma-related mental health problems (e.g., posttraumatic stress disorder [PTSD], depression), substance use problems, and other risk behaviors (e.g., risky sexual behavior, non-suicidal self-injury)	18–24 weekly, 60–90 minute sessions with periodic check-ins between scheduled appointments. Duration: 24 weeks	3 (Promising)	N/A	Yes[345]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Individual and Family Counseling						
Step-by-Step Parenting Program© Breaks down essential child-care skills for children from birth to about 3 years or age into small steps. A wide-range of parenting skills are covered related to child health, safety, and development, including: newborn care; feeding and nutrition; diapering; bathing; home and sleep safety; first aid; toilet training; parent-child interactions; and positive behavior support.[346]	Parents who lack parenting skills, parents with learning differences, risk of child neglect, risk of child developmental delay and behavior problems	1 home visit per week for 1.5–2 hours; the number of visits may be extended to 2–3 visits per week, Duration: 6 -24 months	3 (Promising)	N/A	Yes	
Trauma Affect Regulation: Guide for Education and Therapy for Adolescents (TARGET-A) For children and caregivers experiencing traumatic stress; very frequently with single parents or with families whose children have limited contact with bio parents (foster kids and residential placements) and diversity of religious affiliations.[347]	Ages 10–18+	10 sessions Duration: 10–12 weeks	3 (Promising) One RCT of 59 delinquent teen girls found effects compared to treatment as usual. TARGET was favored with small to medium effects for PTSD (0.53), anxiety symptoms (0.32), posttraumatic cognitions (0.21), and emotion regulation (-0.27). (Ford, et al., 2012)	N/A (Training is provided only to programs/ agencies and cost varies depending on number of staff trained; typical range = $15,000 - $75,000 per year)	Yes[348]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Individual and Family Counseling						
Wraparound (in-home parent support focus) Team-based planning process intended to provide individualized and coordinated family-driven care. Wraparound is designed to meet the complex needs of children who are involved with several child and family-serving systems (e.g., mental health, child welfare, juvenile justice, special education, etc.), who are at risk of placement in institutional settings, and who experience emotional, behavioral, or mental health difficulties.[349]	Parents of children ages 0–17	Intensive engagement and planning process of 2, 60–90 minute sessions and 2 team sessions in the first month. Duration: About 14 months	3 (Promising)	Yes but varies by the study[350]	Yes	AR, HI, NE, RI, TN

[1] Studies that help Blues Program meet FFPSA evidence criteria include:

- Stice, E., Rohde, P., Seeley, J. R., & Gau, J. M. (2008). Brief cognitive-behavioral depression prevention program for high-risk adolescents outperforms two alternative interventions: A randomized efficacy trial. Journal of Consulting and Clinical Psychology, 76(4), 595-606.
- Rohde, P., Stice, E., Shaw, H., & Briere, F. N. (2014). Indicated cognitive behavioral group depression prevention compared to bibliotherapy and brochure control: Acute effects of an effectiveness trial with adolescents. Journal of Consulting and Clinical Psychology, 82 (1), 65-74.
- Stice, E., Rohde, P., Gau, J. M., & Wade, E. (2010). Efficacy trial of a brief cognitive-behavioral depression prevention program for high-risk adolescents: Effects at 1- and 2-year follow-up. Journal of Consulting and Clinical Psychology, 78(6), 856-867.
- Rohde, P., Stice, E., Shaw, H., & Gau, J. M. (2015). Effectiveness Trial of an Indicated Cognitive-Behavioral Group Adolescent Depression Prevention Program versus Bibliotherapy and Brochure Control at 1- and 2-Year Follow-Up. Journal of Consulting and Clinical Psychology, 83(4), 736–747. http://doi.org/10.1037/ccp0000022

[2] Studies that help Building Confidence meet FFPSA evidence criteria include two main studies with sample sizes less than 50 but with 40 or more children:

- Wood, J. J., Piacentini, J. C., Southam-Gerow, M., Chu, B. C., & Sigman, M. (2006). Family cognitive behavioral therapy for child anxiety disorders. *Journal of the American Academy of Child & Adolescent Psychiatry,* 45(3), 314-321.
- Chiu, Angela W., Langer, David A., McLeod, Bryce D., Har, Kim, Drahota, Amy, Galla, Brian M., . . . Wood, Jeffrey J. (2013). Effectiveness of Modular CBT for Child anxiety in elementary schools. *School Psychology Quarterly*, 28(2), 141-153.
- Wood, Jeffrey J., McLeod, Bryce D., Piacentini, John C., & Sigman, Marian. (2009). One-year follow-up of family versus child cbt for anxiety disorders: exploring the roles of child age and parental intrusiveness. *Child Psychiatry and Human Development,* 40(2), 301-316.
- Galla, Brian M., Wood, Jeffrey J., Chiu, Angela W., Langer, David A., Jacobs, Jeffrey, Ifekwunigwe, Muriel, & Larkins, Clare. (2012). One year follow-up to modular cognitive behavioral therapy for the treatment of pediatric anxiety disorders in an elementary school setting. *Child Psychiatry and Human Development,* 43(2), 219-226.

[3] Studies that help Chicago Parent Program meet FFPSA evidence criteria include:

- Gross, D., Garvey, C., Julion, W., Fogg, L., Tucker, S., & Mokros, H. (2009). Efficacy of the Chicago Parent Program with Low-Income African American and Latino parents of young children. *Prevention Science: The Official Journal of the Society for Prevention Research,* 10(1), 54–65. http://doi.org/10.1007/s11121-008-0116-7
- Breitenstein, S. M., Gross, D., Fogg, L., Ridge, A., Garvey, C., Julion, W., & Tucker, S. (2012). The Chicago Parent Program: Comparing 1-Year outcomes for African American and Latino parents of young children. *Research in Nursing & Health*, 35(5), 475–489. http://doi.org/10.1002/nur.21489
- Additional research may be found at: http://www.chicagoparentprogram.org/our-research

[4] Studies that help CBT for Child & Adolescent Depression meet FFPSA evidence criteria include:

- Brent, D., Holder, D., Kolko, D., Birmaher, B., Baugher, M., Roth, C., . . . Johnson, B. (1997). A Clinical psychotherapy trial for adolescent depression comparing cognitive, family, and supportive therapy. *Archives of General Psychiatry*, 54(9), 877-885.
- Clarke, Gregory, DeBar, Lynn L., Pearson, John A., Dickerson, John F., Lynch, Frances L., Gullion, Christina M., & Leo, Michael C. (2016). Cognitive behavioral therapy in primary care for youth declining antidepressants: A randomized trial. *Pediatrics*, 137(5), 1.
- Brent, Kolko, Birmaher, Baugher, Bridge, Roth, & Holder. (1998). Predictors of Treatment efficacy in a clinical trial of three psychosocial treatments for adolescent depression. *Journal of the American Academy of Child & Adolescent Psychiatry*, 37(9), 906-914.
- Reinecke, Ryan, & Dubois. (1998). Cognitive-Behavioral Therapy of depression and depressive symptoms during adolescence: A review and meta-analysis. *Journal of the American Academy of Child & Adolescent Psychiatry*, 37(1), 26-34.
- A cost-benefit analysis conducted by the Washington State Institute for Public Policy may be found here: http://www.wsipp.wa.gov/BenefitCost/Program/542

[5] Studies that help CBT Group Therapy for Children with Anxiety meet FFPSA evidence criteria include:

- Barrett, P. (1998). Evaluation of cognitive-behavioral group treatments for childhood anxiety disorders. *Journal of Clinical Child Psychology*, 27(4), 459-468.
- Wergeland, Fjermestad, Marin, Haugland, Bjaastad, Oeding, . . . Heiervang. (2014). An effectiveness study of individual vs. group cognitive behavioral therapy for anxiety disorders in youth. *Behaviour Research and Therapy*, 57(1), 1-12.
- Hudson, Rapee, Deveney, Schniering, Lyneham, & Bovopoulos. (2009). Cognitive-behavioral treatment versus an active control for children and adolescents with anxiety disorders: A randomized trial. Journal of the American Academy of Child & Adolescent Psychiatry, 48(5), 533-544.
- Lau, Chan, Li, & Au. (2010). Effectiveness of group cognitive-behavioral treatment for childhood anxiety in community clinics. *Behaviour Research and Therapy*, 48(11), 1067-1077.
- A cost-benefit analysis conducted by the Washington State Institute of Public Policy may be found here: http://www.wsipp.wa.gov/BenefitCost/Program/66

[6] Studies that help CBT Parent Counseling for Young Children with Anxiety meet FFPSA evidence criteria include:

- Waters, Ford, Wharton, & Cobham. (2009). Cognitive-behavioural therapy for young children with anxiety disorders: Comparison of a Child Parent condition versus a Parent Only condition. *Behaviour Research and Therapy*, 47(8), 654-662.
- Rapee, R., Kennedy, S., Ingram, M., Edwards, S., & Sweeney, L. (2010). Altering the trajectory of anxiety in at-risk young children. *American Journal of Psychiatry*, 167(12), 1518-1525.
- Kennedy, Rapee, & Edwards. (2009). A selective intervention program for inhibited preschool-aged children of parents with an anxiety disorder: effects on current anxiety disorders and temperament. *Journal of the American Academy of Child & Adolescent Psychiatry*, 48(6), 602-609.

[7] Studies that help Dialectical Behavior Therapy (DBT) meet FFPSA evidence criteria include:

- Mccauley, E., Berk, M., Asarnow, J., Adrian, M., Cohen, J., Korslund, K., . . . Linehan, M. (2018). Efficacy of Dialectical Behavior Therapy for adolescents at high risk for suicide: A randomized clinical trial. *JAMA Psychiatry*, 20 June 2018.
- Linehan, M., Comtois, K., Murray, A., Brown, M., Gallop, R., Heard, H., . . . Lindenboim, N. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry*, 63(7), 757-766.
- Neacsiu, Lungu, Harned, Rizvi, & Linehan. (2014). Impact of dialectical behavior therapy versus community treatment by experts on emotional experience, expression, and acceptance in borderline personality disorder. *Behaviour Research and Therapy*, 53(1), 47-54.
- Linehan, M., Armstrong, H., Suarez, A., Allmon, D., & Heard, H. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, 48(12), 1060-1064.
- Additional research on Dialectical Behavior Therapy may be found here: https://behavioraltech.org/research/evidence/#domains

[8] Studies that help Families and Schools Together (FAST) meet FFPSA evidence criteria include:

- Kratochwill, T.R., McDonald, L., Levin, J.R., Young Bear-Tibbetts, H., & Demaray, M.K. (2004). Families and Schools Together: An Experimental analysis of a parent-mediated multi-family group program for american Indian children. *Journal of School Psychology*, 42(5), 359-383.
- McDonald, Lynn, Moberg, D. Paul, Brown, Roger, Rodriguez-Espiricueta, Ismael, Flores, Nydia I., Burke, Melissa P., & Coover, Gail. (2006). After-school multifamily groups: A randomized controlled trial involving low-income, urban, Latino children. *Children & Schools,* 28(1), 25-34.
- Kratochwill, Mcdonald, Levin, Scalia, & Coover. (2009). Families And Schools Together: An experimental study of multi-family support groups for children at risk. *Journal of School Psychology,* 47(4), 245-265.
- Additional research on FAST may be found here: https://www.familiesandschools.org/why-fast-works/ And a cost-benefit analysis from the Washington State Institute for Public Policy may be found here: http://www.wsipp.wa.gov/BenefitCost/ProgramPdf/150/Families-and-Schools-Together-FAST

[9] Studies that help Family-Focused Treatment for Adolescents (FFT-A) meet FFPSA evidence criteria include:

- Miklowitz, D., Schneck, C., George, E., Taylor, D., Sugar, C., Birmaher, B., . . . Axelson, D. (2014). Pharmacotherapy and Family-Focused Treatment for Adolescents With Bipolar I and II Disorders: A 2-Year Randomized Trial. American Journal of Psychiatry, 171(6), 658-667.
- Miklowitz, Axelson, George, Taylor, Schneck, Sullivan, . . . Birmaher. (2009). Expressed Emotion Moderates the Effects of Family-Focused Treatment for Bipolar Adolescents. Journal of the American Academy of Child & Adolescent Psychiatry, 48(6), 643-651.
- Miklowitz, George, Axelson, Kim, Birmaher, Schneck, . . . Brent. (2004). Family-focused treatment for adolescents with bipolar disorder. Journal of Affective Disorders, 82(S), S113-S128.

[10] Studies that help Interpersonal Psychotherapy-Adolescent Skills Training (IPA-AST) meet FFPSA evidence criteria include:

- Young, J., Jones, J., Sbrilli, M., Benas, J., Spiro, C., Haimm, C., . . . Gillham, J. (2018). Long-term effects from a school-based trial comparing Interpersonal Psychotherapy-Adolescent Skills Training to group counseling. *Journal of Clinical Child & Adolescent Psychology,* 1-10.
- Young, Jami F., Mufson, Laura, & Davies, Mark. (2006). Efficacy of Interpersonal Psychotherapy-Adolescent Skills Training: An indicated preventive intervention for depression. *Journal of Child Psychology and Psychiatry,* 47(12), 1254-1262.
- Young, J., Mufson, L., & Gallop, R. (2010). Preventing depression: A randomized trial of interpersonal psychotherapy-adolescent skills training. *Depression and Anxiety*, 27(5), 426-433.
- Mufson, & Fairbanks. (1996). Interpersonal Psychotherapy for Depressed Adolescents: A one-year naturalistic follow-up study. *Journal of the American Academy of Child & Adolescent Psychiatry,* 35(9), 1145-1155.
- Mufson, L., Weissman, M., Moreau, D., & Garfinkel, R. (1999). Efficacy of Interpersonal Psychotherapy for depressed adolescents. *Archives of General Psychiatry*, 56(6), 573-579.

[11] Studies that help Wraparound meet FFPSA evidence criteria include:

- Carney, M. M., & Butell, F. (2003). Reducing juvenile recidivism: Evaluating the wraparound services model. *Research on Social Work Practice, 13*(5), 551-568. doi:10.1177/1049731503253364
- Clark, H. B., Lee, B., Prange, M. E., & McDonald, B. A. (1996). Children lost within the foster care system: Can wraparound service strategies improve placement outcomes? *Journal of Child and Family Studies, 5*(1), 39-54. doi:10.1007/BF02234677
- Grimes, K.E., Schulz, M.F., Cohen, S.A., Mullin, B.O., Lehar, S.E., & Tien, S. (2011) Pursuing cost-effectiveness in mental health service delivery for youth with complex needs. *J Ment Health Policy Econ.*14(2):73-83. PMID: 21881163.
- Jeong, S., Lee, B. H., & Martin, J. H. (2014). Evaluating the effectiveness of a special needs diversionary program in reducing reoffending among mentally ill youthful offenders. *International Journal of Offender Therapy and Comparative Criminology*, 58(9), 1058–1080. doi:10.1177/0306624x13492403
- Mears, S. L., Yaffe, J., & Harris, N. J. (2009). Evaluation of Wraparound services for severely emotionally disturbed youths. *Research on Social Work Practice, 19,* 678-685. doi:10.1177/1049731508329385
- Pullman, M. D., Kerbs, J., Koroloff, N., Veach-White, E., Gaylor, R., & Sieler, D. (2006). Juvenile offenders with mental health needs: Reducing recidivism using Wraparound. *Crime and Delinquency, 52*(3), 375-397. doi:10.1177/0011128705278632
- Rast, J., Bruns, E. J., Brown, E. C., Peterson, C. R., & Mears, S. L. (2008). *Outcomes of the wraparound process for children involved in the child welfare system: Results of a matched comparison study.* Manuscript submitted for publication.

[12] Studies that help Buprenorphine Maintenance Treatment for Opioid Use Disorder meet the FFPSA evidence criteria include:

- Johnson, R., Jaffe, J., & Fudala, P. (1992). A Controlled Trial of Buprenorphine Treatment for Opioid Dependence. JAMA, 267(20), 2750-2755.

- D'Onofrio, G., Chawarski, M., O'Connor, C., Pantalon, P., Busch, G., Owens, M., . . . Fiellin, H. (2017). Emergency Department-Initiated Buprenorphine for Opioid Dependence with Continuation in Primary Care: Outcomes During and After Intervention. Journal of General Internal Medicine, 32(6), 660-666.
- O'connor, Oliveto, Shi, Triffleman, Carroll, Kosten, . . . Schottenfeld. (1998). A randomized trial of buprenorphine maintenance for heroin dependence in a primary care clinic for substance users versus a methadone clinic. The American Journal of Medicine, 105(2), 100-105.
- Johnson, Eissenberg, Stitzer, Strain, Liebson, & Bigelow. (1995). A placebo controlled clinical trial of buprenorphine as a treatment for opioid dependence. Drug and Alcohol Dependence, 40(1), 17-25.
- Knudsen, Ducharme, & Roman. (2006). Early adoption of buprenorphine in substance abuse treatment centers: Data from the private and public sectors. Journal of Substance Abuse Treatment, 30(4), 363-373.

[13] Studies that help Assertive Continuing Care (ACC) meet FFPSA evidence criteria include:

- Godley, Mark D., Godley, Susan H., Dennis, Michael L., Funk, Rodney R., Passetti, Lora L., Petry, Nancy M., & Nezu, Arthur M. (2014). A Randomized Trial of Assertive Continuing Care and Contingency Management for Adolescents With Substance Use Disorders. Journal of Consulting and Clinical Psychology, 82(1), 40-51.
- Garner, Bryan R., Godley, Mark D., Funk, Rodney R., Dennis, Michael L., Godley, Susan H., & Shaffer, Howard J. (2007). The Impact of Continuing Care Adherence on Environmental Risks, Substance Use, and Substance-Related Problems Following Adolescent Residential Treatment. Psychology of Addictive Behaviors, 21(4), 488-497.
- Godley, Mark D., Godley, Susan H., Dennis, Michael L., Funk, Rodney R., & Passetti, Lora L. (2007). The effect of assertive continuing care on continuing care linkage, adherence and abstinence following residential treatment for adolescents with substance use disorders. Addiction, 102(1), 81-93.

[14] Studies that help Adolescent Community Reinforcement Approach (A-CRA) meet FFPSA evidence criteria include:

- Dennis, Godley, Diamond, Tims, Babor, Donaldson, . . . Funk. (2004). The Cannabis Youth Treatment (CYT) Study: Main findings from two randomized trials. Journal of Substance Abuse Treatment, 27(3), 197-213.
- Hunter, B. D., Godley, S. H., Hesson-McInnis, M. S., & Roozen, H. G. (2014). Longitudinal change mechanisms for substance use and illegal activity for adolescents in treatment. Psychology of Addictive Behaviors, 28(2), 507-515.
- Slesnick, Prestopnik, Meyers, & Glassman. (2007). Treatment outcome for street-living, homeless youth. Addictive Behaviors, 32(6), 1237-1251.

[15] Studies that help Adolescent Coping with Depression (CWD-A) meet FFPSA evidence criteria include:

- Lewinsohn, Clarke, Hops, & Andrews. (1990). Cognitive-behavioral treatment for depressed adolescents. Behavior Therapy, 21(4), 385-401.
- Clarke, Rohde, Lewinsohn, Hops, & Seeley. (1999). Cognitive-Behavioral Treatment of Adolescent Depression: Efficacy of Acute Group Treatment and Booster Sessions. Journal of the American Academy of Child & Adolescent Psychiatry, 38(3), 272-279.
- Clarke, G., Hornbrook, Lynch, Polen, Gale, Beardslee, . . . Seeley. (2001). A Randomized Trial of a Group Cognitive Intervention for Preventing Depression in Adolescent Offspring of Depressed Parents. Archives of General Psychiatry, 58(12), 1127-1134.
- Clarke, Hornbrook, Lynch, Polen, Gale, O'connor, . . . Debar. (2002). Group Cognitive-Behavioral Treatment for Depressed Adolescent Offspring of Depressed Parents in a Health Maintenance Organization. Journal of the American Academy of Child & Adolescent Psychiatry, 41(3), 305-313.

[16] Studies that help Brief Marijuana Dependence Counseling (BMDC) meet FFPSA evidence criteria include:

- Babor, Thomas F. (2004). Brief treatments for cannabis dependence: Findings from a randomized multisite trial. *Journal of Consulting and Clinical Psycholo*gy, 72(3), 455-466.
- Litt, M., Kadden, R., Kabela-Cormier, E., & Petry, N. (2008). Coping skills training and contingency management treatments for marijuana dependence: Exploring mechanisms of behavior change. *Addiction*, 103(4), 638-648.
- The BMDC program manual may be found here: https://www.integration.samhsa.gov/clinical-practice/sbirt/brief_counseling_for_marijuana_dependence.pdf and a cost-benefit analysis conducted by the Washington State Institute for Public Policy may be found here: http://www.wsipp.wa.gov/BenefitCost/ProgramPdf/306/Brief-Marijuana-Dependence-Counseling

[17] Studies that help Ecologically Based Family Therapy (EBFT) meet FFPSA evidence criteria include:

- Slesnick, & Prestopnik. (2005). Ecologically based family therapy outcome with substance abusing runaway adolescents. *Journal of Adolescence,* 28(2), 277-298.
- Slesnick, N., & Prestopnik, J. (2009). Comparison of family therapy outcome with alcohol-abusing, runaway adolescents. *Journal of Marital and Family Therapy*, 35(3), 255-277.

[18] Studies that help Functional Family Therapy (FFT) for adolescents with SUDs meet the FFPSA evidence criteria include:

- Waldron, H. B., Slesnick, N., Brody, J. L., Peterson, T. R., & Turner, C. W. (2001). Treatment outcomes for adolescent substance abuse at 4- and 7-month assessments, *Journal of Consulting and Clinical Psychology, 69*(5), 802-813.
- Slesnick, N., & Prestopnik, J. (2009). Comparison of family therapy outcome with alcohol-abusing, runaway adolescents. *Journal of Marital & Family Therapy, 35*(3), 255-277.
- Slesnick, N., & Prestopnik, J. (2004). Office versus home-based family therapy for runaway, alcohol abusing adolescents: Examination of factors associated with treatment attendance. *Alcoholism Treatment Quarterly, 22*(2), 3-19.
- Alexander J. F., & Parsons, B. V. (1973). Short-term behavioral intervention with delinquent families: Impact on family process and recidivism. *Journal of Abnormal Psychology, 81*(3), 219-225.
- Parsons, B., & Alexander, J. (1973). Short-term family intervention: A therapy outcome study. *Journal of Consulting and Clinical Psychology, 41*(2), 195-201.
- Alexander, J., Barton, C., Schiavo, R., & Parsons, B. (1976). Systems-behavioral intervention with families of delinquents: Therapist characteristics, family behavior, and outcome. *Journal of Consulting and Clinical Psychology, 44*(4), 656-664.
- Klein, N., Alexander, J., & Parsons, B. (1977). Impact of family systems intervention on recidivism and sibling delinquency: A model of primary prevention and program evaluation. *Journal of Consulting and Clinical Psychology, 45*(3), 469-474.
- Friedman, A. (1989). Family therapy vs. parent groups: Effects on adolescent drug abusers. *American Journal of Family Therapy, 17*(4), 335-347.
- Rohde, P., Waldron, H. B., Turner, C. W., Brody, J., & Jorgensen, J. (2014). Sequenced Versus Coordinated Treatment for Adolescents With Comorbid Depressive and Substance Use Disorders. *Journal of Consulting & Clinical Psychology*, *82*(2), 342-348. doi:10.1037/a0035808

[19] Studies that help Helping Women Recover & Beyond Trauma (HWR/BT) for substance abuse treatment in women meet the FFPSA evidence criteria include:

- Messina, N., Grella, C. E., Cartier, J., & Torres, S. (2010). A randomized experimental study of gender-responsive substance abuse treatment for women in prison. *Journal of Substance Abuse Treatment, 38*(2), 97–107.
- Messina, N., Calhoun, S., & Warda, U. (2012). Gender responsive drug court treatment: A randomized controlled trial. *Criminal Justice and Behavior, 9*(12), 1539-1558.
- Covington, S., Burke, C., Keaton, S., & Norcott, C. (2008). Evaluation of a trauma-informed and gender-responsive intervention for women in drug treatment. *Journal of Psychoactive Drugs, SARC Supplement 5,* 387-398.
- Saxena, P., Messina, N., & Grella, C. E., (2014). Who benefits from gender responsive treatment. Accounting for abuse history on longitudinal outcomes for women in prison. *Criminal Justice and Behavior, 41*(4), 417–432.

[20] Studies that help Interim Methadone Maintenance for Opioid use (IMM) meet the FFPSA evidence criteria include:

- Schwartz, R. P., Highfield, D. A., Jaffe, J. H., Brady, J. V., Butler, C. B., Rouse, C. O., ... & Breteler, M. M. (2006). A randomized controlled trial of interim methadone maintenance. *Archives of General Psychiatry*, *63*(1), 102-109.
- Schwartz, R. P., Kelly, S. M., O'grady, K. E., Gandhi, D., & Jaffe, J. H. (2012). Randomized trial of standard methadone treatment compared to initiating methadone without counseling: 12-month findings. *Addiction*, *107*(5), 943-952.
- Schwartz, R. P., Kelly, S. M., O'Grady, K. E., Gandhi, D., & Jaffe, J. H. (2011). Interim methadone treatment compared to standard methadone treatment: 4-month findings. *Journal of substance abuse treatment*, *41*(1), 21-29.
- Schwartz, R. P., Kelly, S. M., O'grady, K. E., Gandhi, D., & Jaffe, J. H. (2012). Randomized trial of standard methadone treatment compared to initiating methadone without counseling: 12-month findings. *Addiction*, *107*(5), 943-952.
- Gruber, V. A., Delucchi, K. L., Kielstein, A., & Batki, S. L. (2008). A randomized trial of 6-month methadone maintenance with standard or minimal counseling versus 21-day methadone detoxification. *Drug and alcohol dependence*, *94*(1-3), 199-206.
- Schwartz, R. P., Jaffe, J. H., O'Grady, K. E., Kinlock, T. W., Gordon, M. S., Kelly, S. M., ... & Ahmed, A. (2009). Interim methadone treatment: impact on arrests. *Drug and Alcohol Dependence*, *103*(3), 148-154.
- Schwartz, R. P., Kelly, S. M., Mitchell, S. G., Gryczynski, J., O'Grady, K. E., Gandhi, D., & ... Jaffe, J. H. (2017). Patient-centered methadone treatment: a randomized clinical trial. *Addiction*, *112*(3), 454-464. doi:10.1111/add.13622
- Yancovitz, S. K., Des Jarlais, D. C., Peskoe Peyser, N., Drew, E., Friedmann, P., Trigg, H. L., & Robinson, J. W. (1991). A Randomized Trial of an Interim Methadone Maintenance Clinic. *American Journal Of Public Health*, *81*(9), 1185-1191.

- Gryczynski, J., Schwartz, R., O'Grady, K., & Jaffe, J. (2009). Treatment Entry among Individuals on a Waiting List for Methadone Maintenance. *American Journal Of Drug & Alcohol Abuse*, *35*(5), 290-294. doi:10.1080/00952990902968577
- Interim methadone maintenance therapy makes a difference. (2006). *Inpharma Weekly*, (1529), 8.

[21]Studies that help Family Spirit meet the FFPSA evidence criteria include these below:

- Barlow A, Varipatis-Baker E, Speakman K, et al. Home-visiting intervention to improve child care among American Indian adolescent mothers: A randomized trial. *Arch Pediatr Adolesc Med.* 2006; 160(11):1101-1107.
- Barlow, A., Mullany, B., Neault, N., et al. (2015). Paraprofessional Delivered, Home-Visiting Intervention for American Indian Teen Mothers and Children: Three-Year Outcomes from a Randomized Controlled Trial. *American Journal of Psychiatry*, 172(2), 154-162. doi: 10.1176/appi.ajp.2014.14030332.
- Walkup J.T., Barlow, A., Mullany, B.C., et al. (2009). Randomized controlled trial of a paraprofessional-delivered in-home intervention for young reservation-based American Indian mothers. *J Am Acad Child Adolesc Psychiatry,* 48(6), 591-601.

[22] Studies that help Home Instruction for Parents of Preschool Youngsters (HIPPY) meet the FFPSA evidence criteria include:

- Baker, A. J. L., Piotrkowski, C. S., & Brooks-Gunn, J. (1998). The effects of the Home Instruction Program for Preschool Youngsters (HIPPY) on children's school performance at the end of the program and one year later. *Early Childhood Research Quarterly, 13*(4), 571-588.
- Brown, A., & Lee, J. (2014). School performance in elementary, middle, and high school: A comparison of children based on HIPPY participation during the preschool years. *School Community, 24*(2), 83-106.
- Nievar, M. A., Jacobson, A., Chen, Q., Johnson, U., & Dier, S. (2011). Impact of HIPPY on home learning environments of Latino families. *Early Childhood Research Quarterly, 26,* 268-277.
- Barhava-Monteith, G., Harre, N., & Field, J. (1999). A promising start: An evaluation of the HIPPY program in New Zealand. *Early Child Development and Care, 159*, 145-157.
- Bradley, R. H., & Gilkey, B. (2002). The impact of the Home Instructional Program for Preschool Youngsters (HIPPY) on school performance in 3rd and 6th Grades. *Early Education and Development, 13*(3), 301-311.
- Brown, A. L. (2013). The impact of early intervention on the school readiness of children born to teenage mothers. *Journal of Early Childhood Research.* Advance online publication. doi: 10.1177/1476718X13479048

[23]Studies that help SafeCare meet the FFPSA evidence criteria:

- Justice Research Center (July 2009) Parenting with Love and Limits Research Outcome – 2009-2010
- Karam, E. A., Sterrett, E. M., & Kiaer, L. (2015). The integration of family and group therapy as an alternative to juvenile incarceration: A quasi-experimental evaluation using parenting with love and limits. *Family Process*, *56*,
- Sterrett-Hong, E. M., Karam, E., & Kiaer, L. (2017). Statewide implementation of Parenting with Love and Limits (PLL) among youth with co-existing emotional and behavioral problems to reduce return to service rates and treatment costs. *Administration and Policy in Mental Health and Mental Health Services Research*, 44(5):792-809, doi:10.1007/s10488-016-0788-4.

[24] Studies that help Child-Parent Psychotherapy (CPP) meet the FFPSA evidence criteria include:

- Cicchetti, D., Rogosh, F. A., & Toth, S. L. (2006). Fostering secure attachment in infants in maltreating families through preventive interventions. *Development and Psychopathology, 18*, 623-649.
- Cicchetti, D., Toth, S. L., & Rogosch, F. A. (1999). The efficacy of Toddler-Parent psychotherapy to increase attachment security in off-spring of depressed mothers. *Attachment & Human Development, 1*(1), 34-66.
- Lieberman, A. F., Ghosh Ippen, C., & Van Horn, P. (2006). Child-Parent Psychotherapy: 6-month follow-up of a randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*(8), 913-918. doi:10.1097.01.chi.0000222784.03735.92
- Lieberman, A. F., Van Horn, P., & Ghosh Ippen, C. (2005). Toward evidence-based treatment: Child-Parent Psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*(12), 1241-1448.
- Lieberman, A. F., Weston, D. R., & Pawl, J. H. (1991). Preventive interaction and outcome with anxiously attached dyads. *Child Development, 62,* 199-209.

[25] Studies that help Functional Family Therapy (FFT) meet the FFPSA evidence criteria for the outcomes listed in the table include those below. Also see https://www.fftllc.com/documents/FFT-CW-Model-Effectiveness.pdf

- Baglivio, M. T., Jackowski, K., Greenwald, M. A. and Howell, J. C. (2014), Serious, Violent, and Chronic Juvenile Offenders. Criminology & Public Policy, 13: 83-116. doi:10.1111/1745-9133.12064
- Barnoski, R. (2004, January). *Outcome Evaluation of Washington State's Research-Based Programs for Juvenile Offenders* (Document No. 04-01-1201). Olympia: Washington State Institute for Public Policy.
- Barton, C., Alexander, J. F., Waldron, H., Turner, C. W., & Warburton, J. (1985). Generalizing treatment effects of Functional Family Therapy: Three replications. American Journal of Family Therapy, 13(3), 16–26.
- Darnell, A.J., & Schuler, M.S. (2015). Quasi-experimental study of Functional Family Therapy effectiveness for juvenile justice aftercare in a racially and ethnically diverse community sample. *Children and Youth Services Review, 50*, 75-82.
- Gordon, D. A., Graves, K., & Arbuthnot, J. (1995). The effect of Functional Family Therapy for delinquents on adult criminal behavior. Criminal Justice and Behavior, 22(1), 60–73.
- Hansson, K., Cederblad, M., & Hook, B. (2000). Functional family therapy: A method for treating juvenile delinquents. Socialvetenskaplig tidskrift, 3, 231-243. [Being translated into English.]
- Hansson, K., Johansson, Drott-Englén, & Benderix (2004). Functional Family Therapy in child psychiatric practice. *Nordisk Psykologi*, 56, 4, 304–320. [Being translated into English.]
- Kerig, P. K., & Alexander, J. F. (2012). Family Matters: Integrating Trauma Treatment into Functional Family Therapy for Traumatized Delinquent Youth. *Journal of Child & Adolescent Trauma*, *5*(3), 205-223. doi:10.1080/19361521.2012.697103
- Rohde, P., Waldron, H., Turner, C., Brody, J., & Jorgensen, J. (2014). Sequenced versus coordinated treatment for adolescents with comorbid depressive and substance use disorders. *Journal Of Consulting And Clinical Psychology,* 82(2):342-8. doi: 10.1037/a0035808
- Sexton, T., & Turner, C. W. (2010). The effectiveness of functional family therapy for youth with behavioral problems in a community practice setting. *Journal Of Family Psychology*, *24*(3), 339-348. doi:10.1037/a0019406
- Stanton, M.D., & Shadish, W.R. (1997). Outcome, attrition, and family-couples treatment for drug abuse: A meta-analysis and review of the controlled, comparative studies. *Psychological Bulletin*.122, 170–191.
- Stout, B.D & Holleran, D. (2013). The impact of evidence-based practices on requests for out-of-home placements in the context of system reform. *Journal of Child and Family Studies*, 22:311–321 DOI 10.1007/s10826-012-9580-6
- Waldron, H. B., Slesnick, N., Brody, J. L., Turner, C. W., & Peterson, T. R. (2001). Treatment outcomes for adolescent substance abuse at 4- and 7- month assessments. *Journal of Consulting and Clinical Psychology*, 69, 802-813.

[26] Studies that help HOMEBUILDERS meet the FFPSA evidence criteria are documented in these two meta-analyses:

- Walton, E. (1998). In-home family focused reunification: A six-year follow-up of a successful experiment. *Social Work Research, 22*(4), 205-214.
- Fraser, M. W., Walton, E., Lewis, R. E., Pecora, P. J., & Walton, W. K. (1996). An experiment in family reunification: Correlates of outcomes at one-year follow-up. *Children and Youth Services Review, 18*(4/5), 335-361.
- Forrester, D., Copello, A., Waissbein, C., & Pokhrel, S. (2008). Evaluation of an intensive family preservation service for families affected by parental substance misuse. *Child Abuse Review*, *17*(6), 410-426.
- Department for Community Based Services. (2008) Kentucky's Family Preservation Program: Comprehensive Program Evaluation. (DCBS).
- Stuva, D., Ringle, J. L., Thompson, R. W., Chmelka, B., Juliano, N., & Bohn, K. (2016). In-Home Family Services: Providing Lasting Results to Crisis Helpline Callers. *American Journal Of Family Therapy*, *44*(5), 245-254. doi:10.1080/01926187.2016.1223566
- Al, C. M. W., Stams, G. J. J. M., Bek, M. S., Damen, E. M., Asscher, J. J., & van der Laan, P. H. (2012). A meta-analysis of intensive family preservation programs: Placement prevention and improvement of family functioning. *Children and Youth Services Review*, *34*(8), 1472–1479. doi:10.1016/j.childyouth.2012.04.002
- Schweitzer, D. D., Pecora, P. J., Nelson, K., Walters, B., & Blythe, B. J. (2015). Building the evidence base for intensive family preservation services. *Journal of Public Child Welfare*, *9*(5), 423–443. doi:10.1080/15548732.2015.1090363

[27] Studies that help Building Confidence meet FFPSA evidence criteria include:

- Justice Research Center (July 2009) Parenting with Love and Limits Research Outcome – 2009-2010
- Karam, E. A., Sterrett, E. M., & Kiaer, L. (2015). The integration of family and group therapy as an alternative to juvenile incarceration: A quasi-experimental evaluation using parenting with love and limits. *Family Process*, *56*,

- Sterrett-Hong, E. M., Karam, E., & Kiaer, L. (2017). Statewide implementation of Parenting with Love and Limits (PLL) among youth with co-existing emotional and behavioral problems to reduce return to service rates and treatment costs . *Administration and Policy in Mental Health and Mental Health Services Research*, 44(5):792-809, doi:10.1007/s10488-016-0788-4.
- Winokur-Early, K, Chapman, S. F., & Hand, G. A. (2013). Family-focused juvenile reentry services: A quasi-experimental design evaluation of recidivism outcomes. *Journal of Juvenile Justice, 2*(2), 1–22.

[28] http://wsipp.wa.gov/BenefitCost/Program/668 and http://wsipp.wa.gov/BenefitCost

[29] In cases where the cost of the program is less than the alternative (usually treatment as usual), a benefit cost ratio cannot be calculated because the savings are realized up-front.

[30] https://contextualscience.org/list_of_resources_for_learning_act

[31] http://wsipp.wa.gov/BenefitCost/Program/756

[32] https://contextualscience.org/list_of_resources_for_learning_act

[33] http://wsipp.wa.gov/BenefitCost/Program/668

[34] http://wsipp.wa.gov/BenefitCost/Program/668 and http://www.wsipp.wa.gov/BenefitCost/Pdf/8/WSIPP_BenefitCost_Adult-Mental-Health

[35] https://contextualscience.org/list_of_resources_for_learning_act

[36] http://wsipp.wa.gov/BenefitCost/Program/667

[37] http://wsipp.wa.gov/BenefitCost/Program/667 and http://www.wsipp.wa.gov/BenefitCost/Pdf/8/WSIPP_BenefitCost_Adult-Mental-Health

[38] https://contextualscience.org/list_of_resources_for_learning_act

[39] Http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health.

[40] https://contextualscience.org/list_of_resources_for_learning_act

[41]For CEBC rating and summary, see: http://www.cebc4cw.org/program/aggression-replacement-training/

[42] Source: WSIPP, 6-2016; http://www.wsipp.wa.gov/BenefitCost

[43] WSIPP (2017) http://wsipp.wa.gov/BenefitCost http://wsipp.wa.gov/BenefitCost http://wsipp.wa.gov/BenefitCost http://wsipp.wa.gov/BenefitCost

[44] http://aggressionreplacementtraining.com/

[45] https://www.infantcaregiverproject.com/training-in-abc

[46] Personal communication, Mary Dozier, July 2, 2018. See http://Abcintervention.org

[47] http://legacy.nreppadmin.net/ViewIntervention.aspx?id=305

[48] (Berkowitz, Stover, & Marans, 2010).

[49] Total costs for 1 agency (up to 30 trainees) = 10,800 $3000 x 2) for 2-day training + $4800 (12 x 400) for 6 months of biweekly (12) consultation calls for 6 months for 2 sets of trainees ($200/ per call for 15 trainees each).

[50] http://www.cebc4cw.org/program/child-and-family-traumatic-stress-intervention-cftsi/detailed

[51]Rotter, M., & Carr, A. (2010). *Targeting criminal recidivism in justice-involved people with mental illness: Structured clinical approaches*. Washington, DC: The CMHS National GAINS Center. Retrieved from: http://gainscenter.samhsa.gov/cms-assets/documents/69181-899513.rottercarr2010.pdf. Several types of CBT have been highlighted as helpful for child welfare: remote CBT for anxious children, individual CBT for anxious children, parent CBT for anxious children, CBT for depressed adolescents, and trauma-focused CBT. For session length see: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=106. For reviews of traditional CBT interventions, see:
Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review, 26,* 17-31.
Leichsenring, F., & Leibing, E. (2003). The effectiveness of psychodynamic therapy and cognitive behavior therapy in the treatment of personality disorders: A meta-analysis. *American Journal of Psychology, 160,* 1223-1232.

[52] In-Albon, T., & Schneider, S. (2006). Psychotherapy of Childhood Anxiety Disorders: A Meta-Analysis. *Psychotherapy and Psychosomatics*, *76*(1), 15–24. http://doi.org/10.1159/000096361

[53] Reynolds, S., Wilson, C., Austin, J., & Hooper, L. (2012). Effects of psychotherapy for anxiety in children and adolescents: a meta-analytic review. *Clinical Psychology Review*, *32*(4), 251–62. http://doi.org/10.1016/j.cpr.2012.01.005

[54] Reynolds, S., Wilson, C., Austin, J., & Hooper, L. (2012).

[55] WSIPP, June -2016: http://www.wsipp.wa.gov/BenefitCost

[56] http://www.abct.org/Resources/?m=mResources&fa=ClinicalResources

[57] http://wsipp.wa.gov/BenefitCost/Program/71

[58] http://www.cebc4cw.org/program/cognitive-behavioral-therapy-cbt-for-adult-depression/

[59] http://wsipp.wa.gov/BenefitCost/Program/71 and http://www.wsipp.wa.gov/BenefitCost/Pdf/8/WSIPP_BenefitCost_Adult-Mental-Health

[60] http://www.abct.org/Resources/?m=mResources&fa=ClinicalResources

[61] http://www.wsipp.wa.gov/ReportFile/1466

[62] http://wsipp.wa.gov/BenefitCost/Program/87

[63] http://wsipp.wa.gov/BenefitCost/Program/87 and http://www.wsipp.wa.gov/BenefitCost/Pdf/8/WSIPP_BenefitCost_Adult-Mental-Health

[64] http://www.abct.org/Resources/?m=mResources&fa=ClinicalResources

[65] http://wsipp.wa.gov/BenefitCost/Program/241

[66] http://www.cebc4cw.org/program/cognitive-behavioral-therapy-cbt-for-adult-depression/

[67] http://wsipp.wa.gov/BenefitCost/Program/241 and \http://www.wsipp.wa.gov/BenefitCost/Pdf/8/WSIPP_BenefitCost_Adult-Mental-Health

[68] http://www.abct.org/Resources/?m=mResources&fa=ClinicalResources

[69] https://academic.oup.com/schizophreniabulletin/article/40/5/958/2886806

[70] http://www.cebc4cw.org/program/cognitive-behavioral-therapy-cbt-for-adult-depression/

[71] http://wsipp.wa.gov/BenefitCost/Program/494 and Washington State Institute for Public Policy (2017a). *Adult mental health.* Retrieved April 20, 2018, from http://www.wsipp.wa.gov/BenefitCost/Pdf/8/WSIPP_BenefitCost_Adult-Mental-Health

[72] http://www.abct.org/Resources/?m=mResources&fa=ClinicalResources

[73] http://www.mychildwithoutlimits.org/plan/common-treatments-and-therapies/cognitive-therapy/espanol-terapia-cognitiva-del-comportamiento/

[74] http://www.cebc4cw.org/program/cognitive-behavioral-therapy-cbt-for-adult-depression/

[75] http://wsipp.wa.gov/BenefitCost/Program/64

[76] http://www.abct.org/Resources/?m=mResources&fa=ClinicalResources

[77] http://www.cebc4cw.org/program/cognitive-behavioral-therapy-cbt-for-adult-depression/

[78] http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/detailed

[79] http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/detailed

[80] http://wsipp.wa.gov/BenefitCost/Program/155 and http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health.

[81] https://secure.workbookpublishing.com/cat_prod.php?cPath=21_26

[82] http://wsipp.wa.gov/BenefitCost/Program/650 and WSIPP (2017) http://wsipp.wa.gov/BenefitCost

[83] http://www.copingpower.com/Manuals.aspx

[84] http://www.cebc4cw.org/program/eye-movement-desensitization-and-reprocessing-for-adults/detailed

[85] http://www.cebc4cw.org/program/eye-movement-desensitization-and-reprocessing-for-adults/

[86] Washington State Institute for Public Policy (2017a). *Adult mental health.* Retrieved from http://www.wsipp.wa.gov/BenefitCost/Pdf/8/WSIPP_BenefitCost_Adult-Mental-Health

[87] http://wsipp.wa.gov/BenefitCost/Program/635 and http://www.traumarecoveryhapstore.com/Manuals_c_14.html

[88]EMDR information:

- CEBC summary and rating: Retrieved Sept. 16, 2015, from: http://www.cebc4cw.org/program/eye-movement-desensitization-and-reprocessing-for-adults/
- Eye Movement Desensitization and Reprocessing Institute, Inc. (2012). *What is EMDR?* Retrieved from http://www.emdr.com/general-information/what-is-emdr.html

- Field, A., & Cottrell, D. (2011). Eye movement desensitization and reprocessing as a therapeutic intervention for traumatized children and adolescents: A systematic review of the evidence for family therapists. *Journal of Family Therapy*, *33*(4), 374-388.
- Soberman, G. B., Greenwald, R., & Rule, D. L. (2002). A controlled study of Eye Movement Desensitization and Reprocessing (EMDR) for boys with conduct problems. *Journal of Aggression, Maltreatment, & Trauma, 6*(1), 217-236.

[89] http://www.cebc4cw.org/program/eye-movement-desensitization-and-reprocessing-for-adults/detailed

[90] http://www.cebc4cw.org/program/eye-movement-desensitization-and-reprocessing/detailed

[91] http://wsipp.wa.gov/BenefitCost/Program/156

[92] http://www.emdr.com/product-category/books/

[93] http://www.cebc4cw.org/program/mindfulness-based-cognitive-therapy/detailed

[94] http://www.cebc4cw.org/program/multidimensional-family-therapy/detailed

[95] http://www.mdft.org/Training-Materials

[96] http://wsipp.wa.gov/BenefitCost/Program/76 and http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health

[97] http://www.pcit.org/store/c2/Manuals.html

[98] http://www.cebc4cw.org/program/problem-solving-skills-training/detailed

[99] See http://www.cebc4cw.org/program/prolonged-exposure-therapy-for-adolescents/detailed

[100] http://www.med.upenn.edu/ctsa/workshops_ptsd.html

[101] http://www.cebc4cw.org/program/prolonged-exposure-therapy-for-adolescents/detailed

[102] Mannarino, A. P., Cohen, J. A., Runyon, M. K., Deblinger, E., & Steer, R. A. (2012). Trauma-Focused Cognitive-Behavioral Therapy for children sustained impact of treatment 6 and 12 months later. *Child Maltreatment, 17*(3), 231-241.

[103] National Child Traumatic Stress Network. (2012). *Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).* Los Angeles, CA: University of California, Los Angeles. Retrieved from http://depts.washington.edu/hcsats/PDF/TF-%20CBT/pages/Theoretical%20Perspective/TF-CBT%20fact%20sheet%20therapists.pdf.

[104] http://wsipp.wa.gov/BenefitCost/Program/155

[105] https://tfcbt2.musc.edu/resources

[106] http://wsipp.wa.gov/BenefitCost/Program/80

[107] http://wsipp.wa.gov/BenefitCost/Program/80

[108] http://www.cebc4cw.org/program/triple-p-positive-parenting-program-level-4-level-4-triple-p/detailed

[109] https://www.communitiesthatcare.net/Prevention%20Strategies%20Guide/introduction.pdf

[110] https://www.nrepp.samhsa.gov/Legacy/ViewIntervention.aspx?id=392

[111] http://wsipp.wa.gov/BenefitCost/Program/115

[112] http://www.sdrg.org/ctcresource/Community%20Building%20and%20Foundational%20Material/Tools%20for%20Community%20Leaders.pdf

[113] The effect was strongest at post-intervention SMD 0.79 (95%CI 0.48 to 1.09) and weaker at short follow-up SMD0.17 (95%CI 0.09 to 0.26]), and medium follow-up SMD 0.15 (95%CI 0.04 to 0.25]). For long follow-up, the effect was not significant SMD 0.06 (95%CI -0.16 to 0.28). See https://www.campbellcollaboration.org/library/multidimension-family-therapy-youth-drug-use.html, p. 27.

[114] http://wsipp.wa.gov/BenefitCost/Program/497 and http://www.wsipp.wa.gov/BenefitCost/Pdf/7/WSIPP_BenefitCost_Substance-Use-Disorders

[115] http://www.motivationalinterviewing.org/books

[116] http://www.cebc4cw.org/program/multidimensional-family-therapy/detailed

[117] Dose titrates down as the treatment progresses. The dose is more intense in the first third of treatment and is gradually reduced to 1 session per week during the last 4–6 weeks.

[118] Pooled results of the four studies providing data on drug abuse frequency reduction favored MDFT. The effect of MDFT for youth drug abuse frequency reduction was small at 6 months post-intake (overall around 20 percent of a standard deviation for the different control combinations) (SMD = -0.24; 95% CI -0.43 to -0.06; p=0.01 compared to CBT, peer group, TAU and

MET/CBT5). It was not statistically significant at 12 month follow-up compared to CBT, peer group, TAU and MET/CBT5/ACRA. See https://www.campbellcollaboration.org/library/multidimension-family-therapy-youth-drug-use.html

[119] http://wsipp.wa.gov/BenefitCost/Program/195 and http://www.wsipp.wa.gov/BenefitCost/Pdf/7/WSIPP_BenefitCost_Substance-Use-Disorders

[120] http://www.mdft.org/Training-Materials

[121] http://wsipp.wa.gov/BenefitCost/Program/652

[122] http://wsipp.wa.gov/BenefitCost/Program/652

[123] http://pediatrics.aappublications.org/content/132/Supplement_2/S140.long

[124] ++Not yet rated by the CEBC but two RCT studies have been conducted on this program. The Family Connects program has been studied in two rigorous randomized controlled trials, the results of which have been published in highly-regarded journals including Pediatrics and the American Journal of Public Health. ***Higher-quality parenting behaviors:*** Durham Connects mothers reported significantly more positive parenting behaviors with their infant, such as, hugging and reading. Researchers, who were unaware of which families they were observing had been enrolled in Durham Connects, also found that mothers in the program provided higher-quality parenting, such as sensitivity to, and acceptance of, the infant. ***Enhanced home environments***: Researchers found Durham Connects families had higher quality home environments when it came to such factors as safety, books, toys and learning materials. ***Improved mother mental health:*** Durham Connects mothers were 28 percent less likely to report possible clinical anxiety. ***Reduced emergency medical care for infants:*** Durham Connects mothers reported 34 percent less total infant emergency medical care. Research shows that decrease is sustained through age 2. For effect sizes see: McLeigh, J. D., McDonell, J. R., & Melton, G. B. (2015). Community differences in the implementation of Strong Communities for Children. *Child abuse & neglect*, *41*, 97-112. See http://www.familyconnects.org/evidencebase/

[125] http://pediatrics.aappublications.org/content/132/Supplement_2/S140.long

[126] Based on the findings, researchers estimate that for cities of a similar size averaging about 3,187 births a year, an annual investment of $2.2 million in nurse home visiting would result in a community health care cost savings of about $7 million in the first two years of a child's life. See http://www.familyconnects.org/evidencebase/

[127] http://www.cebc4cw.org/program/healthy-families-america-home-visiting-for-child-well-being/

[128] http://www.cebc4cw.org/program/healthy-families-america-home-visiting-for-child-well-being/detailed

[129] http://wsipp.wa.gov/BenefitCost/Program/119

[130] http://wsipp.wa.gov/BenefitCost/Program/119

[131] http://www.cebc4cw.org/program/healthy-families-america-home-visiting-for-child-well-being/detailed

[132] https://homvee.acf.hhs.gov/Implementation/3/Nurse-Family-Partnership-NFP-/14/5/

[133] Ideally, nurses begin 60-90 minute visits with pregnant mothers early in their pregnancy (at about 16 weeks gestation). Registered nurses visit weekly for the first month after enrollment and then every other week until the baby is born. Visits are weekly for the first six weeks after the baby is born, and then every other week through the child's first birthday. Visits continue on an every-other-week basis until the baby is 20 months. The last four visits are monthly until the child is two years old.

[134] http://wsipp.wa.gov/BenefitCost/Program/35 and http://wsipp.wa.gov/BenefitCost

[135] https://medicine.yale.edu/childstudy/communitypartnerships/mtb/

[136] https://medicine.yale.edu/childstudy/research/implementation/community/mindingthebaby/

[137] Information provided by Crista Marchesseault, Operations Director for Minding the Baby (mcrista.marchesseault@yale.edu)

[138] Information provided by Crista Marchesseault, Operations Director for Minding the Baby (mcrista.marchesseault@yale.edu)

[139] http://wsipp.wa.gov/BenefitCost/Program/158 and http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health.

[140] http://www.cebc4cw.org/program/the-incredible-years/detailed

[141] http://drexel.edu/cnhp/academics/continuing-education/Health-Professions-CE-Programs/ABFT/

[142] Diamond (2013)

[143] The intervention is tailored to address the specific needs of each child and family and can be integrated into many service settings. See http://www.cebc4cw.org/program/family-check-up/detailed

[144] http://wsipp.wa.gov/BenefitCost/Program/380

[145] http://www.cebc4cw.org/program/family-check-up/detailed

[146] https://nrepp.samhsa.gov/ProgramProfile.aspx?id=7

[147] http://www.blueprintsprograms.com/factsheet/blues-program

[148] http://www.blueprintsprograms.com/factsheet/blues-program

[149] http://wsipp.wa.gov/BenefitCost/Program/537 and http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health.

[150] https://thebluesprogram.weebly.com/manuals.html P

[151]http://www.cebc4cw.org/program/building-confidence/detailed

[152] http://www.cebc4cw.org/program/childhaven-childhood-trauma-treatment/detailed

[153] Summary and evidence rating abstracted from SANMHSA NREP: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=106. Also see:

- Brent, D. A., Holder, D., Kolko, D., Birmaher, B., Baugher, M., Roth, C., et al. (1997). A clinical psychotherapy trial for adolescent depression comparing cognitive, family, and supportive therapy. *Archives of General Psychiatry, 54,* 877-885.
- Weersing, V. R., Iyengar, S., Kolko, D. J., Birmaher, B., & Brent, D. A. (2006). Effectiveness of cognitive-behavioral therapy for adolescent depression: A benchmarking investigation. *Behavior Therapy, 37*, 36-48.

[154] http://www.wsipp.wa.gov/BenefitCost/Program/542 and http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health

[155] https://www.guilford.com/books/CBT-for-Depression-in-Children-and-Adolescents/Kennard-Hughes-Foxwell/9781462525256

[156] http://www.wsipp.wa.gov/BenefitCost/Program/66

[157] http://www.wsipp.wa.gov/BenefitCost/Program/66 and http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health.

[158] http://www.wsipp.wa.gov/BenefitCost/Program/66 CEBC rates Trauma-Focused CBT for children as "Well-Supported" for treatment of PTSD, of which anxiety is a symptom.

[159] http://wsipp.wa.gov/BenefitCost/Program/65

[160] Http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health.

[161] CBT has been extensively researched. CEBC rates Trauma-Focused CBT for children as "Well-Supported" for treatment of PTSD, of which anxiety is a symptom.

[162] Http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health.

[163] http://www.cebc4cw.org/program/collaborative-proactive-solutions/detailed

[164] http://www.cebc4cw.org/program/community-reinforcement-vouchers-approach/detailed

[165] http://www.cebc4cw.org/program/community-reinforcement-vouchers-approach/detailed

[166] http://wsipp.wa.gov/BenefitCost/Program/298

[167] DBT for Substance Abusers focuses on the following five main objectives: (1) motivating patients to change dysfunctional behaviors, (2) enhancing patient skills, (3) ensuring the new skills are used in daily life, (4) structuring the client's environment, and (5) training and consultation to improve the counselor's skills. For substance abusers, the primary target of the intervention is the substance abuse and specific goals include reducing abuse, alleviating withdrawal symptoms, reducing cravings, and avoiding opportunities and triggers for substance use. Abstracted from:

- Krawitz, R. (2013). Financial cost-effectiveness of, and other dialectical behavior therapy information, for funders, administrators and providers of services for people with borderline personality disorder. Waikato District Health Board, Hamilton, New Zealand. Abridged version retrieved from http://behavioraltech.org/downloads/Financial-Cost-Effectiveness-DBT.pdf
- Linahan, M. (2015). DBT® Skills Training Manual, Second Edition. New York: Guilford Press. Also see http://www.wsipp.wa.gov/BenefitCost/Program/339
- For ages and duration see SAMHSA NREP summary at : http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=36

[168] An intensive residential treatment adaptation of DBT for women with PTSD associated with childhood sexual abuse was effective for reducing PTSD symptoms. See Harned, M. S., Jackson, S. C., Comtois, K. A., & Linehan, M.M. (2010). Dialectical behavior therapy as a precursor to PTSD treatment for suicidal and/or self-injuring women with borderline personality disorder. *Journal of Traumatic Stress*, 23, 421–429.

[169] Steil, R., Dyer, A., Priebe, K., Kleindienst, N., & Bohus, M. (2011). Dialectical behavior therapy for posttraumatic stress disorder related to childhood sexual abuse: A pilot study of an intensive residential treatment program. *Journal of Traumatic Stress*, 24, 102–106.

[170] https://childmind.org/article/dbt-dialectical-behavior-therapy/

[171]Groves, S., Backer, H. S., van den Bosch, W., & Miller, A. (2012). Dialectical behaviour therapy with adolescents. *Child and Adolescent Mental Health*, *17*(2), 65–75. http://doi.org/10.1111/j.1475-3588.2011.00611.x

[172] A 2012 Cochrane review found that DBT is the only treatment with sufficient research to conclude it is effective for people with borderline personality disorder. See https://www.cochrane.org/CD005652/BEHAV_psychological-therapies-borderline-personality-disorder. Overall, DBT has been designated as an empirically supported treatment with strong research support for treating BPD (American Psychological Association, Division 12).

[173] http://wsipp.wa.gov/BenefitCost/Program/264

[174]WSIPP has calculated Adult-focused Family Behavior Therapy cost savings and B/C ratio for providing DVT for youth in the juvenile justice system. The vast majority of the benefits ($56,000 out $59,000) for the program are due to reductions in crime (in a population already convicted of a crime). It is unlikely that DBT for borderline personality disorder and other complex mental health conditions would yield the same cost savings. See WSIPP (2017) http://wsipp.wa.gov/BenefitCost

[175] https://www.guilford.com/books/DBT-Skills-Training-Manual/Marsha-Linehan/9781462516995/summary

[176] More than 30 randomized controlled trials (RCTs), produced by nearly 20 independent research groups in nine countries have demonstrated the effectiveness of DBT. Meta-analyses of this extensive research have found moderate to large significant effects indicating DBT is more effective than treatment as usual in reducing suicide attempts, non-suicidal self-injury, and anger, and improving general functioning among people with borderline personality disorder (Stoffers et al., 2012; Kliem et al., 2010). For example, DBT decreased suicide attempts by 50% and psychiatric hospitalizations for suicidality by 73% when compared to community treatment by non-behavioral experts (Linehan et al., 2006). The available research suggests that DBT is comparably effective as other comprehensive psychotherapies for BPD. See Kliem S., Kröger, C., & Kosfelder, J.(2010). Dialectical behavior therapy for borderline personality disorder: a meta-analysis using mixed-effects modeling. *J Consult Clin Psychology*, 78 (6):936-51. doi: 10.1037/a0021015. And Stoffers-Winterling J.M., Völlm, B.A., Rücker, G., Timmer, A., Huband, N. & Lieb, K. (2012). Psychological therapies for people with borderline personality disorder. In *Cochrane Database of Systematic Reviews*, No. 8, New York: John Wiley & Sons, Ltd, DOI: 10.1002/14651858.CD005652.pub2 Retrieved from https://doi.org//10.1002/14651858.CD005652.pub2

[177] Http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health.

[178] https://www.newharbinger.com/blog/dbt-adolescent-self-harm-and-suicidality

[179] https://www.nrepp.samhsa.gov/Legacy/ViewIntervention.aspx?id=375

[180] https://www.nrepp.samhsa.gov/Legacy/ViewIntervention.aspx?id=375

[181] http://wsipp.wa.gov/BenefitCost/Program/150

[182] Http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health

[183] http://itp.wceruw.org/documents/FAST.pdf

[184] http://www.cebc4cw.org/program/family-focused-treatment-for-adolescents/detailed

[185] https://global.oup.com/academic/product/preventing-adolescent-depression-9780190243180

[186] http://www.cebc4cw.org/program/multi-family-psychoeducational-psychotherapy/detailed

[187] http://www.blueprintsprograms.com/factsheet/new-beginnings-for-children-of-divorce

[188] http://www.blueprintsprograms.com/factsheet/new-beginnings-for-children-of-divorce

[189] http://www.cebc4cw.org/program/positive-peer-culture/detailed

[190] http://www.cebc4cw.org/program/positive-peer-culture/detailed

[191] http://www.cebc4cw.org/program/primary-and-secondary-control-enhancement-training/detailed

[192] http://www.cebc4cw.org/program/children-with-sexual-behavior-problems-cognitive-behavioral-treatment-program-school-age-group-2/detailed

[193] http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy-tf-cbt-sexual-behavior-problems-in-children-treatment-of/

[194] http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy-tf-cbt-sexual-behavior-problems-in-children-treatment-of/detailed

[195] https://nrepp.samhsa.gov/ProgramProfile.aspx?id=154#hide4

[196] https://nrepp.samhsa.gov/ProgramProfile.aspx?id=116

[197] http://wsipp.wa.gov/BenefitCost/Program/298

[198] http://www.cebc4cw.org/program/adolescent-community-reinforcement-approach/detailed

[199] https://nrepp.samhsa.gov/ProgramProfile.aspx?id=176#hide4

[200] Reductions in non-opioid drug use (e.g., cannabis, amphetamine, ecstasy or cocaine) among young people aged 11-21 years were measured. The main conclusion of the review was that there is a lack of firm evidence on the effect of FBT. t 12 month post-intake, Azrin et al. (2001) found no statistically significant difference between FBT and the comparison treatment, SMD=-0.03 (95% CI -0.58, 0.52). For family functioning, measured at end of treatment, the standardized mean difference was 0.58 (95% CI 0.02, 1.13) reported by parents and 0.29 (95% CI -0.72, 1.30) reported by youth. See https://www.campbellcollaboration.org/library/family-behaviour-therapy-youth-drug-use-treatment.html, p. 9; and Azrin, N. H., Donohue, B., Teichner, G. A., Crum, T., Howell, J. & DeCato, L. A. (2001). A Controlled Evaluation and Description of Individual-Cognitive Problem Solving and Family-Behavior Therapies in Dually-Diagnosed Conduct-Disordered and Substance-Dependent Youth. Journal of Child & Adolescent Substance Abuse, 11, 1-43.

[201] http://wsipp.wa.gov/BenefitCost/Program/306

[202] See http://www.cebc4cw.org/program/brief-strategic-family-therapy/detailed *Condensed from description found at http://archives.drugabuse.gov/TXManuals/BSFT/BSFT2.html on May 2, 2014.*

[203] A summary of BSFT can be found here: https://brief-strategic-family-therapy.com/what-we-do/

[204] See Santisteban, D., Suarez-Morales, L., Robbins, M., & Szapocznik, J. (2006). Brief Strategic Family Therapy: Lessons learned in efficacy research and challenges to blending research and practice. *Family Process, 45*(2), 259-271. And https://brief-strategic-family-therapy.com/what-we-do/

[205] https://brief-strategic-family-therapy.com/what-we-do/

[206] http://www.cebc4cw.org/program/ecologically-based-family-therapy/detailed

[207] http://www.cebc4cw.org/program/families-facing-the-future/detailed

[208] http://www.cebc4cw.org/program/families-facing-the-future/detailed

[209] Children attend 12 of these sessions to practice the skills with their parents. Parent sessions are conducted with groups of six to eight families.

[210] http://www.cebc4cw.org/program/families-facing-the-future/detailed

[211] http://www.cebc4cw.org/program/functional-family-therapy/

[212] https://www.campbellcollaboration.org/library/functional-family-therapy-youth-drug-use-treatment.html

[213] The cost savings b/ information for Functional Family Therapy is based on the youth involved in the juvenile justice system. Most of the monetary benefits come from reduced crime. See http://wsipp.wa.gov/BenefitCost/Program/663

[214] http://www.cebc4cw.org/program/functional-family-therapy/detailed

[215] http://www.cebc4cw.org/program/helping-women-recover-beyond-trauma/detailed

[216] http://www.cebc4cw.org/program/helping-women-recover-beyond-trauma/detailed

[217] https://nrepp.samhsa.gov/, Interim Methadone Maintenance

[218] http://wsipp.wa.gov/BenefitCost/Program/694 and http://www.wsipp.wa.gov/BenefitCost/Pdf/7/WSIPP_BenefitCost_Substance-Use-Disorders

[219] https://nrepp.samhsa.gov. (Note that the NREPP review of Buprenorphine for opioid use as effective is for "Brief Negotiation Interview with Emergency Department Initiated Buprenorphine).

[220] http://wsipp.wa.gov/BenefitCost/Program/695

[221] Patients also receive counseling therapies such as cognitive behavioral treatment or motivational enhancement therapy. Injections are typically administered monthly for one to six months.

[222] http://www.wsipp.wa.gov/BenefitCost/Program/592

[223] http://wsipp.wa.gov/BenefitCost/Program/662

[224] http://www.cebc4cw.org/program/avance-parent-child-education-program/detailed

[225] http://www.cebc4cw.org/program/avance-parent-child-education-program/detailed

[226] http://wsipp.wa.gov/BenefitCost/Program/748

[227] https://www.hippyusa.org/the-hippy-model/starting-a-program/

[228] http://wsipp.wa.gov/BenefitCost/Program/160 and http://wsipp.wa.gov/BenefitCost

[229] http://www.cebc4cw.org/program/safecare/detailed

[230] http://www.tuningintokids.org.au/professionals/products/

[231] http://www.tuningintokids.org.au/professionals/products/

[232] http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health

[233] http://www.bsft.org/documents/BSFTNIDATherapyManual.pdf

[234] https://www.dropbox.com/s/ohjixk5t7z2khri/CPP%20Training%20Overview%2003132013.pdf

[235] Range of $826.67-1656.67 per trainee based on total costs for 1 trainer for 1 site (total costs range $24,800-$49,700) and not including indirect costs or costs of manuals. Training for one site occurs over an 18-month period https://www.dropbox.com/s/ohjixk5t7z2khri/CPP%20Training%20Overview%2003132013.pdf

[236] http://www.cebc4cw.org/program/child-parent-psychotherapy/detailed

[237] Taxy, S., Liberman, A. M., Roman, J. K., & Downey, M. (2012). *The costs and benefits of Functional Family Therapy for Washington, DC*. Washington, DC: District of Columbia Crime Policy Institute and the Urban Institute. Retrieved from http://www.urban.org/UploadedPDF/412685-The-Costs-and-Benefits-of-Functional-Family-Therapy-for-Washington-DC.pdf. For additional information, see http://www.fftllc.com.

[238] http://fftllc.com/about-fft-training/clinical-model.html http://fftllc.com/about-fft-training/clinical-model.html http://fftllc.com/about-fft-training/clinical-model.html http://fftllc.com/about-fft-training/clinical-model.html

[239] A study published in 2017 compared the efficiency and effectiveness of Functional Family Therapy-Child Welfare (FFT-CW®, n = 1625) to Usual Care (UC: n = 2250) in reducing child maltreatment. Families receiving FFT-CW® completed treatment more quickly than UC and they were significantly more likely to meet all of the planned service goals. Higher treatment fidelity was associated with more favorable outcomes. Fewer FFT-CW® families were transferred to another program at closing, and they had fewer recurring allegations. FFT-CW had fewer out-of-home placements in families with higher levels of risk factors. The FFT-CW program was more efficient in completing service, and more effective than UC in meeting treatment goals while also avoiding adverse outcome. See Turner, C.W., Robbins, M.S., Rowlands, S.C. & Weaver, L.R. (2017). Summary of comparison between FFT-CW® and Usual Care sample from Administration for Children's Services. *Child Abuse and Neglect*, 69, 85-95.

[240] The New Jersey FFT study measured outcomes and cost savings from 2005 to 2011. See Stout, B. D., & Holleran, D. (2013). The impact of evidence-based practices on requests for out-of-home placements in the context of system reform. *Journal of Child and Family Studies*, 22(3), 311–321. doi:10.1007/s10826-012-9580-6 For additional information about FFT cost-savings see WSIPP (2017) http://wsipp.wa.gov/BenefitCost http://wsipp.wa.gov/BenefitCost http://wsipp.wa.gov/BenefitCost http://wsipp.wa.gov/BenefitCost

[241] https://www.dropbox.com/s/ohjixk5t7z2khri/CPP%20Training%20Overview%2003132013.pdf

[242] A meta-analysis of IPFS research published in 2012 found that intensive family preservation programs did have a medium and positive effect on family functioning, but were generally not effective in preventing out-of-home placement. Due to a limited number of studies examining family functioning, moderator effects were examined for out-of-home placement only. These moderator analyses revealed that the effect of intensive family preservation programs was moderated by sex and age of the child, parent age, number of children in the family, single parenthood, non-white ethnicity, and caseload of the social workers, but not by adherence to the Homebuilders model and intervention duration. In addition, study characteristics (study design and study quality), and publication characteristics (publication type, publication year and journal impact factor) were found to be associated with placement prevention outcomes. The finding that intensive family preservation programs were found to be effective in preventing foster care placement for multi-problem families, but not for families experiencing abuse and neglect can be explained as follows. In the latter case, out-of-home placement may simply be unavoidable (see also Schuerman, Rzepnicki, & Littell, 1994), whereas out-of-home placement may be prevented in multi-problem families where risk of placement is relatively low compared to families experiencing maltreatment (Al et al., 2012, p. 1476). Another meta-analysis of IFPS studies in five states, published in 2015, found that while it reported rates of repeat child maltreatment, the analysis used placement rates as the main outcome measure and compares effect sizes using Cohen's arcsine transformation for data reported as proportions. Significant differences in rates of child out-of-home placement and repeat maltreatment were found in some studies, particularly for higher risk families (Schweitzer et al., 2015, p. 423). See:

- Al, C. M. W., Stams, G. J. J. M., Bek, M. S., Damen, E. M., Asscher, J. J., & van der Laan, P. H. (2012). A meta-analysis of intensive family preservation programs: Placement prevention and improvement of family functioning. *Children and Youth Services Review*, *34*(8), 1472–1479. doi:10.1016/j.childyouth.2012.04.002
- Schuerman, J. R., Rzepnicki, T. L., & Littell, J. H. (1994). Putting families first: An experiment in family preservation. New York: Aldine de Gruyter.
- Schweitzer, D. D., Pecora, P. J., Nelson, K., Walters, B., & Blythe, B. J. (2015). Building the evidence base for intensive family preservation services. *Journal of Public Child Welfare*, *9*(5), 423–443. doi:10.1080/15548732.2015.1090363

[243] http://wsipp.wa.gov/BenefitCost/Program/78 WSIPP (2017) http://wsipp.wa.gov/BenefitCost

[244] http://www.institutefamily.org/resources.asp

[245] http://mstservices.com/files/howitsdone.pdf

[246] A 2015 Campbell review found that the most rigorous (intent-to-treat) analysis found no significant differences between MST and usual services in restrictive out-of-home placements and arrests or convictions. Pooled results that include studies with data of varying quality tend to favor MST, but these relative effects are not significantly different from zero. The study sample size is small and effects are not consistent across studies; hence, it is not clear whether MST has clinically significant advantages over other services. See https://www.campbellcollaboration.org/library/multisystemic-therapy-social-emotional-behavioral-problems.html

[247] http://wsipp.wa.gov/BenefitCost/Program/36 and http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health

[248] http://www.cebc4cw.org/program/multisystemic-therapy/detailed

[249] PLL has an additional component of six group education sessions conducted at a community location. The group component is used as an ongoing engagement strategy and to introduce parenting skills. However, all skills introduced in the group component are also reviewed 1:1 in-home during the six family coaching sessions and the group material can be presented in-home Personal Communication, Alison Blodgett, November 5, 2018).

[250] Sterrett-Hong, E. M., Karam, E., & Kiaer, L. (2017). Statewide implementation of Parenting with Love and Limits (PLL) among youth with co-existing emotional and behavioral problems to reduce return to service rates and treatment costs. *Administration and Policy in Mental Health and Mental Health Services Research*, 44(5):792-809, doi:10.1007/s10488-016-0788-4

[251] http://wsipp.wa.gov/BenefitCost/Program/138

[252] http://www.cebc4cw.org/program/1-2-3-magic-effective-discipline-for-children-2-12/detailed

[253] https://www.123magic.com/books

[254]NREPP Moral Reconation Therapy summary retrieved Sept. 20, 2015, from http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=11. For more information see:

- Deschamps, T. (1998). *MRT: Is it effective in decreasing recidivism rates with young offenders?* Unpublished master's thesis, University of Windsor, Windsor, Ontario, Canada.
- Little, G. L., Robinson, K. D., & Burnette, K. D. (1991). Treating drug offenders with Moral Reconation Therapy: A three-year report. *Psychological Reports*, 69, 1151-1154.
- Information re: training located here: http://www.blueprintsprograms.com/program-costs/adolescent-coping-with-depression Training cost = $5,000 = $2000 / day for 1-2 day training sessions + travel costs for trainer. Following costs only for trained therapists to lead the group. No cost for curriculum or licensing. Training cost estimate does not include cost for the salaries of participating therapist who are being trained. (Source: Blueprints for Healthy Youth Development, hosted by the Center for the Study and Prevention of Violence (CSPV), at Institute of Behavior Science, Univ. of Colorado Boulder.)

[255] See entry for CBT for adolescent depression)

[256] https://research.kpchr.org/Research/Research-Areas/Mental-Health/Youth-Depression-Programs

[257] http://www.workbookpublishing.com/anxiety.html

[258] https://nrepp.samhsa.gov/ProgramProfile.aspx?id=1225

[259] The CCPT model has also been implemented in the school setting following a 16-session format delivered twice weekly for 30 minutes over 8 weeks. CCPT can be provided in the context of longer treatment requirements and may be used in a small group format.

[260] CEBC summary: http://www.cebc4cw.org/program/effective-black-parenting-program/detailed. Also see Myers, H. F., Alvy, K. T., Arlington, A., Richardson, M. A., Marigna, M., Huff, R., & Newcomb, M. D. (1992). The impact of a parent training program on inner-city African-American families, *Journal of Community Psychology, 20*(2), 132-147.

[261]CEBC review and summary retrieved Sept. 30, 2015, from: http://www.cebc4cw.org/program/cognitive-processing-therapy-cpt/detailed. See:http://www.cebc4cw.org/program/cognitive-processing-therapy-cpt/detailed. See:

- Chard, K. M. (2005). An evaluation of cognitive processing therapy for the treatment of posttraumatic stress disorder related to childhood sexual abuse. *Journal of Consulting and Clinical Psychology, 73*, 965–971.
- Kelly, K. A., Rizvi, S. L., Monson, C. M., & Resick, P. A. (2009). The impact of sudden gains in cognitive behavioral therapy for posttraumatic stress disorder. *Journal of Traumatic Stress, 22*, 287–293.
- NREP summary retrieved Sept. 30, 2015, from: http://nrepp.samhsa.gov/ViewIntervention.aspx?id=386.
- Resick, P. A., Williams, L. F., Suvak, M. K., Monson, C. M., & Gradus, J. L. (2012). Long-term outcomes of cognitive-behavioral treatments for posttraumatic stress disorder among female rape survivors. *Journal of Consulting and Clinical Psychology, 80,* 201–210.

[262] https://www.guilford.com/books/Cognitive-Processing-Therapy-for-PTSD/Resick-Monson-Chard/9781462528646

[263] http://www.blueprintsprograms.com/program-costs/parent-child-interaction-therapy

[264] http://www.oxfordclinicalpsych.com/view/10.1093/med:psych/9780199916887.001.0001/med-9780199916887

[265] http://www.cebc4cw.org/program/fairy-tale-model-treating-problem-behaviors-a-trauma-informed-approach/detailed

[266] http://www.cebc4cw.org/program/family-connections/detailed

[267] Family Spirit is being implemented across the country in 120 tribal communities across 19 states. (Personal communication, Kristen Speakman, Ausust 8, 2018.)

[268] http://www.cebc4cw.org/program/helping-the-noncompliant-child/

[269] http://wsipp.wa.gov/BenefitCost/Program/541

[270] https://www.guilford.com/books/Helping-the-Noncompliant-Child/McMahon-Forehand/9781593852412

[271] http://www.cebc4cw.org/program/interpersonal-psychotherapy-for-depressed-adolescents/detailed

[272] http://www.cebc4cw.org/program/mindfulness-based-cognitive-therapy-for-children-mbct-c/detailed

[273] Schaeffer, C. M., Swenson, C. C., Tuerk, E. H., & Lenggeler, S. W. (2013). Comprehensive treatment for co-occurring child maltreatment and parental substance abuse: Outcomes from a 24-month pilot study of the MST-Building Stronger Families program. *Child Abuse & Neglect, 37*(8), 596-607. doi:10.1016/j.chiabu.2013.04.004

[274] MST was developed by psychologists but has always had social workers involved and relies heavily on social ecological theory, in-home services, family work, and consultation with schools and other entities (e.g., juvenile services or CW) that are also involved with the family.

[275] http://www.cebc4cw.org/program/nurturing-parenting-program-for-parents-and-their-school-age-children-5-to-12-years/detailed

[276] Despite the fact that some program expenses like supervision, rent, and other non-personnel costs were not included, savings would be substantially greater if other outcomes associated with the prevention of maltreatment were included, such as medical costs (hospitalizations, chronic health conditions, doctor visits, prescriptions), non-medical costs (judicial and criminal services, special education), and lost productivity (lost earnings). See Maher, E. J., Corwin, T. W., Hodnett, R., & Faulk, K. (2012). A cost-savings analysis of a statewide parenting education program in child welfare. *Research on Social Work Practice, 22*, 615 - 625.

[277] http://www.cebc4cw.org/program/parents-anonymous/detailed

[278] http://www.cebc4cw.org/program/parents-anonymous/detailed

[279] http://www.cebc4cw.org/program/solution-based-casework/detailed

[280] http://www.cebc4cw.org/program/solution-based-casework/detailed

[281] Ford & Russo (2006),

[282] Layne, Saltzman, Pynoos, et al. (2000).

[283] See (DBT: Miller, Rathus, & Linehan, 2006),

[284] With SPACS, youth were half as likely to run away, were one-fourth less likely to experience placement interruptions (arrests, hospitalizations, runaways etc.), and showed improvement in risk behaviors measured with the Child and Adolescent Needs and Strengths (CANS) instrument.
See http://promising.futureswithoutviolence.org/?program=structured-psychotherapy-for-adolescents-responding-to-chronic-stress-sparcs

[285] http://resources.childhealthcare.org/resources/sparcs_general.pdf

[286] http://www.cebc4cw.org/program/sitcap-art/detailed

[287] http://www.cebc4cw.org/program/trauma-grief-component-therapy-for-adolescents/detailed

[288] Students in treatment condition reported significant ($p < .05$) pre- to post-treatment reductions in PTSD symptoms (58% at post-treatment; 81% at 4-month follow-up) compare favorably to those reported in a rigorously conducted treatment efficacy trials.

[289] http://www.cebc4cw.org/program/trauma-grief-component-therapy-for-adolescents/detailed

[290] See the Wraparound program initiative website at http://nwi.pdx.edu

[291] http://www.cebc4cw.org/program/c-a-r-e-s-coordination-advocacy-resources-education-and-support/detailed

[292] http://www.cebc4cw.org/program/seeking-safety-for-adolescents/detailed

[293] http://wsipp.wa.gov/BenefitCost/Program/307

[294] https://www.treatment-innovations.org/store/p2/Seeking_Safety_book_-_English_language.html

[295] ABCT begins with a 2–3-hour assessment for detailed treatment planning to determine contributing factors to alcohol use, the state of the relationship, and the reason for abstinence.

[296]McHugh K.R., Hearon B.A., & Otto M.W. (2010). Cognitive-behavioral therapy for substance use disorders. *Psychiatr. Clin. N. America*, 33:511–525. doi: 10.1016/j.psc.2010.04.012

[297] http://www.wsipp.wa.gov/BenefitCost/Pdf/7/WSIPP_BenefitCost_Substance-Use-Disorders

[298] http://www.wsipp.wa.gov/BenefitCost/Program/292

[299]http://www.cebc4cw.org/program/seeking-safety-for-adolescents/detailed

[300] http://wsipp.wa.gov/BenefitCost/Program/307

[301] https://www.treatment-innovations.org/store/p2/Seeking_Safety_book_-_English_language.html

[302] https://www.nrepp.samhsa.gov/Legacy/ViewIntervention.aspx?id=358

[303] http://wsipp.wa.gov/BenefitCost/Program/313

[304] https://www.nrepp.samhsa.gov/Legacy/ViewIntervention.aspx?id=358

[305] https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-4

[306] https://www.campbellcollaboration.org/library/12-step-programmes-illicit-drug-abuse-reduction.html

[307] http://wsipp.wa.gov/BenefitCost/Program/313 and http://www.wsipp.wa.gov/BenefitCost/Pdf/7/WSIPP_BenefitCost_Substance-Use-Disorders

[308] https://pubs.niaaa.nih.gov/publications/projectmatch/match01.pdf

[309] The program promotes five protective factors that have been shown to increase the likelihood of positive outcomes for young children and their families and to reduce the likelihood of child abuse and neglect: 1) parental resilience, 2) social connections, 3) knowledge of parenting and child development, 4) concrete support in times of need, and 5) social and emotional competence of children. The program's components are developed to provide new parents with practical demonstrations of infant soothing and strategies for managing normal stress in parenting. See https://nrepp.samhsa.gov/ProgramProfile.aspx?id=118#hide4

[310] http://www.cebc4cw.org/program/circle-of-security-home-visiting-4/detailed

[311] https://www.circleofsecurityinternational.com/books

[312]Abstracted from the CEBC website: http://www.cebc4cw.org/program/collaborative-problem-solving/

[313] https://homvee.acf.hhs.gov/Implementation/3/Early-Head-Start-Home-Visiting--EHS-HV--Implementation/8

[314] https://homvee.acf.hhs.gov/Implementation/3/Early-Head-Start-Home-Visiting--EHS-HV--Implementation/8

[315] Federal HOMVEE program summary

[316] Federal HOMVEE home visiting program summary.

[317] http://wsipp.wa.gov/BenefitCost/Program/749

[318] http://www.cebc4cw.org/program/the-oregon-model-parent-management-training-pmto/detailed

[319] http://www.cebc4cw.org/program/the-oregon-model-parent-management-training-pmto/detailed

[320] http://wsipp.wa.gov/BenefitCost/Program/539 http://wsipp.wa.gov/BenefitCost/Program/544

[321] http://www.cebc4cw.org/program/the-oregon-model-parent-management-training-pmto/detailed

[322] Abstracted from CEBC: http://www.cebc4cw.org/program/parents-as-teachers/

[323] Parents and youth meet separately for instruction during the first hour and together for family activities during the second hour.

[324] Dr. Kolko says: per participant cost varies by who is providing it, who pays for it, insurance regulation dictates, delivery setting, etc.

[325] http://wsipp.wa.gov/BenefitCost/Program/388

[326] Federal HOMVEE home visiting program summary.

[327] http://www.blueprintsprograms.com

[328]Perini, S.J., Wuthrich, V.M. & Rapee, R.M. (2013).Cool Kids in Denmark: Commentary on a cognitive-behavioral therapy group for anxious youth. *Pragmatic Case Studies in Psychotherapy,* (9), Module 3, Article 4, pp. 359-370.

[329] Perini et al., (2013).

[330] http://www.cebc4cw.org/program/cool-kids/detailed

[331] https://global.oup.com/academic/product/cue-centered-therapy-for-youth-experiencing-posttraumatic-symptoms-9780190201326

[332] Arias, Arce, & Vilariño. (2013). Batterer intervention programmes: A meta-analytic review of effectiveness. *Psychosocial Intervention*, 22(2), 153-160.

[333] One meta-analysis found a "lack of a significant treatment effect" for the Duluth Model. See Arias, Arce, & Vilarino, (2013),

[334] https://www.theduluthmodel.org/product-category/booksmanuals/

[335] http://www.marquette.edu/education/early-pathways/

[336] http://www.marquette.edu/education/early-pathways/

[337] http://www.cebc4cw.org/program/families-first/detailed

[338] http://www.cebc4cw.org/program/family-centered-treatment/

[339] http://www.cebc4cw.org/program/parent-child-assistance-program/detailed

[340] Varies by outcome – see Maher, E.J. & Grant, T. (2013). *Parent-Child Assistance Program outcomes suggest sources of cost savings for Washington State*. (Research brief) Seattle: Casey Family Programs. And http://www.wsipp.wa.gov/BenefitCost/Program/346

[341] See http://pfrprogram.org/ and http://www.cebc4cw.org/program/promoting-first-relationships/

[342]A RCT study was recently published on open CPS investigation cases but the outcomes measured do not include repeat child maltreatment

[343] http://www.cebc4cw.org/program/promoting-first-relationships/detailed

[344] See http://www.cebc4cw.org/program/risk-reduction-through-family-therapy/detailed

[345] http://www.cebc4cw.org/program/risk-reduction-through-family-therapy/detailed

[346] http://www.cebc4cw.org/program/step-by-step-parenting-program/detailed

[347] No meta-analysis of TARGET-A has been completed to date. Ford, Julian D., Steinberg, Karen L., Hawke, Josephine, Levine, Joan, & Zhang, Wanli. (2012). Randomized Trial comparison of emotion regulation and relational psychotherapies for PTSD with girls involved in delinquency. *Journal of Clinical Child and Adolescent Psychology*, 41(1), 27-37.

[348] http://www.cebc4cw.org/program/trauma-affect-regulation-guide-for-education-and-therapy-adolescents/detailed

[349] See http://www.cebc4cw.org/program/wraparound/detailed

[350] See the Wraparound program initiative website at http://nwi.pdx.edu

HHS Initial Practice Criteria and First List of Services and Programs Selected for Review as part of the *Title IV-E Prevention Services Clearinghouse*

The Family First Prevention Services Act requires HHS to conduct an independent systematic review of evidence to rate services and programs as promising, supported, and well-supported practices.

On June 22, 2018, HHS published a Federal Register Notice (FRN; 83 FR 29122) requesting public comment on initial criteria and potential services and programs to be considered for systematic review in the *Title IV-E Prevention Services Clearinghouse (herein the Clearinghouse)*. The initial criteria were intended to (a) determine eligibility of programs and services for review by the Clearinghouse, (b) prioritize eligible programs and services for review, (c) determine eligibility of studies aligned with prioritized programs and services, (d) prioritize eligible studies for rating, (e) rate studies, and (f) rate programs and services as promising, supported, and well-supported practices. The FRN also requested recommendations of potential services and programs to be considered for systematic review. The comment period closed on July 22, 2018. Over 360 responses were received, most containing multiple comments. Commenters included state and local administrators, service and program developers, foundations, non-profit organizations, researchers and evaluators, and other stakeholders.

This attachment includes revised initial criteria and the first dozen services and programs selected for systematic review. The Clearinghouse will select additional services and programs for review on a rolling basis. In developing these revised initial criteria and selecting the first dozen services and programs, HHS considered public comments on the FRN and input from federal partners, as well as other key stakeholders including the California Evidence-Based Clearinghouse.

Overall, public comments recommended adopting broad and inclusive criteria to determine services or programs and associated studies considered for review. Public comments and feasibility considerations informed several notable revisions to the initial criteria. For example, the revised initial criteria no longer consider target population/sample, implementation period, trauma-informed approach, magnitude of effects, and in-home delivery setting in determining eligibility, prioritization, or rating. When possible, the Clearinghouse will document and release additional information beyond that considered as part of the revised initial criteria. This additional information may include, but is not limited to details about: the extent to which the service or program is provided under an organizational structure or framework in accordance with principles of a trauma informed approach and/or represents a trauma specific intervention; intended target population of service or program; availability of culturally specific, location or population-based adaptation of service or program; service or program delivery setting; and study specific information such as effect sizes, power, and additional detail on study sample and subsample.

I. Revised Initial Criteria

The Clearinghouse will use the *Service or Program Eligibility and Prioritization Criteria* to identify and prioritize services and programs for review. Subsequently, the Clearinghouse will

use the *Study Eligibility and Prioritization Criteria* to identify and prioritize our review of studies for each of the selected services and programs. The Clearinghouse will use the *Study Rating Criteria* to assess the design, execution, and impacts of studies. The Clearinghouse will use the *Service or Program Rating Criteria* to rate services or programs as "promising," "supported," "well-supported," or "does not currently meet criteria." A more detailed description of the revised initial criteria and procedures for systematic review and re-review along with definitions of key terminology will be included in the forthcoming Title IV-E Prevention Services Clearinghouse Procedures Handbook.

1. *Service or Program Eligibility Criteria.* Services or programs must, at a minimum, meet the following criteria to be eligible for review by the Clearinghouse [sections 471(e)(1) and 471(e)(4)(C) of the Social Security Act (the Act)]:
    a. Types of Services and Programs. Eligibility will be limited to mental health and substance abuse prevention and treatment services and in-home parent skill-based programs as well as kinship navigator programs.
    b. Book/Manual/Writings Available. Eligibility will be limited to services or programs that have a book, manual, or other available documentation that specifies the components of the practice protocol and describes how to administer the practice.

2. *Service or Program Prioritization Criteria.* Timing and resources may not allow for the Clearinghouse to conduct a detailed review of all services and programs that meet the *Service or Program Eligibility Criteria.* Services or programs will be prioritized for Clearinghouse review using the following criteria:
    a. Target Outcomes. Services or programs that aim to impact target outcomes identified by the Clearinghouse will be prioritized for review [section 471(e)(4)(C) of the Act]. Target outcomes for mental health and substance abuse prevention and treatment services and in-home parent skill-based programs will include a wide array of outcomes that fall broadly under the following domains: child safety, child permanency, child well-being, and adult (parent and kin caregiver) well-being. Target outcomes for kinship navigator programs will include all outcome domains listed above as well as access to, referral to, and satisfaction with services and programs.
    b. In Use/Active. Services or programs currently in use with a book, manual, or other documentation available in English will be prioritized.
    c. Implementation and Fidelity Support. Services or Programs that have implementation training and staff support and/or fidelity monitoring tools and resources available to implementers in English will be prioritized.

    Initially, the *Title IV-E Prevention Services Clearinghouse* will give particular consideration to services and programs recommended by state and local government administrators in response to the FRN, included as part of existing evidence reviews, and/or evaluated by Title IV-E Child Welfare Waiver Demonstrations. The Clearinghouse will also give particular consideration to ensure services and programs from each category (i.e., mental health, substance abuse, in-home parent, or kinship navigator) are represented.

3. *Study Eligibility Criteria.* Studies examining each of the selected services and programs will be screened for eligibility for inclusion in the Clearinghouse using the following criteria:
    a. Source. Eligibility will be limited to studies included in peer-reviewed journal articles and/or publicly available literature that may include, but is not limited to federal, state, and local government and foundation reports.
    b. Study Design. Eligibility will be limited to study designs that assess effectiveness (i.e., impact) using quantitative methods and utilize an appropriate control. Eligible study designs include Randomized Controlled Trials (RCT), Quasi-Experimental Designs (QED), and other non-experimental designs that utilize an appropriate control.
    c. Target Outcomes. Eligibility will be limited to studies that examine the impact of the service or program on at least one 'target outcome.' Target outcomes for studies of mental health and substance abuse prevention and treatment services and in-home parent skill-based programs will include a wide array of outcomes that fall broadly under the following domains: child safety, child permanency, child well-being, and adult (parent and kin caregiver) well-being. Target outcomes for studies of kinship navigator programs will include all outcome domains listed above as well as access to, referral to, and satisfaction with services and programs.
    d. Study Available in English. Eligibility will be limited to studies available in English.

    Initially, the *Title IV-E Prevention Services Clearinghouse* will give particular consideration to studies published or prepared in or after 1990.

4. *Study Prioritization Criteria.* Timing and resources may not allow for the Clearinghouse to conduct a detailed review of all studies determined within a selected service or program to be eligible according to the *Study Eligibility Criteria.* The order and depth of review for studies will be determined on the basis of study features that may include sample size, duration of sustained effects examined, and type of study design.

5. *Study Rating Criteria.* The Clearinghouse will rate studies using the following criteria:
    a. Study Design and Execution. Building from the standards of existing evidence reviews such as the What Works Clearinghouse (WWC) and Home Visiting Evidence of Effectiveness (HomVEE), the Clearinghouse will assess studies on the basis of study design, overall and differential sample attrition, the equivalence of intervention and comparison groups at baseline (as applicable), and when necessary, procedures accounting for clustering. In addition, the study must account for confounding factors and examine at least one "target outcome" (see *Study Eligibility Criteria)* using a measure that is reliable and achieves face validity. Inconsistencies in systematic administration, as noted in study text, will also be considered. Studies will be rated as "high," "moderate," or "low." The study-level ratings will provide an indicator of the extent to which a study provides unbiased estimates of model impacts.

b. Effects. The following effects, defined using conventional standards of statistical significance, will be examined in the full analysis sample for studies that achieve a "high" or "moderate" rating on Study Design and Execution:
    i. Favorable Effects. Studies will be rated based on whether they demonstrate at least one meaningful favorable effect (i.e., positive significant effect) on a 'target outcome.'
    ii. Unfavorable Effects. Studies will be rated based on the number of unfavorable effects (i.e., negative significant effects) on either 'target' or non-target outcomes.
    iii. Sustained Favorable Effect. Studies with at least one meaningful favorable effect on a 'target outcome' will be rated on whether or not they demonstrate a favorable effect sustained beyond the end of treatment. Studies will be classified as not demonstrating a sustained favorable effect (i.e., effects are demonstrated for less than 6 months), demonstrating a sustained favorable effect of 6 months or more (but less than 12 months), or demonstrating a sustained favorable effect of 12 months or more.

Initially, due to time and resource constraints, the Clearinghouse will use only effects resulting from analyses of the full study sample for rating. This decision may be reconsidered in the future.

6. *Service or Program Rating Criteria*. The Clearinghouse will rate a service or program as a 'promising,' 'supported,' or 'well-supported' practice if it meets the below criteria that collectively assess the strength of evidence for a practice and build from the *Study Rating Criteria* [section 471(e)(4)(C) of the Act].
    a. *Promising Practice:* A service or program will be rated as a 'promising practice' if the service or program has at least one study that achieves a rating of 'moderate' or 'high' on Study Design and Execution and demonstrates a favorable effect on at least one 'target outcome.'
    b. *Supported Practice:* A service or program will be rated as a 'supported practice' if the service or program has at least one study carried out in a usual care or practice setting that achieves a rating of 'moderate' or 'high' on Study Design and Execution and demonstrates a sustained favorable effect of at least 6 months beyond the end of treatment on at least one target outcome.
    c. *Well-Supported Practice:* A service or program will be rated as a 'well-supported practice' if the service or program has at least two studies with non-overlapping analytic samples carried out in a usual care or practice setting that achieve a rating of 'moderate' or 'high' on Study Design and Execution. At least one of the studies must demonstrate a sustained favorable effect of at least 12 months beyond the end of treatment on at least one target outcome.
    d. *Does Not Currently Meet Criteria:* A service or program will be rated as 'does not currently meet criteria' if the service or program has been reviewed and does not currently meet the evidence criteria for 'promising,' 'supported,' or 'well-supported" practices.

> In accordance with the Family First Prevention Services Act, a service or program will not be rated as a 'promising,' 'supported,' or 'well-supported practice' if there is an empirical basis, as evidenced by multiple unfavorable effects on target or non-target outcomes across reviewed studies that suggest the overall weight of evidence does not support the benefits of the service or program.

II. First Services and Programs Selected for Systematic Review

HHS received and carefully considered a high volume of recommendations for services and programs to review as part of the Clearinghouse. The recommendations have informed the first services and programs selected for review and will inform additional services and programs to be selected for review on a rolling basis. Building from recommendations received from the FRN, federal partners, and other key stakeholders, as well as new information gathered, the Clearinghouse will utilize the forthcoming procedures and revised initial criteria to identify and prioritize additional services and programs for review.

The first services and programs selected for systematic review met at least two of the following conditions: (1) recommendation from State or local government administrators in response to the FRN; (2) rated by the California Evidence-Based Clearinghouse; (3) evaluated by Title IV-E Child Welfare Waiver Demonstrations; (4) recipient of a Family Connection Discretionary Grant; and/or (5) recommendation solicited from federal partners in the Administration for Children and Families, Health Resources and Services Administration, the National Institutes of Health, the Centers for Disease Control and Prevention, the Office of the Assistant Secretary for Planning and Evaluation, and the Substance Abuse and Mental Health Services Administration. Findings from the review of the first dozen services and programs are scheduled for release in Spring 2019. This review will rate programs as "promising," "supported," "well-supported," or "does not currently meet criteria." The Clearinghouse will select additional services and programs for review on a rolling basis using the revised initial criteria.

Prevention Services and Programs
Mental Health:
Parent-Child Interaction Therapy
Trauma Focused-Cognitive Behavioral Therapy
Multisystemic Therapy[1]
Functional Family Therapy

Substance Abuse:
Motivational Interviewing
Multisystemic Therapy[2]
Families Facing the Future
Methadone Maintenance Therapy

[1] Also included under the "Substance Abuse" category
[2] Also included under the "Mental Health" category

In-Home Parent Skill-Based:
Nurse-Family Partnership
Healthy Families America
Parents as Teachers

Kinship Navigator Programs
Children's Home Society of New Jersey Kinship Navigator Model
Children's Home Inc. Kinship Interdisciplinary Navigation Technologically-Advanced Model (KIN-Tech)

The Clearinghouse will release procedures for implementing the *Service or Program Eligibility and Prioritization Criteria* along with definitions of key terminology in the forthcoming Title IV-E Prevention Services Clearinghouse Procedures Handbook.