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.
- 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.