Interventions Shown to Be Effective with Children and Families of Color and LGBTQ2SI+ Persons Who May Be Served with Family First Funding

Research Brief (Second Edition)

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Abstract

The Prevention Services Clearinghouse has evaluated and rated as *Promising* or higher 81 interventions as of November 20, 2023. Our review finds that 61 of the 81 interventions currently rated as *Promising*, *Supported,* or *Well-Supporte*d are effective with at least one non-white ethnic group -- likely because of one or more of their intervention model components (e.g., clinical strategies, being family-centered, carefully listening to family perspectives, building upon family social support networks, incorporating a strengths-oriented assessment). However, we found very little evidence that any of these interventions are effective with LGBTQ2SI+ people (only 5 interventions had evidence for this group). While many of the developers said their interventions are effective with this population these interventions need additional evaluation to provide specific evidence.

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Sections of this report are based on material from the Casey Title IV-E Waiver Interventions Research Brief. (See https://www.casey.org/title-iv-e-research/). Special thanks to the intervention developers and their researchers for identifying relevant studies; and our Casey colleagues for their review of prior versions of this summary. We also appreciate the advice and resources from Gerald Mallon (Hunter College) and Ronita Nath (The Trevor Project).

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Introduction

Overview

The Family First Prevention Services Act (FFPSA) was signed into law in February 2018 under the Bipartisan Budget Act of 2018, Division E, Title VII.[1] The FFPSA reorganized federal funding for child welfare to improve supports that strengthen families and reduce inappropriate placements in foster care and group homes. The services to be reimbursed under that law must meet certain criteria to show evidence of effectiveness.[2] One aim of the FFPSA is to ensure that child safety is addressed in context with other challenges facing families in high-risk situations—including risk factors in the communities they live in. Child welfare services are concerned with long-term child outcomes *and* with building on the strengths of healthy communities that support families. Thus, under the FFPSA, the child welfare service population covers both at-risk families *and* their broad, diverse natural supports and communities.[3]

System reform strategies in the areas of practice, administration, and policy have changed the conditions for maltreated children and have accelerated permanency planning, thereby safely reducing the number of children in foster care.[4] Some of these strategies have used evidence-based practices (EBPs), wherein funding for child welfare services is allocated differently to create better futures and outcomes for children. But cost-savings resulting from foster care reductions and other program reforms should be reinvested in high-quality, evidence-based, and culturally informed services for the parents and children who need them.[5]

To that end, this document provides information about three areas:

(1) Evidence standards set by the FFPSA of 2018

(2) How certain interventions have been rated by the Title IV-E FFPSA Prevention Clearinghouse

(3) Which interventions rated as *Promising*, *Supported*, or *Well-Supported* by the Prevention Services Clearinghouse have been shown to be effective with children and families of color and LGBTQ2SI+ persons.[6]

Note that this is a very dynamic situation, and the Prevention Services Clearinghouse is adding and updating intervention ratings frequently. For example, in 2020, Washington, DC received federal approval for the practice of Motivational Interviewing to be partially reimbursed via FFPSA as a ***case management tool***, in addition to its use as a substance abuse treatment service. Updates of this summary will be issued periodically to keep this document as accurate as possible.

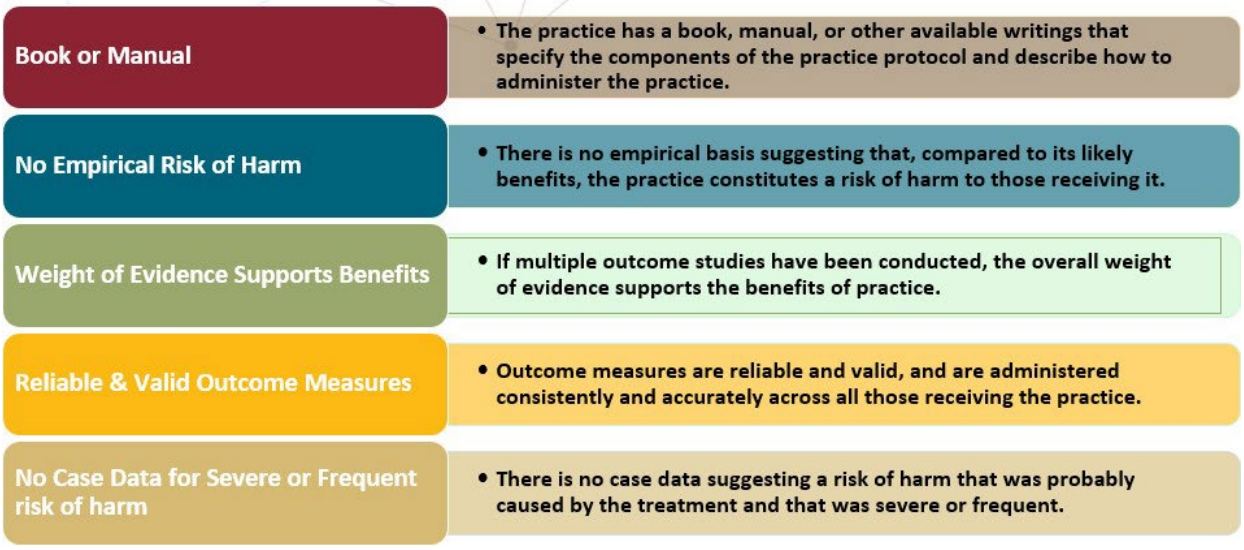
One caution should be noted: We do not provide a systematic evaluation of the quality of the research studies, but we do assess credible evidence in those studies to ascertain whether the intervention is effective with families of color and, where possible, effective with LGBTQ2SI+ persons. Research indicates that LGBTQ2SI+ youth and youth of color are over-represented in out-of-home care in certain program sectors and in some

communities.[7] This area warrants additional study, and we will strive to add more information in future editions about FFPSA-rated interventions that have evidence of effectiveness with both population groups.

Evidence Standards for Family First

In Figures 1 and 2, we summarize some of the key requirements for an intervention to be rated as *Promising* or higher by the Prevention Services Clearinghouse. Its handbook summarizes the research criteria in more detail.[8] Note that a new edition of the Prevention Services Clearinghouse Handbook should be finalized by early 2024.

FIGURE 1. FFPSA EVIDENCE STANDARDS FOR INTERVENTIONS: GENERAL PRACTICE REQUIREMENTS



Source: Abstracted from the Prevention Services Clearinghouse handbook; see: https://preventionservices.abtsites.com/review-process.

FIGURE 2. FFPSA EVIDENCE LEVELS AND STANDARDS FOR INTERVENTIONS

Evidence Level	Requirements for All Evidence Levels	Control Group	Sustained Effect
Promising	• The practice is superior to an appropriate comparison practice using conventional standards of statistical significance. • The practice has been rated by an independent systematic review. • For ***Supported*** and ***Well-Supported***…the practice has been carried out in usual care or practice setting.	• 1 untreated control, waitlist, or placebo study	• No follow-up study is required.
Supported		• 1 randomized control trial (RCT) or rigorous quasi-experimental study	• 6 months
Well-Supported		• 2 randomized control trials (RCT) or rigorous quasi-experimental studies	• 12 months

Source: Abstracted from the Prevention Services Clearinghouse handbook; see: https://preventionservices.abtsites.com/review-process.

Intended Program Outcomes

Below are some of the program impacts that the FFSPA-related interventions are intended to address:

- Child safety: Self-reports of maltreatment
- Child safety: Child welfare administrative reports
- Child permanency: Out-of-home placement
- Child permanency: Planned placement exits
- Child well-being: Substance use
- Child well-being: Behavioral and emotional functioning
- Child well-being: Cognitive functions and abilities
- Child well-being: Physical development and health
- Child well-being: Delinquent behavior
- Child well-being: Educational achievement and attainment
- Child well-being: Social functioning
- Adult well-being: Parent/caregiver substance use
- Adult well-being: Family functioning

- Adult well-being: Parent/caregiver mental or emotional health
- Adult well-being: Positive parenting practices
- Adult well-being: Economic and housing stability

Issues With Culturally Relevant Interventions

Issues of race and ethnicity must be considered when choosing an intervention, in addition to factors such as treatment needs, economic class, gender, and sexual identity. Yet further clarification is needed to highlight which child welfare interventions are effective across different kinds of groups. Many child welfare interventions have been created by white developers and researchers using participant samples that are largely comprised of white people. There is a clear need to rigorously evaluate culturally specific interventions to build up their evidence base (e.g., Culturally Modified Trauma-Focused Treatment [CM-TFT], Community Outreach Program Esperanza [COPE], Positive Indian Parenting Program).

Fortunately, many of the current interventions with a strong evidence base "travel well" across different racial/ethnic and sexual identity groups because of the core components of their intervention model (e.g., being youth and family-centered, carefully listening to family perspectives, building upon family social support networks, and incorporating a strengths-oriented assessment). But many interventions have needed modifications, such as Incredible Years, where the developers revised their video material to make those materials more relevant for different family situations. So, the need for modification depends on the intervention, which populations are to be served, characteristics of the interventionists and their relationship to the population, and where the intervention takes place.

Modifying a program with new examples to help it be more culturally relevant is allowed by the Clearinghouse. But more significant changes mean that the modified program will be viewed as a "new" intervention that must be evaluated separately. This requires a new line of evaluation research for each culturally modified intervention. ***Because of this requirement, we need more focused support for Black, indigenous, and other people of color as well as LGBTQ2SI+ persons to document and evaluate those interventions that have been adapted to meet their needs.*** (See Figures 3 and 4, which are abstracted from the Prevention Services Clearinghouse handbook. Note that a new version of the Handbook was recently published for public comment.)

In addition, Dee Bigfoot, an American Indian clinical researcher, has noted that ***how*** an intervention is implemented needs to be considered: we need to consider not only the nature of the intervention in terms of its clinical focus and strategies, but also consider the required behaviors of the provider(s).[9]

Note that the Clearinghouse has been encouraged to revise their approach to how cultural adaptations are considered and what kinds of evidence should be considered. For example, the state of Maryland in their comments on the draft handbook procedures urged the federal government to incorporate other ways of evidence-building and a more diverse set of experts to rate interventions -- "informed by AI/AN cultural and ethical frameworks or methodologies that are interconnected, relational, and non-linear such as:

a. *Storytelling:* This is a traditional way of sharing knowledge in many tribal cultures. It involves sharing stories as a means of transmitting cultural knowledge, values, and lessons.

b. *Community-Based Participatory Research (CBPR):* This approach involves the tribal community in all aspects of the research process, ensuring that the research is meaningful, respectful, and beneficial to the community.

c. *Land-Based Learning:* This involves learning from the land and nature, which is common practice in many tribal cultures.

d. *Sharing Circles:* Similar to focus groups, sharing circles are a qualitative indigenous research method where participants are encouraged to share and learn from their thoughts and experiences."[10]

FIGURE 3. ADAPTIONS TO PROGRAMS OR SERVICES

Many manualized programs have formal adaptations available (i.e., alternative manualized versions of the original program designed to address particular issues or populations). When programs and services that are identified for inclusion in the Prevention Services Clearinghouse have multiple formal adaptations or multiple treatment manuals available, each is reviewed as a separate program or service.

Programs or services that go by different names in different local implementations but that clearly use the same manual are considered to be the same program for purposes of review. Minor modifications to programs or services that are not considered formal adaptations are addressed in Section 4.1.6 below.

In order to maximize the number of different programs reviewed, the Prevention Services Clearinghouse may select one program adaptation for review when multiple formal adaptations are available. In most cases, the Prevention Services Clearinghouse will select the standard, original, or most comprehensive or complete version of a program or service; however, it may also consider other adaptations.

Source: Prevention Services Clearinghouse handbook, p. 4.

Issues with Interventions for LGBTQ2SI+ Youth and Families

Because LGBTQ2SI+ youth are over-represented in out-of-home care and because of the detrimental impact of minority stress[11] on the mental well-being of LGBTQ2SI+ youth, Bocchicchio and others emphasize the importance of examining and bolstering the availability of evidence-based treatments for this community.[12] Unfortunately, as our review shows, the evaluation studies do not focus on these youth or are unable to analyze the data because of data collection limitations such as the inability to obtain sexual identity data from current management information systems. We learned of these challenges via conversations with intervention developers and evaluators, and some of comprehensive literature reviews that have been completed. It is ironic that there is some evidence that cognitive behavioral therapy can be adapted and is effective with many non-white ethnic groups who are LGBTQ2SI+, and yet CBT has not yet been rated as *Promising* or higher by the Prevention Clearinghouse.[13]

FIGURE 4. EXAMPLES OF PROGRAM AND SERVICE ADAPTATIONS WITHIN A STUDY FOR THE PURPOSE OF STUDY REVIEW

Eligible Adaptations	Adaptations That Result in Different Program or Service
• Modestly changing session frequency or duration • Delivering the intervention in the home compared to an office-based delivery • Making small changes to increase the cultural relevancy of the intervention (e.g., changing examples to match the cultural background of subjects; providing the intervention in a different language) without changing program components • Delivering the program by slightly different types of professionals than those described in the manual or original research on the program or service (e.g., using social workers instead of counselors to deliver the program)	• Changing from individual to group therapy • Adding any new modules or session content • Subtracting any modules or session content that was part of the original intervention • Radically changing content for different cultural groups, such as to reflect particular issues experienced by those groups • Delivery of the program by substantially different providers than described in the manual (e.g., using para-professionals instead of nurses to deliver the program)

Source: Prevention Services Clearinghouse handbook, p. 15.

What Interventions Have Been Reviewed and are Under Review by the Clearinghouse?

Programs and Services Planned for Review

The Clearinghouse's working list of programs and services planned for systematic review as of November 20, 2023, is presented below. The programs and services were identified and prioritized using the Clearinghouse's *Handbook of Standards and Procedures*. Priority consideration was given to programs and services recommended by State or local government administrators; rated by other clearinghouses (such as CEBC or HomVEE); recommended by federal partners; and/or evaluated as part of grants supported by the Children's Bureau (such as the Title IV-E Child Welfare Demonstrations or Regional Partnership Grants).

Mental Health:

- Acceptance and Commitment Therapy [also listed under substance abuse]
- ACT Raising Safe Kids [also listed under in-home parent skill-based]
- Dialectical Behavior Therapy
- Fatherhood is Sacred/Motherhood is Sacred [also listed under in-home parent skill-based]
- Keeping Foster and Kin Parents Supported and Trained

- Make Parenting a Pleasure
- Project Venture [also listed under substance abuse]
- Relief Nursery [also listed under in-home parent skill-based]

Substance Abuse:

- Acceptance and Commitment Therapy [also listed under mental health]
- Creating Lasting Family Connections
- Gathering of Native Americans
- Prize Contingency Management
- Project Venture [also listed under mental health]

In-home Parent Skill-based:

- ACT Raising Safe Kids [also listed under mental health]
- Fatherhood is Sacred/Motherhood is Sacred [also listed under mental health]
- Relief Nursery [also listed under mental health]
- SafeCare (Re-Review)

Kinship Navigator:

- 30 Days to Family
- A Second Chance Kinship Navigator Program
- Kinship Interdisciplinary Navigation Technologically-Advanced Model (Re-Review)

Programs that have been rated by the FFPSA Prevention Services Clearinghouse and their program categories as of November 20, 2023, are listed in Table 1 below.

TABLE 1. PROGRAMS THAT HAVE BEEN RATED BY THE FFPSA PREVENTION SERVICES CLEARINGHOUSE AND THEIR PROGRAM CATEGORIES AS OF NOVEMBER 20, 2023

Program and Evidence Rating	In-Home Parent Skill-Based	Mental Health	Substance Abuse Treatment	Kinship Navigator
WELL-SUPPORTED				
Brief Strategic Family Therapy (BSFT)	X	X	X	
Familias Unidas	X	X	X	
Families First (Utah Youth Village Model)	X	X		
Family Check-up	X	X		
Family Foundation	X	X		
Functional Family Therapy (FFT)		X		
Generation PMTO – Group		X		

Program and Evidence Rating	In-Home Parent Skill-Based	Mental Health	Substance Abuse Treatment	Kinship Navigator
Guiding Good Choices	X	X	X	
Healthy Families America	X			
Homebuilders Intensive Family Preservation and Reunification Services	X			
Intercept	X			
Maternal Early Childhood Sustained Home-visiting® (MECSH)	X			
Mindfulness–Based Cognitive Therapy (MBCT)		X		
Motivational Interviewing (MI)[1]			X	
Multisystemic Therapy (MST)		X	X	
Nurse-Family Partnership (NFP)	X			
Parent-Child Interaction Therapy (PCIT)		X		
Parents as Teachers	X			
Strong African American Families (SAAF)		X	X	
SUPPORTED				
Arizona Kinship Support Services				X
Child First	X	X		
Eye Movement Desensitization and Reprocessing - Standard Protocol	X			
Families Facing the Future			X	
Family Centered Treatment® (FCT)	X			
Fostering Healthy Futures® for Preteens (FHF-P)		X		
Guiding Good Choices	X	X	X	
Interpersonal Psychotherapy for Depressed Adolescents (Weissman et al., manual)		X		
Mindfulness-Based Cognitive Therapy for Parents (MBCT-P)		X		
Multi-Dimensional Family Therapy	X	X	X	

[1] Washington D.C. has been approved to also use Motivational Interviewing as a "cross-cutting" case management intervention, in addition to treating substance abuse.

Program and Evidence Rating	In-Home Parent Skill-Based	Mental Health	Substance Abuse Treatment	Kinship Navigator
Multisystemic Therapy- Building Stronger Families (MST-BSF)	X	X	X	
Parenting with Love and Limits® (PLL	X	X		
Parents Anonymous	X	X	X	
Prolonged Exposure Therapy for Adolescents with PTSD		X		
Promoting First Relationships	X	X		
SafeCare	X			
Sobriety Treatment and Recovery Teams (START)	X		X	
Strengthening Families Program: For Parents and Youth 10-14 (SFP 10-14)		X	X	
Triple P – Positive Parenting Program – Online (Level 4)		X		
PROMISING				
Adolescent Community Reinforcement Approach			X	
Aggression Replacement Training® (ART)		X		
Attachment-Based Family Therapy		X		
Bounce Back		X		
Child-Centered Group Play Therapy		X		
Child-Centered Play Therapy		X		
Child-Parent Psychotherapy (CPP)		X		
Child-Parent Relationship Therapy		X		
Cognitive Behavioral Intervention for Trauma in School		X		
Cognitive Processing Therapy (CPT		X		
Colorado Kinnected Kinship Navigator Program (Colorado Kinnected)				X
Common Sense Parenting- School Age		X		

Program and Evidence Rating	In-Home Parent Skill-Based	Mental Health	Substance Abuse Treatment	Kinship Navigator
Community Reinforcement Approach + Vouchers (CRA + Vouchers)			X	
Coping Cat – Group		X		
Coping Cat – Individua		X		
Effective Black Parenting Program (EBPP)		X		
Families and Schools Together- Elementary School Level		X		
Family Spirit	X			
Foster Kinship Navigator Program				X
Generation PMTO – Individual [formerly known as Parent Management Training – Oregon Model (PMTO®)]	X	X		
Incredible Years – School Age Basic Program	X			
Incredible Years – Toddler Basic Program	X			
Intensive Care Coordination Using High Fidelity Wraparound (Wraparound)		X		
Interpersonal Psychotherapy for Depressed Adolescents		X		
Iowa Parent Partner Approach	X			
Methadone Maintenance Therapy			X	
Mindful Mood Balance (MMB)		X		
Narrative Exposure Therapy		X		
Ohio's Kinship Supports Intervention/ProtectOHIO				X
On the Way Home® (OTWH)	X	X		
Parent-Child Care (PC-CARE)	X	X		
Prolonged Exposure Therapy for PTSD (Adults)		X		
Screening, Brief Intervention and Referral to Treatment			X	
Smart Beginnings	X	X		
Trust-Based Relational Therapy for caregivers (TBRI® 101)		X		
Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)		X		

Program and Evidence Rating	In-Home Parent Skill-Based	Mental Health	Substance Abuse Treatment	Kinship Navigator
Treatment Foster Care Oregon for Adolescents	X	X		
Triple P – Positive Parenting Program - Group (Level 4)		X		
Triple P – Positive Parenting Program – Online – Level 4		X		
Triple P – Positive Parenting Program – Self-Directed (Level 4)		X		
Triple P – Positive Parenting Program Standard (Level 4)		X		
Trust-Based Relational Intervention – Caregiver Training		X		
Video Interaction Project	X	X		

Programs That Have Been Judged by the FFPSA Prevention Services Clearinghouse as Having Insufficient Information to be Rated

As of November 20, 2023, the Clearinghouse was unable to rate the following interventions because of insufficient evaluation data or the existing data did not meet the Clearinghouse standards. These are listed in Table 2.

TABLE 2. INTERVENTIONS THAT DID NOT MEET THE CLEARINGHOUSE STANDARDS

Interventions Unable to Be Rated	Interventions Unable to Be Rated
Active Parenting of Teens: Families in Action™	Helping Women Recover (HWR) and Beyond Trauma (BT)[4]
Active Parenting of Teens: Teens in Action	Incredible Years – Parents and Babies Program ("IY-Babies")
Active Parenting of Teens ™	Incredible Years – Preschool Basic Program ("IY-Preschool")
Active Parenting: First Five Years™	Individual Combined Parent-Child Cognitive Behavioral Therapy
Active Parenting™	Interpersonal Psychotherapy (IPT) (Stuart & Robertson Manual)
Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT)	Kinship Interdisciplinary Navigation Technologically-Advanced Model (KIN-Tech)
Assertive Community Treatment	Mindfulness-Based Cognitive Therapy for Anxious Children (MBCT-C)
Autism Parent Navigators	Multimedia Circle of Life
Attachment and Biobehavioral Catch-up (ABC) – Infant	Multisystemic Therapy – Prevention
Attachment and Biobehavioral Catch-up (ABC) – Toddler	Multisystemic Therapy – Substance Abuse
Being Brave (an adaptation of Coping Cat)	Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)
BRAVE	Nurturing Parenting Program for Parents & Their Infants, Toddlers and Pre-Schoolers
C.A.T. Project (an adaptation of Coping Cat)	Nurturing Parenting Program for Parents & Their School Age Children 5 to 11 Years
Camp Cope-A-Lot (an adaptation of Coping Cat)	Parent-Child Assistance Program
Celebrating Families	
Celebrating Families 0 0 thru 3 years	
Chicago Parent Program (CPP)	
Children's Home Society of New Jersey (CHSofNJ) Kinship Navigator Model	
Circle of Security – Intensive™ (COS-Intensive™)	
Circle of Security – Parenting™ (COSP™)	

[4] Two curricula delivered sequentially as one trauma-informed and trauma-responsive intervention (HWR+BT).

Interventions Unable to Be Rated	Interventions Unable to Be Rated
Common Sense Parenting® of Toddlers and Preschoolers	Parent Connectors
Criando con Amor: Promoviendo Armonía y Superación – Jóvenes (CAPAS-Youth)[3]	Parenting Wisely – Teen Edition
e-Family Foundations	Parenting Wisely – Young Child Edition
Early Pathways	Positive Indian Parenting
ezPARENT	Sacred Journey
Familias Fuertes (adapted from Strengthening Families Program)	Safe Environment for Every Kid (SEEK™)
Familias Unidas – eHealth	SafeCare Augmented (an enhanced version of SafeCare)
Families Actively Improving Relationships (FAIR)	Seeking Safety
Families and Schools Together® (FAST®) – Early Childhood Education Level	Solution-Based Casework (SBC)
Families and Schools Together® (FAST®) – High School Level	Strengthening Families Program – 12-16 (SFP 12-16)
Families and Schools Together® (FAST®) – Middle School Level	Strengthening Families Program – 3-5 (SFP 3-5)
Family Behavior Therapy - Adolescent (Adolescent FBT)	Strengthening Families Program – 6-11 (SFP 6-11)
Family Behavior Therapy - Adult (Adult FBT)	Strengthening Families Program – Birth to Three (SFP B-3)
Family Behavior Therapy – Adult with Child Welfare Supplement (Adult FBT-CWS)	Strong African American Families – Teen
FF@Home	Strong Foundations
Fostering Healthy Futures® for Teens (FHF-T)	The Matrix Model
Functional Family Probation and Parole	The Seven Challenges – Adolescent
Functional Family Therapy – Child Welfare	The Seven Challenges – Adult
Functional Family Therapy—Therapeutic Case Management	Together Facing the Challenge (TFTC)
Group Combined Parent-Child Cognitive Behavioral Therapy	Trauma Systems Therapy
	Trauma Systems Therapy for Foster Care
	Treatment Foster Care Oregon for Middle Childhood
	Treatment Foster Care Oregon for Preschoolers
	Washington State Kinship Navigator Program
	Wellbriety & Celebrating Families!™

[3] CAPAS-Youth is a group-based parenting and family functioning intervention adapted from GenerationPMTO – Group, also known as Parenting Through Change (PTC) and formerly known as Parent Management Training – Oregon Model (PMTO®).

Effectiveness of FFPSA Interventions with Families of Color and LGBTQ2SI+ Persons

Overview

While there is evidence of culturally and linguistically relevant child welfare, home visiting, parent training, and mental health services, more interventions need to be evaluated with children and families of color in child welfare and community-based family support.[14] Table 3 presents each intervention listed in the Prevention Services Clearinghouse alongside its overall evidence rating, and whether research has found the intervention to be effective with certain racial/ethnic and LGBTQ2SI+ groups. Note that the interventions vary in terms of how widely they have been used in child welfare, in the available information on their use with families of color, and in the degree to which the effects with families served by child welfare have been measured.

Appendix A contains more detailed information about each intervention, including target groups (e.g., ages 12-17), issues addressed (e.g., substance use), treatment duration (e.g., 12 weeks), treatment dosage (e.g., weekly meetings), and known levels of support for different racial and ethnic groups. Appendix A also provides a second organization's rating of effectiveness for nearly every intervention, which may serve as a supplementary source of information, particularly when an intervention has not yet been rated by the Prevention Services Clearinghouse. When possible, we drew these supplemental ratings from the California Evidence-Based Clearinghouse for Child Welfare (CEBC).[15] But for other intervention ratings, we drew from the "BLUEPRINTS" intervention registry or the Office of Juvenile Justice and Delinquency Prevention's (OJJDP) Model Programs Guide (MPG).

In addition, we contacted the developers of each of the FFPSA-rated interventions and their primary researchers to see if there were additional studies of effectiveness that could be cited. We received feedback from nearly all of these people. Note that we included evidence of effectiveness if the study included at least 30 children or parents of a particular ethnic group of color or LGBTQ2SI+ and studies that reported a statistically significant effect for the intervention group. With a few exceptions noted in the tables, small sample studies with modest numbers (i.e., less than 30 participants) of any ethnic group of color or LGBTQ2SI+ persons were not considered.

Limitations

In some cases, the evidence base for the effectiveness of a particular intervention within a child welfare environment is sparse, so we rely on the research evidence indicating that the intervention is effective for a particular problem or area of functioning, and where various meta-analyses have reported adequate intervention effect sizes.[16]

There may be additional studies involving non-white ethnic groups but those were not available to us. As we have additional time, we will use additional university-based search engines to supplement this review. Note that Chapin Hall has also published two briefs on elevating culturally specific evidence-based practices.[17]

Finally, with the help of some national LGBTQ experts, we were able to draw upon some comprehensive literature reviews to determine which of these FFPSA-rated interventions are effective with LGBTQ2SI+ persons. In addition, we requested this information from all the intervention developers and have included in Appendix A any LGBTQ2SI+-related information provided to us. In future editions of this document, as the literature grows in this area, we hope to include a more comprehensive review of the research for these interventions related to LGBTQ2SI+ youth and families.

TABLE 3. INTERVENTIONS RATED BY THE PREVENTION SERVICES CLEARINGHOUSE WITH EVIDENCE OF EFFECTIVENESS FOR CHILDREN AND FAMILIES OF COLOR AND LGBTQ2SI+ PERSONS

(Interventions marked with a P [preliminary] have some evidence of effectiveness for LGBTQ2SI+ persons but did not meet our sample size standard or other criteria for inclusion.)

*Promising, ** Supported, ***Well-Supported								
Intervention and Rating	**American Indian or Alaskan Native**	**Asian/ Pacific Islander**	**Bi-Racial or Multi-Racial**	**African American**	**Latinx/ Hispanic**	**Native Hawaiian or Pacific Islander**	**Other**	**LGBTQ2SI+**
Adolescent Community Reinforcement Approach*				X	X			
Aggression Replacement Training®*							X[5]	
Arizona Kinship Support Services**							X[6]	
Attachment-Based Family Therapy* (ABFT)				X				P[7]
Brief Strategic Family Therapy (BFST)***			X	X	X			
Bounce Back*					X			
Child-Centered Play Therapy*				X				
Child First** (formerly Child and Family Interagency Resource, Support, and Training)					X			
Child-Parent Psychotherapy*			X	X	X			
Child-Parent Relationship Therapy*		X			X			
Cognitive Behavioral Intervention for Trauma in Schools*		X		X	X			
Colorado Kinnected Kinship Navigator Program (Colorado Kinnected)*					X			
Common Sense Parenting- School Age*				X	X		X	

[5] Aggression Replacement Training had evidence that it was effective for Turkish people.

[6] Arizona Kinship Support Services had data that it was effective for Non-White, non-Hispanic people.

[7] A small sample study with 8 participants completing all sessions showed effects in three areas of child functioning.

*Promising, ** Supported, ***Well-Supported								
Intervention and Rating	**American Indian or Alaskan Native**	**Asian/ Pacific Islander**	**Bi-Racial or Multi-Racial**	**African American**	**Latinx/ Hispanic**	**Native Hawaiian or Pacific Islander**	**Other**	**LGBTQ2SI+**
Community Reinforcement Approach + Vouchers (CRA = Vouchers)					X[8]			P[9]
Effective Black Parenting Program (EBPP)				X				
Eye Movement Desensitization and Reprocessing – Standard Protocol**							X[10]	
Families and Schools Together-Elementary School Level (FAST®)*	X				X			
Familias Unidas***					X			X
Families Facing the Future (formerly Focus on Families)**								
Families First (Utah Youth Village Model)					X[11]			
Family Centered Treatment**				X	X			
Family Check-up®***				X	X			
Family Spirit*	X							
Foster Kinship Navigator Program*		X		X	X	X		
Fostering Healthy Futures for Preteens**				X	X			
Functional Family Therapy (FFT)***				X	X			
Healthy Families America***	X	X	X	X	X	X		
Homebuilders—Intensive Family Preservation and Reunification Services***	X			X	X	X		
Incredible Years—School Age Basic Program*		X		X			X	

[8] Study conducted in Spain.

[9] The CRA approach without vouchers showed effectiveness with lesbian and gay youth.

[10] EMDR has been proven effective by studies in countries other than the United States.

[11] About 55 Latino youth were in the treatment sample and a large number were in the comparison group, but outcomes for that specific ethnic group were not reported.

*Promising, ** Supported, ***Well-Supported								
Intervention and Rating	**American Indian or Alaskan Native**	**Asian/ Pacific Islander**	**Bi-Racial or Multi-Racial**	**African American**	**Latinx/ Hispanic**	**Native Hawaiian or Pacific Islander**	**Other**	**LGBTQ2SI+**
Intensive Care Coordination Using High Fidelity Wraparound* (Wraparound)				X				
Intercept ®*** (formerly Youth Villages Intercept)				X				
Interpersonal Psychotherapy (Weissman et al. Manual)**				X			X	
Interpersonal Psychotherapy for Depressed Adolescents*					X			
Iowa Parent Partner Approach*					X			
Methadone Maintenance Therapy**				X	X			
Motivational Interviewing***	X		X	X	X			X
Multidimensional Family Therapy (MDFT)**				X	X		X	
Multisystemic Therapy (MST)**		X		X	X			
Narrative Exposure Therapy*		X					X	
Nurse-Family Partnership (NFP)***				X	X			
Ohio's Kinship Supports Intervention/ProtectOHIO				X	X			
Parent-Child Care				X	X			
Parent-Child Interaction Therapy (PCIT)***		X		X	X[12]		X	
Parenting with Love and Limits®**				X				
Parents Anonymous®**				X	X			
Parents as Teachers***				X	X			
Prolonged Exposure Therapy for Adolescents for PTSD*				X			X	
Prolonged Exposure Therapy for PTSD (Adults)*				X				

[12] With Guiando a Ninos Activos – Guiding Active Children -- a culturally adjusted version of PCIT)

*Promising, ** Supported, ***Well-Supported								
Intervention and Rating	**American Indian or Alaskan Native**	**Asian/ Pacific Islander**	**Bi-Racial or Multi-Racial**	**African American**	**Latinx/ Hispanic**	**Native Hawaiian or Pacific Islander**	**Other**	**LGBTQ2SI+**
Promoting First Relationships**	X		X	X	X			
SafeCare**	X			X	X			
Screening Brief Intervention and Referral to Treatment (SBIRT)*		X		X				
Smart Beginnings*				X	X			
Sobriety Treatment and Recovery Teams*				X				
Strengthening Families Program: For Parents and Youth 10-14 (SFP 10-14)				X				
Strong African American Families (SAAF)***				X				
Trust-Based Relational Interview (TBRI® 101)*				X				
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)*	X	X	X	X	X			P (N=24)
Triple P – Positive Parenting Program – Group (Level 4)*		X		X	X		X	
Triple P – Positive Parenting Program – Online (Level 4)**				X	X			
Trust-Based Relational Intervention-Caregiver Training*				X				
Video Interaction Project*				X	X			

LGBTQ2SI+: Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Undecided, Intersex, and Asexual.

A sample list of additional interventions that have been recognized as very helpful for various cultural groups but that have not yet been rated by the Prevention Services Clearinghouse are below:[13]

- American Indian Life Skills (Alaskan Natives, American Indian)
- Canoe Journey (Alaskan Natives, American Indian)
- Criando con Amor, Promoviendo Armonía y Superación (CAPAS; Raising Children with Love, Promoting Harmony, and Self-Improvement)
- Drumming Ceremonies (Alaskan Natives, American Indian)
- Family Connections (Alaskan Natives, American Indian)
- Honoring Fatherhood Program (Alaskan Natives, American Indian)
- Native H.O.P.E. (Alaskan Natives, American Indian)
- Native STAND (Alaskan Natives, American Indian)
- Nurturing Families 5-19 (African American, American Indian, Haitian, Latinx)
- Nurturing Parenting Program (NPP) including the American Indian supplement (African American, American Indian, Haitian, Latinx)
- Ohana Program (Hawaiian/Pacific Islander)
- Positive Indian Parenting Program (Alaskan Natives, American Indian)
- Project Venture (Alaskan Natives, American Indian)
- Red Road Approach to Wellness and Healing (White Bison) (Alaskan Natives, American Indian)
- Sweat Lodge Ceremonies (Alaskan Natives, American Indian)
- Talking Circles (Alaskan Natives, American Indian)
- The Model Adolescent Suicide Prevention Program (Alaskan Natives, American Indian)
- Trauma-Systems Therapy for Refugees (TST- R) (Somali, Somali Bantu, and Bhutanese refugee youth)

Conclusions

The Prevention Services Clearinghouse has evaluated and rated as *Promising* or higher 81 interventions as of November 20, 2023. Our review finds that 61 of the 81 interventions currently rated as *Promising*, *Supported,* or *Well-Supporte*d are effective

[13] Special thanks to Angelina Callis of the Colorado Office of Children, Youth and Families and the Research, Analytics, and Data team of the Colorado Department of Human Services for their identification of some of these American Indian interventions.

with at least one ethnic group – likely because of one or more of their intervention model components (e.g., clinical strategies, being family-centered, carefully listening to family perspectives, building upon family social support networks, incorporating a strengths-oriented assessment). However, we found very little evidence that any of these interventions are effective with LGBTQ2SI+ persons (only five interventions had evidence for this group). While many of the developers said their interventions are effective with this population these interventions need additional evaluation to provide specific evidence.

As we mentioned earlier, modifying a program with new examples to help it be more culturally relevant or competent is allowed by the Prevention Services Clearinghouse. But more significant changes mean that the modified program is viewed as a "new" intervention that must be evaluated separately. This requires a new line of evaluation research for each culturally modified intervention. ***Because of this requirement, we need more focused support for Indian tribal nations and other communities of color to document and evaluate those interventions that have been culturally adapted.*** This is important because there has historically been significant emphasis in funding research on interventions developed by white people.[18] This includes initial funding to develop interventions as well as funding to evaluate the interventions. Thus, many advocates are calling for equity and funding evaluations for interventions developed for and by indigenous and other ethnic minority developers and researchers.

It is important to note that some American Indian tribal nations have an alternate pathway to have an intervention certified for FFPSA funding. These tribal nations can use culturally appropriate practice-based evidence. This is related to a broader movement: advocates of *practice-based evidence* (PBE) emphasize the value of cultural knowledge as a cornerstone of healing and recovery.[19] Fundamental to PBE is the following:[20]

- Knowledge of the function of cultural help-seeking patterns.
- Understanding the cultural context of problem identification.
- Use of culturally informed therapeutic intervention(s).
- Provision of therapeutic interventions and support in a manner that consistently recognizes the value of the cultural self to wellness and recovery.
- Engaging the local community and/or cultural resources to achieve and sustain the long-term positive effects from the intervention.

Outcome studies using rigorous evaluation designs and economic analyses would not only better establish the effectiveness of these interventions, but they would also measure whether these inventions produce any cost-savings.[21] As jurisdictions optimize their array of interventions and consider innovative funding approaches such as increased use of Medicaid funding, pay-for-success and social impact bonds,[22] studies of culturally and LGBTQ2SI+ relevant interventions that use comparison groups and Return On Investment components will be needed.

Appendix A: Interventions Rated by the Clearinghouse as Promising, Supported or Well-Supported as of November 20th, 2023 – With Evidence of Effectiveness with Families of Color and LGTBQ2SI+

PSB: In-home parent skill-building programs; **MH:** Mental health programs and services; **NR** (not able to be rated); **SA:** Substance abuse treatment

Intervention summaries are abstracted from the FFPSA Prevention Clearinghouse, California Evidence-based Clearinghouse (CEBC) and the developer's website.

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
Adolescent Community Reinforcement Approach A behavioral intervention that aims to support adolescents and young adults with substance use disorders, A-CRA treatment supports adolescents' substance use recovery by providing cognitive-behavioral skills training to encourage positive family and peer relationships, helping adolescents engage in reinforcing prosocial activities, and other recovery enhancing services. A-CRA includes guidelines for three types of sessions: adolescents alone, caregivers alone, and adolescents and caregivers together.	**Promising: SA** (CEBC: Supported) Child well-being: • Substance use	Adolescents and young adults ages 12 to 25 with substance abuse issues	**12 to 14 weeks.** 10 individual weekly sessions of 60 minutes, plus two or more 90-minute sessions with their parent[s]/ caregiver[s].	*Child well-being:* African American: • Substance use disorder[23] • Substance use disorder[24] • Cost-effectiveness (secondary outcome)[25] Hispanic: • Substance use disorder[26] • Substance use disorder[27]

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
				LGBTQ2SI+: The CRA approach without vouchers showed effectiveness with lesbian and gay youth.[28]
Aggression Replacement Training® (ART) Aggression Replacement Training® (ART) is a cognitive-behaviorally-based intervention designed to serve youth who display violent and aggressive behavior. ART consists of three components: *social skills training*, where youth learn how to replace aggressive behaviors with prosocial behaviors; *anger control training*, where youth learn how to handle anger-provoking situations; and *moral reasoning training*, where youth learn how to perspective-take and develop concern for others.	**Promising: MH** (CEBC: Promising) Child well-being: • Behavioral and emotional functioning	Youth who display violent and aggressive behavior	**10 weeks.** Delivered three times per week over 10 weeks for a total of 30 sessions.	*Child well-being:* Turkish youth in Turkey:[29] • Trait Anger levels • Increased Anger Control scores • Decreased Physical Aggression scores • Decreased Hostility scores • Increased Social Problem-Solving total scores • Increased Anger Control scores LGBTQ2SI+: No evidence published.
Arizona Kinship Support Services (AKSS) Arizona Kinship Support Services (AKSS) is designed for kinship caregivers to support kinship families by addressing the safety, permanency, and well-being of children in formal and informal kinship care. All AKSS	**Supported: Kinship Navigator** (CEBC: not rated) Child permanency:	Kinship caregivers of children who are at risk of becoming or are dependents of the	**3 months to 2 years**. Duration and intensity of services depends	*Child permanency:* Non-white/Non-Hispanic: • Least restrictive parent[30] • Planned permanent exits[31]

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
services are voluntary and based on the needs of the kinship family.	• Least restrictive parent Child permanency: • Planned permanent exits	Arizona Department of Child Safety	on the needs of the kinship family, ranging from 3 months to 2 years.	LGBTQ2SI+: No evidence published.
Attachment-Based Family Therapy (ABFT) Attachment-Based Family Therapy (ABFT) is a mental health program designed to treat depression in adolescents and young adults. ABFT aims to repair trust between adolescents and their parent(s) and re-establish parents as a source of support for the adolescent. By promoting secure relationships (i.e., attachment) between an adolescent and their parents, ABFT aims to help adolescents regulate emotional distress and promote autonomy.	**Promising: MH** (CEBC: Promising) Child well-being: • Behavioral and emotional functioning Adult well-being: • Family functioning	ABFT is designed for adolescents and young adults with depression and their parent(s).	**12-16 weeks.** Sessions are 60–90 minutes each.	*Child well-being:* African American: • Behavioral and emotional functioning[32] *Adult well-being:* African American: • Family functioning[33] LGBTQ2SI+: Note this is a small sample study with 8 participants completing all sessions so that is why this intervention is included in Table 3 as "preliminary": Child Well-being. • Decrease in suicidal ideation. • Decrease in depressive symptoms.

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
				• Decrease in attachment related avoidance.[34]
Brief Strategic Family Therapy (BFST) Uses a structured family systems approach to treating families with children or adolescents (6 to 17 years) who display or are at risk for developing problem behaviors including substance abuse, conduct problems, and delinquency. There are three intervention components. First, counselors establish relationships with family members to better understand and "join" the family system. Second, counselors observe how family members behave with one another in order to identify interactional patterns that are associated with problematic youth behavior. Third, counselors work in the present, using reframes, assigning tasks, and coaching family members to try new ways of relating to one another to promote more effective and adaptive family interactions.	**Well-supported: MH, SA, PSB** (CEBC: Supported) Child well-being: • Behavioral and emotional functioning • Substance use • Delinquent behavior Adult well-being: • Parent/caregiver substance use • Family functioning	Families with youth ages 6 to 17 who display or are at risk of developing behaviors including substance abuse, conduct problems, and delinquency.	**12 - 16 weeks.** Weekly sessions	*Child well-being:* African American: • Conduct problems (externalizing behaviors), delinquency (arrests)[35] • Substance use disorder[36] Latinx: • Conduct problems (externalizing behaviors), delinquency (arrests)[37] • Substance use disorder [38] *Adult well-being:* African American: • Family functioning[39] • Substance use disorder [40] Bi-racial[41] Latinx: • Family functioning[42] • Substance use disorder [43]

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
				LGBTQ2SI+: No evidence published.
Bounce Back Bounce Back, an adaptation of Cognitive Behavioral Intervention for Trauma in Schools (CBITS) for younger children, is a school-based intervention designed to help children in grades K–5 who have experienced stressful and traumatic life events. Bounce Back uses cognitive-behavioral techniques to reduce symptoms related to trauma exposure, build skills for handling stress and anxiety, and build peer and caregiver support.	**Promising: MH** (CEBC: Promising) Child well-being: • Behavioral and emotional functioning • Social functioning	Children in elementary school grades Kindergarten through 5th grade (ages 5-11) who have experienced traumatic events.	**10 group sessions and 2-3 individual sessions.**	*Child well-being:* Latinx: • Behavioral and emotional functioning[44] • Social functioning[45] LGBTQ2SI+: No evidence published.
Child-Centered Group Play Therapy Child-Centered Group Play Therapy (CCGPT), a group-based adaptation of Child-Centered Play Therapy (CCPT), is designed for children ages 3–10 who are experiencing social, emotional, behavioral, or relational disorders. CCGPT aims to create a safe and consistent environment that allows children to grow	**Promising: MH** Child well-being: • Behavioral and emotional functioning	Children ages 3–10 who are experiencing social, emotional, behavioral, and relational disorders, especially children who struggle	**35–40 sessions of about 45 minutes each.**	*Child well-being:* Chinese, Thai, and Vietnamese: • Less relationship difficulties • More signs of happiness and improved affective function[46] *Parent Functioning:*

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
and uses play and the therapeutic relationship to improve children's functioning. The therapeutic relationship with the therapist and interactions with the other children in the group are the primary techniques of CCGPT. Children interact with one to two other children during their sessions, allowing each child to learn and practice new skills with peers.	• Social functioning Adult well-being: • Family functioning	with peer or sibling relationships.		Chinese, Thai, and Vietnamese:[47] • Increased sense of freedom in the parental role LGBTQ2SI+: No evidence published.
Child-Centered Play Therapy (CCPT) This is a one-on-one intervention that uses the play and the therapeutic relationship to improve children's social, emotional, behavioral, and relationship functioning. The therapist uses play to help a child experience acceptance, empathy, understanding, and self-guided actions and conversations with only necessary limitations. Sessions take place in a playroom with special objects, toys, and décor that aid the child in self-expression of emotions and to explore the world through pretend and role play. Therapists sometimes consult with parents and educators.	**Promising: MH** (CEBC: Promising) Child well-being: • Behavioral and emotional functioning • Social functioning • Educational achievement and attainment	Children ages 3-10 who are experiencing social, emotional, behavioral, or relational disorders.	**35-40 sessions are recommended.** Frequency and duration vary based on child's needs. Sessions are typically 45 minutes but range from 30-50 minutes.	*Child well-being:* African American: • Child's overall social-emotional competence and empathy, as reported by parents. • Practically significant improvement and responsibility, as reported by teachers.[48] LGBTQ2SI+: No evidence published.

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
Child First (formerly known as Child and Family Interagency Resource, Support, and Training) This is a home-based intervention that aims to promote healthy child and family development through a combination of psychotherapy and care coordination. Child First is provided by a clinical team that includes a mental health clinician and a care coordinator.	**Supported: MH, PSB** (CEBC: Supported) Child safety: • Reports of maltreatment Child well-being: • Behavioral and emotional functioning • Cognitive functions and abilities Adult well-being: • Family functioning	Families with young children (prenatal through age 5 at entry). The program targets children with social-emotional, behavioral, developmental, or learning problems. These children usually come from families experiencing trauma and adversity. Many of these families also experience multiple social, economic, or psychological challenges (e.g., depression, substance misuse, intimate	**12 months.** In-Home: Initially 90 minutes twice weekly, and then 60-75 minutes at least once a week thereafter. May extend beyond 12 months based on need.	*Child well-being:* Latinx: • Family and nonfamily violence event, decrease in PTSD trauma symptoms[49] LGBTQ2SI+**:** No evidence published.

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
	• Parent/caregiver mental or emotional health	partner violence, abuse and neglect, homelessness).		
Child-Parent Psychotherapy (CPP) Aims to support family strengths and relationships, to help families heal and grow after stressful experiences, and to respect family and cultural values. The CPP program typically progresses in three stages. During the first stage, providers use questionnaires and meetings with parents/caregivers to familiarize themselves with the family's needs and create a plan for treatment. During the second stage, sessions focus on helping children to express their feelings through play, strengthening parent-child relationships, and deepening parents' understanding of their child's experiences and behaviors. In the third stage, providers celebrate progress with the family and discuss what supports the family will need moving forward.	**Promising: MH** (CEBC: Supported) Child well-being: • Behavioral and emotional functioning Adult well-being: • Parent/caregiver mental or emotional health	Families with children ages 0-5.	**20 to 32 weeks.** Weekly sessions of 60 to 90 minutes.	*Child well-being:* African American: • Behavioral and emotional functioning[50] Biracial: • Behavioral and emotional functioning[51] Latinx: • Behavioral and emotional functioning ("attachment")[52] • Behavioral and emotional functioning[53] *Adult well-being:* Latinx: • Parent/caregiver mental or emotional health ("attachment")[54] LGBTQ2SI+: No evidence published.

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
Child-Parent Relationship Therapy (CPRT) CPRT, is a 10-week attachment-focused group intervention adapted from Child-Centered Play Therapy. It is designed for parents of children ages 2-10, who are experiencing social, emotional, and relational disorders. CPRT aims to strengthen the parent-child relationship by teaching parents ways to attune and respond more effectively to their children's emotional and behavioral needs rather than symptoms. A therapist teaches parents to accept and connect with their children using play and child-centered principles Such as unconditional acceptance, recognizing and reflecting the child's feelings, and respect for the child's problem-solving skills. As a result, children learn that they can rely on their parents to consistently meet their needs for love, acceptance, safety, and security.	**Promising: MH** (CEBC: Promising) Child well-being: • Behavioral and emotional functioning Adult well-being: • Positive parenting practices • Parent/caregiver mental or emotional health • Family functioning	Families with children ages 2-10	**10 weeks.** Weekly structured 2-hour group sessions.	*Child well-being:* • Behavioral and emotional functioning Asian: • Increased child self-concept.[55] Latinx: • Decreased child behavior problems[56] *Adult well-being:* • Positive parenting practices • Parent/caregiver mental or emotional health • Family functioning Asian: • Increase in empathic interaction with their children. • Increase in acceptance of their children. • Reduction of parental stress related to parenting. • Reduction of perceived problems related to their children's behavior. Latinx:

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
				• Decreased parental stress[57] LGBTQ2SI+: No evidence published.
Cognitive Behavioral Intervention for Trauma in Schools (CBITS) CBITS is a school-based, group and individual intervention designed to reduce symptoms of posttraumatic stress disorder (PTSD), depression, and behavioral problems among students exposed to traumatic life events, such as exposure to community and school violence, accidents, physical abuse, and domestic violence. It is designed for students, who have experienced a traumatic event and have current distress related to that event. The goals of the intervention are to reduce symptoms and behavior problems and improve functioning, improve peer and parent support, and enhance coping skills.	**Promising: MH** (CEBC: Promising) Child well-being: • Behavioral and emotional functioning • Educational achievement	3rd through 8th grade students who screened positive for exposure to a traumatic event and symptoms of posttraumatic stress disorder related to that event, largely focusing on community violence exposure; may be used with older students as well.	**10 or more weeks.** 10 student group sessions, 1-3 student individual sessions, 2 parent sessions, and a teacher educational session.	*Child Well-Being:* African-American • Behavioral and emotional functioning[58] Latinx: • Behavioral and emotional functioning[59] • Educational achievement and attainment[60] Asian • Behavioral and emotional functioning[61] • Educational achievement and attainment[62] LGBTQ2SI+: No evidence published.
Cognitive Processing Therapy Cognitive Processing Therapy (CPT) is a cognitive-behavioral treatment for posttraumatic stress disorder	**Promising: MH** (CEBC: Well-Supported)	adults with PTSD. CPT is not appropriate for individuals without	**12 sessions.**	Unable to find any relevant literature documenting significant child welfare-related

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
(PTSD). CPT aims to help clients identify and address ways of thinking about traumatic experiences that might interfere with their recovery.	Adult well-being: • Parent/caregiver mental or emotional health	trauma symptoms, those who are an immediate danger to themselves or others, or those who are experiencing psychotic symptoms		outcomes for non-white, non-Latinx children or families or families – or LGBTQ2SI+ persons.
Colorado Kinnected Kinship Navigator Program (Colorado Kinnected) A three-pronged program simultaneously offering: (1) Kinship Services, (2) Facilitated Family Engagement, and (3) Family Search and Engagement. Colorado Kinnected is designed to strengthen supports to children and families with open child welfare cases and entering a new kinship placement with the goal of keeping children/youth with their relatives until the parents meet their case goals and reunification can safely occur. The Kinship Navigators integrate multiple trauma-informed interventions and coordinate support for kinship caregivers and families in their home and community settings.	**Promising: Kinship Navigator Programs** (CEBC: not rated) Child permanency: Planned permanent exits	Families with an open child welfare case where the children/youth are entering a new kinship placement.	From start to end of the kinship placement regardless of how long the children/youth are with kin. Some services taper off gradually as the need subsides.	*Kinship Navigator:* Latinx: • Child permanency: Planned permanent exits[63] LGBTQ2SI+**:** No evidence published

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
Common Sense Parenting (CSP)- School Age Common Sense Parenting® (CSP) – School Age is a group-based parent training class designed for parents of children ages 6–16. The program aims to teach positive parenting techniques to strengthen the parent-child bond, and behavior management strategies to help increase positive child behaviors, decrease child problem behaviors, and model appropriate options to address child behaviors.	**Promising: MH** (CEBC: not rated) Child well-being: • Behavioral and emotional functioning Adult well-being: • Family functioning	CSP – School Age is designed for parents of children ages 6–16.	**6 weeks.** Trainers deliver six weekly 2-hour CSP – School Age sessions in-person to groups of 8–10 parents.	*Child Well-Being:* African-American • Behavioral and emotional functioning[64] East Indians and Africans in Trinidad and Tobago: • Increase in positive parenting practices[65] *Adult Well-Being:* East Indians and Africans in Trinidad and Tobago: • Increase in positive parenting practices[66] Latinx: • Increase in positive parenting practices[67] LGBTQ2SI+: No evidence published
Community Reinforcement Approach + Vouchers (CRA = Vouchers) Community Reinforcement Approach + Vouchers (CRA + Vouchers) is designed to treat adults with cocaine	**Promising: SA (CEBC: Supported)** Adult well-being:	adults with cocaine use issues. The program may also be implemented with	**24 weeks.** Therapists meet individually with patients for 1-hour	*Adult Well-Being:* Hispanic (Study in Spain): • Substance abuse abstinence[68]

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
use issues through therapy, skills training, and incentives for drug abstinence and treatment retention. CRA + Vouchers has two main components: (1) the CRA component is an intensive psychosocial therapy intended to help patients make lifestyle changes and develop drug-refusal skills and strategies; and, (2) the voucher component provides incentives for remaining in treatment and sustaining cocaine abstinence.	• Caregiver substance use	adults with other substance use issues.	sessions. These sessions happen twice per week for the first 12 weeks and once per week for the last 12 weeks	LGBTQ2SI+: The CRA approach without vouchers showed effectiveness with lesbian and gay youth.[69]
Coping Cat -- Group Coping Cat – Group is a cognitive-behavioral approach designed to treat children ages 7–13 who are diagnosed with an anxiety disorder (e.g., generalized anxiety disorder, social phobia, separation anxiety disorder) and their parents.	**Promising: MH** (CEBC: Well-Supported for general program) Child well-being: • Behavioral and emotional functioning	Children ages 7–13	**18 90-minute weekly sessions.** Group sessions of 3-5 children. Larger groups can be accommodated if delivered with a co-therapist.	Unable to find any relevant literature documenting significant child welfare-related outcomes for non-white, non-Latinx children or families or families – or LGBTQ2SI+ persons.

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
Coping Cat -- Individual Coping Cat – Individual is a cognitive-behavioral approach designed to treat children ages 7–13 who are diagnosed with an anxiety disorder (e.g., generalized anxiety disorder, social phobia, separation anxiety disorder) and their parents	**Promising: MH** (CEBC: Well-Supported for general program) Child well-being: • Behavioral and emotional functioning	Children ages 7–13 who are diagnosed with an anxiety disorder (e.g., generalized anxiety disorder, social phobia, separation anxiety disorder) and their parents.	**16 sessions divided into two phases.**	Unable to find any relevant literature documenting significant child welfare-related outcomes for non-white, non-Latinx children or families or families – or LGBTQ2SI+ persons.
Effective Black Parenting Program (EBPP) Effective Black Parenting Program (EBPP) is a group-based parent skills training program designed to serve Black and African American families. EBPP aims to promote family pride and cohesion and to help families cope with the negative effects of racism. In the first session, instructors introduce a framework called the Pyramid of Success for Black Children to help parents set goals for their children and identify what their children need to reach those goals. The remaining sessions teach parenting skills and educate parents on how children learn and develop.	**Promising: MH** (CEBC: Promising) Adult well-being: Positive parenting practices	Black and African American families with children ages 17 and younger.	**14-28 weeks.** 14 weekly or bi-weekly group sessions of 15–30 parents that last 90 minutes each.	*Adult Well-Being:* African-American: • Positive parenting practices[70] LGBTQ2SI+**:** No evidence published

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
Eye Movement Desensitization and Reprocessing – Standard Protocol A psychotherapy treatment for children and adults aimed at minimizing distress associated with traumatic memories and other adverse life experiences. It is based on the Adaptive Information Processing (AIP) model, which assumes unprocessed experiences are the basis for clients' present dysfunctional reactions and mental disorders. EMDR – Standard Protocol aims to reduce symptoms by having clients process the components of the distressing memory and link the memory with other more adaptive information while focusing on an external stimulus (e.g., clinician-directed lateral eye movements, hand-tapping, audio stimulation). EMDR – Standard Protocol uses a three-pronged treatment protocol where clients and clinicians focus on (1) the *past*—to identify earlier events contributing to present dysfunction that need reprocessing, (2) the *present*—to address current circumstances and triggers that evoke disturbing reactions and behaviors, and (3) the *future*—to increase the client's ability to	**Supported: MH** (CEBC: Well-supported) Child well-being: • Behavioral and emotional functioning Adult well-being: • Parent/caregiver mental or emotional health • Parent/caregiver physical health	Designed to treat children and adults experiencing distress associated with traumatic memories. It is also applied to a variety of other mental health problems.	**3-12 sessions.** The initial intake session typically lasts for at least 50 minutes and subsequent sessions typically last for about 90 minutes each.[71]	*Child Well-Being:* Other (Australian, Iranian, Italian, Netherlands, Sweden): • Post-traumatic symptom outcomes, and positive behaviors[72] LGBTQ2SI+**:** No evidence published.

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
make new choices by processing fears and identifying a template for desired future behavior.				
Families and Schools Together- Elementary School Level (FAST®) FAST Elementary School Level is a prevention/early intervention program engaging parents of children ages 4-10. Program goals focus on strengthening the parent-child relationship, promoting children's socio-emotional development and school success, and building supportive connections between parents, schools, and communities.	**Promising: MH** (CEBC: not rated) Child well-being: • Behavioral and emotional functioning • Cognitive functions and abilities • Educational achievement and attainment Adult well-being: • Positive parenting practices	Parents of elementary school children ages 4-10	**8-10 weeks.** Weekly structured multi-family group sessions followed by monthly unstructured parent review meetings.	*Child Well-Being:* American Indian: • Behavioral functioning[73] Hmong: • Parents reported statistically significant improvements in child anxiety (CBCL internalizing), child social skills (SSRS) and family adaptability[74] Latinx: • Behavioral functioning[75] • Pro-social skills and fewer teacher-reported peer problems[76] Adult well-being: Latinx: • Adult social capital increased such as (1) responsive communication; (2) reciprocal communication; (3) shared experiences; and (4) institutional linkage[77]

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
	• Family functioning			LGBTQ2SI+: No evidence published.
Familias Unidas A family-centered intervention that aims to prevent substance use and risky sexual behavior among Hispanic adolescents. Familias Unidas aims to empower parents by increasing their support network, teaching them about protective and risk factors, improving parenting skills, enhancing parent-adolescent communication, and facilitating parental involvement and investment in adolescents' lives.	**Well-Supported: MH, PSB, SA** (CEBC: Well-supported) Child well-being: • Behavioral and emotional functioning • Substance abuse Adult well-being: • Family functioning • Positive parenting	Parents who want to prevent substance use and risky sexual behavior among Hispanic adolescents	**12 weeks.** Eight parent support network group sessions and four individual family visit sessions (1 session per week) Parent group session: 2 hours Family visit session: 1 hour	*Child well-being:* Latinx: • Behavioral and emotional functioning[78] • Substance abuse[79] *Adult well-being:* Latinx: • Family functioning[80] • Positive parenting[81] LGBTQ2SI+: • Latinx youth with same-gender sexual behaviors.[82]
Families Facing the Future (formerly Focus on Families)	**Supported: SA** (CEBC: Well-supported)	Families with one or more caregivers receiving methadone treatment who have	**16 weeks.** One initial 5-hour group retreat for	Unable to find any relevant literature documenting significant child welfare-related outcomes for non-white, non-Latinx children or families – or LGBTQ2SI+ persons.

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
An intensive program for parents in methadone treatment who have children or young adolescents. FFF teaches parenting and relapse prevention skills to parents and aims to protect their at-risk children from adverse outcomes, including drug use. Case managers work collaboratively with families to identify positive activities, connect them with available services, and identify ways to reinforce use of new skills.	Adult well-being: • Parent/caregiver substance use	children or young adolescents.	families, followed by twice weekly sessions of 90 minutes for parents/caregivers . Children attend 12 of the 32 sessions with their parents/caregivers .	
Families First (Utah Youth Village Model) Families First (Utah Youth Village Model) is designed to help families with youth birth to age 17 build on family strengths and improve family functioning. Families First specialists help strengthen parents' confidence in their parenting and communication skills using positive reinforcement, modeling, and role-playing. Specialists teach parents how to maintain discipline without anger or violence and how to promote positive social skills, effective communication, and healthy boundaries. Specialists link families to community resources.	**Well-Supported: MH, PSB** (CEBC: Not rated) Child safety: • No CPS report Child well-being: • Delinquent behavior	Families with youth birth to age 17 who have been referred for intensive in-home services from child welfare services, juvenile justice, or court systems or self-refer.	**8-12 weeks.** 48–52 face-to-face service hours with families 6–10 hours per week.	*Child well-being:* Latino: • Lower recidivism rate than the risk-adjusted juvenile court group, based on a 1-year follow-up of new misdemeanor or felony charges. • Reduced self-reported rebelliousness, attitudes favorable to antisocial behavior, and attitudes favorable to drug use, and increased belief in the moral order.[83] LGBTQ2SI+: No evidence published.

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
Family Centered Treatment (FCT) Family Centered Treatment (FCT) is a trauma treatment model of home- based therapy. FCT is designed for families who are at-risk of dissolution or in need of reunification. It is also designed to serve youth who move between the child welfare, behavioral health, and juvenile justice systems. During treatment, FCT practitioners aim to help families identify their core emotional issues, identify functions of behaviors in a family systems context, change the emotional tone and behavioral interaction patterns among family members, and develop secure relationships by strengthening the attachment bond.	**Supported: PSB** (CEBC: Promising) Child permanency: • Out of home placement • Least restrictive placement Child well-being: • Delinquent behavior	Parents who want to prevent substance use and risky sexual behavior among Hispanic adolescents.	**6 weeks.** One initial 5-hour group retreat for families, followed by twice weekly sessions of 90 minutes for parents/ caregivers. Children attend 12 of the 32 sessions with their parents/caregivers .	Unable to find any relevant literature documenting significant child welfare-related outcomes for non-white, non-Latinx children or families or families – or LGBTQ2SI+ persons.
Family Check-Up® A program with three main components: (1) an initial interview that involves rapport building and motivational interviewing to explore parental strengths and challenges related to parenting and the family context; (2) an ecological family assessment that includes parent and child questionnaires, a teacher questionnaire for children who are in school, and a	**Well-Supported: MH, PSB (CEBC: Well-Supported)** Child well-being:	For families with children ages 2 through 17	**3 sessions** (After completing the feedback session, families may choose to complete follow-up services. These follow-up	*Child Well-Being:* African-American: • Behavioral functioning[84] Hispanic/Latinx: • Behavioral functioning[85]

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
videotaped observation of family interactions; and (3) tailored feedback that involves reviewing assessment results and discussing follow-up service options for the family. Follow-up services may include clinical or support services in the community. They may also include the Everyday Parenting program, which is a parenting management program that is typically delivered by the provider.	• Behavioral and emotional functioning • Cognitive functions and abilities • Educational achievement and attainment Adult well-being: • Parent/caregiver mental or emotional health • Positive parenting		services can vary in intensity and duration based on family interest and need.)	LGBTQ2SI+: No evidence published
Family Foundation Family Foundations (FF) is a parenting education program designed for couples expecting their first child. FF aims to help couples develop a team approach to caregiving, maintain family bonds, reduce stress, and promote adult and child well-being. In FF, couples are	**Well-Supported: MH, PSB** Child well-being: • Behavioral and emotional functioning	Couples expecting their first child. In FF, couples are defined as any two individuals who plan to care for the child together and can include the parent	**Nine weekly 2-hour classes** FF typically includes five classes before birth and four after	No relevant literature documenting significant child welfare-related outcomes for non-white, non-Latinx children or families or families – or LGBTQ2SI+ persons.

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
defined as any two individuals who plan to care for the child together and can include the parent and another individual such as a grandparent or new romantic partner. Couples participate in FF together and typically begin FF classes during pregnancy.	• Cognitive functions and abilities Adult well-being: • Family functioning • Parent/caregiver criminal behavior • Parent/caregiver mental or emotional health • Positive parenting practices	and another individual such as a grandparent or new romantic partner.	birth, but all nine classes can be delivered after birth.	
Family Spirit® A culturally tailored home visiting program designed for young American Indian mothers (age 14-24) who enroll during the second trimester of pregnancy. The goal of Family Spirit® is to address intergenerational behavioral health problems and promote positive behavioral and	**Promising: PSB** (CEBC: Promising) Child well-being:	For young American Indian mothers (age 14-24) who enroll during the second trimester of pregnancy. Other family members can participate in the	**28 weeks gestation to 3 years.** 63 lessons are taught during 52 home visits that	American Indian/Alaskan Native: Child well-being: • Behavioral and emotional functioning[86] Adult well-being:

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
emotional outcomes among mothers and children. The program uses a culturally informed, strengths-based approach for helping mothers develop positive parenting practices, strengthen their coping skills, and learn how to avoid coercive parenting behaviors and substance abuse. Community health paraprofessional home visitors deliver program lessons to participating mothers through six modules: (1) Prenatal Care, (2) Infant Care, (3) Your Growing Child, (4) Toddler Care, (5) My Family and Me, and (6) Healthy Living.	• Behavioral and emotional functioning Adult well-being: • Family functioning • Parent/caregiver mental or emotional health • Parent/caregiver substance use	program lessons alongside mothers.	are 45-90 minutes long. Weekly visits then taper back over time to bimonthly visits between 23 and 36 months postpartum.	• Parent/caregiver mental or emotional health[87] • Parent/caregiver substance use disorder[88] LGBTQ2SI+: No evidence published.

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
Foster Kinship Navigator Program Foster Kinship Navigator Program is designed to serve kinship caregivers, both relatives and non-relative kin who are raising children in nonparental care. Foster Kinship Navigator Program aims to strengthen kinship caregivers' capacity to provide safe, stable, nurturing homes for children who cannot live with their parents. The program's targeted support focuses on reducing uncertainty for new caregivers and enabling them to understand and access available resources. Program services focus on four service areas: (1) legal capacity, (2) financial sustainability, (3) parenting and child community connection, and (4) caregiver emotional support.	**Promising: Kinship Navigator** (CEBC: not rated) Child permanency: • Placement stability	Foster Kinship Navigator Program is designed to serve kinship caregivers, both relatives and non-relative kin raising children in nonparental care.	**Up to 6 months.** The information, referral and support services component vary in frequency and duration depending on kinship caregiver needs and the services selected. Family Advocates deliver the case management services component for eligible caregivers for up to 6 months.	*Child permanency*: African American: • Placement stability[8990] Asian: • Placement stability[9192] Latino: • Placement stability[9394] Pacific Islander: • Placement stability[9596] LGBTQ2SI+**:** No evidence published.
Fostering Healthy Futures for Preteens Fostering Healthy Futures® for Preteens (FHF-P) is a skills training and mentoring program. FHF-P is	**Supported: MH (CEBC: Supported)**	Children ages 9–11 with current or previous child welfare involvement due to	**30 weeks** Each week, children	*Child well-being:* African American:

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
designed for children ages 9–11 with current or prior child welfare involvement due to maltreatment and one or more adverse childhood experiences. The program is composed of two parts: group sessions and one-on-one mentoring.	Child permanency: • Placement stability Child well-being: • Behavioral and emotional functioning	maltreatment and one or more adverse childhood experiences (e.g., exposure to violence; experiencing homelessness; parental substance use, mental illness, or incarceration	participate in a 90-minute group session and 2–4 hours of one-on-one mentoring. Group supervisors and group co-leaders deliver group sessions typically consisting of eight children.[97]	• Lower (i.e., better) on the mental health index • Lower on posttraumatic stress symptoms • Lower on dissociation • Less likely to be receiving mental health treatment post-treatment[98] Latinx: • Lower (i.e., better) on the mental health index • Lower on posttraumatic stress symptoms • Lower on dissociation • Less likely to be receiving mental health treatment post-treatment[99] LGBTQ2SI+: No evidence published.
Functional Family Therapy (FFT) A short-term prevention program for at-risk youth and their families. FFT aims to address risk and protective factors that impact the adaptive development of 11- to	**Well-supported: MH** (CEBC: Well-supported)	Youth ages 11 to 18 who have been referred for behavioral or emotional problems	**12 to 24 weeks.** (8 to 14 weekly sessions, held in	*Child well-being:* African American: • Delinquent behavior, including youth with drug charges, the percent of youth

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
18-year-old youth who have been referred for behavioral or emotional problems. The program is organized in multiple phases and focuses on developing a positive relationship between therapist/program and family, increasing motivation for change, identifying specific needs of the family, supporting individual skill-building of youth and family, and generalizing changes to a broader context.	Child well-being: • Behavioral and emotional functioning • Substance use • Delinquent behavior Adult well-being: • Family functioning	by juvenile justice, mental health, school, or child welfare systems	person for between 60 to 90 minutes and by phone for up to 30 minutes)	adjudicated, and the percent with property charges[100] Asian youth in Singapore: • Youth more likely to complete probation[101] Latinx: • Delinquent behavior[102] Adult Well-Being: Asian families in Singapore: • For youth at or above the clinical range at the baseline assessment, families in FFT showed significantly more improvement (clinical recovery) in family functioning[103] LGBTQ2SI+: No evidence published.
Generation PMTO – Individual [formerly known as Parent Management Training – Oregon Model (PMTO®)]	**Promising: MH, PSB** (CEBC: Well-supported)	Parents of children ages 2–17 with behavioral problems such as aggression, antisocial behaviors,	**6–25 sessions over 3–6 months.**	Unable to find any relevant literature documenting significant child welfare-related outcomes for non-white, non-Latinx children or families – or LGBTQ2SI+ persons.

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
	Child well-being: ▪ Social functioning	conduct problems, oppositional defiance, delinquency, and substance use.	(Typically 50 minutes in duration)	
GenerationPMTO – Group GenerationPMTO – Group, also known as Parenting through Change (PTC) and formerly known as Parent Management Training – Oregon Model (PMTO®), is a group-based parenting and family functioning intervention. The intervention is designed to increase parenting skills and promote effective family management.	**Well-supported: MH** (CEBC: Well-supported) Child well-being: ▪ Behavioral and emotional functioning ▪ Social functioning ▪ Delinquent behavior Adult well-being: ▪ Positive parenting practices	Parents of children ages 2–17 with behavioral problems such as aggression, antisocial behaviors, conduct problems, oppositional defiance, delinquency, and substance use.	**3-4 months.** PMTO Group is delivered by two to three parent facilitators in weekly parent group sessions. Each session lasts about 90 minutes. Parents attend 14 sessions over 3–4 months.	Unable to find any relevant literature documenting significant child welfare-related outcomes for non-white, non-Latinx children or families – or LGBTQ2SI+ persons.

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
	▪ Parent/caregiver mental or emotional health, ▪ Economic and housing stability			
Guiding Good Choices Guiding Good Choices® (GGC), formerly known as Preparing for the Drug Free Years (PDFY), aims to prevent teen substance use and risky behaviors by training parents to develop positive parenting and family management skills. GGC includes five sessions that cover (1) how to promote health and wellbeing during the teen years, (2) setting clear guidelines, (3) managing conflict, (4) helping children avoid trouble, and (5) strengthening family bonds.	**Well-supported: MH, PSB, SA** (CEBC: Supported) Child well-being: ▪ Substance use Adult well-being: ▪ Positive parenting practices ▪ Family functioning	Families with children ages 9–14.	**5-6 weeks.** Five weekly in-person or virtual group sessions with an additional introductory session delivered in the virtual format. Each session lasts 2–2.5 hours. Most sessions are for parents only, but Session 4 involves both children and parents.	Unable to find any relevant literature documenting significant child welfare-related outcomes for non-white, non-Latinx children or families – or LGBTQ2SI+ persons.

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
Healthy Families America A home visiting program for new and expectant families with children who are at-risk for maltreatment or adverse childhood experiences. HFA is a nationally accredited program that was developed by Prevent Child Abuse America. The overall goals of the program are to cultivate and strengthen nurturing parent-child relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors. HFA includes screening and assessments to identify families most in need of services, offering intensive, long-term and culturally responsive services to both parent(s) and children, and linking families to a medical provider and other community services as needed.	**Well-supported: PSB** (CEBC: Well-supported) Child safety: • Self-reports of maltreatment Child well-being: • Behavioral and emotional functioning • Cognitive functions and abilities • Delinquent behavior • Educational achievement and attainment	Families of children who have increased risk for maltreatment or other adverse childhood experiences. Families are eligible to receive services beginning prenatally or within three months of birth	**At least 3 years.** (Services may begin prenatally. At initiation of services families are offered weekly home visits (approximately 60 minutes in length). As families meet standardized progress criteria, visits become less frequent [every other week, then monthly], continuing to age three and up to age five. Visit frequency may increase in times of crisis.)	*Child safety:* African American: • Maltreatment[104] • Maltreatment[105] Asian or Filipino: • Maltreatment[106] *Child Safety*: Native Hawaiian or Pacific Islander: • Child maltreatment[107] Latinx: • Child maltreatment[108] • Harsh parenting[109] *Child well-being:* African American: • Educational achievement[110] • Low birth weight[111] Alaskan Native: • Behavioral and emotional functioning[112] Asian/Pacific Islander:

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
	Adult well-being • Positive parenting practices • Parent/caregiver mental or emotional health • Family functioning			• Cognitive functions and abilities (preventive health)[113] Latinx: • Cognitive functions and abilities (preventive health)[114] • Educational achievement[115] • Health (breastfeeding)[116] Multi-racial: • Cognitive functions and abilities (preventive health)[117] *Adult well-being:* African American: • Positive parenting practices [118] Asian/Filipino/Hawaiian/Pacific Islander: • Caregiver emotional health: self-efficacy[119] Latinx: • Positive parenting practices (quality of home environment, mobilizing resources, positive linguistics reading to child, household routines, mental health)[120]

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
				• Substance use disorder [121] Other race/ethnicity: (mixture of African American, American Indian/Alaska Native, or Asian/Pacific Islander): • Positive parenting practices[122] LGBTQ2SI+: No evidence published
Homebuilders – Intensive Family Preservation and Reunification Services Provides intensive, in-home counseling, skill building, and support services. Homebuilders' practitioners conduct behaviorally specific, ongoing, and holistic assessments that include information about family strengths, values, and barriers to goal attainment. The practitioners then collaborate with family members and referents in developing intervention goals and corresponding service plans. These intervention goals and service plans focus on factors directly related to the risk of out-of-home placement or to reunification. Throughout the intervention practitioners develop	**Well-supported: PSB** (CEBC: Supported) Child permanency: • Out-of-home placement • Planned permanent exits Adult well-being: • Economic and housing stability	Families with youth age 0-18 at imminent risk of out-of-home placement or who are in placement and cannot be reunified without intensive in-home services	**4 to 6 weeks** 40 or more hours of direct face-to-face services, with sessions tailored and scheduled flexibly depending on family needs, goals, values, culture, circumstances, learning style, and abilities. Practitioners are available to family	*Child permanency:* African American: • Out-of-home placement [123] American Indian: • Out-of-home placement[124] Asian/Pacific Islanders: • Out-of-home placement [64] Latinx: • Out-of-home placement[64] LGBTQ2SI+: No evidence published.

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
safety plans and use clinical strategies designed to promote safety.			members 24/7, with back up from the Homebuilders' supervisor.	
Incredible Years – Toddler Basic Program (IY-Toddlers) Focuses on eight developmentally appropriate topics during the sessions: (1) child-directed play, (2) promoting toddler's language, (3) social and emotion coaching, (4) praise and encouragement, (5) incentives, (6) separations and reunions, (7) limit setting, and (8) handling misbehavior. During each group session, parents watch 8 to 10 situational video vignettes. They engage in discussions facilitated by the group leaders and problem-solve about best parenting practices. Parents are also encouraged to complete activities at home to apply the skills they learned with the group.	**Promising: MH** (CEBC: Well-Supported) Adult well-being: • Positive parenting practices	For parents with toddlers (1 to 3 years). Program typically targets higher-risk parents who need support forming secure attachments with their toddlers or addressing their toddlers' behavior problems.	**12 to 13 weekly group sessions** Each group session lasts about 2 hours.	We were not able to find studies with effectiveness data with specific ethnic groups for this model version. See information for IY-School Age below.
Incredible Years – School Age Basic Program (IY-School Age)	**Promising: MH**	For parents of children 6 to 12 years. The program typically	**12 to 20 weekly group sessions**.	*Adult Well-being:* African American, Hispanic, and Asian:

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
Aims to strengthen parent-child interactions and attachment and reduce harsh discipline. It also aims to foster the parents' abilities to promote children's social, emotional, and academic development and reduce behavior problems. IY-School Age focuses on three developmentally appropriate topics during the sessions: (1) promoting positive behavior, (2) reducing inappropriate behaviors, and (3) supporting children's education.	(CEBC: Well-Supported) Adult well-being: • Positive parenting practices	targets higher-risk populations and parents of children diagnosed with problems such as oppositional defiant disorder and attention deficit hyperactivity disorder (ADHD).	Each group session lasts about 2 hours.	• Positive parenting practices[125] LGBTQ2SI+: No evidence published.
Intensive Care Coordination Using High Fidelity Wraparound (Wraparound Intensive Care Coordination Using High Fidelity Wraparound (Wraparound), also known as High Fidelity Wraparound, uses an individualized, team-based, collaborative process to provide a coordinated set of services and supports. It is typically targeted toward children and youth with complex emotional, behavioral, or mental health needs, and their families. Throughout the process, youth and their families work with a care coordinator who convenes, facilitates, and coordinates efforts of the wraparound team. The care coordinator further helps the family navigate planned services and supports, including informal and	**Promising: MH** (CEBC: Promising – cataloged as "Wraparound") Child permanency: • Least restrictive placement Child well-being:	Children birth to age 21 and their parents/caregivers	**Varies.** Duration and intensity of wraparound varies	*Child permanency:* African American • Least restrictive placement[126] *Child well-being:* • Behavioral and emotional functioning[127] LGBTQ2SI+: No evidence published.

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
community-based options; tracks progress and satisfaction to revise the plan of care as needed; and ensures program fidelity.	• Behavioral and emotional functioning			
Intercept® (formerly Youth Villages Intercept) Provides intensive in-home services. It aims to reduce foster care use by providing prevention services, and to reduce time spent in foster care by providing reunification services. Using GuideTree, an integrative process combining evidenced-based clinical content and consultation with a program expert. Family Intervention Specialists provide integrated, trauma-informed interventions to meet individualized family and child needs. They work to address needs identified in all systems that affect children and families including individual, family, schools, peer groups, neighborhoods, and communities.	**Well-Supported: PSB** (CEBC: Not listed) Child permanency: • Out-of-home placement • Planned permanent exits	Children ages 0 to 18 who are at risk of entry or re-entry into out-of-home placements (e.g., foster care, residential facilities, or group homes) or who are currently in out-of-home placements	**16 to 24 weeks** for *Prevention Services* **24 to 36 weeks** for *Reunification Services* An average of 3 sessions weekly with crisis support available 24/7.	*Child well-being and Permanency:* African American: • Out-of-home placement[128] • Exit to permanency[129] LGBTQ2SI+**:** No evidence published.
Interpersonal Psychotherapy (Weissman et al. Manual; IPT) An acute (time-limited) treatment that aims to support patients with major depression in improving	**Supported: MH** (CEBC: Well-supported) Adult well-being:	Adults who have been diagnosed with major depression.	**12 to 16 weeks** Weekly sessions of 45 to 50 minutes.	*Adult well-being:* African American: • Caregiver mental health[130] African (Ugandan): • Mental health, such as depression[131]

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
interpersonal relationships or circumstances that are directly related to a current depressive episode.	• Parent/caregiver mental or emotional health • Family functioning			Many other countries, including Arabic countries such as Egypt, Columbia, India, Russia, Sub-Sahara Africa (e.g., Kenya), and Thailand[132] LGBTQ2SI+: No evidence published.
Interpersonal Psychotherapy for Depressed Adolescents (IPT-A) Focus is on the reciprocal relationship between mood and relationships. Therapists also focus on the impact on depressive symptoms. IPT-A aims to help adolescents identify their feelings and understand how interpersonal and environmental factors impact their mood, strengthen communication and problem-solving skills, improve interpersonal skills and relationships, and manage or decrease depressive symptoms. IPT-A is an individual treatment; however, therapists might also meet with parents or guardians for 1-3 sessions as needed. IPT-A is an adaptation of Interpersonal Psychotherapy (IPT) for depressed adults (Weissman et al. Manual).	**Promising: MH** (CEBC: Well-supported) Child well-being: • Behavioral and emotional functioning • Social functioning	For adolescents with depressive disorders.	**12 weeks** Weekly sessions, of 45-60 minutes.	*Child well-being:* Latinx: • Depressive symptoms and functioning[133] LGBTQ2SI+: No evidence published.

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
Iowa Parent Partner Approach Pairs "Parent Partners" with parents whose children have been removed from the home. It also pairs Parent Partners with parents who can only reside with their children under special conditions set by the courts. Parent Partners are parents who were formerly involved with the child welfare system and who have achieved reunification with their children. They are selected based upon their interpersonal skills, successes, and proven ability to overcome obstacles. To be eligible, Parent Partners must have maintained reunification with their children for at least one year. Parent Partners mentor eligible families by providing social support, offering guidance on how to navigate the process of reunification, and working with social workers and other professionals to ensure the family is getting needed resources. The goal is to support reunification and reduce recurrence of child maltreatment.	**Promising: PSB** (CEBC: Promising) Child permanency: • Out-of-home placement	Parents whose children (age 0 to 17) have been removed from the home or parents who can only reside with their children under special conditions set by the courts (e.g., after receiving substance use treatment).	**Undefined** Frequency varies over time, beginning with 4 in-person visits per month plus possible phone contact between visits. Meetings may decrease after 2 to 3 months depending on family need.	*Child permanency:* Hispanic/Latinx: • Out-of-home placement[134] LGBTQ2SI+**:** No evidence published.
Maternal Early Childhood Sustained Home-visiting® (MECSH)	**Supported: PSB (CEBC:**	Families with children under age 2 who are at risk of poor maternal	**A minimum of 25 home visits for families who**	Unable to find any relevant literature documenting significant child welfare-related

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Maternal Early Childhood Sustained Home-visiting® (MECSH) is a nurse home visiting program designed for families with children under age 2 who are at risk of poor maternal or child health and development outcomes. MECSH aims to support (1) the transition to parenthood, (2) maternal health and wellbeing, (3) child health and wellbeing, (4) parents' future goals and aspirations, and (5) social relationships and networks, including access to social services and other resources.	Child well-being: • Cognitive functions and abilities Adult well-being: • Parent/caregiver mental or emotional health • Parent/caregiver physical health • Positive parenting practices	or child health and development outcomes.	**enroll prenatally and 22 visits for families who enroll postnatally**. Families who enroll prenatally receive at least three 30–60-minute visits before the child is born. After the child is born, all families receive at least weekly 60–90-minute visits until the child is 6 weeks old, then 60–90-minute visits every 2 weeks until the child is 12 weeks old, then 30–60-	outcomes for non-white, non-Latinx children or families – or LGBTQ2SI+ persons.

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
			minute visits every 3 weeks until the child is 6 months old, and then 60–90-minute visits every 6 weeks until the child is 1 year old.	
Methadone Maintenance Therapy A medication-assisted treatment that aims to reduce the use of heroin and other opioids for individuals who have an opioid use disorder. Methadone is itself an opioid medication. It is prescribed and administered at levels calibrated to avert the onset of painful withdrawal symptoms and can be tapered slowly to reduce or end opioid dependence. MMT also includes counseling and social support services. Methadone dosage and the length of treatment vary according to the individual's needs. MMT programs must be certified through the Substance Abuse and Mental Health Services Administration (SAMHSA) Division of Pharmacologic Therapies (DPT).[135]	**Promising: SA** (CEBC: Not listed) Adult well-being: • Parent/caregiver substance use	Individuals who have an opioid use disorder. Typically restricted to individuals age 18 and over, but individuals under age 18 may be eligible if they have already had two unsuccessful treatment attempts and they have parent/guardian consent.	**1 year or more.** Daily methadone treatment, plus counseling and social support, depending on need. Methadone is typically administered in a clinical setting, but some individuals can take methadone at	*Adult well-being:* African American: • Substance use disorder [136] Latinx: • Substance abuse disorder [137] LGBTQ2SI+**:** No evidence published.

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			home between visits.	
Mindful Mood Balance Mindful Mood Balance (MMB), an online adaptation of Mindfulness-Based Cognitive Therapy (MBCT), aims to treat adults with depression symptoms and prevent depressive relapse through mindfulness practices. MMB is designed to teach individuals how to become aware of and manage their thoughts, feelings, and body sensations.	**Promising: MH** Adult well-being: • Parent/caregiver mental or emotional health	Adults with histories of depression and residual depression symptoms.	**8 weeks.** Eight sessions intended to be completed once per week	Unable to find any relevant literature documenting significant child welfare-related outcomes for non-white, non-Latinx children or families – or LGBTQ2SI+ persons.
Mindfulness-Based Cognitive Behavior Therapy for Adults Mindfulness–Based Cognitive Therapy (MBCT) aims to treat adults with depression symptoms and prevent depressive relapse through mindfulness practices. MBCT is designed to teach individuals how to become aware of and manage their thoughts, feelings, and body sensations.	**Well-supported: MH** (CEBC: Well-Supported) Adult well-being: • Parent/caregiver mental or emotional health • Parent/caregiver physical health	Adults with depression symptoms. MBCT can also be used to treat adults with other mental disorders, such as anxiety.	**8 weeks.** Instructors lead 2-hour group sessions once per week	Unable to find any relevant literature documenting significant child welfare-related outcomes for non-white, non-Latinx children or families – or LGBTQ2SI+ persons.

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Motivational Interviewing (MI) A method of communication to promote behavior change in positive directions. Based on the "spirit" of MI, including acceptance and compassion, MI practitioners assist clients in identifying ambivalence for change as well as hope for change. Clients are guided to consider their personal goals and how their current behaviors may compete with attainment of those goals. MI practitioners use specific skills, such as open-ended questions, affirmations, and reflective listening, to help clients identify reasons to change their behavior and how they might go about doing so. The Prevention Services Clearinghouse reviewed studies of MI focused on illicit substance and alcohol use or abuse among youth and adults, and nicotine or tobacco use among youth under 18. Sessions are often used prior to or in conjunction with other therapies or programs. They are usually conducted in community agencies, clinical office settings, care facilities, or hospitals. While there are no required qualifications for individuals to deliver MI,	**Well-supported: SA**[138] (CEBC: Well-supported) Child well-being: • Substance use Adult well-being: • Parent/caregiver substance use • Parent/caregiver mental or emotional health • Parent/caregiver criminal behavior • Family functioning • Parent/caregiver physical health • Economic and housing stability	Promote behavior change with a range of target populations and for a variety of problem areas.	**30 to 150 minutes.** 1 to 3 sessions of 30 to 50 minutes	*Child well-being:* Hispanic: • Substance use disorder [139] African American: • Substance use disorder [140] *Adult well-being:* African American: • Substance use disorder [141] American Indian: • Substance use disorder [142] Hispanic: • Substance use disorder [143] Multi-Ethnic: • Substance use disorder[144] Others: • Substance use disorder[145] *LGBTQQ:* • Substance use disorder and other outcomes[146]

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training can be provided by MINT (Motivational Interviewing Network of Trainers) certified trainers.				
Multidimensional Family Therapy (MDFT) Focuses on addressing the needs of adolescents and young adults with substance use, delinquency, mental health, and emotional problems. MDFT is an integrated therapy model that incorporates and supports parents, families, and community partners (e.g., child welfare, schools). MDFT seeks to enhance coping, problem-solving, and communication skills; stabilize mental health issues; reduce youth substance use; and improve school achievement among adolescents and young adults. MDFT also aims to improve parenting skills, parental functioning, family communication, and attachment, and to reduce parenting stress.	**Supported: MH, PSB, SA** (CEBC: Well-supported) Child well-being: • Behavioral and emotional functioning • Social functioning • Substance use • Delinquent behavior • Educational achievement and attainment Adult well-being: • Positive parenting practices	Adolescents and young adults ages 9 to 26 with substance use, delinquency, mental health, academic/vocational, and emotional problems. At least one parent/guardian or parental figure must also participate in treatment.	**12 to 24 weeks.** (1 to 3 sessions weekly of 45 to 90 minutes. Length and frequency decrease over time with the goal of reducing to one session per week for the last four to six weeks of treatment. Additional support provided by phone or text between sessions)	*Child well-being:* African American: • Delinquent behavior/detention to community[147] • Educational achievement and attainment (school functioning)[148] • Internet gaming[149] • Prevention of residential treatment placement[150] • Substance use disorder, including cannabis use[151] European: • Substance abuse disorder [152] Hispanic: • Delinquent behavior/detention to community[153] • Educational achievement and attainment (i.e., school functioning)[154]

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
	• Family functioning			• Internet gaming[155] • Placement prevention[156] including prevention of residential treatment[157] • Substance use disorder [158] *Adult well-being:* African American: • Family functioning[159] • Positive parenting practices[160] Hispanic: • Family functioning[161] • Positive parenting practices[162]
Multisystemic Therapy (MST) An intensive treatment for troubled youth delivered in multiple settings. This program aims to promote pro-social behavior and reduce criminal activity, mental health symptomology, out-of-home placements, and illicit substance use in 12- to 17-year-old youth. The MST program addresses the core causes of delinquent and antisocial conduct by identifying key drivers of the behaviors through an ecological assessment of the	**Well-supported: MH, SA** (CEBC: Well-supported) Child permanency: • Out-of-home placement	Youth age 12 to 17 and their families, especially youth who are at risk for or are engaging in delinquent activity or substance misuse, who are experiencing mental health issues, and who	**12 to 20 weeks.** Multiple sessions weekly depending on need.	*Child permanency:* African American: • Out-of-home placement[163] Hispanic: • Out-of-home placement[164] *Child well-being:* African American:

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youth, their family, and school and community. The intervention strategies are personalized to address the identified drivers. The program is delivered for an average of three to five months, and services are available 24/7, which enables timely crisis management and allows families to choose which times will work best for them.	Child well-being: • Behavioral and emotional functioning • Substance use • Delinquent behavior Adult well-being: • Positive parenting practices • Parent/caregiver mental or emotional health • Family functioning	are at risk for out-of-home placement.		• Behavioral and emotional functioning ("socialized-aggressive problem behavior/ disruptive behavior, conduct disorder, self-injurious behavior)[165] • Behavioral and emotional functioning, delinquent behavior (rearrests and days incarcerated)[166] • Delinquent behavior (including problem sexual behavior), substance use disorder [167] • Completion of community service[168] • Faster recovery than hospitalization compared to White youth[169] • Increased youth hope as part of clinical engagement[170] Asian/Pacific Islander: • Improvements in behavior on the CBCL[171] Hispanic/Latino: • Behavioral and emotional functioning, prevention of delinquent behavior, arrests and incarceration (including

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				problem sexual behavior), substance use disorder [172] • Completion of community service[173] Norway (with some immigrant groups): • Behavioral and emotional functioning, prevention of delinquent behavior, arrests and incarceration (including problem sexual behavior), substance use disorder[174] *Adult well-being:* African American: • Positive parenting practices, caregiver mental or emotional health, family functioning[175] LGBTQ2SI+: No evidence published.
Narrative Exposure Therapy (NET) Narrative Exposure Therapy (NET) is a culturally universal intervention. Given its focus on the autobiographical elaboration of traumatic	**Promising: MH** (CEBC: Well-supported)	NET is designed for child, adolescent, or adult survivors of traumatic experiences such as childhood	**4–12 sessions of 90–120 minutes at least once every week.**	*Child well-being:* Other (Ugandan children & Refugee children in Finland): • Behavioral and emotional functioning[176]

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experiences, *NET* is particularly suited for populations affected by multiple and continuous traumatic experiences, such as organized violence, torture, war, rape, and childhood abuse. *NET* has been developed as a standardized short-term approach. Goals of NET include reducing clinical symptoms of post-traumatic stress disorder, depression, anxiety, suicidality, substance use, self-harm, aggressive acting out, guilt, and shame. NET also aims to improve functioning at social, occupational, scholastic, and emotional levels.	Child well-being: • Behavioral and emotional functioning Adult well-being: • Parent/caregiver mental or emotional health • Family Functioning • Parent/caregiver physical health	abuse, war, torture, sexual assault, rape, and other forms of violence.	The number of sessions depends on the intensity and complexity of the trauma.	*Adult well-being:* Asian: • Parent/caregiver mental or emotional health[177] • Parent/caregiver physical health[178] (Other: Iranian Women; Refugees and Asylum seekers in Norway; Sudanese, Rwandan, and Somalian Refugees) • Parent/caregiver mental or emotional health[179] • Family Functioning[180] LGBTQ2SI+**:** No evidence published.
Nurse-Family Partnership (NFP) A home-visiting program that is typically implemented by trained registered nurses. The primary aims of NFP are to improve the health, relationships, and economic well-being of mothers and their children. Typically, nurses provide support related to individualized goal setting, preventative health practices, parenting skills, and educational and career planning. However, the	**Well-supported: PSB, MH** (CEBC: Well-supported) Child safety:	Young, first-time, low-income mothers from early pregnancy through their child's first two years. The program also encourages the participation of fathers	**Undefined.** 60 visits of 60 to 75 minutes. Participants must enroll early in pregnancy [no later than the 28th week of gestation]	*Child well-being:* African American: • Cognitive functions and abilities[181] • Cognitive functions and abilities (physical aggression)[182] Mexican American: • Cognitive functions and abilities[183]

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
content of the program can vary based on the needs and requests of the mother.	• Child welfare administrative reports Child well-being: • Cognitive functions and abilities • Physical development and health Adult well-being: • Economic and housing stability	and other family members.	and may continue until the child turns 2. Weekly visits in the first month post-enrollment. Biweekly or as-needed visits after the first month.	*Adult well-being:* African American: • Domestic violence[184] Mexican American: • Domestic violence[185] LGBTQ2SI+: No evidence published.
Ohio's Kinship Supports Intervention/ProtectOHIO Designed to promote and support kinship placements. The goal of the intervention is to meet children's physical, emotional, financial, and basic needs by connecting kinship caregivers with federal, state, and local resources. Monthly face-to-face interactions establish trust between the kinship caregiver and coordinator. They are designed to promote more	**Promising: Kinship Navigator** Child permanency: • Placement stability	Relatives caring for a child in out-of-home care.	**Monthly home visit with a kinship coordinator.** Assessments conducted within 30 days of the child's placement	*Child permanency*: African American: • Placement stability[186] Latinx: • Placement stability[187] LGBTQ2SI+: No evidence published.

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effective communication, education, assessment, planning, and support for the family.			and every 90 days thereafter.	
On the Way Home On the Way Home® (OTWH) is designed to support families with youth ages 12–18 as youth transition from residential out-of-home care to home, school, and community settings. OTWH supports this transition by empowering families, enhancing family relationships, and supporting academic engagement and success. The program integrates three interventions: Check & Connect, Common Sense Parenting (CSP), and homework support.	**Promising: MH, PSB** (CEBC: Supported) Child Permanency: • Out of home placement	Families with youth ages 12–18 transitioning from residential out-of-home care to home, school, and community settings.	**Up to 12 months after a youth exits an out-of-home placement.** 6 weekly individual sessions. Across all three interventions, family consultants typically provide 2 hours per week of direct services.	Unable to find any relevant literature documenting significant child welfare-related outcomes for non-white, non-Latinx children or families – or LGBTQ2SI+ persons.
Parent-Child Care (PC-CARE) Parent-Child Care (PC-CARE) is a parenting program designed to provide brief support to caregivers with children ages 1–10. PC-CARE aims to help caregivers improve relationships with their child and learn new child behavior management strategies.	**Promising: MH, PSB** (CEBC: Promising) Child well-being:	Caregivers with children ages 1–10. The caregiver should have either custody of or regular visits with the child and be willing	**Seven weekly sessions with one caregiver and one child.**	*Child well-being:* African American: • Decrease in child behavior problems • Decrease in trauma symptoms

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	• Behavioral and emotional functioning Adult well-being: • Positive parenting practices	and able to participate in the "Daily CARE" activity.	But one can also deliver the program to multiple children or multiple caregivers. Each session lasts 1 hour. Providers conduct a follow-up call with the caregiver 1 month after treatment has ended and can offer an additional booster session at that time.	• Children's resilience and self-regulation[188] Latinx: • Decrease in child behavior problems • Decrease in trauma symptoms • Children's resilience and self-regulation[189] LGBTQ2SI+: No evidence published.
Parent-Child Interaction Therapy (PCIT) Coaches parents by a trained therapist in behavior-management and relationship skills. PCIT aims to decrease externalizing child behavior problems, increase positive parenting behaviors, and improve the quality of the parent-child relationship. During weekly	**Well-supported: MH** (CEBC: Well-supported) Child well-being:	Families with children ages 2 to 7 who experience emotional and behavioral problems that are frequent and intense.	**12 to 20 weeks.** Weekly sessions of 60 minutes.	*Child safety:* African American: • Physical abuse[190] *Child well-being:*

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sessions, therapists coach caregivers in skills such as child-centered play, communication, increasing child compliance, and problem-solving. Therapists use "bug-in-the-ear" technology to provide live coaching to parents or caregivers from behind a one-way mirror (in some modifications, live same-room coaching is also used).	• Behavioral and emotional functioning Adult well-being: • Positive parenting practices • Parent/caregiver mental or emotional health			Hong Kong Chinese: • Behavioral and emotional functioning (disruptive behavior)[191] *Adult well-being:* African American: • Positive parenting practices (parent negative behaviors)[192] Hong Kong Chinese: • Positive parenting practices (and decrease in negative parenting practices), mental or emotional health (parenting stress, negative emotions)[193] Latino: • Positive parenting practices (with Guiando a Ninos Activos – Guiding Active Children -- a culturally adjusted version of PCIT) LGBTQ2SI+: No evidence published.

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
Parenting with Love and Limits® Family-focused intervention for teenagers (ages 10-18) with severe emotional and behavioral problems (e.g., conduct disorder, oppositional defiant disorder, attention-deficit/hyperactivity disorder). The program is designed to help families re-establish adult authority through setting consistent limits and reclaiming loving relationships. PLL consists of both multifamily group therapy sessions and individual family therapy coaching sessions.	**Supported: MH, PSB, SA** (CEBC: Supported) Child well-being: • Delinquent behavior	Parents of teenagers ages 10-18 with severe emotional and behavioral problems.	**4 to 6 months.** Families participate in six 2-hour weekly multifamily group sessions led by one PLL Coach and one co-facilitator.[194]	*Child well-being:* African American: • Delinquent behavior (e.g., Rearrest Rate, Re-adjudication Rate, Felony Adjudication Rate, Recommitment Rate)[195] LGBTQ2SI+**:** No evidence published.
Parents Anonymous® Seeks to enhance family functioning and parent/caregiver resilience to prevent and treat child maltreatment by offering groups for parents/caregivers and their children/youth. Groups are guided by four core principles and therapeutic processes: mutual support, parent leadership, shared leadership®, and personal growth and change. Groups are also linked to six additional strength-based goals: (1) increasing protective factors and reducing risk factors, (2) improving family functioning, (3) mitigating the impact of and preventing adverse childhood experiences	**Supported: MH, PSB, SA** (CEBC: Promising) Child safety: • Child welfare administrative reports Child permanency:	For children or adolescents ages 0 to 18, and parents or caregivers of children ages 0 to 18.For parents/caregivers of children ages: 0 – 18	**Median dosage of 5 months, but 12-18 months for child welfare-involved families.[196]** Weekly 2-hour group sessions; more than 2 hours per week for Supportive Services, In-Home	*Adult well-Being:* African American: • Child maltreatment outcomes, protective factors, risk factors[197] *Child safety:* African American: • Child welfare administrative reports for CPS referrals and substantiated referrals[198]

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
(ACEs), (4) preventing and intervening in substance use disorders, (5) preventing and intervening in domestic violence, and (6) enhancing the physical and mental health of parents/caregivers. Both adult and children/youth groups aim to provide safe and caring environments created through trauma-informed practices.	• Out-of-home placement		Parenting, Parent Partner and Navigator, and Helpline Services	Latinx: • Child welfare administrative reports for CPS referrals and substantiated referrals[199] LGBTQ2SI+: No evidence published.
Parents as Teachers (PAT) A home-visiting parent education program that teaches new and expectant parents skills intended to promote positive child development and prevent child maltreatment. PAT aims to increase parent knowledge of early childhood development, improve parenting practices, promote early detection of developmental delays and health issues, prevent child abuse and neglect, and increase school readiness and success. The PAT model includes four core components: personal home visits, supportive group connection events, child health and developmental screenings, and community resource networks. PAT is designed so that it can be delivered to all families although PAT sites typically target families with specific risk factors based on funder requirements or community needs.	**Well-supported: PSB** (CEBC: Promising) Child safety: • Child welfare administrative reports Child well-being: • Social functioning • Cognitive functions and abilities	New and expectant parents, starting prenatally and continuing until their child reaches kindergarten, especially families in possible high-risk environments such as teen parents, parents with low educational attainment, history of substance abuse in the family, and chronic health conditions.	**Undefined.** Biweekly or monthly meetings of 60 minutes are offered prenatally and until the child starts kindergarten.	*Child safety:* African American: • Child welfare administrative reports (re-reports to CPS)[200] • Child welfare administrative reports (open case of child abuse or neglect)[201] Latina (mothers): • Child welfare administrative reports (open case of child abuse or neglect)[202] *Child well-being:* Latina (mothers): • Social functioning, cognitive functioning and abilities[203] *Adult well-being:*

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
Each participant is assigned a parent educator who must have a high school degree or GED with two or more years of experience working with children and parents. Parent educators must attend five days of PAT training and annually meet 20 hours of professional development.				African American: • Positive parenting practices, mental and emotional functioning (happiness with caretaking of child)[204] Hispanic/Latina (mothers): • Positive parenting practices (parent efficacy)[205] LGBTQ2SI+: No evidence published.
Prolonged Exposure Therapy for Adolescents for PTSD* A cognitive-behavioral approach to treating adolescents who are diagnosed with PTSD or who manifest trauma-related symptoms. PE-A is an adaptation of Prolonged Exposure Therapy for PTSD and is designed to highlight the developmentally appropriate concerns, strengths, and needs of adolescents.	**Promising: MH** (CEBC: Supported) Child well-being: • Behavioral and emotional functioning	For children and adolescents ages 12 to 18.	**2-4 months.** Approximately 8-15 sessions. Phases are designed to allow adolescents to go at their own pace. Adolescents complete developmentally appropriate homework	*Child well-being:* African American: • Behavioral and emotional functioning in terms of PTSD symptoms[206] South African:[207] LGBTQ2SI+: No evidence published.

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			assignments between sessions.	
Prolonged Exposure Therapy for PTSD (Adults; PE) A cognitive-behavioral approach to treating adults who are diagnosed with PTSD or who manifest trauma-related symptoms. PE is designed to help trauma survivors emotionally process their traumatic experiences in order to diminish PTSD and other trauma-related symptoms.	**Promising: MH** (CEBC: Well-supported) Adult well-being: • Parent/caregiver mental or emotional health	For treating adult patients who are diagnosed with PTSD or who manifest trauma-related symptoms.	**At least four sessions.**	*Adult well-being:* African American: • Anxiety and depression[208] • Social functioning[209] • Decrease in PTSD symptoms[210] LGBTQ2SI+: No evidence published.
Promoting First Relationships Promoting First Relationships® (PFR) is a home visiting prevention program designed for caregivers of children ages 0–5 years. PFR aims to promote secure and healthy relationships between caregivers and children through strengths-based parenting strategies. PFR uses reflective processes to help caregivers understand their own feelings and needs and those of their children. PFR promotes children's social-emotional development, builds trust and security between	**Supported: MH, PSB** (CEBC: Supported) Child well-being: • Behavioral and emotional functioning Adult well-being:	PFR is designed for caregivers of children ages 0–5 years. Providers can implement PFR with multiple populations, including parents, grandparents, childcare teachers, families experiencing homelessness,	**Ten sessions.** Providers deliver PFR to caregivers and their children in 10 weekly sessions lasting 60–75 minutes. In five of the 10 sessions, the provider videotapes a	*Child well-being:* African American • Behavioral and emotional functioning[211] American Indian/Alaskan Native: • Caregivers' depressive symptoms • Caregiver sensitivity to child needs • Parents' knowledge of child social and emotional development[212]

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
children and caregivers, encourages children and caregivers' emotion regulation and self- reflection, and helps caregivers address challenging behaviors.	• Positive Parenting Practices Adult well-being: • Parent/caregiver mental or emotional health Adult well-being: • Family Functioning	caregivers with a mental health diagnosis, adolescent mothers, first-time parents, foster parents, families with children in the child welfare system, or families of children with special needs.	caregiver-child interaction for 10–20 minutes and discusses the video with the caregiver the following week.	Hispanic/Latina • Behavioral and emotional functioning[213] Multiracial • Behavioral and emotional functioning[214] *Adult well-being:* African American • Positive Parenting Practices[215] • Parent/caregiver mental or emotional health[216] • Family Functioning[217] American Indian • Behavioral and emotional functioning[218] • Positive Parenting Practices[219] • Parent/caregiver mental or emotional health[220] • Family Functioning[221] Hispanic/Latino: • Positive Parenting Practices[222]

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
				• Parent/caregiver mental or emotional health[223] • Family Functioning[224] Multiracial: • Positive Parenting Practices[225] • Parent/caregiver mental or emotional health[226] • Family Functioning[227] LGBTQ2SI+: No evidence published.
SafeCare An in-home behavioral parenting program that promotes positive parent-child interactions, informed caregiver response to childhood illness and injury, and a safe home environment. The program aims to reduce child maltreatment. The SafeCare curriculum is delivered by trained and certified providers. The curriculum includes three modules: (1) The home safety module targets risk factors for environmental neglect and unintentional injury by helping parents/caregivers identify and eliminate common	**Supported: PSB** (CEBC: Supported) Child permanency: • Out-of-home placement	Parents and caregivers of children ages 0 to 5 five who are either at-risk for or have a history of child neglect and/ or physical abuse.	**18 sessions but varies.** 18 sessions of 50 to 90 minutes, depending on the needs of the parents and/or other caregivers.	*Child permanency:* American Indian: • Out-of-home care placements[228] *Child safety:* African American: • Maltreatment (CPS recidivism)[229] Hispanic: • Maltreatment (CPS recidivism)[230]

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
household hazards and teaching them about age-appropriate supervision. (2) The health module targets risk factors for medical neglect by teaching parents/caregivers how to identify and address illness, injury, and health generally. (3) The parent-child/parent-infant interaction module targets risk factors associated with neglect and physical abuse by teaching parents/caregivers how to positively interact with their infant/child and how to structure activities to engage their children and promote positive behavior.				American Indian: • Maltreatment (CPS recidivism)[231] LGBTQ2SI+: No evidence published.
Screening Brief Intervention and Referral to Treatment (SBIRT) SBIRT is designed as a health clinic intervention for youth and adults that aims to prevent and treat moderate to severe substance use and substance use disorders through screening, treatments, and referrals. Providers such as doctors, nurses, social workers, and health educators conduct screening for all youth and adults in a range of settings (e.g., primary care offices, emergency rooms, school health clinics), SBIRT is a universal program to screen everyone regardless of any indicators of substance use, substance disorders,	**Promising: SA** (CEBC: not rated) Adult well-being: • Parent/caregiver substance use	Any youth or adult with risks for harmful substance use	**Varies**. Commonly starts with a 5-minute screening. Additional time for intervention and referrals varies based on individual needs	*Adult well-being:* African American: • Parent/caregiver substance use[232] • Less need for a referral to follow-up specialty treatment[233] Asian: • Less need for a referral to follow-up specialty treatment[234] *Child well-being:* African-American:

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
or whether the person actively seeking services. Those who screen at high risk are referred to specialty providers while those at moderate to low risk.				• Had lower odds of alcohol use disorder diagnoses.[235] Latino: • Had lower odds of any substance, including any drug and marijuana use disorder diagnoses.[236] LGBTQ2SI+: No evidence published.
Smart Beginnings Smart Beginnings is a tiered approach designed to promote school readiness and positive behavioral outcomes for children ages 0–3 that combines the Video Interaction Project (VIP)* program with the Family Check-Up® (FCU)* program. All families receive VIP, which aims to use regularly scheduled pediatrician visits to support child development, school readiness, and educational outcomes. In VIP sessions, coaches focus on increasing responsive parenting, a parenting style where parents learn to observe their child's behavior, interpret their cues, and act in a way that meets the child's needs. Beginning when the child	**Promising: MH, PSB** (CEBC: not rated) Adult well-being: • Positive parenting practices	Smart Beginnings is designed to serve parents and children ages 0–3.	**VIP includes up to 14 sessions.** Each session lasts 30–45 minutes. VIP sessions are designed to be delivered in conjunction with regularly scheduled pediatric well-child	*Adult well-being:* African American: • Positive parenting practices, such as cognitive stimulation of the children.[238] Latinx: • Positive parenting practices, such as cognitive stimulation of the children.[239] LGBTQ2SI+: No evidence published.

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
is 6 months of age, VIP coaches administer screenings for parent, parenting, and child risk factors. If the coach identifies the family as having additional risks, the coach asks the parent if they'd like to participate in FCU. FCU is a brief, strengths-based intervention that aims to improve parenting skills and family management practices. *The Video Interaction Project and Family Check-Up® are also listed independently in this table with evidence of effectiveness for racial/ethnic groups.			visits from birth to 3 years.[237]	
Sobriety Treatment and Recovery Teams (START) Designed to recruit, engage, and retain parents in substance use disorder (SUD) treatment while keeping children safe. The goals of START are to prevent out-of-home placements, promote child safety and well-being, increase permanency for children, encourage parental SUD recovery, and improve family stability and self-sufficiency.	**Supported: PSB and SA** (CEBC: Promising: PSB, SA) Child permanency: • Out-of-home placement	Families with at least one child under 6 who is involved in the child welfare system and has a parent with an SUD	**14 months (Avg.).** Initial treatment planning meeting, SUD assessment, and four intensive SUD treatment sessions required within the first 30 to 45 days. Weekly home	*Child permanency:* African American: • Out-of-home placement[240] • Out-of-home placement[241] *Adult well-being:* African American: • Substance use disorder[242] • Substance use disorder[243]

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
			visits by CPS caseworker for at least the first 60 days, and by family peer mentors for at least the first 90 days.	LGBTQ2SI+: No evidence published.
Strengthening Families Program: For Parents and Youth 10-14 (SFP 10-14) The Strengthening Families Program: For Parents and Youth 10-14 (SFP 10-14) is a family skills training program designed to serve families with youth ages 10–14. SFP 10-14 aims to help parents increase their youth's protective factors, such as pro-social peer relationships, and reduce their youth's risk factors for behavioral, social, substance use, and academic problems. Note that the culturally adapted version of SFP 10-14 makes use of videotapes that include both African American and European American narrators and actors. African American consultants assisted in	**Supported: MH, SA** (CEBC: Well-Supported) Child Well-Being: Substance abuse	Families with youth ages 10–14	**6-7 weekly multi-family group sessions of 7–10 families.** A smaller group size is recommended for families with youth exhibiting problematic behavior. Each session lasts 2 hours. Group	*Child well-being:* African American: • Positive child skills and behaviors such as setting goals, managing stress, and effective communication with parents.[245] LGBTQ2SI+: No evidence published.

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
enhancing the cultural sensitivity of the project and suggested that it should be called *Harambee*, a Swahili word meaning pulling together. The teaching manuals, program videotapes, promotional videotape and brochure, and all correspondence to families referred to the project as *Harambee*. These materials presented photographs and videos that included depictions of African American participants and program implementers. They also displayed artwork that the consultants had deemed to be appropriate for the target population.[244]			facilitators can offer four optional booster sessions 3–12 months after families have completed the 7-week program.	
Strong African American Families (SAAF) A group-based program for families of African American/Black youth between ages 10 and 14. SAAF aims to build on the strengths of African American families to prevent substance use and other risky behaviors. Parent sessions focus on improving parental monitoring and engagement, communication about sex and substance use, and positive racial socialization. Youth sessions promote setting and achieving goals, resisting risky behaviors, and accepting parental influences. Youth and parents meet	**Well-Supported: MH, SA** (CEBC: Well-Supported) Child well-being: • Substance use Adult well-being: • Positive parenting practices	African American/ Black youth ages 10-14 and their parents.	**7 weekly 2-hour sessions.** In person, community settings delivered with the first hour parents alone and youth alone, second hour parents and youth together.	*Child well-being:* African American: • Substance use *Parent well-being:* African American: • Positive parenting practices LGBTQ2SI+**:** No evidence published.

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
separately for one hour and the next hour meet together.[246]				
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Treats children/adolescents who have post-traumatic stress disorder (PTSD) symptoms, dysfunctional feelings or thoughts, or behavioral problems. The intervention also supports caregivers in overcoming their personal distress, implementing effective parenting skills, and fostering positive interactions with their child/adolescent. After ensuring the safety of the child/adolescent, TF-CBT is structured into three phases: (1) skill building for the child/adolescent's self-regulation and the caregiver's behavior management and supportive care abilities, (2) addressing the traumatic experience, and (3) joint therapy sessions between caregiver and child/adolescent. TF-CBT is usually administered in clinical office settings.	**Promising: MH** (CEBC: Well-supported) Child well-being: • Behavioral and emotional functioning • Social functioning Adult well-being: • Positive parenting practices • Parent/caregiver mental or emotional health	Children and adolescents who have experienced trauma, including those with PTSD symptoms, dysfunctional feelings or thoughts, or behavioral problems. Caregivers are included in treatment as long as they did not perpetrate the trauma and the child's safety is maintained.	**12-16 sessions.** Typically, 12 to 16 sessions of 45 to 90 minutes.	*Child well-being:* American Indian/Alaskan native: • Social functioning, behavioral and emotional functioning [247] African American: • Social functioning, behavioral and emotional functioning[248] Asian: • Social functioning, behavioral and emotional functioning[249] Hispanic: • Behavioral and emotional functioning[250] • Social functioning, behavioral and emotional functioning[251] Japanese: • Behavioral and emotional functioning[252] Zambian: • Behavioral and emotional functioning[253]

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
				Multiracial: • Social functioning, behavioral and emotional functioning[254] *Parent well-being:* African American: • Positive parenting practices, parent/caregiver mental or emotional health[255] LGBTQ2SI+: A study showing a reduction in PTSD symptoms with a sample of 24 youth has been completed.[256]
Treatment Foster Care Oregon for Adolescents (TFCO-A) Formerly called Multidimensional Treatment Foster care – Adolescents, TFCO-A aims to support adolescents ages 12-17 with severe emotional and behavioral problems, to live in a family setting during treatment. It is an alternative to group or institutional settings and designed to support parents/caregivers to provide effective parenting. The youth is placed in a therapeutic foster family and supported by a team that	**Promising: MH, PSB** (CEBC: Well-supported; Promising for Educational) Child well-being: • Substance use	Youth ages 12-17 with severe emotional and behavioral problems	**6-12 months with at least 3 months of aftercare support.** The youth and their various support team members meet at least weekly.	Unable to find any relevant literature documenting significant child welfare-related outcomes for non-white, non-Latinx children or families – or LGBTQ2SI+ persons.

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
includes a case manager, foster parents, youth therapist, family therapist, skills coach, and a person that communicates daily with the foster parents.	• Delinquent behavior[257]		Foster parents receive a call each day.	
Triple P – Positive Parenting Program – Group (Level 4) A group-based parenting intervention. Group Triple P is for parents who are interested in promoting their child's development and potential or who are concerned about their child's behavior problems or simply wish to prevent behavior problems from developing. Group sessions typically focus on topics such as positive parenting, helping children develop, managing misbehavior, and planning ahead. Practitioners then provide individual feedback on progress using positive parenting strategies, and they help parents set goals, maintain changes, and plan ahead.	**Promising: MH** (CEBC: Not listed) Child well-being: • Behavioral and emotional functioning Adult well-being: • Positive parenting practices • Parent/caregiver mental or emotional health	Families with children up to age 12	**8 weeks.** Five group sessions of 120 minutes, plus three individual sessions of 15 to 30 minutes.	Triple P has been evaluated in many countries with positive outcomes. Listed below is just a sample of those results. *Child well-being:* African American: • Behavioral and emotional functioning (externalizing behavior)[258] Portuguese: • Behavioral and emotional functioning[259] Chinese parents in China and New Zealand: • Reduction in child adjustment problems, reduced child academic problem behaviours, increased child report of positive parenting.[260] Chinese in Hong Kong: ▪ Behavioral and emotional functioning,[261]

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
				▪ Decrease in child behaviour problems[262] Japanese parents in Japan: • Child behavior • Parenting practices, • Parental competence, • Family functioning • Parental adjustment[263] *Adult well-being:* African American: • Positive parenting practices, mental or emotional health; reduction in parent laxness, over-reactivity; increase in parent positive parenting, satisfaction with parental tasks, parental efficacy, and social support[264] Chinese in China: • Reduction in dysfunctional parenting, improved parental adjustment, increased parenting confidence, improved parenting in academic

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
				context\increase in parent satisfaction with child's academic achievement[265] Chinese in Hong Kong and New Zealand:[266] • Positive parenting practices[267] • Increase in parenting confidence[268] • Reduction in parental stress, reduction in parental conflict, and reduction in use of dysfunctional parenting styles (laxness and over-reactivity)[269] Iranian mothers: *Child wellbeing:* • Reduction in child behaviour problems[270] *Adult wellbeing:* • Improved parenting style • Improved mother-child relationship • Reductions in maternal depression, anxiety, and stress[271] Latina mothers: *Child wellbeing* • Significant reduction in child behavioural problems

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
				• Significant reductions in child emotional and conduct problems • Significant reduction in hyperactivity • Significant increase in pro- social behaviour[272] *Adult wellbeing* • Significant reduction in depression, anxiety, and stress • Significant reduction in ineffective parenting techniques[273] LGBTQ2SI+**:** No evidence published.
Triple P – Positive Parenting Program – Online (Level 4) Designed to offer parents support for encouraging children's positive behaviors; managing misbehaviors, tantrums, and disobedience; and teaching new skills to children. Online Triple P includes eight modules intended to help parents understand the foundations of positive parenting, manage children's behaviors, teach children new skills, deal with disobedience, plan ahead	**Supported: MH** (CEBC: Not listed) Child well-being: • Behavioral and emotional functioning Adult well-being:	Families with children (up to 12 years) with significant social, emotional or behavioral problems. It also serves families who wish to prevent such problems.	**Eight 60-minute modules.** Online Triple P access codes stay active for 12 months. This allows parents to complete the program at their	*Child Well-Being:* African American: • Child behavioral problems.[274] Latinx: • Child behavioral problems, reduced lax/permissive and over-reactive parenting, and decreased parental stress.[275]

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
to prevent problems, raise confident children, and apply consequences and rewards.	• Parent/caregiver mental or emotional health • Positive parenting practices		own pace, with a recommended completion rate of one module per week.	*Parent functioning and well-being:* African American: • Child behavioral problems, reduced lax/permissive and over-reactive parenting, and decreased parental stress.[276] Latinx: • Child behavioral problems, reduced lax/permissive and over-reactive parenting, and decreased parental stress.[277] LGBTQ2SI+**:** No evidence published.
Triple P – Positive Parenting Program – Self-Directed (Level 4) A self-help parenting intervention for families with children up to 12 years. Parents use a workbook to complete readings and practice tasks. These activities are designed to teach parents how to manage	**Promising: MH** (CEBC: Not listed) Child well-being: • Behavioral and emotional functioning Adult well-being:	Families with children up to age 12, especially families who live in rural or remote areas or who want help without direct	**10 weeks.** (Self-paced)	Unable to find any relevant literature documenting significant child welfare-related outcomes for non-white, non-Latinx children or families.

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
children's behavior, provide supervision, and educate their child.	• Parent/caregiver mental or emotional health • Positive parenting practices	contact with a practitioner.		
Triple P – Positive Parenting Program – Standard (Level 4) A parenting intervention for families with concerns about their child's moderate to severe behavioral problem. As a part of Triple P – Standard, parents engage in one-on-one sessions with a practitioner. These sessions focus on promoting child development, managing misbehavior, and implementing planned activities and routines to encourage independent child play.	**Promising: MH** (CEBC: Well-supported) Child well-being: • Behavioral and emotional functioning Adult well-being: • Positive parenting practices • Parent/caregiver mental or emotional health	Families with children up to age 12 who exhibit behavior problems or emotional difficulties.	**10 weeks.** Weekly individual sessions of 60 minutes.	Unable to find any relevant literature documenting significant child welfare-related outcomes for non-white, non-Latinx children or families.
Trust-Based Relational Interview (TBRI® 101) A self-administered approach to Trust-Based Relational Intervention® for caregivers of children who	**Promising: MH** (CEBC: Promising)	Parents or caregivers of children who have experienced adversity,	**Self-paced.**	*Child well-being:* African American: Behavioral and emotional functioning[278]

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
have experienced abuse, neglect, and/or other trauma. This program includes self-guided virtual training that is delivered through a series of video lessons. TBRI 101 uses an attachment-based and trauma-informed approach. It aims to provide parents and caregivers with the tools needed to meet the needs of their children.	Child well-being: Behavioral and emotional functioning	early harm, toxic stress, or trauma.	Five online modules totaling 7.5 hours. Self-paced and not time limited.	LGBTQ2SI+: No evidence published.
Trust-Based Relational Intervention – Caregiver Training (TBRI) An intervention for caregivers of children who have faced abuse, neglect, and/or other trauma. Uses an attachment-based and trauma-informed approach. Provides parents and caregivers with the tools needed to meet the needs of these children. Training emphasizes three core principles: (1) TBRI Connecting Principles, which focus on building trust and positive relationships between caregivers and children; (2) TBRI Empowering Principles, which focus on addressing children's physical and environmental needs and building children's self-regulation skills; and	**Promising: MH** (CEBC: Promising) Child well-being: • Behavioral and emotional functioning	Parents and/or caregivers of children between age 0 to 17 who have experienced adversity, early harm, toxic stress, and/or trauma.	**Six one-hour in-person training sessions** Four group sessions of six hours.	*Child Well-Being:* African American: • Child's emotional problems, conduct problems, total difficulties, and hyperactivity/inattention.[279] LGBTQ2SI+: No evidence published.

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
(3) TBRI Correcting Principles, which focus on building children's social competencies.				
Video Interaction Project (VIP) The Video Interaction Project (VIP) aims to use regularly scheduled pediatrician visits for children ages 0–5 to support child development, school readiness, and educational outcomes. VIP sessions focus on increasing responsive parenting, a parenting style where parents learn to observe their child's behavior, interpret their cues, and act in a way that meets the child's needs. Trained VIP coaches meet with the parent and child together either before or after the child's regularly scheduled pediatric well-child visit (i.e., check-up).	**Promising: MH, PSB** (CEBC: not rated) Child well-being: • Behavioral and emotional functioning • Social functioning • Cognitive functions Adult well-being: • Positive Parenting Practices • Parent/caregiver mental or emotional health	VIP is designed to serve parents and children ages 0–5.	**Not prescribed.** VIP sessions are designed to be delivered in conjunction with regularly scheduled pediatric well-child visits. These well-child visits occur every few months during infancy and toddlerhood and then less frequently as children get older.	*Child well-being:* African American: • Cognitive functions[280] Latinx: • Behavioral and emotional functioning[281] • Social functioning[282] • Cognitive functions[283] *Adult well-being:* African American: • Positive parenting practices[284] • Parent/caregiver mental or emotional health[285] • Family functioning[286] Latinx:

Program Model or Intervention	FFPSA Evidence Rating and Program Area with Service Impacts (other clearinghouse rating)	Ages and Problem or Skill Area Addressed	Duration and Dosage	Racial/Ethnic Groups and LGBTQ2SI+ Where We Found Evidence of Effectiveness
	• Family functioning			• Positive parenting practices[287] • Parent/caregiver mental or emotional health[288] • Family functioning[289] LGBTQ2SI+: No evidence published.

Endnotes

[1] The FFPSA law can be found here: https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf The recent request for comments is located here and contains additional criteria about how the intervention studies will be reviewed and rated: https://www.federalregister.gov/d/2018-13420.

[2] The FFPSA Clearinghouse handbook can be found here: https://preventionservices.abtsites.com/review-process

[3] Casey Family Programs. (2014). *Annual report*. Seattle, WA: Author. Retrieved from www.casey.org.

[4] See for example:

- Pecora, P. J., Sanders, D., Wilson, D., English, D., Puckett, A., & Rudlang-Perman, K. (2012). Addressing common forms of child maltreatment: Intervention strategies and gaps in our knowledge base. *Child and Family Social Work, 19*(3) 1-12, doi: 10.1111/cfs.12021.
- Rogg, C. S., Davis, C. W., & O'Brien, K. (2011). *Permanency roundtable project: 12-month outcome evaluation report*. Seattle, WA: Casey Family Programs.
- Townsend, S., Hignight, A., & Rubovits, D. (2008). Factors affecting permanency outcomes for foster children before and after passage of the Adoption and Safe Families Act of 1997. *Illinois Child Welfare, 4*(1), 59-73.

[5] Casey Family Programs. (2012). *Shifting resources in child welfare to achieve better outcomes for children and families.* Seattle, WA: Author. Retrieved from http://www.casey.org/Resources/Publications/pdf/ShiftingResources.pdf U.S. Department of Health and Human Services, Administration for Children and Families, Administration for Children and Families, Children's Bureau. (2012). *Promoting the social and emotional well-being of children and youth receiving child welfare services.* Memorandum No. ACYF-CB-IM-12-04. Washington, DC: Author. Retrieved from http://www.acf.hhs.gov/programs/cb/resource/im1204.

[6]LGBTQ2SI+: Lesbian, Gay, Bisexual, Transgender, Queer, Two-Spirit, Intersex +

[7] See for example:

- New York City Administration for Children's Services (ACS). 2020. *Experiences and well-being of sexual and gender diverse youth in foster care in New York City: Disproportionality and disparities.* Author.
- Wilson, B. D., & Kastanis, A. A. (2015). Sexual and gender minority disproportionality and disparities in child welfare: A population-based study. *Children and Youth Services Review*, *58,* 11-17
- Wulczyn, F. (2023). On causal inference and the limits of disproportionality as a construct: The case of foster care placement. *Social Service Review, 97(2),* 362-397. https://www.journals.uchicago.edu/doi/epdf/10.1086/724657
- Wulczyn, F. & Halloran, J. (2017). Foster care dynamics and system science: Implications for research and policy. *International Journal of Environmental Research and Public Health*. 14. 1181, 1-12. DOI: 10.3390/ijerph14101181

[8]For the Prevention Services Clearinghouse handbook, see https://preventionservices.abtsites.com/review-process.

[9] Dee Bigfoot, personal communication, December 14, 2020.

[10] Maryland Department of Human Services; (2023). *Comments on Title IV-E Clearinghouse Handbook of Standards and Procedures, Draft Version 2.0.* Annapolis, MD: Author, pp. 4-5.

[11] Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129(5), 674–697. https://doi.org/10.1037/0033-2909.129.5.674

[12] See, for example:

- American Psychological Association (APA). (2006). *APA presidential task force on evidence-based practice* (APA EBP). Author.
- Austin, A., & Craig, S. L. (2015). Empirically supported interventions for sexual and gender minority youth. Journal of Evidence-Informed Social Work, 12(6), 567–578. https://doi.org/10.1080/15433714.2014.884958
- Bochicchio L., Reeder, K., Ivanoff, A., Pope, H. & Stefancic, A. (2022) Psychotherapeutic interventions for LGBTQ + youth: A systematic review, *Journal of LGBT Youth*, 19:2, 152-179, DOI: 10.1080/19361653.2020.1766393

[13] See for example, Austin et al. (2018) and Bochicchio et al. (2022), pp. 162-163 and 168-169 and Expósito-Campos (2023). Also see Briana McGeough & Adrian Aguilera (2020) Clinical interventions with sexual minority clients: Review, critique, and future directions, *Journal of Gay & Lesbian Social Services*, 32:4, 421-439, DOI: 10.1080/10538720.2020.1764895 In addition, "although the efficacy of cognitive– behavioral therapy (CBT) for SM adults is beginning to be established (e.g., Hart, Tulloch, & O'Cleirigh, 2014; Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015; Ross, Doctor, Dimito, Kuehl, & Armstrong, 2007), empirical research exploring the efficacy of CBT with SMY [sexual minority youth] is almost nonexistent. Case studies and conceptual literature have suggested CBT as an acceptable approach with SMY (Craig, Austin, & Alessi, 2013; Duarte-Velez, Bernal, & Bonilla, 2010) because CBT encourages youth to modify maladaptive thoughts and behaviors, develop and maintain healthy coping strategies, and create social support systems" (Hobaica, Alman, Jackowich, & Kwon, 2018, p.2). References for the above:

- Austin, A., Craig, S. L., & D'Souza, S. A. (2018). An AFFIRMative cognitive behavioral intervention for transgender youth: Preliminary effectiveness. *Professional Psychology: Research and Practice, 49*(1), 1–8. https://doi.org/10.1037/pro0000154
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- Duarté-Vélez, Y., Bernal, G., & Bonilla, K. (2010). Culturally adapted cognitive-behavior therapy: Integrating sexual, spiritual, and family identities in an evidence-based treatment of a depressed Latino adolescent. *Journal of Clinical Psychology, 66,* 895–906. http://dx.doi.org/10.1002/jclp.20710
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- Hart, T. A., Tulloch, T. G., & O'Cleirigh, C. (2014). Integrated cognitive behavioral therapy for social anxiety and HIV prevention for gay and bisexual men. *Cognitive and Behavioral Practice, 21,* 149–160. http://dx.doi.org/10.1016/j.cbpra.2013.07.001\
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- Pachankis, J. E., Hatzenbuehler, M. L., Rendina, H. J., Safren, S. A., & Parsons, J. T. (2015). LGB-affirmative cognitive-behavioral therapy for young adult gay and bisexual men: A randomized controlled trial of a transdiagnostic minority stress approach. *Journal of Consulting and Clinical Psychology, 83,* 875– 889. http://dx.doi.org/10.1037/ccp0000037
- Ross, L. E., Doctor, F., Dimito, A., Kuehl, D., & Armstrong, M. S. (2007). Can talking about oppression reduce depression? Modified CBT group treatment for LGBT people with depression. *Journal of Gay & Lesbian Social Services, 19,* 1–15. http://dx.doi.org/10.1300/J041v19n01_01

[14] See, for example:

- Huey, S. J. & Polo, A. (2008). Evidence-based psychosocial treatments for ethnic minority youth. *Journal of Clinical Child & Adolescent Psychology*, *37*(1), 262-301.
- Hutchful, E. (2024). *Culture is healing: Removing the barriers facing providers of culturally responsive services*. Center for the Study of Social Policy. https://cssp.org/resource/culture-is-healing/
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- Substance Abuse and Mental Health Administration (SAMHSA) (2020*). CCBHCs and Cultural Competence.* Washington, DC: Author. Retrieved from https://www.samhsa.gov/section-223/cultural-competency

[15] Interventions that were rated by the CEBC according to its established criteria using the three highest levels of effectiveness for the CEBC classification system as follows:

1. ***Well-Supported by Research Evidence***: Sample criteria include multiple-site replication and at least two randomized control trials (RCTs) in different usual care or practice settings that have found the practice to be superior to an appropriate comparison practice. The RCTs have been reported in published peer-reviewed literature.
2. ***Supported by Research Evidence***: Sample criteria include at least one RCT in usual care or a practice setting that has found the practice to be superior to an appropriate comparison practice. The RCT has been reported in published peer-reviewed literature. In at least one RCT, the practice has shown to have a sustained effect for at least one year beyond the end of treatment.
3. ***Promising Research Evidence***: Sample criteria include at least one study using some form of comparison (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. In at least one RCT, the practice had a sustained effect for at least six months beyond the end of treatment. (See http://www.cebc4cw.org/ratings/scientific-rating-scale/ for more complete definitions.)

[16] 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: systematic review. *European Child & Adolescent Psychiatry* 22:269-283.

[17] See:

- Hyland, S. T., & O'Brien, J. (2023). Evidence-based programs desk guide 2023. Chapin Hall at the University of Chicago. Retrieved from https://www.chapinhall.org/wp-content/uploads/Chapin-Hall_EBP-Desk-Guide_December-2023.pdf
- O'Brien, J., Evans, J., Heaton, L., Hyland, S., & Weiner, D. (2021). *Elevating culturally specific evidence-based practices*. Chicago: Chapin Hall at the University of Chicago. Retrieved from https://www.chapinhall.org/wp-content/uploads/Elevating-Culturally-Specific-EBPs.pdf

[18] For example, see:

- https://www.ascb.org/science-policy/ending-racial-disparities-in-nih-funding/
- https://advances.sciencemag.org/content/5/10/eaaw7238
- https://www.npr.org/sections/health-shots/2019/10/18/768690216/whats-behind-the-research-funding-gap-for-black-scientists

[19] Practice-based evidence is also referred to as *community-defined evidence* (CDE).

[20] Echo-Hawk, Holly (2018). *Family First Prevention Services Act of 2018 Background: Culturally Based and Emerging Evidence-Based Practice*. Paper prepared for Casey Family Programs. Seattle, WA. E-mail: echohawk@pacifier.com, Page 2.

[21] For articles discussing the need for more economic analyses, see:

- Karoly, L. A., Kilburn, M. R., Bigelow, J. H., Caulkins, J. P., & Cannon, J. S. (2001). *Assessing costs and benefits of early childhood intervention programs: Overview and applications to the Starting Early, Starting Smart Program*. Santa Monica, CA: RAND.
- Lee, S., & Aos, S. (2011). Using cost-benefit analysis to understand the value of social interventions. *Research on Social Work Practice*, *21*(6), 682-688.
- Mullen, E. J., & Shuluk, J. (2010). Outcomes of social work intervention in the context of evidence-based practice. *Journal of Social Work*, *11*(1), 49-63.

[22] Rudd, T., Nicoleletti, E., Misner, K., & Bonsu, J. (2013). *Financing promising evidence-based programs: Early lessons from the New York City Social Impact Bond*. New York, NY: MDRC. Retrieved from http://www.mdrc.org/sites/default/files/Financing_Promising_evidence-Based_Programs_FR.pdf. Also see: https://www.whitehouse.gov/omb/factsheet/paying-for-success

[23] Godley, S. H., Hedges, K., & Hunter, B. (2011). Gender and racial differences in treatment process and outcome among participants in the Adolescent Community Reinforcement Approach. *Psychology of Addictive Behaviors, 25*(1), 143-154.

[24] Smith, D. C., Godley, S. H., Godley, M. D., & Dennis, M. L. (2011). Adolescent Community Reinforcement Approach outcomes differ among emerging adults and adolescents. *Journal of Substance Abuse Treatment, 41*(4), 422-430. [NOTE: Contains sample sizes of 30 or more African American, Hispanic, and Other/biracial study participants but does not disaggregate results based on race.]

[25] Dennis, M., Godley, S. H., Diamond, G., Tims, F. M, Babor, T., Donaldson, J., Liddle, H., Titus, J.C., Kaminer, Y., Webb, C., Hamilton, N., & Funk, R. (2004). The Cannabis Youth Treatment (CYT) Study: Main findings from two randomized trials. *Journal of Substance Abuse Treatment, 27*(3), 197-213. [NOTE: Sample size sufficient bur results not disaggregated by race.]

[26] Godley, et al. (2011). Note that in an early study CRAT was associated with *less* engagement in substance abuse treatment by Latino and multi-racial youth. See Lee, M. T., Garnick, D. W., O'Brien, P. L., Panas, L., Ritter, G. A., Acevedo, A., Garner, B. R., Funk, R. R., & Godley, M. D. (2012). Adolescent treatment initiation and engagement in an evidence-based practice initiative. *Journal of substance abuse treatment*, *42*(4), 346–355. https://doi.org/10.1016/j.jsat.2011.09.00 on page 8.

[27] Smith, D. C. et al. (2011). [NOTE: Contains >=30 sample sizes of African American, Hispanic, and Other/biracial populations, but does not disaggregate results based on race.]

[28] Grafsky, E.L., Letcher, A., Slesnick, N., Serovich, J.M. (2011). Comparison of treatment response among GLB and non-GLB street living youth. *Children and Youth Services Review*, 1;33(5):569-574. doi: 10.1016/j.childyouth.2010.10.007. PMID: 21516226; PMCID: PMC3079217.

[29] Kaya, F., & Buzlu, S. (2016). Effects of Aggression Replacement Training on problem solving, anger and aggressive behaviour among adolescents with criminal attempts in Turkey: A quasi-experimental study. *Archives of Psychiatric Nursing*, 30(6), 729-735. https://doi.org/10.1016/j.apnu.2016.07.001 Note that there have also been studies showing effectiveness with youth in Northwest Russia and Norway, and Black youth in the United States, but not of the ART model that was rated by the Prevention Clearinghouse. See Nugent, W. R., Bruley, C., & Allen, P. (1998). The effects of Aggression Replacement Training on antisocial behavior in a runaway shelter. *Research on Social Work Practice, 8*(6), 637-656. doi:10.1177/104973159800800602

[30] Schmidt, M. C., & Treinen, J. (2021). *Outcomes of the Arizona Kinship Support Services: Impact of kinship navigation on child permanency outcomes.* Phoenix: LeCroy & Milligan Associates, Inc. https://www.arizonaschildren.org/wp-content/uploads/2021/10/AKSS_KinshipNavigation_QEDStudyReport_Final_Aug2021.pdf

[31] Schmidt et al. (2021).

[32] Diamond, G., Creed, T., Gillham, J., Gallop, R., & Hamilton, J. L. (2012). Sexual trauma history does not moderate treatment outcome in Attachment-Based Family Therapy (ABFT) for adolescents with suicide ideation. Journal of Family Psychology, 26(4), 595–605. https://doi.org/10.1037/a0028414; and Diamond, G. S., Wintersteen, M. B., Brown, G. K., Diamond, G. M., Gallop, R., Shelef, K., & Levy, S. (2010). Attachment- Based Family Therapy for adolescents with suicidal ideation: A randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry, 49*(2), 122–131. https://doi.org/10.1016/j.jaac.2009.11.002

[33] Diamond et al. (2012).

[34]Diamond, G. M., Diamond, G. S., Levy, S., Closs, C., Ladipo, T., & Siqueland, L. (2012). Attachment-based family therapy for suicidal lesbian, gay, and bisexual adolescents: A treatment development study and open trial with preliminary findings. *Psychotherapy*, 49(1), 62–71. https://doi.org/10.1037/a0026247.

[35] Horigian, V. E, Feaster, D. J., Robbins, M. S., Brincks, A. M., Ucha, J,, Rohrbaugh, M. J., Shoham, V., Bachrach, K., Miller, M., Burlew, A. K., Hodgkins, C. C., Carrion, I. S., Silverstein, M., Werstlein, R., & Szapocznik, J. (2015). A cross-sectional assessment of the long-term effects of Brief Strategic Family Therapy for adolescent substance use. *The American Journal on Addictions, 24*(7), 637-645. [NOTE: Contains >=30 sample sizes of African American and Hispanic populations but does not disaggregate results based on race.] Also see comments in Pina, A.A., Polo, A.J. &. Huey, S.J. (2019) Evidence-Based Psychosocial Interventions for Ethnic Minority Youth: The 10-Year Update, *Journal of Clinical Child & Adolescent Psychology*, 48:2, 179-202, DOI: 10.1080/15374416.2019.1567350, pp. 190 and 196.

[36] Horigian, V. E., Feaster, D. J., Brincks, A., Robbins, M. S., Perez, M. A., & Szapocznik, J. (2014). The effects of Brief Strategic Family Therapy (BSFT) on parent substance use and the association between parent and adolescent substance use. *Addictive Behaviors, 42*, 44-50. [NOTE: Sample size sufficient but not disaggregated by race.]

[37]Horigian, V. E et al. (2015).

[38] Horigian, V.E. et al. (2014).

[39]Robbins, M. S., Feaster, D. J., Horigian, V. E., Rohrbaugh, M., Shoham, V., Bachrach, K., Miller, M., Burlew, K. A., Hodgkins, C., Carrion, I., Vandermark, N., Schindler, E., Werstlein, R., & Szapocznik, J. (2011). Brief Strategic Family Therapy versus treatment as usual: Results of a multisite randomized trial for substance using adolescents. *Journal of Consulting and Clinical Psychology*, *79*(6), 713–727. https://doi.org/10.1037/a0025477. [NOTE: Sample size sufficient but results not disaggregated by race. Child participant demographics reported but not parents'.]

[40] Horigian et al. (2014). [NOTE: Sample size sufficient but not disaggregated by race.]

[41] Personal Communication, José Szapocznik, December 15, 2023.

[42] Robbins, M. S., Feaster, D. J., Horigian, V. E., Rohrbaugh, M., Shoham, V., Bachrach, K., Miller, M., Burlew, K. A., Hodgkins, C., Carrion, I., Vandermark, N., Schindler, E., Werstlein, R., & Szapocznik, J. (2011). [NOTE: Sample size sufficient but results not disaggregated by race. Child participant demographics reported but not parents'.]

[43] Horigian et al. (2014). [NOTE: Sample size sufficient but not disaggregated by race.]

[44] See:

- Humphrey, N., & Panayiotou, M. (2020). Bounce Back: Randomised trial of a brief, school-based group intervention for children with emergent mental health difficulties. European Child & Adolescent Psychiatry, 31, 205–210. https://doi.org/10.1007/s00787-020-01612-6
- Langley, A. K., Gonzalez, A., Sugar, C. A., Solis, D., & Jaycox, L. (2015). Bounce Back: Effectiveness of an elementary school-based intervention for multicultural children exposed to traumatic events. Journal of Consulting and Clinical Psychology, 83(5), 853-865. https://doi.org/10.1037/ccp0000051
- Santiago, C. D., Raviv, T., Ros, A. M., Brewer, S. K., Distel, L. M. L., Torres, S. A., Fuller, A. K., Lewis, K. M., Coyne, C. A., Cicchetti, C., & Langley, A. K. (2018). Implementing the Bounce Back trauma intervention

in urban elementary schools: A real-world replication trial. School Psychology Quarterly, 33(1), 1–9. https://doi.org/10.1037/spq0000229

[45] Langley et al., (2015).

[46] Su, S. H., & Tsai, M. H. (2016). Group play therapy with children of new immigrants in Taiwan who are exhibiting relationship difficulties. *International Journal of Play Therapy*, 25(2), 91-101. https://doi.org/10.1037/pla0000014

[47] Su & Tsai (2016).

[48] Taylor, L., & Ray, D. C. (2021). Child-Centered Play Therapy and social–emotional competencies of African American children: A randomized controlled trial. *International Journal of Play Therapy, 30*(2), 74–85. https://doi.org/10.1037/pla0000152

[49] Crusto, C. A. Lowell, D. I., Paulicin, B., Reynolds, J., Feinn, R., Friedman, S. R., & Kaufman, J. S. (2008). Evaluation of a Wraparound process for children exposed to family violence. *Best Practices in Mental Health: An International Journal, 4*(1), 1-18.

[50] Weiner, D. A., Schneider, A., & Lyons, J. S. (2009). Evidence-based treatments for trauma among culturally diverse foster care youth: Treatment retention and outcomes. *Children and Youth Services Review, 31*(11), 1199-1205. doi: https://doi.org/10.1016/j.childyouth.2009.08.013.

[51] Weiner et al.. (2009).

[52] Cicchetti, D., Rogosch, F., Toth, S., & Sturge-Apple, M. (2011). Normalizing the development of cortisol regulation in maltreated infants through preventive interventions. *Development and Psychopathology, 23*(3), 789-800. doi:10.1017/S0954579411000307

[53] Lieberman, A., Weston, D., & Pawl, J. (1991). Preventive intervention and outcome with anxiously attached dyads. *Child Development, 62*(1), 199-209. doi:10.2307/1130715 [NOTE: Intervention is “infant-parent psychotherapy,” which was later renamed as “child-parent psychotherapy.” Infant sample Latinx ethnicity is not explicit but inferred from biological mother ethnicity, which is reported as “Latina”.]

[54] Lieberman et al. (1991). And Lavi, I., Gard, A. M., Hagan, M., Van Horn, P., & Lieberman, A. F. (2015). Child-Parent Psychotherapy Examined in a Perinatal Sample: Depression, Posttraumatic Stress Symptoms and Child-Rearing Attitudes. *Journal of Social and Clinical Psychology*, 34(1), 64–82. https://doi.org/10.1521/jscp.2015.34.1.64

[55] See:

- Yuen, T., Landreth, G., & Baggerly, J. (2002). Filial therapy with immigrant Chinese families. *International Journal of Play Therapy, 11*(2), 63–90. https://doi.org/10.1037/h0088865
- Lee, M. K., & Landreth, G. L. (2003). Filial therapy with immigrant Korean parents in the United States. *International Journal of Play Therapy, 12*(2), 67–85. https://doi.org/10.1037/h0088879

[56] Ceballos, P. L., & Bratton, S. C. (2010). Empowering Latino families: Effects of a culturally responsive intervention for low-income immigrant Latino parents on children's behaviors and parental stress. *Psychology in the Schools, 47*(8), 761–775. https://doi.org/10.1002/pits.20502

[57] Ceballos & Bratton (2010).

[58] Jaycox, L. H., Cohen, J. A., Mannarino, A. P., Walker, D. W., Langley, A. K., Gegenheimer, K. L., Scott, M., & Schonlau, M. (2010). Children's mental health care following Hurricane Katrina: A field trial of trauma–focused psychotherapies. *Journal of Traumatic Stress, 23*(2), 223–231. https://doi.org/10.1002/jts.20518 Also see comments in Pina, A.A., Polo, A.J. &. Huey, S.J. (2019) Evidence-Based Psychosocial Interventions for Ethnic Minority Youth: The 10-Year Update, *Journal of Clinical Child & Adolescent Psychology*, 48:2, 179-202, DOI: 10.1080/15374416.2019.1567350, pp. 190 and 196.

[59] See:

- Kataoka, S. H., Stein, B. D., Jaycox, L. H., Wong, M., Escudero, P., Tu, W., Zaragoza, C., & Fink, A. (2003). A school-based mental health program for traumatized Latino immigrant children. Journal of the American Academy of Child and Adolescent Psychiatry, 42(3), 311-318. https://doi.org/10.1097/00004583-200303000-00011
- Sumi, W.C., Woodbridge, M.W., Wei, X., Thornton, S.P., & Roundfield, K.D. (2021). Measuring the Impact of Trauma-Focused, Cognitive Behavioral Group Therapy with Middle School Students. School Mental Health. Doi:10.1007/s12310-021-09452-8
- Also see comments in Pina, A.A., Polo, A.J. &. Huey, S.J. (2019) Evidence-Based Psychosocial Interventions for Ethnic Minority Youth: The 10-Year Update, *Journal of Clinical Child & Adolescent Psychology*, 48:2, 179-202, DOI: 10.1080/15374416.2019.1567350, pp. 190 and 196.

[60] Sumi et al. (2021).

[61] Sumi et al. (2021).

[62] Sumi et al. (2021).

[63] Forehand, G., Alessi, L., & Winokur, M. (2022). *Impact study of the Colorado Kinnected Kinship Navigator Program*. Human Services Research Institute; Social Work Research Center, Colorado State University. https://drive.google.com/file/d/1gX-AcIcsuPVex2fdcXDy6FAjPtQZMhO_/view

[64] Mason, W. A., Fleming, C. B., Ringle, J. L., Thompson, R. W., Haggerty, K. P., & Snyder, J. J. (2015). Reducing risks for problem behaviors during the high school transition: Proximal outcomes in the Common Sense Parenting trial. *Journal of Child and Family Studies*, 24(9), 2568-2578. https://doi.org/10.1007/s10826-014-0059-5

[65] Note that positive child improvement was noted in the families in Trinidad and Tobago but the study did not utilize a comparison group but instead used a pre-test/posttest quasi-experimental design. See Jameson-Charles, M. & Hamlett, M. (2018). *Assessment of the Common Sense Parenting programme.* Boys Town, NE: Author.

[66] Note that positive parent improvement was noted in the families in Trinidad and Tobago but the study did not utilize a comparison group but instead used a pre-test/posttest quasi-experimental design. See Jameson-Charles, M. & Hamlett, M. (2018).

[67] Boys Town (2023). *Common Sense Parenting: Pre-Post Outcomes Reports for English and Spanish-Speaking Participants.* Boys Town, NE: Author.

[68] Secades-Villa, R., Garcia-Rodriguez, O., Garcia-Fernandez, G., Sanchez-Hervas, E., Fernandez-Hermida, J. R., & Higgins, S. T. (2011). Community Reinforcement Approach Plus Vouchers among cocaine-dependent outpatients: Twelve-month outcomes. *Psychology of Addictive Behaviors, 25*(1), 174-179. https://doi.org/10.1037/a0021451

[69] Grafsky et al. (2011).

[70] Myers, H. F., Alvy, K. T., Arrington, A., Richardson, M. A., Marigna, M., Huff, R., Main, M., & 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. https://doi.org/10.1002/1520-6629(199204)20:2%3C132::AID-JCOP2290200204%3E3.0.CO;2-Z

[71] The length of EMDR treatment must include at least two sessions but depends on the specific problem and client history (e.g., the number of traumas, the age when trauma was experienced, the age of symptom onset). The clinician and client mutually determine the frequency of sessions.

[72] For EMDR international research studies, see, for example:

- Ahmad, A., Larsson, B., & Sundelin-Wahlstein, V. (2007). EMDR treatment for children with PTSD: Results of a randomized controlled trial. *Nordic Journal of Psychiatry, 61*(5), 349-354.

- Fernandez, I., Gallinari, E., & Lorenzetti, A. (2004). A school-based EMDR intervention for children who witnessed the Pirelli building airplane crash in Milan, Italy. *Journal of Brief Therapy, 2,* 129-136.
- Jaberghaderi, N., Greenwald, R., Rubin, A., Dolatabadim S., & Zand, S. O. (2004). A comparison of CBT and EMDR for sexually abused Iranian girls. *Clinical Psychology and Psychotherapy, 11*(5), 358-368.
- Kemp, M., Drummond, P., & McDermott, B. (2010). A wait-list controlled pilot study of Eye Movement Desensitization and Reprocessing (EMDR) for children with post-traumatic stress disorder (PTSD) symptoms from motor vehicle accidents. *Clinical Child Psychology & Psychiatry, 15*(1), 5-25.
- Roos, C., Greenwald, R., Hollander-Gusman, M., Noorthoorn, E., Buuren, S., & Jongh, A. (2011). A randomised comparison of cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR) in disaster-exposed children. *European Journal of Psychotraumatology, North America, 2.* https://doi.org/10.3402/ejpt.v2i0.5694 (Published on-line with no page numbers.)

[73] 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. http://dx.doi.org/10.1016/j.jsp.2004.08.001

[74] Parents reported statistically significant improvements in these areas but note this was for the FAST intervention focused on parents. See McDonald L, Coover G, Sandler J, Thao T, Shalhoub H. Cultural adaptation of an evidence-based parenting programme with elders from South East Asia in the US: co-producing Families and Schools Together - FAST. *Journal of Children's Services* 2012;7(2):113-27. [DOI: 10.1108/17466661211238673]

[75] McDonald, L., Moberg, D. P., Brown, R., Rodriguez-Espiricueta, I., Flores, N. I., Burke, M. P., & Coover, G. (2006). After-school multifamily groups: A randomized controlled trial involving low-income, urban, Latino children. *Children & Schools*, 28(1), 25-34. https://doi-org.ezproxy.lib.uconn.edu/10.1093/cs/28.1.25

[76] Gamoran, A., Turley, R. N., Turner, A., & Fish, R. (2012). Differences between Hispanic and Non-Hispanic families in social capital and child development: First-year findings from an experimental study. *Research in Social Stratification and Mobility*, *30*(1), 97–112. https://doi.org/10.1016/j.rssm.2011.08.001 See pages 106 and 108.

[77] Note this was more of a qualitative study of parent perceptions using interviews and focus groups: Shoji, M.N., Haskins, A.R., Rangel, D.E., Sorensen, K.N. (2014). The emergence of social capital in low-income Latino elementary schools. *Early Childhood Research Quarterly,* 29(4):600-613. doi: 10.1016/j.ecresq.2014.07.003. PMID: 25246729; PMCID: PMC4169003.

[78] For child effects, see:

- Pantin, H., Prado, G., Lopez, B., Huang, S., Tapia, M. I., Schwartz, S. J., Sabillon, E., Brown, C. H., & Branchini, J. (2009). A randomized controlled trial of Familias Unidas for Hispanic adolescents with behavior problems. *Psychosomatic Medicine*, *71*(9), 987–995. https://doi.org/10.1097/PSY.0b013e3181bb2913;
- Estrada, Y., Lee, T. K., Huang, S., Tapia, M. I., Velazquez, M.-R., Martinez, M. J., Pantin, H., Ocasio, M. A., Vidot, D. C., Molleda, L., Villamar, J., Stepanenko, B. A., Brown, C. H., & Prado, G. (2017). Parent-centered prevention of risky behaviors among hispanic youths in Florida. *American Journal of Public Health*, 107(4), 607-613. https://doi.org/10.2105/AJPH.2017.303653

[79] Pantin et al. (2009); Estrada et al. (2017)

[80] Pantin et al. (2009); Estrada et al. (2017)

[81] Lee, T. K., Estrada, Y., Soares, M. H., Sanchez Ahumada, M., Correa Molina, M., Bahamon, M. M., & Prado, G. (2019). Efficacy of a family-based intervention on parent-adolescent discrepancies in positive parenting and substance use among Hispanic youth. *Journal of Adolescent Health*, 64(4), 494-501. https://doi.org/10.1016/j.jadohealth.2018.10.002.

[82] Ocasio et al. (2022)

[83] See page 18 in Hess, J. Z., Arner, W., Sykes, E., Price, A. G., & Tanana, M. (2012). Helping juvenile offenders on their own "turf": Tracking the recidivism outcomes of a home-based paraprofessional intervention. *OJJDP Journal of Juvenile Justice*, 2(1), 12-24. https://s35598.pcdn.co/wp-content/uploads/2020/05/3Hess_Study.pdf There is some preliminary evidence that Families First (Utah Villages Model) is also effective for Black youth. In one study about 28 youth were Black in the treatment sample (N= 415) but the outcomes for them are not reported separately. See West, K., Shuppy, L., & Broadbent, M. (2021). *The Families First program impact on child maltreatment: Final evaluation report.* Social Research Institute, College of Social Work, University of Utah. https://youthvillage.org/wp-content/uploads/2021/04/Families-FIrst-Program-Impact.pdf

[84] Dishion, T. J., Shaw, D., Connell, A., Gardner, F., Weaver, C., & Wilson, M. (2008). The Family Check-Up with high-risk indigent families: Preventing problem behavior by increasing parents' positive behavior support in early childhood. *Child Development, 79*(5), 1395-1414. http://dx.doi.org/10.1111/j.1467-8624.2008.01195.x Also see Shaw, D. S., Sitnick, S. L., Brennan, L. M., Choe, D. E., Dishion, T. J., Wilson, M. N., & Gardner, F. (2015). The long-term effectiveness of the Family Check-Up on school-age conduct problems: Moderation by neighborhood deprivation. *Development and Psychopathology, 28*, 1471-1486. doi:10.1017/S0954579415001212 [NOTE: Sample size was sufficient but the results were not disaggregated by race.]

[85] Dishion et al. (2008); Shaw et al. (2015). [NOTE: Sample size was sufficient but the results were not disaggregated by race.]

[86] For child effects, see A., Mullany, B., Neault, N., Compton, S., Carter, A., Hastings, R., Billy, T., Coho-Mescal, V., Lorenzo, S., & Walkup, J. T. (2013). Effect of a paraprofessional home-visiting intervention on American Indian teen mothers' and infants' behavioral risks: A randomized controlled trial. *The American Journal of Psychiatry*, *170*(1), 83-93. https://doi.org/10.1176/appi.ajp.2012.12010121

[87] For parent caregiver emotional well-being, see:

- Barlow et al. (2013).
- Barlow, A., Mullany, B., Neault, N., Goklish, N., Billy, T., Hastings, R., Lorenzo, S., Kee, C., Lake, K., Redmond, C., Carter, A., & Walkup, J. T. (2015). Paraprofessional-delivered home-visiting intervention for American Indian teen mothers and children: 3-year outcomes from a randomized controlled trial. *The American Journal of Psychiatry*, *172*(2), 154-162. https://doi.org/10.1176/appi.ajp.2014.14030332

[88] For parent substance abuse, see Barlow et al. (2013) and Barlow et al. (2015).

[89] Preston, M. S. (2021a). *Foster Kinship Navigator Program: A two-study mixed-method evaluation project.* Preston Management and Organizational Consulting. https://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Programs/CWS/Foster_Care/Last_Revised_Study_2_-_Report_2-2021_Updated_12-2022.pdf

[90] Preston, M. S. (2021b). *Foster Kinship Navigator Program: An outcome evaluation.* Preston Management and Organizational Consulting. https://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Programs/CWS/Foster_Care/Last_Revised_Draft_Study_3_Report_9-2021_Updated_12-2022.pdf

[91] Preston, M. S. (2021a).

[92] Preston, M. S. (2021b).

[93] Preston, M. S. (2021a).

[94] Preston, M. S. (2021b).

[95] Preston, M. S. (2021a).

[96] Preston, M. S. (2021b).

[97] Each Fostering Healthy Futures group session includes 1 hour of skill-building and a 30-minute dinner. Mentors meet individually with children.

[98] Taussig, H. N., Weiler, L. M., Garrido, E. F., Rhodes, T., Boat, A., & Fadell, M. (2019). A Positive Youth Development Approach to Improving Mental Health Outcomes for Maltreated Children in Foster Care: Replication and Extension of an RCT of the Fostering Healthy Futures Program. *American Journal of Community Psychology*, *64*(3-4), 405–417. https://doi.org/10.1002/ajcp.12385 Note that the researchers examined whether being Hispanic (n = 219; over half of the sample) or Black (n= 120) moderated the impact of the intervention on mental health outcomes. Neither racial/ethnic group moderated the impact of the intervention.

[99] Taussig et al. (2019). Note that the researchers examined whether being Hispanic (n = 219; over half of the sample) or Black (n= 120) moderated the impact of the intervention on mental health outcomes. Neither racial/ethnic group moderated the impact of the intervention.

[100] Specific youth outcomes may vary by study:

- Celinska, K., Sung, H. E., Kim, C., & Valdimarsdottir, M.. (2019). An outcome evaluation of Functional Family Therapy for court-involved youth. Journal of Family Therapy, 41(2), 251-276. [NOTE: Sample size sufficient but results not disaggregated by race.]
- Dunham, J. B. (2009). *Examining the effectiveness of functional family therapy across diverse client ethnic groups* (Order No. 3380076). Available from ProQuest Dissertations & Theses Global. (304902868). Retrieved from https://search.proquest.com/dissertations-theses/examining-effectiveness-functional-family-therapy/docview/304902868/se-2?accountid=14784
- Gottfredson, D. C., Kearley, B., Thornberry, T. P., Slothower, M., Devlin, D., & Fader, J. J. (2018). Scaling-Up Evidence-Based Programs Using a Public Funding Stream: a Randomized Trial of Functional Family Therapy for Court-Involved Youth. *Prevention science: the official journal of the Society for Prevention Research*, *19*(7), 939–953. https://doi.org/10.1007/s11121-018-0936-z Note that the sample in this study was predominately African American, however, analyses were not reported for subgroups.
- Thornberry, T.P., Kearley, B., Gottfredson, D.C., Slothower, M., Devlin, D. & Fader J.J. (2018). Reducing crime among youth at risk for gang involvement - A randomized trial. *Criminology and Public Policy*, 17(4), 953-989.

[101] Gan, D.Z.Q., Zhou, Y., binte Abdul Wahab, N.D., Ruby, K., & Hoo, E. (2021). Effectiveness of functional family therapy in a non-Western context: Findings from a randomized-controlled evaluation of youth offenders in Singapore. *Family Process*, 60, 1170–1184. 10.1111/famp.12630 - DOI

[102] Dunham, J. B. (2009).

[103] Gan et al. (2021).

[104] DuMont, K., Mitchell-Herzfeld, S., Greene, R., Lee, E., Lowenfels, A., Rodriguez, M., & Dorabawila, V. (2008). Healthy Families New York (HFNY) randomized trial: Effects on early child abuse and neglect. *Child Abuse & Neglect, 32*(3), 295-315. https://doi.org/10.1016/j.chiabu.2007.07.007 [Sample size sufficient but results not disaggregated by race.]

[105] See:

- Easterbrooks, M. A., Kotake, C., & Fauth, R. (2019). Recurrence of maltreatment after newborn home visiting: A randomized controlled trial. *American Journal of Public Health*, *109*(5), 729-735. https://doi.org/10.2105/AJPH.2019.304957. [NOTE: Sample size sufficient but results not disaggregated by race.]
- Lee, E., Kirkland, K., Miranda-Julian, C., Greene, R. (2018). Reducing maltreatment recurrence through home visitation: A promising intervention for child welfare involved families. *Child Abuse and Neglect, 86*, 55-66. [NOTE: Sample size sufficient but results not disaggregated by race.]

[106] Duggan, A., McFarlane, E., Fuddy, L., Burrell, L., Higman, S. M., Windham, A., & Sia, C. (2004). Randomized trial of a statewide home visiting program: impact in preventing child abuse and neglect. *Child Abuse & Neglect*, *28*(6),

597-622. https://doi.org/10.1016/j.chiabu.2003.08.007 [NOTE: Only the child's maternal demographics reported. Sample size sufficient but results not disaggregated by race.]

[107] Duggan et al. (2004). [NOTE: Only the child's maternal demographics reported. Sample size sufficient but results not disaggregated by race.]

[108] See:

- Easterbrooks et al (2014). [NOTE: Sample size was sufficient but the results were not disaggregated by race.]
- LeCroy, C. W., & Lopez, D. (2020). A randomized controlled trial of Healthy Families: 6-month and 1-year follow-up. *Prevention Science*, *21*, 25-35.
- Lee et al. (2018).

[109] LeCroy, C. & Krysik, J. (2011). Randomized trial of the Healthy Families Arizona home visiting program. *Children and Youth Services Review,* 33, 1761-1766.

[110] Kirkland, K., & Mitchell-Herzfeld, S. (2012). *Evaluating the effectiveness of home visiting services in promoting children's adjustment in school. Final report to Pew Center on the States.* https://www.pewtrusts.org/-/media/legacy/uploadedfiles/pcs_assets/2013/schoolreadinessreportpdf.pdf Also see Kirkland, K. (2013). Effectiveness of home visiting as a strategy for promoting children's adjustment to school. *Zero to Three*, *33*(3), 31-37. [NOTE: Race not reported, same sample as Kirkland (2012).]

[111] Lee, E., Mitchell-Herzfeld, S., Lowenfels, A. A., Greene, R., Dorabawila, V., & DuMont, K. A. (2009). Reducing low birth weight through home visitation: A randomized controlled trial. *American Journal of Preventive Medicine*, *36*(2), 154-160. doi:10.1016/j.amepre.2008.09.029

[112] Caldera, D., Burrell, L., Rodriguez, K., Crowne, S. S., Rohde, C., & Duggan, A. (2007). Impact of a statewide home visiting program on parenting and on child health and development. *Child Abuse & Neglect*, *31*(8), 829-852. https://doi.org/10.1016/j.chiabu.2007.02.008 [NOTE: Only the child's maternal demographics reported. Sample size sufficient but results not disaggregated by race.]

[113] Green, B., Sanders, M. B., & Tarte, J. M. (2020). Effects of home visiting program implementation on preventive health care access and utilization: Results from a randomized trial of Healthy Families Oregon. *Prevention Science*, *21*(1), 15-24. https://doi.org/10.1007/s11121-018-0964-8 [NOTE: Sample size sufficient but the results were not disaggregated by race.]

[114] Green, et al. (2020). [NOTE: Sample size sufficient but the results were not disaggregated by race.]

[115] Kirkland, K., & Mitchell-Herzfield, S. (2012). Also see Kirkland, K. (2013).

[116] LeCroy, C. W., & Lopez, D. (2020). A randomized controlled trial of Healthy Families: 6-month and 1-year follow-up. *Prevention Science, 21*, 25-35.

[117] Green et al. (2020). [NOTE: Sample size was sufficient, but the results were not disaggregated by race.]

[118] DuMont, K., Mitchell-Herzfeld, S., Greene, R., Lee, E., Lowenfels, A., Rodriguez, M., & Dorabawila, V. (2008). Healthy Families New York (HFNY) randomized trial: Effects on early child abuse and neglect. *Child Abuse & Neglect, 32*(3), 295-315. https://doi.org/10.1016/j.chiabu.2007.07.007 [Sample size was sufficient, but the results were not disaggregated by race.]

[119] Duggan, A. K., McFarlane, E. C., Windham, A. M., Rohde, C. A., Salkever, D. S., Fuddy, L., et al. (1999). Evaluation of Hawaii's Healthy Start program. *Future of Children*, 9(1), 66-90; discussion 177–178.

[120] Green, B. L., Tarte, J., Harrison, P. M., Nygren, M., & Sanders, M. B. (2014). Results from a randomized trial of the Healthy Families Oregon accredited statewide program: Early program impacts on parenting. *Children and Youth Services Review*, 44, 288-298. [NOTE: Sample size was sufficient but the results were not disaggregated by race.] Also see LeCroy, C. W., & Davis, M. F. (2016). Randomized trial of Healthy Families Arizona: Quantitative and qualitative outcomes. *Research on Social Work Practice, 33,* 1761-1766.

[121] LeCroy, C. W., & Krysik, J. (2011). This reference contains elements of a different reference immediately above. Something is off.

[122] Green et al. (2014). Results from a randomized trial of the Healthy Families Oregon accredited statewide program: Early program impacts on parenting. *Children and Youth Services Review*, *44*, 288-298. [NOTE: Sample size was sufficient, but the results were not disaggregated by race.] Also see LeCroy, C. W., & Lopez, D. (2020). A randomized controlled trial of Healthy Families: 6-month and 1-year follow-up. *Prevention Science*, *21,* 25-35.

[123] Berry, M., Propp, J., & Martens, P. (2007). The use of intensive family preservation services with adoptive families. *Child & Family Social Work, 12*(1), 43-53. In addition, the Family Enhancement Program—a modified version of the Homebuilders Program— has also found it to be effective with African American families. They initially provided intensive family preservation and support services for four to six weeks, with an optional 90-day aftercare period. Then later, the intervention period was expanded to a four- to eight-week period. Services are family-oriented, either in-home or in the Albina community, and include a combination of treatment modalities, such as individual treatment, groups, parenting education, basic survival skills, or other services as needed to keep target children at home. See Ciliberti, P. (1998). An innovative family preservation program in an African American community: Longitudinal analysis, *Journal of Family Strengths*, *3*(2), Article 6. https://digitalcommons.library.tmc.edu/jfs/vol3/iss2/6

[124] Behavioral Sciences Institute (Evaluation summary in preparation).

[125] See:

- Reid, M. J., Webster-Stratton, C., & Beauchaine, T. P. (2001). Parent training in Head Start: A comparison of program response among African American, Asian American, Caucasian, and Hispanic mothers. *Prevention Science, 2*(4), 209-227. Note that overall there was a significant intervention effect but the researchers could not separate out the impact by ethnic group because of small sample sizes – even though there appeared to be over 30 cases for African-American, Asian and Latino children.
- Scott, S., O'Connor, T. G., Futh, A., Matias, C., Price, J., & Doolan, M. (2010). Impact of a parenting program in a high-risk, multi-ethnic community: The PALS trial. *Journal of Child Psychology and Psychiatry, and Allied Disciplines*, *51*(12), 1331–1341. https://doi.org/10.1111/j.1469-7610.2010.02302.x

[126] See:

- Clark, H. B., Prange, M. E., Lee, B., Boyd, L. A., McDonald, B. A., & Stewart, E. S. (1994). Improving adjustment outcomes for foster children with emotional and behavioral disorders: Early findings from a controlled study on individualized services. *Journal of Emotional and Behavioral Disorders*, 2(4), 207-218. https://doi.org/10.1177/106342669400200403
- Cohen, E., Ferguson, C., Berzin, S., Thomas, K., Lorentzen, B., & Dawson, W. (2004). *California's title IV-E child welfare waiver demonstration project evaluation: Final report.* University of California, Berkeley, School of Social Welfare, Child Welfare Research Center.

[127] Clark et al. (1994) and Cohen et al., (2004).

[128] Huhr, S., & Wulczyn, F. (2020a). *Do intensive in-home services prevent placement? A case study of Youth Villages' Intercept® program.* The Center for State Child Welfare Data. https://fcda.chapinhall.org/wp-content/uploads/2019/10/YV-Intercept-Results-1-8-2020-final.pdf [NOTE: Sample size sufficient but results not disaggregated by race; study authors noted that Intercept has a positive effect on permanency rates for Black children.]

[129] Huhr, S., & Wulczyn, F. (2020b). *Do intensive in-home services promote permanency? A case study of Youth Villages' Intercept® program.* The Center for State Child Welfare Data. https://fcda.chapinhall.org/wp-content/uploads/2020/09/Permanency-YVIntercept-final-982020.pdf [NOTE: Sample size sufficient but results not disaggregated by race.]

[130] Toth, S. L., Rogosch, F. A., Oshri, A., Gravener-Davis, J., Sturm, R., & Morgan-Lopez, A. A. (2013). The efficacy of Interpersonal Psychotherapy for depression among economically disadvantaged mothers. *Development and*

Psychopathology, 25(4), 1065-1078. https://doi.org/10.1017/S0954579413000370 [NOTE: Sample size sufficient but results not disaggregated by race.]

[131] Bolton, P., Bass, J., Neugebauer, R., Verdeli, H., Clougherty, K. F., Wickramaratne, P., Speelman, L., Ndogoni, L., & Weissman, M. (2003). Group interpersonal psychotherapy for depression in rural Uganda: A randomized controlled trial. *JAMA*, *289*(23), 3117-3124. https://doi.org/10.1001/jama.289.23.3117 [NOTE: Study does not specify whether adult participants are parents/caregivers.]

[132] For international adaptations for low-income countries for Interpersonal Therapy, see:

- Ravitz, P., Watson, P., Lawson, A., Constantino, M.J., NBernecker, S., Park, J. & Swartz, H.A. (2019). Interpersonal Psychotherapy: A scoping review and historical perspective (1974-2017). *Harvard Review of Psychiatry, 27*(3), 165-180. doi: 20.1097/HRP.0000000000000219.
- Weissman, M. R. (undated). *Interpersonal Psychotherapy: The global reach.* (PowerPoint slide deck)New York City: Columbia University, Vagelos College of Physicians and Surgeons.
- Weissman, M. R. (2021). IPT: From humble origins as "high contact therapy" to international success story. *Psychiatric News,* April, 30-31.

[133] See, for example:

- Mufson, L., Dorta, K. P., Wickramaratne, P., Nomura, Y., Olfson, M., & Weissman, M. M. (2004). A randomized effectiveness trial of Interpersonal Psychotherapy for depressed adolescents. *Archives of General Psychiatry, 61*(6), 577-584. https://doi.org/10.1001/archpsyc.61.6.577
- Mufson, L., Yanes-Lutkin, P., Gunlicks-Stoessel, M., & Wickramaratne, P. (2014). Cultural competency and its effect on treatment outcome of IPT-A in school-based health clinics. *American Journal of Psychotherapy, 68*(4), 417-442. https://doi.org/10.1176/appi.psychotherapy.2014.68.4.417
- Reyes-Portillo, J. A., McGlinchey, E. L., Yanes-Lukin, P. K., Turner, J. B., & Mufson, L. (2017). Mediators of Interpersonal Psychotherapy for depressed adolescents on outcomes in Latinos: The role of peer and family interpersonal functioning. *Journal of Latina/o Psychology, 5*(4), 248-260. https://doi.org/10.1037/lat0000096

[134] Chambers, J. M., Lint, S., Thompson, M. G., Carlson, M. W., & Graef, M. I. (2019). Outcomes of the Iowa Parent Partner program evaluation: Stability of reunification and re-entry into foster care. *Children and Youth Services Review*, *104* (2019), Article 104353. https://doi.org/10.1016/j.childyouth.2019.05.030. [NOTE: Sample size sufficient but results not disaggregated by race.]

[135] Note that buprenorphine has fewer interactions with other medications than methadone. Most importantly it can be administered outside of licensed opioid treatment programs and is therefore not limited to states and counties that have such programs. It also has fewer interactions with other prescribed medications and street drugs. (Personal Communication, Valerie Gruber, April 15, 2021). See, for example, Mattick et al. (2014). Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence.https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD002207.pub4/full?highlightAbstract=disord%7Cdisorder%7Cuse%7Copioid

[136] Zhang, Z., Friedmann, P. D., & Gerstein, D. R. (2003). Does retention matter? Treatment duration and improvement in drug use. *Addiction (Abingdon, England)*, *98*(5), 673-684. https://doi.org/10.1046/j.1360-0443.2003.00354.x. [NOTE: Sample size sufficient but results not disaggregated by race.] Also see Mattick et al. (2009). *Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence.* https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD002209.pub2/full?highlightAbstract=disord%7Cdisorder%7Cuse%7Copioid

[137] Mattick et al. (2009).

[138] Washington DC has been approved to also use Motivational Interviewing for case management, in addition to substance abuse.

[139] D'Amico, E. J., Parast, L., Shadel, W. G., Meredith, L. S., Seelam, R., & Stein, B. D. (2018). Brief Motivational Interviewing intervention to reduce alcohol and marijuana use for at-risk adolescents in primary care. *Journal of Consulting and Clinical Psychology, 86*(9), 775-786. doi: http://dx.doi.org/10.1037/ccp0000332. [NOTE: Sample size sufficient but results not disaggregated by race.]

[140] D'Amico et al. (2018). [NOTE: Sample size sufficient but results not disaggregated by race.]

[141] Bernstein, J., Bernstein, E., Tassiopoulos, K., Heeren, T., Levenson, S., & Hingson, R. (2005). Brief motivational intervention at a clinic visit reduces cocaine and heroin use. *Drug and Alcohol Dependence*, *77*(1), 49-59. https://doi.org/10.1016/j.drugalcdep.2004.07.006. [NOTE: Sample size sufficient but results not disaggregated by race.]

[142] *Motivational interviewing and culture for urban Native American youth (MICUNAY): A randomized controlled trial.* Retrieved from https://www.sciencedirect.com/science/article/pii/S0740547219302715?casa_token=oMRAo5ri4ioAAAAA:9knR2AayyNrcdl6HSX1SZEU_DPpx1xHcYy7L18n2g4L4TgLbgr9A-YCbowW7O-Le52ykeYwk1Q Also, see this article for how motivational interviewing was creatively combined with AI/An cultural practices: Dickerson, D. L., Brown, R. A., Johnson, C. L., Schweigman, K., & D'Amico, E. J. (2015). Integrating motivational interviewing and traditional practices to address alcohol and drug use among urban American Indian/Alaska Native youth. *Journal of Substance Abuse Treatment, 65,* 26-35. https://www.sciencedirect.com/science/article/pii/S0740547215001865?casa_token=ZQJSh_vJGC4AAAAA:RzMAro8qpzp2ggou8jhT5tk75Bq3ZHnWwIX5lm28JKLgE80wy_30_NOj9tB_ugTzJYHl2Jm7

[143] Field, C. A., Caetano, R., Harris, T. R., Frankowski, R., & Roudsari, B. (2010). Ethnic differences in drinking outcomes following a brief alcohol intervention in the trauma care setting. *Addiction, 105*(1), 62-73. doi: http://dx.doi.org/10.1111/j.1360-0443.2009.02737.x Also see Bernstein, J., Bernstein, E., Tassiopoulos, K., Heeren, T., Levenson, S., & Hingson, R. (2005). Brief motivational intervention at a clinic visit reduces cocaine and heroin use. *Drug and Alcohol Dependence*, *77*(1), 49-59. https://doi.org/10.1016/j.drugalcdep.2004.07.006. [NOTE: Sample size sufficient but results not disaggregated by race.]

[144] Stormshak, E. A., Seeley, J. R., Caruthers, A. S., Cardenas, L., Moore, K. J.,Tyler, M. S., Fleming,C. M., Jeff Gau, J., & Danaher, B. (2019). Evaluating the efficacy of the Family Check-Up Online: A school-based, eHealth model for the prevention of problem behavior during the middle school years. *Development and Psychopathology*, 1-14 doi:10.1017/S0954579419000907

[145] See, for example:

- *One-year outcomes of a drug abuse prevention program for older teens and emerging adults: Evaluating a motivational interviewing booster component.* Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3276711/
- *Examining the feasibility and acceptability of a motivational interviewing early intervention program to prevent high school dropout.* Retrieved from: https://academic.oup.com/cs/article-abstract/38/4/209/2236164
- Motivational interviewing and caregiver engagement in the Family Check-Up 4 Health. Retrieved from: https://link.springer.com/content/pdf/10.1007/s11121-020-01112-8.pdf
- *Effectiveness of Motivational Interviewing: Enhanced behavior therapy for adolescents with attention-deficit/hyperactivity disorder: A randomized …* Retrieved from: https://www.sciencedirect.com/science/article/pii/S0890856720313757?casa_token=Rz7fZasFAbEAAAAA:ep3aPo5KDVz4VKzQPx2VflfMgEXI1NLU4yeeOSYAWz6RN_sWdTb6qppEbANfr7RIXYbgZKU87Q
- Motivational Interviewing in ethnic populations. See https://link.springer.com/article/10.1007/s10903-019-00940-3

- Implementing parent-teen motivational interviewing+ behavior therapy for ADHD in community mental health. Retrieved from: https://link.springer.com/article/10.1007/s11121-020-01105-7

[146] See, for example:

- Finding the right approach for interventions with LGBTQ populations. Retrieved from: https://books.google.com/books?hl=en&lr=&id=Kgb5DwAAQBAJ&oi=fnd&pg=PA204&dq=motivational+interviewing+lgbtq&ots=OMMoqxKb7L&sig=LhnJTGQq2CKZgv7U1LLFqURqgx8#v=onepage&q=motivational%20interviewing%20lgbtq&f=false
- Motivational interviewing with personalized feedback to reduce alcohol use in HIV-infected men who have sex with men: A randomized controlled trial. Retrieved from: https://psycnet.apa.org/record/2018-35470-001
- Training young adult peers in a mobile Motivational Interviewing-based mentoring approach to upstream HIV prevention. Retrieved from: https://onlinelibrary.wiley.com/doi/pdf/10.1002/ajcp.12471?casa_token=DlCMJkR9QyoAAAAA:CFwEK_VrU4F7-Fb53NwLo_rpW0ZEPlccV7tdURjbVxuN9c8LV15r2v_X3ckOjqHQMSJfowU2lkiJnjc
- Using Motivational Interviewing to support the coming-out process. Retrieved from: https://journals.sagepub.com/doi/pdf/10.1177/1044389419890522?casa_token=DmuaDzNNVXQAAAAA:BL89EPI7Z2FeEFbwjvnImjEIL0UsXw9MKlOW5OVi2shnXpwdoITE5Kyv-4f1d3s47kxDS22F95-c

[147] Liddle, H. A., Dakof, G. A., Henderson, C. E., & Rowe, C. L. (2011). Implementation outcomes of multidimensional family therapy-detention to community (DTC): A re-entry program for drug-using juvenile detainees. *International Journal of Offender Therapy and Comparative Criminology, 55*, 587-604. doi: 10.1177/0306624X10366960

[148] Liddle, H. A., Rowe, C. L., Dakof, G. A., Henderson, C. E., & Greenbaum, P. E. (2009). Multidimensional family therapy for young adolescent substance abuse: Twelve-month outcomes of a randomized controlled trial. *Journal of Consulting and Clinical Psychology,* 77(1), 12-25. https://doi.org/10.1037/a0014160. [NOTE: Sample size sufficient but results not disaggregated by race.]

[149] Nielson, P., Christensen, M., Henderson, C., Liddle, H. A., Croquette-Krokar, M., Favez, N., & Riger, H. (In press). Multidimensional family therapy reduces problematic gaming in adolescents: A randomized controlled trial. *Journal of Behavioral Addictions* Incomplete reference.

[150] Dakof, G. A., Henderson, C. S., Rowe, C. L, Boustani, M., Greenbaum, P., Wang, W., Hawes, S., Linares, C., & Liddle, H. A. (2015). A randomized controlled trial of multidimensional family therapy in juvenile drug court. *Journal of Family Psychology, 29*, 232-241. doi: 10.1037/fam0000053

[151] See:

- Dakof, G. A., Henderson, C. S., Rowe, C. L, Boustani, M., Greenbaum, P., Wang, W., Hawes, S., Linares, C., & Liddle, H. A. (2015). A randomized controlled trial of multidimensional family therapy in juvenile drug court. *Journal of Family Psychology, 29*, 232-241. doi: 10.1037/fam0000053
- Dennis, M., Godley, S. H., Diamond, G., Tims, F. M, Babor, T., Donaldson, J., Liddle, H., Titus, J. C., Kaminer, Y., Webb, C., Hamilton, N., & Funk, R. (2004). The Cannabis Youth Treatment (CYT) Study: Main findings from two randomized trials. *Journal of Substance Abuse Treatment, 27*(3), 197-213. [NOTE: Sample size sufficient but results not disaggregated by race.]
- Liddle, H. A., Dakof, G. A., Parker, K., Diamond, G. S., Barrett, K., & Tejeda, M. (2001). Multidimensional Family Therapy for adolescent drug abuse: Results of a randomized clinical trial. *American Journal of Drug and Alcohol Abuse*, *27*(4), 651-688.
- Liddle, H. A., Dakof, G. A., Turner, T. M., Henderson, C. E., Greenbaum, P. E. (2008). Treating adolescent drug abuse: A randomized trial comparing multidimensional family therapy and cognitive behavior therapy. *Addiction, 103*, 1660-1670. doi: 10.1111/j.1360-0443.2008.02274.x
- Liddle, H. A., Rowe, C. L., Dakof, G. A., Ungaro, R. A., & Henderson, C. E. (2004). Early intervention for adolescent substance abuse: Pretreatment to posttreatment outcomes of a randomized clinical trial comparing

multidimensional family therapy and peer group treatment. *Journal of Psychoactive Drugs, 36*, 49-63. doi: 10.1080/02791072.2004.10399723

- Liddle, H. A., Rowe, C. L., Dakof, G. A., Henderson, C., & Greenbaum, P. (2009). Multidimensional Family Therapy for early adolescent substance abusers: Twelve-month outcomes of a randomized controlled trial. *Journal of Consulting and Clinical Psychology, 77*, 12-25. doi: 10.1037/a0014160
- *Cannabis use with African-American children*: Dennis, M., Godley, S. H., Diamond, G., Tims, F. M., Babor, T., Donaldson, J., Funk, R. (2004). The Cannabis Youth Treatment (CYT) study: Main findings from two randomized trials. *Journal of Substance Abuse Treatment, 27*, 197-213. doi: 10.1016/j.jsat.2003.09.005

[152] Note that 40% of participants were of foreign descent, but no race/ethnicity breakdown was available. For additional research see:

- Rowe, C. L., Rigter, H., Henderson, C., Gantner, A., Mos, K., Nielson, P., Phan, O. (2013). Implementation fidelity of Multidimensional Family Therapy in an international trial. *Journal of Substance Abuse Treatment, 44*, 391-399. doi: 10.1016/j.jsat.2012.08.225
- Cannabis dependence: Rigter, H., Henderson, C. E., Pelc, I., Tossmann, P., Phan, O., Hendriks, V., Rowe, C. L. (2013). Multidimensional family therapy lowers the rate of cannabis dependence in adolescents: A randomised controlled trial in Western European outpatient settings. *Drug and Alcohol Dependence, 130*, 85-93. doi: 10.1016/j.drugalcdep.2012.10.013

[153] Liddle, H. A., Dakof, G. A., Henderson, C. E., & Rowe, C. L. (2011). Implementation outcomes of multidimensional family therapy-detention to community (DTC): A re-entry program for drug-using juvenile detainees. *International Journal of Offender Therapy and Comparative Criminology, 55*, 587-604. doi: 10.1177/0306624X10366960

[154] Liddle et al., 2009 [NOTE: Sample size sufficient but results not disaggregated by race.]

[155] Nielson, P., Christensen, M., Henderson, C., Liddle, H. A., Croquette-Krokar, M., Favez, N., & Riger, H. (In press). Multidimensional family therapy reduces problematic gaming in adolescents: A randomized controlled trial. *Journal of Behavioral Addictions* Incomplete

[156] Hogue, A., Liddle, H. A., Becker, D., & Johnson-Leckrone, J. (2002). Family-based prevention counseling for high-risk young adolescents: Immediate outcomes. *Journal of Community Psychology. 30*(1), 1 -22. doi: doi.org/10.1002/jcop.1047

[157] Dakof et al. (2015).

[158] See:

- Dakof et al. (2015).
- Liddle, H. A., Rowe, C. L., Dakof, G. A., Henderson, C. E., & Greenbaum, P. E. (2009). Multidimensional Family Therapy for young adolescent substance abuse: Twelve-month outcomes of a randomized controlled trial. *Journal of Consulting and Clinical Psychology, 77*(1), 12-25. https://doi.org/10.1037/a0014160. [NOTE: Sample size sufficient but results not disaggregated by race.]
- Liddle, H. A., Rowe, C. L., Gonzalez, A., Henderson, C. E., Dakof, G. A., & Greenbaum, P.E. (2006). Changing provider practices, program environment and improving outcomes by transporting Multidimensional Family Therapy to an adolescent drug treatment setting. *The American Journal of Addictions, 15*, 102-112. doi: 10.1080/10550490601003698

[159] Liddle et al., (2009). [NOTE: Adult race/ethnicity not reported and based on adolescent sample. The adolescent sample size was sufficient but the results were not disaggregated by race. Family functioning was self-reported by adolescents, not the adults.]

[160] Henderson, C. E., Rowe, C. L., Dakof, G. A., Hawes, S. W., & Liddle, H. A. (2009). Parenting practices as mediators of treatment effects in an early-intervention trial of multidimensional family therapy. *The American Journal of Drug and Alcohol Abuse*, *35*(4), 220–226. https://doi.org/10.1080/00952990903005890. [NOTE: Adult race/ethnicity was not reported and is based on adolescent reports. The adolescent sample size was sufficient,

but the results were not disaggregated by race. Family functioning was self-reported by adolescents, not the adults.]

[161] See:

- Liddle et al. (2004).
- Liddle et al. (2009). [NOTE: Adult race/ethnicity was not reported and is based on adolescent sample. The adolescent sample size was sufficient, but the results were not disaggregated by race. Family functioning was self-reported by adolescents, not by adults.]

[162] Henderson et al. (2009). [NOTE: Adult race/ethnicity was not reported and is based on adolescent reports. The adolescent sample size was sufficient, but the results were not disaggregated by race. Family functioning was self-reported by adolescents, not by adults.]

[163] Letourneau, E. J., Henggeler, S. W., Borduin, C. M., Schewe, P. A., McCart, M. R., Chapman, J. E., & Saldana, L. (2009). Multisystemic therapy for juvenile sexual offenders: 1-year results from a randomized effectiveness trial. *Journal of Family Psychology, 23*(1), 89-102. [NOTE: Sample size was sufficient but the results were not disaggregated by race.]

[164] Letourneau et al. (2009). [NOTE: Sample size was sufficient but the results were not disaggregated by race.]

[165] See:

- Pina, A.A., Polo, A.J. &. Huey, S.J. (2019) Evidence-Based psychosocial interventions for ethnic minority youth: The 10-year update, *Journal of Clinical Child & Adolescent Psychology*, 48:2, 179-202, DOI: 10.1080/15374416.2019.1567350
- Scherer, D. G., Brondino, M. J., Henggeler, S. W., Melton, G. B., & Hanley, J. H. (1994). Multisystemic Family Preservation Therapy: Preliminary findings from a study of rural and minority serious adolescent offenders. *Journal of Emotional and Behavioral Disorders, 2*(4), 198-206. DOI: http://dx.doi.org/10.1177/106342669400200402. [NOTE: Sample size was sufficient, but the results were not disaggregated by race for the Scherer et al. study.]

[166] Henggeler, S. W., Melton, G. B., Brondino, M. J., Scherer, D. G., & Hanley, J. H. (1997). Multisystemic therapy with violent and chronic juvenile offenders and their families: The role of treatment fidelity in successful dissemination. *Journal of Consulting and Clinical Psychology, 65*, 821-833. [NOTE: Sample size was sufficient but the results were not disaggregated by race.]

[167] Halliday-Boykins, C.A., Schoenwald, S.K., & Letourneau, E.J. (2005). Caregiver-therapist ethnic similarity predicts youth outcomes from an empirically based treatment. *Journal of Consulting and Clinical Psychology*, 73, 808 – 818. Also see Letourneau et al. (2009). NOTE: Sample size was sufficient but the results were not disaggregated by race.]

[168] Fain, T., Greathouse, S. M., Turner, S. F., & Weinberg, H. D. (2014). Effectiveness of multisystemic therapy for minority youth: Outcomes over 8 years in Los Angeles County. OJJDP *Journal of Juvenile Justice*, 3, 24 – 37.

[169] Huey, S. J., Henggeler, S. W., Rowland, M. D., Halliday-Boykins, C. A., Cunningham, P. B., Pickrel, S. G., & Edwards, J. (2004). Multisystemic therapy effects on attempted suicide by youths presenting psychiatric emergencies. *Journal of the American Academy of Child & Adolescent Psychiatry,* 43(2), 183–190. doi: 10.1097/00004583-200402000-00014

[170] Carcone, A. I., MacDonell, K. E., Naar-King, S., Ellis, D. E., Cunningham, P. B., & Kaljee, L. (2011). Treatment engagement in a weight-loss intervention for African-American adolescents and their families. Children's Health Care, 40, 1– 21.

[171] Halliday-Boykins et al., (2005)..

[172] Fain, T., Greathouse, S. M., Turner, S. F., & Weinberg, H. D. (2014). Effectiveness of multisystemic therapy for minority youth: Outcomes over 8 years in Los Angeles County. OJJDP *Journal of Juvenile Justice*, 3, 24 – 37. Also see Letourneau et al. (2009). [NOTE: Sample size sufficient but results not disaggregated by race.]

[173] Fain et al. (2014).

[174] Keles, S., Taraldsen, K., & Olseth, A. R. (2021). Identification of multisystemic therapy (MST) subgroups with distinct trajectories on ultimate outcomes in Norway. *Research on Child and Adolescent Psychopathology*, 49, 429-442. doi.org/10.1007/s10802-020-00735-3

[175] Scherer, D. G., Brondino, M. J., Henggeler, S. W., Melton, G. B., & Hanley, J. H. (1994). Multisystemic Family Preservation Therapy: Preliminary findings from a study of rural and minority serious adolescent offenders. *Journal of Emotional and Behavioral Disorders, 2*(4), 198-206. doi: http://dx.doi.org/10.1177/106342669400200402. [NOTE: Sample size sufficient but results not disaggregated by race.]

[176] See:

- Ertl, V., Pfeiffer, A., Schauer, E., Elbert, T., & Neuner, F. (2011). Community-implemented trauma therapy for former child soldiers in Northern Uganda: A randomized controlled trial. *JAMA*, 306(5), 503-512. https://doi.org/10.1001/jama.2011.1060
- Kangaslampi, S., Garoff, F., & Peltonen, K. (2015). Narrative Exposure Therapy for immigrant children traumatized by war: Study protocol for a randomized controlled trial of effectiveness and mechanisms of change. *BMC Psychiatry*, 15, Article 127. https://doi.org/10.1186/s12888-015-0520-z
- Kangaslampi, S., & Peltonen, K. (2019). Changes in traumatic memories and posttraumatic cognitions associate with PTSD symptom improvement in treatment of multiply traumatized children and adolescents. *Journal of Child & Adolescent Trauma*, 13(1), 103-112. https://doi.org/10.1007/s40653-019-00255-3
- Peltonen, K., & Kangaslampi, S. (2019). Treating children and adolescents with multiple traumas: A randomized clinical trial of Narrative Exposure Therapy. *European Journal of Psychotraumatology*, 10(1), Article 1558708. https://doi.org/10.1080/20008198.2018.1558708

[177] Fan, Y., Shi, Y., Zhang, J., Sun, D., Wang, X., Fu, G., Mo, D., Wen, J., Xiao, X., & Kong, L. (2021). The effects of Narrative Exposure Therapy on COVID-19 patients with post-traumatic stress symptoms: A randomized controlled trial. *Journal of Affective Disorders*, 293, 141-147. https://doi.org/10.1016/j.jad.2021.06.019

[178] Fan et al. (2021).

[179] See for example:

- Jacob, N., Neuner, F., Maedl, A., Schaal, S., & Elbert, T. (2014). Dissemination of psychotherapy for trauma-spectrum disorders in resource-poor countries: A randomized controlled trial in Rwanda. *Psychotherapy and Psychosomatics, 83*(6), 354–363. https://doi.org/10.1159/000365114
- Neuner, F., Onyut, P. L., Ertl, V., Odenwald, M., Schauer, E., & Elbert, T. (2008). Treatment of posttraumatic stress disorder by trained lay counselors in an African refugee settlement: A randomized controlled trial. *Journal of Consulting and Clinical Psychology, 76*(4), 686–694. https://doi.org/10.1037/0022-006X.76.4.686
- Neuner, F., Schauer, M., Klaschik, C., Karunakara, U., & Elbert, T. (2004) A comparison of Narrative Exposure Therapy, supportive counseling, and psychoeducation for treating posttraumatic stress disorder in an African refugee settlement. *Journal of Consulting and Clinical Psychology, 72*(4), 579–587. https://doi.org/10.1037/0022-006X.72.4.579
- Orang, T., Ayoughi, S., Moran, J. K., Ghaffari, H., Mostafavi, S., Rasoulian, M., & Elbert, T. (2018). The efficacy of Narrative Exposure Therapy in a sample of Iranian women exposed to ongoing intimate partner violence—A randomized controlled trial. *Clinical Psychology & Psychotherapy*, 25(6), 827-841. https://doi.org/10.1002/cpp.2318

- Stenmark, H., Catani, C., Neuner, F., Elbert, T., & Holen, A. (2013). Treating PTSD in refugees and asylum seekers within the general health care system: A randomized controlled multicenter study. *Behaviour Research and Therapy,* 51(10), 641-647. https://doi.org/10.1016/j.brat.2013.07.002

[180] Orang et al. 2018.

[181] Olds, D. L., Robinson, J., Pettitt, L., Luckey, D. W., Holmberg, J., Ng, R. K., & Henderson, C. R. (2004). Effects of home visits by paraprofessionals and by nurses: Age 4 follow-up results of a randomized trial. *Pediatrics, 114*(6), 1560-1568. [NOTE: Adult sample race is reported but child sample race is not. Adult/child sample sizes sufficient but results not disaggregated by race.]

[182] Sidora-Arcoleo, K., Anson, E., Lorber, M., Cole, R., Olds, D., & Kitzman, H. (2010). Differential effects of a nurse home-visiting intervention on physically aggressive behavior in children. *Journal of Pediatric Nursing, 25*, 35-45. [NOTE: Sample size was sufficient, but the results were not disaggregated by race.]

[183] Olds et al. (2004). [NOTE: Adult sample race was reported but the child sample race was not. Adult/child sample sizes sufficient but the results were not disaggregated by race.]

[184] Olds et al. (2004). [NOTE: Sample size was sufficient, but the results were not disaggregated by race.]

[185] Oldset al. (2004). [NOTE: Sample size was sufficient, but the results were not disaggregated by race.]

[186] For child effects, see:

- Wheeler, C. B., Newton-Curtis, L., Forehand, G., Oliver, S., Mendoza, G., Hervey, K., Woodruff, K. D., & Petraglia, E. E. (2020). *ProtectOHIO final evaluation report: Ohio's Title IV-E waiver demonstration report.* Ohio Department of Job and Family Services, Office of Children and Families. [For demographics of the populations in this study, see the appendices.]
- Wheeler, C. B., Newton-Curtis, L., Schisler, A., Vollet, J., Mettenberg, J., Woodruff, K. D., Das, B., Baskin, R. M., Petraglia, E. E., Orlebeke, B., Wulczyn, F., Huhr, S., & Zhou, X. (2015). *ProtectOHIO final evaluation report: Ohio's Title IV-E waiver demonstration project*. The Ohio Department of Job and Family Services. [For demographics of the populations in this study, see the appendices.]

[187] Wheeler et al. (2020); Wheeler et al. (2015)

[188] Timmer, S. (2021). *Fostering secure placements for traumatized children in transition*. (Annual report, October 1, 2020- September 30, 2021) Davis, CA: University of California at Davis.

[189] Timmer (2021).

[190] Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., Jackson, S., Lensgraf, J., & Bonner, B. L. (2004). Parent-Child Interaction Therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology, 72*(3), 500–510. https://doi.org/10.1037/0022-006X.72.3.500. [NOTE: Adult sample race was reported but not for the child sample. Sample size was sufficient but the results were not disaggregated by race. Authors noted, however, that no significant moderating effects were found among participant demographics (including race).]

[191] Leung, C., Tsang, S., Sin, T. C. S., & Choi, S. Y. (2015). The efficacy of Parent-Child Interaction Therapy with Chinese families: Randomized controlled trial. *Research on Social Work Practice, 25*(1), 117-128.

[192] Chaffin et al. (2004). [NOTE: Adult sample race was reported but not for the child sample. Sample size was sufficient but the results were not disaggregated by race. Authors noted, however, that no significant moderating effects were found among participant demographics (including race).]

[193] Leung et al. (2015)..

[194] For Parenting with Love and Limits Up to six families meet all together for the first hour of each session. Parents and teenagers split into breakout groups for the second hour of each session. In addition to group sessions, families participate in 4 to 20 individual family therapy sessions led by a PLL Coach. The number of individual

sessions is based on problem severity and need. Families typically participate in about four to eight individual sessions lasting 1 to 2 hours each.

[195] For child effects, see:

- Early, K. W., Chapman, S. F., & Hand, G. A. (2013). Family-focused juvenile reentry services: A quasi-experimental design evaluation of recidivism outcomes. OJJDP *Journal of Juvenile Justice*, 2(2), 1-22. https://www.ojp.gov/pdffiles/251063.pdf.
- Ryon, S. B., Early, K. W., & Kosloski, A. E. (2017). Community-based and family-focused alternatives to incarceration: A quasi-experimental evaluation of interventions for delinquent youth. *Journal of Criminal Justice,* 51(2017), 59-66. https://doi.org/10.1016/j.jcrimjus.2017.06.002
- Karam, E. A., Sterrett, E. M., & Kiaer, L. (2017). 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(2), 331-347. https://doi.org/10.1111/famp.12187

[196] For at least four months, groups are open-ended and ongoing; parents/caregivers attend whenever they want for as long as they want. For child-welfare-involved families, for at least 12-18 months (or more) with the program's services such as supportive services, groups, in-home parenting, parent partner and kinship navigator, and helpline services. For parents with children and youth with severe emotional challenges, 12-18 months with the program's services such as groups, ongoing supportive services, and helpline services.

[197] Polinsky, M. L., Pion-Berlin, L., Williams, S., & Wolf, A. M. (2010). Preventing child abuse and neglect: A national evaluation of Parents Anonymous® groups. *Child Welfare, 89*(6), 43-62.

[198] Burnson, C., Covington, S., Arvizo, B., Qiao, J., & Harris, E. (2021). The impact of Parents Anonymous on child safety and permanency. *Children and Youth Services Review*, *124*, 1-8. https://doi.org/10.1016/j.childyouth.2021.105973

[199] Ainsworth, A. (2019). *Parents Anonymous®: Effectively preventing and treating child abuse and neglect by strengthening families*. https://parentsanonymous.org/wp-content/uploads/2019/11/2019ParentsAnonymous_EvaluationBrief_Final.pdf. See also Burnson et al. (2021).

[200] Jonson-Reid, M., Drake, B., Constantino, J. N., Tandon, M., Pons, L., Kohl, P., Roesch, S., Wideman, E., Dunnigan, A., & Auslander, W. (2018). A randomized trial of home visitation for CPS-involved families: The moderating impact of maternal depression and CPS history. *Child Maltreatment*, *23*(3), 281-293. https://doi.org/10.1177/1077559517751671. [NOTE: Sample size was sufficient, but the results were not disaggregated by race.]

[201] Wagner, M. M., & Clayton, S. L. (1999). The Parents as Teachers program: Results from two demonstrations. *The Future of Children*, *9*(1), 91-115. [NOTE: Adult sample race reported but not child sample. Sample size sufficient but not disaggregated by race.]

[202] Wagner, M. M., & Clayton, S. L. (1999). [NOTE: Adult sample race reported but not child sample. Sample size sufficient but not disaggregated by race.]

[203] Wagner, M. M., & Clayton, S. L. (1999). [NOTE: Adult sample ethnicity reported but not child sample. Sample size sufficient but not disaggregated by race/ethnicity.]

[204] Wagner, M., Spiker, D., & Linn, M. I. (2002). The effectiveness of the Parents as Teachers program with low-income parents and children. *Topics in Early Childhood Special Education*, *22*(2), 67-81. doi: http://dx.doi.org/10.1177/02711214020220020101. NOTE: Sample size was sufficient, but the results were not disaggregated by race.]

[205] Wagner & Clayton (1999).

[206] Foa, E. B., McLean, C. M., Capaldi, S., & Rosenfield, D. (2013). Prolonged exposure vs supportive counseling for sexual abuse-related PTSD in adolescent girls: A randomized clinical trial. *JAMA, 310*(24), 2650-2657. doi:10.1001/jama.2013.282829

[207] Rossouw J, Yadin E, Alexander D, Seedat S. (2018). Prolonged exposure therapy and supportive counselling for post-traumatic stress disorder in adolescents: task-shifting randomised controlled trial. *British Journal of Psychiatry*, 213(4):587–94.

[208] Foa, E. B., Dancu, C. V., Hembree, E. A., Jaycox, L. H., Meadows, E. A., & Street, G. P. (1999**).** A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims. *Journal of Consulting and Clinical Psychology, 67*(2), 194.

[209] See:

- Foa, E. B., Hembree, E. A., Cahill, S. P., Rauch, S. A., Riggs, D. S., Feeny, N. C., & Yadin, E. (2005). Randomized trial of Prolonged Exposure for posttraumatic stress disorder with and without cognitive restructuring: Outcome at academic and community clinics. *Journal of Consulting and Clinical Psychology, 73*(5), 953.
- Rauch, S. A., Grunfeld, T. E., Yadin, E., Cahill, S.P., Hembree, E., & Foa, E. B. (2009). Changes in reported physical health symptoms and social function with Prolonged Exposure therapy for chronic posttraumatic stress disorder. *Depression and Anxiety, 26*, 732-738.

[210] Rauch et al. (2009). Also see Resick, P. A., Nishith, P., Weaver, T. L., Astin, M. C., & Feuer, C. A. (2002)**.** A comparison of Cognitive-Processing Therapy with Prolonged Exposure and a waiting condition for the treatment of chronic posttraumatic stress disorder in female rape victims. *Journal of Counseling and Clinical Psychology, 70*(4), 867-879.

[211] See:

- Oxford, M. L., Hash, J. B., Lohr, M. J., Bleil, M. E., Fleming, C. B., Unützer, J., & Spieker, S. J. (2021). Randomized trial of promoting first relationships for new mothers who received community mental health services in pregnancy. *Developmental Psychology, 57*(8), 1228–1241. https://doi.org/10.1037/dev0001219
- Spieker, S. J., Oxford, M. L., Kelly, J. F., Nelson, E. M., & Fleming, C. B. (2012). Promoting First Relationships: Randomized trial of a relationship-based intervention for toddlers in child welfare. *Child Maltreatment, 17*(4), 271–286. https://doi.org/10.1177/1077559512458176

[212] See:

- Booth-LaForce, C., Oxford, M.L., Barbosa-Leiker, C., Burduli, E., & Buchwald, D.S. (2020). Randomized controlled trial of the Promoting First Relationships® preventive intervention for primary caregivers and toddlers in an American Indian community. *Prevention Science*, 21(1), 98–108.
- Booth-LaForce, C., Oxford, M. L., O'Leary, R., & Buchwald, D. S. (2023). Promoting First Relationships® for Primary Caregivers and Toddlers in a Native Community: A Randomized Controlled Trial. *Prevention Science*, 24(1), 39–49.

[213] Oxford et al. (2016); Oxford et al. (2021); and Pasalich et al. (2019).

[214] See for example:

- Hash, J.B., Oxford, M.L., Nelson, D.C., Lohr, M.J., Fleming, C.B., de Castro, B.A., Spieker, S.J., (2023). *Efficacy of Promoting First Relationships® for English and Spanish Speakers: A Randomized Controlled Trial.* Manuscript under review.
- Oxford et al. (2021)
- Oxford, M. L., Spieker, S. J., Lohr, M. J., & Fleming, C. B. (2016). Promoting First Relationships®: Randomized trial of a 10-week home visiting program with families referred to child protective services. *Child Maltreatment, 21*(4), 267–277. https://doi.org/10.1177/1077559516668274

- Pasalich, D. S., Fleming, C. B., Spieker, S. J., Lohr, M. J., & Oxford, M. L. (2019). Does parents' own history of child abuse moderate the effectiveness of the Promoting First Relationships® intervention in child welfare? *Child Maltreatment, 24*(1), 56–65. https://doi.org/10.1177/1077559518809217
- Spieker et al. (2012).

[215] Spieker et al. (2012), and Oxford et al. (2021).

[216] Spieker et al. (2012).

[217] Spieker et al. (2012).

[218] Booth-LaForce, C., Oxford, M. L., O'Leary, R., & Buchwald, D. S. (2023). Promoting First Relationships® for primary caregivers and toddlers in a Native community: A randomized controlled trial. *Prevention Science, 24*(1) 39–49. https://doi.org/10.1007/s11121-022-01415-y

[219] Booth-LaForce et al. (2023).

[220] Booth-LaForce et al. (2023).

[221] Booth-LaForce et al. (2023).

[222] Oxford et al. (2021); and Pasalich et al. (2019).

[223] Pasalich et al. (2019).

[224] Pasalich et al. (2019).

[225] Spieker et al. (2012) and Oxford et al. (2021).

[226] Spieker et al. (2012).

[227] Spieker et al. (2012).

[228] Chaffin, M., Bard, D., Bigfoot, D. S., & Maher, E. (2012). Is a structured, manualized, evidence-based treatment protocol culturally competent and equivalently effective among American Indian parents in child welfare? *Child Maltreatment, 17,* 242-252. DOI: 10.1177/1077559512457239

[229] Chaffin, M., Hecht, D., Bard, D., Silovsky, J. F., & Beasley, W. H. (2012). A statewide trial of the SafeCare home-based services model with parents in child protective services. *Pediatrics*, *129*(3), 509-515. https://doi.org/10.1542/peds.2011-1840. [NOTE: Adult sample race was reported but not for the child sample. Sample size was sufficient, but the results were not disaggregated by race.]

[230] Chaffin, M., Hecht, D., Bard, D., Silovsky, J. F., & Beasley, W. H. (2012). [NOTE: Adult sample ethnicity was reported but not for the child sample. Sample size was sufficient, but the results were not disaggregated by ethnicity.]

[231] Chaffin, M., Hecht, D., Bard, D., Silovsky, J. F., & Beasley, W. H. (2012). [NOTE: Adult sample race reported but not child sample. Sample size was sufficient, but the results were not disaggregated by race.]

[232] Bruguera, P., Barrio, P., Manthey, J., Oliveras, C., Lopez-Pelayo, H., Nuno, L., Miquel, L., Lopez-Lazcano, A., Blithikioti, C., Caballeria, E., Matrai, S., Rehm, J., Vieta, E., & Gual, A. (2021). Mid- and long-term effects of a SBIRT program for at-risk drinkers attending to an emergency department. Follow up results from a randomized controlled trial. *European Journal of Emergency Medicin*e, 28(5), 373-379. https://doi.org/10.1097/MEJ.0000000000000810

[233] Sterling, S., Kline-Simon, A. H., Satre, D. D., Jones, A., Mertens, J., Wong, A., & Weisner, C. (2015). Implementation of Screening, Brief Intervention, and Referral to Treatment for adolescents in pediatric primary care: A cluster randomized trial. *JAMA Pediatrics*, 169(11), Article e153145. https://doi.org/10.1001/jamapediatrics.2015.3145

[234] Sterling, et al. (2015).

[235] Sterling, S., Parthasarathy, S., Jones, A., Weisner, C., Metz, V., Hartman, L., Saba, K., & Kline-Simon, A. H. (2022). Young Adult substance use and healthcare use associated with Screening, Brief Intervention and Referral to Treatment in pediatric primary care. *The Journal of Adolescent Health: Official publication of the Society for Adolescent Medicine*, *71*(4S), S15–S23. https://doi.org/10.1016/j.jadohealth.2021.11.033

[236] Sterling et al. (2022).

[237] In Smart Beginnings the well-child visits occur every few months during infancy and toddlerhood, and then less frequently as children get older.

[238] See:

- Hails, K. A., Whipps, M. D. M., Gross, R. S., Bogen, D. L., Morris, P. A., Mendelsohn, A. L., & Shaw, D. S. (2021). Breastfeeding and responsive parenting as predictors of infant weight change in the first year. *Journal of Pediatric Psychology,* 46(7), 768-778. https://doi.org/10.1093/jpepsy/jsab049
- Miller, E. B., Canfield, C. F., Morris, P. A., Shaw, D. S., Cates, C. B., & Mendelsohn, A. L. (2020). Sociodemographic and psychosocial predictors of VIP attendance in Smart Beginnings through 6 months: Effectively targeting at-risk mothers in early visits. *Prevention Science*, 21(1), 120-130. https://doi.org/10.1007/s11121-019-01044-y
- Miller, E. B., Roby, E., Zhang, Y., Coskun, L., Rosas, J. M., Scott, M. A., Gutierrez, J., Shaw, D. S., Mendelsohn, A. L., & Morris-Perez, P. A. (2022). Promoting cognitive stimulation in parents across infancy and toddlerhood: A randomized clinical trial. *The Journal of Pediatrics,* 255, 159-165.e4. https://doi.org/10.1016/j.jpeds.2022.11.013
- Miller, E. B., Whipps, M. D. M., Bogen, D. L., Morris, P. A., Mendelsohn, A. L., Shaw, D. S., & Gross, R. S. (2023). Collateral benefits from a school-readiness intervention on breastfeeding: A cross-domain impact evaluation. *Maternal & Child Nutrition,* 19(1), Article e13446. https://doi.org/10.1111/mcn.13446
- Roby, E., Miller, E. B., Shaw, D. S., Morris, P., Gill, A., Bogen, D. L., Rosas, J., Canfield, C. F., Hails, K. A., Wippick, H., Honoroff, J., Cates, C. B., Weisleder, A., Chadwick, K. A., Raak, C. D., & Mendelsohn, A. L. (2021). Improving parent-child interactions in pediatric health care: A two-site randomized controlled trial. *Pediatrics*, 147(3), 1-12. https://doi.org/10.1542/peds.2020-1799

[239] See Hails et al. (2021); Miller et al. (2020); Miller et al. (2022); Miller et al. (2023); Roby et al. (2021).

[240] See:

- Huebner, R. A., Willauer, T., Hall, M. T., Smead, E., Poole, V., Hibbeler, P.G., & Posze, L. (2021). Comparative outcomes for Black children served by the Sobriety Treatment and Recovery Teams program for child welfare families with parental substance abuse and child maltreatment. J*ournal of Substance Abuse Treatment.* 108563. https://doi.org/10.1016/j.jsat.2021.108563
- Huebner, R. A., Willauer, T., & Posze, L. (2012). The impact of Sobriety Treatment and Recovery Teams (START) on family outcomes. *Families in Society Journal of Contemporary Social Services, 93*(3), 196-203. https://doi.org/10.1606%2F1044-3894.4223 [NOTE: Sample size is sufficient for this study but the results are not disaggregated by race.]

[241] Huebner, R.A., Posze, L., Willauer, T.M., & Hall, M.T. (2015). Sobriety Treatment and Recovery Teams: Implementation Fidelity and Related Outcomes. *Substance Use & Misuse,* 50(10), 1341-1350. [NOTE: Sample size sufficient but results are not disaggregated by race.]

[242] Huebner et al. (2012). [NOTE: Sample size sufficient but results not disaggregated by race.]

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- Cohen, J.A., Amaya-Jackson, L., Metzger, I., Mannarino, A.P., & Dandridge, A. (2023). *Trauma-focused cognitive behavioral therapy and racial socialization for traumatized Black youth.* Symposium presented at the 70th Annual Meeting of the American Academy of Child & Adolescent Psychiatry, New York, NY, October 26, 2023. (This is also also published in the JAACAP Supplement.)
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