Interventions Shown to Be Effective with Children and Families of Color Being Served with Family First Funding

Research Brief (First Edition)

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Revised: February 20, 2022. Copyright ©2022 Casey Family Programs. All rights reserved. Compiled by Research Services, Casey Family Programs. For more information, please contact Peter J. Pecora, PhD (PPecora@Casey.org), Reed Klein, MSW (reedthomasklein@gmail.com), June Simon, MSW (junebsimon@gmail.com), or Lovie Jewell Jackson Foster, MSW, PhD (loviejewell.jackson@gmail.com). For related reports, see www.Casey.org.

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/) and an interventions catalog compiled by Diana English, Peter Pecora, Dana Goodman, and Jorie Wackerman. Special thanks to our Casey colleagues for their review of this summary.

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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.[i] 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 competent 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

Note that this is a very dynamic situation, and the Prevention Services Clearinghouse is updating its 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 look for credible evidence in those studies to ascertain whether the intervention is effective with families of

color, and where possible, effective with LGBTQQUIA persons.[6] Emerging research suggests that, among LGBTQQUIA youth in foster care, youth of color may be over-represented.[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 their effectiveness with LGBTQQUIA persons.

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]

Figure 1. FFPSA Evidence Standards for Interventions: General Practice Requirements

Requirement	Description
Book or Manual	• The practice has a book, manual, or other available writings that specify the components of the practice protocol and describe how to administer the practice.
No Empirical Risk of Harm	• There is no empirical basis suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.
Weight of Evidence Supports Benefits	• If multiple outcome studies have been conducted, the overall weight of evidence supports the benefits of practice.
Reliable & Valid Outcome Measures	• Outcome measures are reliable and valid, and are administered consistently and accurately across all those receiving the practice.
No Case Data for Severe or Frequent risk of harm	• There is no case data suggesting a risk of harm that was probably caused by the treatment and that was severe or frequent.

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.

Outcomes Pursued

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

Cultural Issues

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, and with respect to those outcomes, across racial and ethnic groups. Many child welfare interventions have been created by white developers and researchers using participant samples that are largely composed of white people. There is a clear need to rigorously evaluate culturally specific interventions to build up their evidence base (e.g., Positive Indian Parenting Program, Culturally Modified Trauma-Focused Treatment [CM-TFT] for Latinx children, Community Outreach Program Esperanza [COPE]).

Fortunately, many of the current interventions with a strong evidence base "travel well" across different racial and ethnic groups because of the core components of their intervention model (e.g., being 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 it 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 or competent 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. (See Figures 3 and 4, which are abstracted from the Prevention Services Clearinghouse handbook.) ***Because of this stance, we need more targeted support to Black, Indigenous, and other People of Color (BIPOC) to document and evaluate those interventions that have been adapted to meet their needs.***

In addition, Dee Bigfoot, an American Indian researcher and practitioner, 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) (D. Bigfoot, personal communication, December 14, 2020).

Figure 3. Adaptations 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.

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.

Effectiveness of FFPSA Interventions with Families of Color

Overview

While there is evidence of culturally and linguistically competent 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.[9]

Table 1 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 particular racial and/or ethnic 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 on 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).[10] 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).[11]

In addition, we contacted the developers of each of the FFPSA-rated interventions to see if there were additional studies of effectiveness that could be cited. We received feedback from nearly every developer.

Note that we included evidence of effectiveness if the study included at least 30 children or parents of a particular ethnic group of color and studies that reported a statistically significant effect for the intervention group. Very small sample studies with modest numbers (i.e., less than 30) of any ethnic group of color 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.[12]

There well may be additional ethnic/racial groups that have been studied but a study was not available to us. As we have additional time, we will use additional university-based search engines to supplement this review. But Chapin Hall has published a brief on elevating culturally specific evidence-based practices.[13]

Finally, with the time available to us, we were not able to conduct a comprehensive review of the literature to determine if these FFPSA-rated interventions are effective with LGBTQQUIA persons. However, we requested this information from some intervention developers and have included in Appendix A any LGBTQQUIA-related information provided to us. In future editions of this document, we hope to include a more comprehensive review of the research literature for these interventions related to LGBTQQUIA youth and families.

Table 1. Interventions Rated by the Prevention Services Clearinghouse That Indicate Their Effectiveness with Children and Families of Color

*Promising, ** Supported, ***Well-Supported

Intervention	American Indian or Alaskan Native	Asian	Bi-Racial or Multi-Racial	African-American	Latinx	Native Hawaiian or Pacific Islander	Other
Adolescent Community Reinforcement Approach				X	X		
Aggression Replacement Training®*							X
Brief Strategic Family Therapy (BFST)***				X	X		
Child First** (formerly Child and Family Interagency Resource, Support, and Training)					X		
Child-Parent Psychotherapy*			X	X	X		
Eye Movement Desensitization and Reprocessing – Standard Protocol**							X
Familias Unidas***					X		
Family Centered Treatment**				X	X		
Family Check-up***				X	X		
Family Spirit*	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
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		
Multidimensional Family Therapy (MDFT)**				X	X		X

Intervention	American Indian or Alaskan Native	Asian	Bi-Racial or Multi-Racial	African-American	Latinx	Native Hawaiian or Pacific Islander	Other
Multisystemic Therapy (MST)**				X	X		
Nurse-Family Partnership (NFP)***				X	X		
Parent-Child Interaction Therapy (PCIT)***		X		X			X
Parenting with Love and Limits®**				X			
Parents Anonymous®**				X	X		
Parents as Teachers***				X	X		
Prolonged Exposure Therapy for Adolescents for PTSD*				X			
Prolonged Exposure Therapy for PTSD (adults)*				X			
SafeCare**	X			X	X		
Sobriety Treatment and Recovery Teams*				X			
TBRI® 101* (Trust-Based Relational Interview)				X			
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)*	X	X	X	X	X		
Triple P – Positive Parenting Program – Group (Level 4)*		X		X			x
Triple P – Positive Parenting Program – Online (Level 4)**				X	X		
Trust-Based Relational Intervention-Caregiver Training*				X			

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:[1]

- American Indian Life Skills (Alaskan Natives, American Indian)
- Canoe Journey (Alaskan Natives, American Indian)
- CICC's Effective Black Parenting Program (EBPP) (African American)

[1] 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.

- 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)
- Wraparound Services (African-American, Alaskan Natives, American Indian)

Conclusions

The Prevention Services Clearinghouse has evaluated and rated as *Promising* or higher 36 interventions thus far. Our review finds that 36 of the 39 interventions currently rated as *Promising*, *Supported,* or *Well-Supporte*d are effective with at least one other ethnic group because of some of their intervention model components (e.g., being family-centered, carefully listening to family perspectives, building upon family social support networks, incorporating a strengths-oriented assessment). However, many interventions appear to need modifications and additional evaluation so they can be rated by the Prevention Services Clearinghouse.

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 stance, we need***

more targeted support to Indian tribal nations and other communities of color to document and evaluate those interventions that have been culturally adapted. This is all the more important because there has historically been significant systemic bias in funding research on interventions developed by white people.[14] 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 BBIPOC developers and researchers.

It is important to note that 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. Practice-based evidence is also referred to as *community-defined evidence* (CDE). Fundamental to PBE or CDE are the following[15]:
:

- 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 supports 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.[16] As jurisdictions optimize their array of interventions and consider innovative funding approaches such as pay for success and social impact bonds,[17] studies of culturally competent interventions that go beyond frequency analyses of management information system data will be needed.

Appendix: Interventions Matrix

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 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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
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 age 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[18] • Substance use disorder[19] • Cost-effectiveness (secondary outcome)[20] Hispanic: • Substance use disorder[21] • Substance use disorder[22]
Aggression Replacement Training® Aggression Replacement Training® (ART) is a cognitive-behaviorally-based intervention designed to serve youth who display violent and aggressive	**Promising: MH** (CEBC: Promising) Child well-being:	Youth who display violent and aggressive behavior	**10 weeks** — delivered three times per week over 10 weeks for	*Child well-being:* Turkish youth in Turkey:[23] • Trait Anger levels • Increased Anger Control scores

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
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.	• Behavioral and emotional functioning		a total of 30 sessions	• Decreased Physical Aggression scores • Decreased Hostility scores • Increased Social Problem-Solving total scores • Increased Anger Control scores
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	**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 to 16 weeks** —Weekly sessions.)	*Child well-being:* African American: • Conduct problems (externalizing behaviors), delinquency (arrests)[24] • Substance use disorder[25] Latinx: • Conduct problems (externalizing behaviors), delinquency (arrests)[26] • Substance use disorder [27] *Adult well-being:* African American: • Family functioning[28] • Substance use disorder [29]

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
new ways of relating to one another to promote more effective and adaptive family interactions.				Latinx: • Family functioning[30] • Substance use disorder[31]
Child First formerly known as Child and Family Interagency Resource, Support, and Training 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 • Parent/caregiver mental or emotional health	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 partner violence, abuse	**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[32]

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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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
		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[33] Biracial: • Behavioral and emotional functioning[34] Latinx: • Behavioral and emotional functioning ("attachment")[35] • Behavioral and emotional functioning[36] *Adult well-being:* Latinx: • Parent/caregiver mental or emotional health ("attachment")[37]

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
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)	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.[38]	*Child Well-Being:* Other (Australian, Iranian, Italian, Netherlands, Sweden): • Post-traumatic symptom outcomes, and positive behaviors[39]

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
make new choices by processing fears and identifying a template for desired future behavior.				
Family Centered Treatment 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 attachment bond	**Supported: PSB** (CEBC: Promising) Child permanency: • Out of home placement • Least restrictive placement Child well-being: • Delinquent behavior	Families who are at-risk of dissolution or in need of reunification. Also designed to serve youth who move between the child welfare, behavioral health, and juvenile justice systems	**6 months** Multi-hour sessions occur two or more times per week	*Child Well-Being:* African-American • Out of home placement[40] Latinx: • Out of home placement[41]
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,	**Well-Supported: MH, PSB, SA** (CEBC: Well-supported) Child well-being:	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	*Child well-being:* Latinx: • Behavioral and emotional functioning • Substance abuse *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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
improving parenting skills, enhancing parent-adolescent communication, and facilitating parental involvement and investment in adolescents' lives.	• Behavioral and emotional functioning • Substance abuse Adult well-being: • Family functioning • Positive parenting		family visit sessions (1 session per week) Parent group session: 2 hours Family visit session: 1 hour	Latinx: • Family functioning • Positive parenting
Families Facing the Future (formerly Focus on Families) 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.	**Supported: SA** (CEBC: Well-supported) Adult well-being: • Parent/caregiver substance use	Families with one or more caregivers receiving methadone treatment who have children or young adolescents.	**16 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-Caucasian 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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
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 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.	**Well-Supported: MH, PSB (CEBC: Well-Supported)** Child well-being: • Behavioral and emotional functioning • Cognitive functions and abilities • Educational achievement and attainment Adult well-being: • Parent/caregiver mental or emotional health • Positive parenting	For families with children age 2 through 17	3 sessions (After completing the feedback session, families may choose to complete follow-up services. These follow-up services can vary in intensity and duration based on family interest and need.)	*Child Well-Being:* African-American: • Behavioral functioning[42] Hispanic/Latinx: • Behavioral functioning[43]
Family Spirit® A culturally tailored home visiting program designed for young American Indian mothers (age 14-24) who enroll	**Promising: PSB** (CEBC: Promising) Child well-being:	For young American Indian mothers (age 14-24) who enroll during the second	28 weeks gestation to 3 years	American Indian/Alaskan Native: Child well-being: • Behavioral and emotional functioning[44]

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
during the second trimester of pregnancy. The goal of Family Spirit® is to address intergenerational behavioral health problems and promote positive behavioral and 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	trimester of pregnancy. Other family members can participate in the program lessons alongside mothers.	63 lessons are taught during 52 home visits that are 45-90 minutes long. Weekly visits then taper back over time to bimonthly visits between 23 and 36 months postpartum.	Adult well-being: • Parent/caregiver mental or emotional health[45] • Parent/caregiver substance use disorder [46]
[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 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	**Well-supported: MH** (CEBC: Well-supported) Child well-being: • Behavioral and emotional functioning • Substance use	Youth ages 11 to 18 who have been referred for behavioral or emotional problems by juvenile justice, mental health, school, or child welfare systems	**12 to 24 weeks** (8 to 14 weekly sessions, held in person for between 60 to 90 minutes and by phone for up to 30 minutes)	*Child well-being:* African American: • Delinquent behavior[47] • Delinquent behavior[48] Latinx: • Delinquent behavior[49]

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
change, identifying specific needs of the family, supporting individual skill-building of youth and family, and generalizing changes to a broader context.	• Delinquent behavior Adult well-being: • Family functioning			
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	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	*Child safety:* African American: • Maltreatment[50] • Maltreatment[51] Asian or Filipino: • Maltreatment[52] *Child Safety*: Native Hawaiian or Pacific Islander: • Child maltreatment[53] Latinx: • Child maltreatment[54] • Harsh parenting[55] *Child well-being:* African American: • Educational achievement[56] • Low birth weight[57]

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
	• Educational achievement and attainment Adult well-being • Positive parenting practices • Parent/caregiver mental or emotional health • Family functioning		frequency may increase in times of crisis.)	Alaskan Native: • Behavioral and emotional functioning[58] Asian/Pacific Islander: • Cognitive functions and abilities (preventive health)[59] Latinx: • Cognitive functions and abilities (preventive health)[60] • Educational achievement[61] • Health (breastfeeding)[62] Multi-racial: • Cognitive functions and abilities (preventive health)[63] *Adult well-being:* African American: • Positive parenting practices [64] Asian/Filipino/Hawaiian/Pacific Islander: • Caregiver emotional health: self-efficacy[65] 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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
				• Positive parenting practices (quality of home environment, mobilizing resources, positive linguistics reading to child, household routines, mental health)[66] • Substance use disorder [67] Other race/ethnicity: (mixture of African American, American Indian/Alaska Native, or Asian/Pacific Islander): • Positive parenting practices[68]
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.	**Well-supported: PSB** (CEBC: Supported) Child permanency: • Out-of-home placement • Planned permanent exits Adult well-being:	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.	*Child permanency:* African American: • Out-of-home placement [69] American Indian: • Out-of-home placement[70] Asian/Pacific Islanders: • Out-of-home placement [64] Latinx: • Out-of-home placement[64]

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
Throughout the intervention practitioners develop safety plans and use clinical strategies designed to promote safety.	• Economic and housing stability		Practitioners are available to family 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.	*Adult well-being:* Was not able to find studies with effectiveness data with specific ethnic groups for this model version. See information for IY-School Age below.

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
Incredible Years – School Age Basic Program (IY-School Age) 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.	**Promising (MH)** (CEBC: Well-Supported) Adult well-being: • Positive parenting practices	For parents of children 6 to 12 years. The program typically targets higher-risk populations and parents of children diagnosed with problems such as oppositional defiant disorder and attention deficit hyperactivity disorder (ADHD).	**12 to 20 weekly group sessions**. Each group session lasts about 2 hours.	*Adult Well-being:* African American, Hispanic, and Asian: • Positive parenting practices[71]
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	**Well-Supported: PSB** (CEBC: Not listed) Child permanency: • Out-of-home placement • Planned permanent exits	Children age 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	*Child well-being and Permanency:* African American: • Out-of-home placement[72] • Exit to permanency[73]

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
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.			with crisis support available 24/7.	
Interpersonal Psychotherapy (Weissman et al. Manual; IPT) An acute (time-limited) treatment that aims to support patients with major depression in improving interpersonal relationships or circumstances that are directly related to a current depressive episode.	**Supported: MH** (CEBC: Well-supported) Adult well-being: • Parent/caregiver mental or emotional health • Family functioning	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[74] African (Ugandan): • Mental health, such as depression[75] Many other countries, including Arable countries such as Egypt, Columbia, India, Russia, Sub-Sahara Africa (e.g., Kenya), and Thailand[76]
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	**Promising** (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[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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
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).				
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	**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[78]

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
workers and other professionals to ensure the family is getting needed resources. The goal is to support reunification and reduce recurrence of child maltreatment.				
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).[79]	**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 home between visits.	*Adult well-being:* African American: • Substance use disorder [80] Latinx: • Substance abuse disorder [81]

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
[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. MI is typically delivered over one to three sessions with each session lasting about 30 to 50 minutes. 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	**Well-supported: SA**[82] (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 [83] African American: • Substance use disorder [84] *Adult well-being:* African American: • Substance use disorder [85] American Indian: • Substance use disorder [86] Hispanic: • Substance use disorder [87] Multi-Ethnic: • Substance use disorder[88] Others: • Substance use disorder[89]

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
hospitals. While there are no required qualifications for individuals to deliver MI, training can be provided by MINT (Motivational Interviewing Network of Trainers) certified trainers.				*LGBTQQ:* • Substance use disorder and other outcomes[90]
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:	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[91] • Educational achievement and attainment (school functioning)[92] • Internet gaming[93] • Prevention of residential treatment placement[94] • Substance use disorder, including cannabis use[95] European: • Substance abuse disorder [96] Hispanic: • Delinquent behavior/detention to community[97]

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
	• Positive parenting practices • Family functioning			• Educational achievement and attainment (i.e., school functioning)[98] • Internet gaming[99] • Placement prevention[100] including prevention of residential treatment[101] • Substance use disorder [102] *Adult well-being:* African American: • Family functioning[103] • Positive parenting practices[104] Hispanic: • Family functioning[105] • Positive parenting practices[106]
[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	**Well-supported: MH, SA** (CEBC: Well-supported) Child permanency:	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	**12 to 20 weeks** Multiple sessions weekly depending on need.	*Child permanency:* African American: • Out-of-home placement[107] Hispanic: • Out-of-home placement[108]

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
MST program addresses the core causes of delinquent and antisocial conduct by identifying key drivers of the behaviors through an ecological assessment of the 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.	• Out-of-home placement 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	experiencing mental health issues, and who are at risk for out-of-home placement.		*Child well-being:* African American: • Behavioral and emotional functioning ("socialized-aggressive problem behavior, conduct disorder)[109] • Behavioral and emotional functioning, delinquent behavior (rearrests and days incarcerated)[110] • Behavioral and emotional functioning, delinquent behavior (including problem sexual behavior), substance use disorder [111] Hispanic: • Behavioral and emotional functioning, delinquent behavior (including problem sexual behavior), substance use disorder [112] *Adult 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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
				• Positive parenting practices, caregiver mental or emotional health, family functioning[113]
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 content of the program can vary based on the needs and requests of the mother.	**Well-supported: PSB, MH** (CEBC: Well-supported) Child safety: • Child welfare administrative reports Child well-being: • Cognitive functions and abilities • Physical development and health Adult well-being: • Economic and housing stability	Young, first-time, low-income mothers from early pregnancy through their child's first two years. The program also encourages the participation of fathers and other family members.	**Undefined** 60 visits of 60 to 75 minutes. Participants must enroll early in pregnancy [no later than the 28th week of gestation] 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.	*Child well-being:* African American: • Cognitive functions and abilities[114] • Cognitive functions and abilities (physical aggression)[115] Mexican American: • Cognitive functions and abilities[116] *Adult well-being:* African American: • Domestic violence[117] Mexican American: • Domestic violence[118]

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
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 effective communication, education, assessment, planning, and support for the family	**Promising: Kinship Care** Child permanency: Placement stability	Relatives caring for a child in out-of-home care.	**Monthly home visit services with a kinship coordinator** Coordinators conduct home assessments within 30 days of the child's placement with the kinship caregiver and needs assessments every 90 days.	No ethnic group results were reported in the primary evaluation study.[119]
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 sessions, therapists coach caregivers in skills such as child-centered play, communication, increasing child	**Well-supported: MH** (CEBC: Well-supported) Child well-being: • Behavioral and emotional functioning	Families with children age 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[120] *Child well-being:* Hong Kong Chinese: • Behavioral and emotional functioning (disruptive behavior)[121]

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
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).	Adult well-being: • Positive parenting practices • Parent/caregiver mental or emotional health			*Adult well-being:* African American: • Positive parenting practices (parent negative behaviors)[122] Hong Kong Chinese: • Positive parenting practices (and decrease in negative parenting practices), mental or emotional health (parenting stress, negative emotions)[123]
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	**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.[124]	*Child well-being:* African American: • Delinquent behavior (e.g., Rearrest Rate, Readjudication Rate, Felony Adjudication Rate, Recommitment Rate)[125]

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
therapy sessions and individual family therapy coaching sessions.				
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 (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.	**Supported: MH, PSB, SA** (CEBC: Promising)	For children or adolescents age 0 to 18, and parents or caregivers of children age 0 to 18.	Median dosage of 5 months[117] 12-18 months for child welfare-involved families.[126] Weekly 2-hour group sessions; more than 2 hours per week for Supportive Services, In-Home Parenting, Parent Partner and Navigator, and Helpline Services	*Adult well-Being:* African American: • Child maltreatment outcomes, protective factors, risk factors[127] *Child safety:* African American: • Child welfare administrative reports for CPS referrals and substantiated referrals[128] Latinx: • Child welfare administrative reports for CPS referrals and substantiated referrals[129]

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
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. 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.	**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)[130] • Child welfare administrative reports (open case of child abuse or neglect)[131] Latina (mothers): • Child welfare administrative reports (open case of child abuse or neglect)[132] *Child well-being:* Latina (mothers): • Social functioning, cognitive functions and abilities[133] *Adult well-being:* African American: • Positive parenting practices, mental and emotional functioning (happiness with caretaking of child)[134] Latina (mothers):

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
				• Positive parenting practices (parent efficacy)[135]
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 age 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 assignments between sessions.	*Child well-being:* African American: • Behavioral and emotional functioning in terms of PTSD symptoms[136]
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	**Promising: MH** (CEBC: Well-supported) Adult well-being:	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[137] • Social functioning[138] • Decrease in PTSD symptoms[139]

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
survivors emotionally process their traumatic experiences in order to diminish PTSD and other trauma-related symptoms.	• Parent/caregiver mental or emotional health			
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 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	**Supported: PSB** (CEBC: Supported) Child permanency: • Out-of-home placement	Parents and caregivers of children age 0 to 5 five who are either at-risk for or have a history of child neglect and/ or physical abuse.	**Undefined** 18 sessions of 50 to 90 minutes, depending on parents'/ caregivers' need	*Child safety:* African American: • Maltreatment (CPS recidivism)[140] Hispanic: • Maltreatment (CPS recidivism)[141] American Indian: • Maltreatment (CPS recidivisma)[142] *Child permanency:* American Indian: • Out-of-home care placements[143]

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
teaching parents/caregivers how to positively interact with their infant/child and how to structure activities to engage their children and promote positive behavior.				
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.	**Promising: SA** (CEBC: Promising: PSB, SA) Child permanency: • Out-of-home placement	Families with at least one child under 6 who are involved in the child welfare system and have 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 visits by CPS caseworker for at least the first 60 days, and by family peer mentors for at least the first 90 days.	*Child permanency:* African American: • Out-of-home placement[144] • Out-of-home placement[145] *Adult well-being:* African American: • Substance use disorder [146] • Substance use disorder [147]
TBRI® 101 (Trust-Based Relational Interview)	**Promising: MH** (CEBC: Promising)	Parents or caregivers of children who have experienced adversity,	**Self-paced** Five online modules totaling	*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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
A self-administered approach to Trust-Based Relational Intervention® for caregivers of children who 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.	7.5 hours. Self-paced and not time limited.	• Behavioral and emotional functioning[148]
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	**Promising: MH** (CEBC: Well-supported) Child well-being: • Behavioral and emotional functioning • Social functioning Adult well-being: • Positive parenting practices	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	**Undefined** Typically 12 to 16 sessions of 45 to 90 minutes.	*Child well-being:* American Indian/Alaskan native: Behavioral and emotional functioning[149] Hispanic: • Behavioral and emotional functioning[150] • Social functioning, behavioral and emotional functioning[151] Zambian: • Behavioral and emotional functioning[152] Japanese:

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
traumatic experience, and (3) joint therapy sessions between caregiver and child/adolescent. TF-CBT is usually administered in clinical office settings.	• Parent/caregiver mental or emotional health	and the child's safety is maintained.		• Behavioral and emotional functioning[153] African American: • Social functioning, behavioral and emotional functioning[154] • Behavioral and emotional functioning[155] Asian: • Social functioning, behavioral and emotional functioning[156] American Indian: • Social functioning, behavioral and emotional functioning[157] Multiracial: • Social functioning, behavioral and emotional functioning[158] *Parent well-being:* African American: • Positive parenting practices, parent/caregiver mental or emotional health[159]

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
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)[160] Portuguese: • Behavioral and emotional functioning[161] Chinese parents in China: • Reduction in child adjustment problems, reduced child academic problem behaviours, increased child report of positive parenting[162] Chinese in Hong Kong: Behavioral and emotional functioning,[163] decrease in child behaviour problems[164] Japanese parents in Japan:

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
				• Child behavior, parenting practices, parental competence, family functioning, and parental adjustment[165] *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[166] Chinese in China: • Reduction in dysfunctional parenting, improved parental adjustment, increased parenting confidence, improved parenting in academic context\increase in parent satisfaction with child's academic achievement[167] Chinese in Hong Kong: • Positive parenting practices[168] • Increase in parenting confidence[169]

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
				• Reduction in parental stress, reduction in parental conflict, and reduction in use of dysfunctional parenting styles (laxness and over-reactivity)[170]
[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 to prevent problems, raise confident children, and apply consequences and rewards.	**Supported: MH** (CEBC: Not listed) Child well-being: • Behavioral and emotional functioning Adult well-being: • Parent/caregiver mental or emotional health • Positive parenting practices	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 own pace, with a recommended completion rate of one module per week.	*Child Well-Being:* African American: • Child behavioral problems.[171] Latinx: • Child behavioral problems, reduced lax/permissive and over-reactive parenting, and decreased parental stress.[172] *Parent functioning and well-being:* African American: • Child behavioral problems, reduced lax/permissive and over-reactive parenting, and decreased parental stress.[173] 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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
				• Child behavioral problems, reduced lax/permissive and over-reactive parenting, and decreased parental stress.[174]
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 children's behavior, provide supervision, and educate their child.	**Promising: MH** (CEBC: Not listed) Child well-being: • Behavioral and emotional functioning Adult well-being: • Parent/caregiver mental or emotional health • Positive parenting practices	Families with children up to age 12, especially families who live in rural or remote areas or who want help without direct contact with a practitioner.	**10 weeks (Self-paced)**	Unable to find any relevant literature documenting significant child welfare-related outcomes for non-Caucasian non-Latinx children or families.
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.	**Promising: MH** (CEBC: Well-supported) Child well-being:	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-Caucasian 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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
These sessions focus on promoting child development, managing misbehavior, and implementing planned activities and routines to encourage independent child play.	• Behavioral and emotional functioning Adult well-being: • Positive parenting practices • Parent/caregiver mental or emotional health			
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.[175]

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 Where We Found Evidence of Effectiveness
I. Interventions Rated by the FFPSA Clearinghouse as Promising, Supported, or Well-Supported				
(3) TBRI Correcting Principles, which focus on building children's social competencies.				

Endnotes

[i]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:

- 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]LGBTQQUIA: Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Undecided, Intersex, and Asexual.

[7] See for example:

- 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
- 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..

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

[9] 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.
- Smith, A. C. (2020). Cultural sensitivity in mental health care: Getting to know your audience. *Psychology Today Blog*, Retrieved from https://www.psychologytoday.com/us/blog/and-running/202009/cultural-sensitivity-in-mental-health-care
- 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

[10] 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.)

[12]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.

[13] 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

[14] See for example:

- 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

[15] 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.

[16] 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.
- 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.

[17] 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

[18] 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.

[19] 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 >=30 sample sizes of African American, Hispanic, and Other/biracial populations but does not disaggregate results based on race.]

[20] 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.]

[21] Godley, et al. (2011).

[22] 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.]

[23] 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

[24] 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.]

[25] 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.]

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

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

[28]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'.]

[29] 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.]

[30] 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'.]

[31] Horigian et al. (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.]

[32] 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.

[33] 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.

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

[35] 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

[36] 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.]

[37] Lieberman et al. (1991).]

[38] 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.

[39]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. Page numbers?*

[40] Sullivan, M. B., & Bennear, L. S. (2021). A quasi-experimental evaluation of Family Centered Treatment® in the Maryland Department of Juvenile Services community based non-residential program: Child permanency. Family Centered Treatment Foundation.

[41] Sullivan et al. (2021).

[42] 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 results not disaggregated by race.]

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

[44] For child effects, see:

- Barlow, 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

[45] 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

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

[47] 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.]

[48] 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.

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

[50] 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.]

[51] 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.]

[52] 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.]

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

[54] See:

- Easterbrooks et al (2014). [NOTE: Sample size sufficient but results 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).

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

[56] 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).]

[57] 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

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[59] 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 results not disaggregated by race.]

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

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

[62]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.

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

[64] 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.]

[65]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.

[66] 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 sufficient but results 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.

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

[68] 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 sufficient but results 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.

[69] 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

[70]Behavioral Sciences Institute (in preparation).

[71] 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.

[72] 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.]

[73] 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.]

[74] 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.]

[75] 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.]

[76]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.

[77] 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

[78] 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.]

[79] 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

[80] 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

[81] Mattick et al. (2009).

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

[83] 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.]

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

[85] 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.]

[86] 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

[87] 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.]

[88] 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

[89] 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

[90] 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:BL89EPI7Z2FeEFbwjvnlmjEIL0UsXw9MKIOW5OVi2shnXpwdoITE5Kyv-4f1d3s47kxDS22F95-c

[91] 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

[92] 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.]

[93] 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.

[94]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

[95]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

[96]See – 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

[97] 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

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

[99]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

[100] 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

[101]Dakof et al. (2015).

[102]See:

- Dakof et al. (2015).
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