


Review of Well-Supported Mental Health Programs on the Title IV-E Prevention Series Clearinghouse

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- Work has focused on children receiving services through public sectors of care, including child welfare and mental health systems

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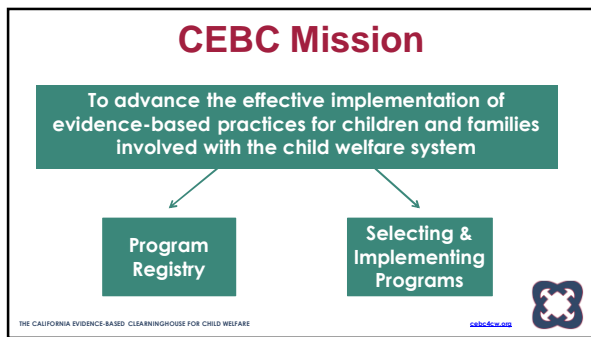
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FFPSA PART 1


- New option for States and Tribes to claim Title IV-E entitlement funds for evidence-based prevention and trauma-informed services for children and youth who are deemed candidates (at imminent risk for entry into foster care)

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FFPSA PART 1


- Evidence-based interventions funded by Title IV-E must be selected from the Title IV-E Prevention Clearinghouse, fall within one of the following categories, and be included in California's Five-Year State Prevention Plan
 - In-home parent skill-based programs
 - Mental health services, and
 - Substance abuse prevention and treatment services

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FFPSA PART 1

- The legislation is intended to **reduce entries into care** by funding prevention services and interventions to mitigate imminent-risk factors and maintain a child and youth's placement in-home

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CALIFORNIA ASSEMBLY BILL (AB)153

The state Budget Act of 2021 includes funding to support prevention planning or service activities consistent for Title IV-E prevention services established by Part 1 of FFPSA.

Assembly Bill 153:

- Offers funding to develop a Comprehensive Plan which includes **primary, secondary, and tertiary intervention strategies** and services to support the ability for parents and families to provide safe, stable, and nurturing environments for their children.
- It requires a **cross-sector collaborative approach** to include tribes and the voices of those disproportionately impacted by child and family welfare systems.

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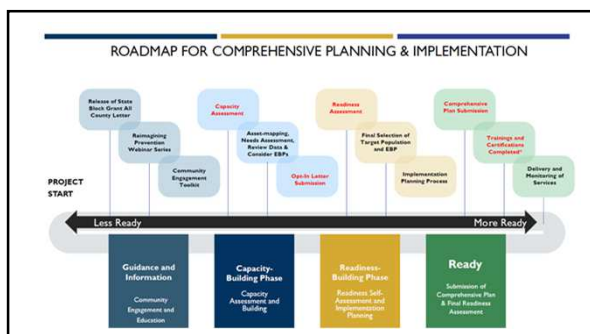
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CALIFORNIA'S FAMILY FIRST PREVENTION SERVICES PROGRAM (FFPS)

- **Leverages current prevention efforts** to reach a broader audience and reach families sooner
- Built from a **comprehensive plan** that includes culturally appropriate and responsive services that are tailored to meet the needs of local families who are disproportionately represented in the child welfare system
- Rooted in a **cross-sector collaborative approach**
- **Meets** the federal requirements of FFPSA Part 1 and **goes beyond** to deliver services across the prevention continuum
- Access to a **Community Pathway approach** to service delivery for early community-based services

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Why does all this matter?

Programs will be selected through Comprehensive Prevention Planning process

FRCs, CAPCs, and CBOs all need to be involved in the development of the Plan

Potential funding source

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FFSPA Service Categories

Mental Health
Services

In-home Parent
Skill-based
Programs

Substance Abuse
Prevention and
Treatment Services

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Mental Health Prevention & Treatment Programs and Services

- Aim to reduce or eliminate behavioral and emotional disorders or risk for such disorders
- May target any mental health issue and DSM or ICD diagnosis is not required
- Can be delivered to children and youth, adults, or families
- Can employ any therapeutic modality
- May have any therapeutic orientation
- Cannot be Medication Only

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Well-Supported Rating

- A program or service is rated as a well-supported practice if it has **at least two** contrasts with non-overlapping samples in studies carried out in usual care or practice settings that achieve a rating of moderate or high on design and execution and demonstrate favorable effects in a target outcome domain.
- At least one of the contrasts must demonstrate a sustained favorable effect of **at least 12 months** beyond the end of treatment on at least one target outcome.

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Well-Supported MH Programs



4 Programs currently in the CA Plan:

Family Check-Up

Functional Family Therapy (FFT)

Multisystemic Therapy (MST)

Parent-Child Interaction Therapy (PCIT)

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1. Family Check-Up









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Family Check-Up



The Family Check-Up® model is a brief, strengths-based intervention for families with children ages 2 through 17. The intervention aims to improve parenting skills and family management practices, with the goals of improving a range of emotional, behavioral and academic child outcomes.

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Family Check-Up

- **Target population:** families with children ages 2 to 17
- **Dosage:**
 - The three main Family Check-Up® components are scheduled individually with families based on their availability.
 - 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.

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Family Check-Up: Goals

- Improve children's social and emotional adjustment by providing assessment-driven support for parents to encourage and support positive parenting, and to reduce coercive conflict
- Reduce young children's behavior problems at school
- Reduce young children's emotional distress
- Increase young children's self-regulation and school readiness
- Improve parent monitoring in adolescence
- Reduce parent-adolescent conflict
- Reduce adolescent depression
- Reduce antisocial behavior and delinquent activity
- Improve grades and school attendance

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Essential 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 that are in school, and a videotaped observation of family interactions

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Essential Components

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.

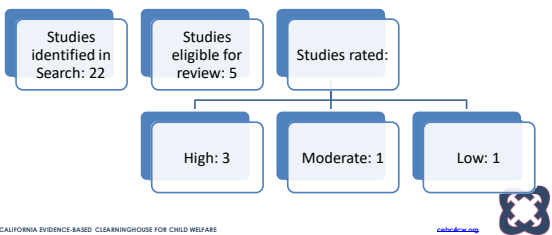
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Family Check-Up: Extent of Evidence



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Family Check-Up: Summary of Child Findings

Child well-being: Behavioral and emotional functioning	Child well-being: Cognitive functions and abilities	Child well-being: Educational achievement and attainment
<ul style="list-style-type: none"> Favorable: 0 No Effect: 23 Unfavorable: 0 	<ul style="list-style-type: none"> Favorable: 0 No Effect: 4 Unfavorable: 0 	<ul style="list-style-type: none"> Favorable: 0 No Effect: 1 Unfavorable: 0

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Family Check-Up: Summary of Adult Findings


Adult well-being: Positive parenting practices	Adult well-being: Parent/caregiver mental or emotional health
<ul style="list-style-type: none"> • Favorable: 4 • No Effect: 20 • Unfavorable: 0 	<ul style="list-style-type: none"> • Favorable: 0 • No Effect: 8 • Unfavorable: 0

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**Family Check-Up:
Study Populations**


- Race/Ethnicity examples:
 - 48.3% African American, 40% Caucasian, and 11.7% Biracial
 - 50% European American, 28% African American, 13% Hispanic American, 13% Biracial, and 9% Other
- Samples
 - Participants enrolled in the Women, Infants and Children (WIC) program
 - Families of kindergarten children recruited from 5 public elementary schools
 - Universal Well-child program

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**Family Check-Up:
Support for Implementation**

- Pre-implementation materials:
 - None
- Formal Support:
 - Available from the REACH (Research and Education Advancing Children's Health) Institute at Arizona State University
- Fidelity:
 - Measures are available
- Implementation Guides or Manuals:
 - Available on the FCU website

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Family Check-Up: Training Requirements

- Education:
 - Master's level (MSW, MS, MA, and M.Ed.) with some clinical experience.
- Training: Available in three formats:
 - In-person 2-day training;
 - Online training that consists of an e-learning course and two webinars; and
 - Hybrid training that consists of an e-learning course, 1-day in-person training, and 1-hour consultations that occur before and after training.

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2. Functional Family Therapy (FFT)









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Functional Family Therapy (FFT)

- Functional Family Therapy (FFT) is 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 youth who have been referred for behavioral or emotional problems.





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Functional Family Therapy (FFT)

- **Target population:**
 - 11- to 18-year-old youth who have been referred for behavioral or emotional problems by juvenile justice, mental health, school, or child welfare systems. Family discord is also a target factor for this program.
- **Dosage:**
 - Typically, therapists will meet weekly with families face-to-face for 60 to 90 minutes and by phone for up to 30 minutes.
 - Most families complete the FFT program in an average of 8 to 14 sessions over the span of three to six months.

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FFT: Goals

- Eliminate youth referral problems (i.e., delinquency, oppositional behaviors, violence, substance use)
- Improve prosocial behaviors (i.e., school attendance)
- Improve family and individual skills

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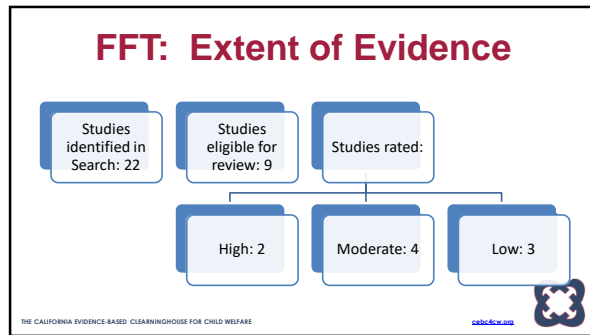

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FFT: Essential Components

- Five distinct intervention phases:
 - Engagement: Introduction/Impression (Pre-Intervention)
 - Motivation: Induction/Therapy (Early sessions)
 - Relational Assessment (by conclusion of early sessions)
 - Behavior Change (Middle sessions)
 - Generalization (Later sessions)
- Each phase has its own unique goals, risk and protective factors addressed, assessment focus, and therapist skills and intervention focus.

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FFT: Summary of Child Findings

Child well-being: Behavioral and emotional functioning	Child well-being: Substance use	Child well-being: Delinquent behavior
<ul style="list-style-type: none"> Favorable: 2 No Effect: 23 Unfavorable: 1 	<ul style="list-style-type: none"> Favorable: 10 No Effect: 8 Unfavorable: 0 	<ul style="list-style-type: none"> Favorable: 2 No Effect: 16 Unfavorable: 2

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FFT: Summary of Adult Findings

Adult well-being: Positive parenting practices	Adult well-being: Family functioning
<ul style="list-style-type: none"> Favorable: 0 No Effect: 9 Unfavorable: 0 	<ul style="list-style-type: none"> Favorable: 2 No Effect: 13 Unfavorable: 0

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FFT: Study Populations

- Race/Ethnicity examples:
 - 44% Hispanic, 29% Anglo, 11% Native American, 11% Other, and 5% African American
 - 36% African American, 36% Latino, 19% White, and 8% Other
- Sample examples
 - Adolescents with an alcohol problem from two runaway shelters and their primary caretakers
 - Adolescents with a history of aggressive behavior, destruction of property, or chronic truancy.
 - Youth sentenced for offending or receiving agency intervention following contact with the police

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FFT: Support for Implementation

- Pre-implementation materials:
 - Available on FFT website
- Formal Support:
 - Formal FFT Statewide Coordinators
- Fidelity:
 - Measures are available
- Implementation Guides or Manuals:
 - Available from FFT during training

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FFT: Training Requirements

- Education:
 - Master's level
- Training: offered by FFT LLC and FFT Associates.
 - FFT LLC - three phases: clinical (weekly consultations and activities (typically over the span of 12 to 18 months), supervision (one-day onsite training, two two-day trainings, and monthly consultations), and maintenance
 - FFT Associates'- four phases: 1) implementation and planning, 2) applying the FFT model, 3) development of on-site clinical supervision and quality assurance systems, and 4) on-going support (continuing education, technical assistance, and quality improvement).

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MST: Goals

- For youth/adolescents:
 - Eliminate or significantly reduce the frequency and severity of problem behavior(s).
 - Learn skills on how to better cope with family, peer, school, and neighborhood problems.
- For parents/caregivers:
 - Learn skills to independently address the inevitable difficulties that arise in raising children and adolescents.
 - Learn skills to help youth to cope with family, peer, school, and neighborhood problems.

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MST: Essential Components

- MST addresses the core causes of delinquent and antisocial conduct by identifying key drivers of the behaviors through an ecological assessment of the youth, his or her family, and school and community.
- The intervention strategies are personalized to address the identified drivers.

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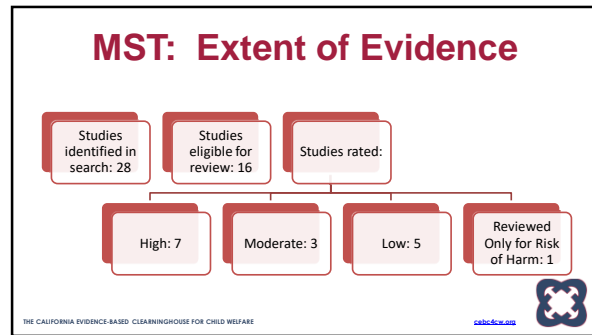

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MST: Essential Components

- 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.
- Master's level therapists from licensed MST providers take on only a small caseload at any given time so that they can be available to meet their clients' needs.

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MST: Summary of Child Findings

Child well-being: Behavioral and emotional functioning	Child well-being: Social Functioning	Child well-being: Cognitive functions and abilities
<ul style="list-style-type: none"> Favorable: 23 No Effect: 58 Unfavorable: 1 	<ul style="list-style-type: none"> Favorable: 0 No Effect: 14 Unfavorable: 0 	<ul style="list-style-type: none"> Favorable: 0 No Effect: 3 Unfavorable: 0

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MST: Summary of Child Findings

Child permanency: Out-of-home placement	Child well-being: Substance use	Child well-being: Delinquent behavior
<ul style="list-style-type: none"> Favorable: 2 No Effect: 3 Unfavorable: 0 	<ul style="list-style-type: none"> Favorable: 1 No Effect: 13 Unfavorable: 0 	<ul style="list-style-type: none"> Favorable: 17 No Effect: 62 Unfavorable: 3

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MST: Summary of Adult Findings

Adult well-being: Positive parenting practices	Adult well-being: Parent/caregiver mental or emotional health	Adult well-being: Family functioning
<ul style="list-style-type: none"> Favorable: 12 No Effect: 34 Unfavorable: 0 	<ul style="list-style-type: none"> Favorable: 3 No Effect: 2 Unfavorable: 0 	<ul style="list-style-type: none"> Favorable: 5 No Effect: 16 Unfavorable: 0

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MST: Study Populations

- Race/Ethnicity examples:
 - 80.6% African American and 19.4% White
 - 62.5% White and 37.5% African American
- Sample examples
 - Violent or chronic juvenile offenders and their primary caregivers
 - Adolescent sexual offenders referred by juvenile court personnel.
 - adolescents (and their families) between 12 and 18 years old who show serious, violent, and chronic antisocial behaviour
 - Students from Moderate Intervention Program (MIP) classrooms in public schools

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MST: Support for Implementation

- Pre-implementation materials:
 - Extensive materials available from MST Services
- Formal Support:
 - Available from MST Services or from any of the more than 20 Network Partner organizations
- Fidelity:
 - Therapist and Supervisor measures are available
- Implementation Guides or Manuals:
 - Available from MST Services

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MST: Training Requirements


- Education:
 - Supervisor: Master's level
- Training:
 - Must work for licensed MST teams and organizations.
 - MST therapists, supervisors, and other staff complete an initial five-day training.
 - Therapists that deliver MST also participate in ongoing trainings. These include quarterly clinically-focused booster sessions that aim to refresh MST skills and weekly consultations provided by MST experts.


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4. Parent-Child Interaction Therapy (PCIT)





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Parent-Child Interaction Therapy (PCIT)

- In Parent-Child Interaction Therapy (PCIT), parents are coached by a trained therapist in behavior-management and relationship skills. PCIT is a program for young children and their parents or caregivers that aims to decrease externalizing child behavior problems, increase positive parenting behaviors, and improve the quality of the parent-child relationship.

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Parent-Child Interaction Therapy (PCIT)

- **Target population:**
 - Children ages 2 - 7 years old with behavior and parent-child relationship problems; may be conducted with parents, foster parents, or other caretakers
- **Dosage:**
 - PCIT is typically delivered over 12-20 weekly hour-long sessions, but the exact treatment length varies based on the needs of the child and family.

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PCIT: Goals

- The goals of the Child-Directed Interaction part:
 - Build close relationships between parents and their children using positive attention strategies
 - Help children feel safe and calm by fostering warmth and security between parents and their children
 - Increase children's organizational and play skills
 - Decrease children's frustration and anger
 - Educate parent about ways to teach child without frustration for parent and child
 - Enhance children's self-esteem
 - Improve children's social skills such as sharing and cooperation
 - Teach parents how to communicate with young children who have limited attention spans

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PCIT: Goals

- The goals of Parent-Directed Interaction part of are:
 - Teach parent specific discipline techniques that help children to listen to instructions and follow directions
 - Decrease problematic child behaviors by teaching parents to be consistent and predictable
 - Help parents develop confidence in managing their children's behaviors at home and in public

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PCIT: Essential Components

- During weekly sessions, therapists coach caregivers in skills such as child-centered play, communication, increasing child compliance, and problem-solving.
- Therapists use “bug-in-the-ear” technology to provide live coaching to parents or caregivers from behind a one-way mirror.
- Parents or caregivers progress through treatment as they master specific competencies, thus there is no fixed length of treatment.

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PCIT: Extent of Evidence



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PCIT: Summary of Child Findings

Child well-being:
Behavioral and emotional
functioning

- Favorable: 18
- No Effect: 28
- Unfavorable: 1

Child well-being: Social
Functioning

- Favorable: 0
- No Effect: 2
- Unfavorable: 0

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PCIT: Summary of Adult Findings

Adult well-being: Positive parenting practices	Adult well-being: Parent/caregiver mental or emotional health	Adult well-being: Family functioning
<ul style="list-style-type: none"> Favorable: 20 No Effect: 5 Unfavorable: 0 	<ul style="list-style-type: none"> Favorable: 4 No Effect: 2 Unfavorable: 0 	<ul style="list-style-type: none"> Favorable: 0 No Effect: 10 Unfavorable: 0

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PCIT: Study Populations

- Race/Ethnicity examples:
 - 52% White, 40% African American, 4% Hispanic/Latino, 1% Asian, 1% Native American, and 2% Other
 - 67% Caucasian, 17% African American, 13% biracial, and 3% Hispanic
- Sample examples
 - Families at nine social services centers in Hong Kong
 - Families seen at a community mental health clinic
 - Boys with high functioning autism spectrum disorders and clinically significant behavioral problems

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PCIT: Support for Implementation

- Pre-implementation materials:
 - Information not provided
- Formal Support:
 - Information not provided
- Fidelity:
 - Measures are available
- Implementation Guides or Manuals:
 - Information not provided

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PCIT: Training Requirements

- Education:
 - Must be a licensed mental health provider with a master's degree (or higher) in a mental health field or a third-year psychology doctoral student who works under the supervision of a licensed mental health service provider.
- Training:
 - 40 hours of training with PCIT trainers and approved materials.
 - Although online-based trainings are offered, at least 30 of the 40 required hours must be in face-to-face training.

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Which Program is the Best Fit for my Agency?

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Ready Children's Community Center, Children's Hospital of Philadelphia, and others

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Why Careful Selection Matters


- The success and sustainability of an EBP begins with selecting the right one
- Negative consequences of adopting an inappropriate EBP

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Why Careful Selection Matters



- The solution may not require adopting a new program
 - Changes to internal processes
 - Expand existing EBPs in place that need more capacity
 - Build evidence for a locally developed program that seems promising




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Using the CEBC to Select & Implement Effective Programs

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Program Descriptions Include

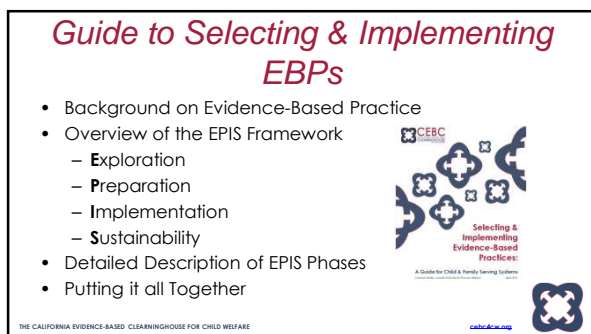
- Scientific Rating & Child Welfare System Relevance Level
- Brief Description
- Target Population
- Essential Components
- Program Goals
- Manual & Training Availability
- Delivery Method, Intensity, & Duration
- Languages Available
- Resources & Requirements Needed to Run the Program
- Published Peer-Reviewed Research
- Contact Information

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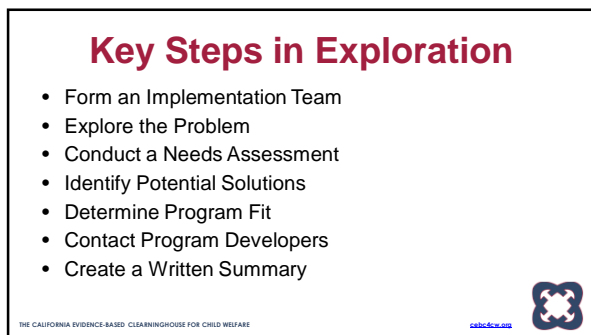
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Explore the Problem

- Identify key aspects
 - Target population
 - Time frames
 - Locations
- Use root cause analysis as needed

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Conduct Needs Assessment

- **Examine** your community and client population and your agency goals
- **Identify gaps or barriers** in current services
- **Develop a plan** to move in a more evidence-based direction



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Identifying Potential Solutions

- Identify key terms related to the problem
- Match key terms with CEBC topic areas
- Summarize potential programs or changes to current services

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CEBC Selection Guide for EBPs in Child Welfare

- Discussion questions for each domain
- Practical strategies on using the CEBC website to address each domain
- Real world examples

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Domains to Consider in the Selection Process

- Ease of Use
- External Compatibility
- Financial Considerations/
Relative Advantage
- Internal Compatibility
- Knowledge Requirements
- Match of Skill Set
- Observability of Benefits
- Reinvention/ Adaptability
- Risk
- Training/Support
- Trialability

Reference: Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, G. (2004). Diffusion of innovations in service organizations: Systemic review and recommendations. *The Milbank Quarterly*, 82(4), 581- 629.

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Example: External Compatibility

Key Questions:

- How compatible is the practice with the beliefs and values of the local community and clients?
- Is the practice compatible with the referral sources currently in place in the community – will they feel comfortable referring clients to it?

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Example: Financial Considerations / Relative Advantage

Key Questions

- What financial resources to fund the practice exist, both in the short and long term?
- What is the cost for initial and ongoing training and consultation?
- Does the practice have a clear advantage for the organization, in terms of efficiency or cost efficiency, compared to what is currently being done?

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Example: Addressing Match of Skill Set

Key Questions

- What education level or pre-existing skill set is required for staff?
- How does this fit with the existing workforce in the community?
- Are staff with the appropriate skill set/education level available to recruit?

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Can We Adapt an EBP?

- Determine if there's a need to adapt prior to program adoption
- Consider trying to adhere to the original model first. The proposed changes may be unnecessary.
- Use **caution** when adapting as it may affect outcomes
- Adaptation **may** be needed to increase program fit & likelihood of sustainment
 - **Work with Program Developer** to ensure adaptations have no unintended consequences.

(Bertram & Kerns, 2010; Chambers, Glasgow, & Strong, 2013; Castro, Barrera, & Holleran Steiker, 2010; Morawski et al., 2012; Morawski et al., 2012; Stirman et al., 2012)

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EBP Adaptations by Risk Level

Green
Light
Changes

Yellow
Light
Changes

Red
Light
Changes

- Usually minor
- Made to increase receptivity, and participation of the community
- May include program names, updated & relevant statistics, or tailored language, pictures, cultural indicators, scenarios, and other content

- Typically add or modify intervention components & contents (deletion)
- May include substitution activities, adding activities, changing session sequence, shifting or expanding the primary audience, changing the delivery format, changing who delivers the program

- Changes to program core / essential components
- May include deleting core components, cutting the program timeline, cutting the program dosage

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(National Cancer Institute, 2019)

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What Happens Next?

- Survey and certificate in the chat now
- Recording and resources available within two days
- Review Well-Supported In-Home Parent Skill-Based Programs on April 21
- Review Well-Supported Substance Abuse Programs on April 28

Stay connected for more free training & resources

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