Levels of Research Evidence and Benefit-Cost Data for Title IV-E Waiver Interventions

Research Brief (Third Edition)

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Table of Contents

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The State Title IV-E demonstration interventions were abstracted from what is publicly available on the ACF website and supplemented by recent state summaries. For related reports, see www.Casey.org. Special thanks to the Title IV-E Child Welfare Demonstration Project leaders from each jurisdiction who reviewed the summary for their state or county.

I. Introduction

Overview

Child welfare services are concerned with three main areas: child safety, permanency, and well-being. The primary goal is to protect children from harm. The second goal is to preserve existing family units, which include birth families or relative families, as appropriate. Helping youth achieve a form of legal and psychological permanence, however, may require a variety of permanency planning alternatives such as family reunification, placement with relatives, different forms of guardianship (depending upon local law), and adoption. The third goal focuses on promoting children's development into adults who can live independently and contribute to their community.[1]

Given these goals, we need to curb the "rescue" mentality that has traditionally influenced child welfare systems to treat the issue of child safety in isolation from all of the other challenges facing at-risk families. Further, we need to limit the view that the challenges families are facing can be treated in isolation from the conditions of the communities in which they live. Child welfare services are concerned with not only long-term child outcomes (e.g., self-sufficiency, healthy parenting, employment, education, and avoiding incarceration) but fostering healthy communities that support families. Thus, the child welfare service population is both at-risk families *and* the communities in which they live.[2]

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.[3] Some of these strategies have used evidence-based practices that show how the money can be allocated differently to be more effective in creating better futures and outcomes for children in at-risk families. Cost-savings resulting from foster care reductions and other program reforms need to be reinvested in high-quality and proven services for the parents and children who need services – whether in- or out-of-home, especially in times of fiscal constraint.[4] Yet the restrictions on certain funds challenge child welfare agencies to leverage their resources in this way. So, how do we better invest existing funds to address the issues listed above? How can child welfare agencies pay for innovations and interventions with known effectiveness to improve community, family, and child outcomes?[5]

Section 1130 of the Federal Social Security Act, enacted in 1994, gave the Secretary of Health and Human Services (HHS) the authority to approve waivers to Title IV-E rules for the purpose of funding demonstration projects in state or county child welfare systems. This authority provides an opportunity for states and tribes that administer Title IV-E funding to use the funds more flexibly in order to test innovative approaches for child welfare service delivery and financing. Across the country, Title IV-E Child Welfare Demonstration Projects are expected to document the benefits of a more balanced array of child welfare services.

In 2011, Congress reauthorized HHS to approve up to ten waivers per year in federal fiscal years (FY) 2012 through 2014, and it revised certain demonstration project goals and requirements. The HHS administration also highlighted child well-being as a priority area and called for an increase in the use of screening and assessment and evidence-based well-being interventions.[6] With a federally approved waiver, states can design and demonstrate a wide range of approaches to reform child welfare and improve safety, permanency, and well-being outcomes for children.[7] In FY 2012, HHS approved nine projects in Arkansas, Colorado, Illinois, Massachusetts, Michigan, Pennsylvania, Utah, Washington, and Wisconsin; in FY 2013, the Department approved eight more projects in the District of Columbia, Hawaii, Idaho, Montana, Nebraska, New York, Rhode Island, and Tennessee; and in FY 2014, the department approved nine projects in Arizona, Kentucky, Maryland, Maine, Nevada, Oklahoma, Oregon, Texas, West Virginia one tribal nation (Port Gamble S'Klallam Tribe). There are also four waiver extension states: California, Florida, Indiana, and Ohio.

Note that in 2015 Montana decided to end their waiver demonstration project. Because of intervention shifts in some states, two interventions are no longer being included in any waiver demonstration: (1) Nurse Family Partnership for Low-Income Families (NFP), (2) Head Start and Early Head Start.

This document categorizes Title IV-E demonstration interventions currently being used or proposed by the complete set of Title IV-E Waiver states and counties according to their effectiveness data. Based on a review of existing literature and resources, we have also compiled benefit-cost data, when available. Note that the benefit-cost results presented in this research brief are primarily based on program evaluation reports of specific interventions and not specific waiver evaluations. Our review and other recent investigations have found that economic analyses are badly needed in child welfare and while we present examples of benefit-cost data, these data are based on studies of varying methods, time horizons, and rigor. [8] We do not provide a systematic evaluation of the quality of these studies when presenting the available benefit-cost data.

Finally, it is important to distinguish between cost neutrality, which is a requirement of the waiver demonstration projects, and the benefit-cost data we review here. *Cost neutrality* refers to the requirement that the set of strategies implemented under the waiver demonstration projects be cost-neutral at the system level. Conversely, many of the benefit-cost studies presented are from the perspective of a single intervention.

In their research evidence and benefit-cost data, the programs we discuss here fall into one of three categories:

1. Demonstrated effectiveness and some benefit-cost data available (Section II)
2. Demonstrated effectiveness and no known benefit-cost data available (Section III)
3. Limited evidence of effectiveness and no known benefit-cost data available (Section IV)

It is important to note that while a particular intervention may be cost-effective in a particular community, it may not be appropriate for another state or county at the present time because of differences in community needs, target population, funding supports, and other factors.

Information on Waiver Interventions and Other Cautions

First, much of the information on the Title IV-E demonstration interventions was provided by the federal waiver summaries. To be as accurate as possible, a Casey Family Programs Strategic Consultant contacted each waiver state to confirm the interventions in use or planned. These state waiver intervention profiles constitute a snapshot in time – with changes to be expected – since jurisdictions are innovating to meet family needs or changing community conditions. Further, some of the states have not finalized interventions to be implemented.

Second, each intervention is rated by its level of effectiveness using the California Evidence-Based Clearinghouse for Child Welfare (CEBC), but the interventions vary in terms of how widely they have been used in child welfare and the degree to which the effects with families served by child welfare have been measured. Third, while we report the benefit-cost data that we could locate for each of the interventions, additional benefit-cost or other forms of economic analysis data may exist. This was not an exhaustive search.

II. Title IV-E Demonstration Intervention Summaries for Programs with Benefit-Cost Data

Overview

Sections II and III cluster state demonstration interventions that were rated by the CEBC according to their established criteria using the three highest levels of effectiveness for the CEBC classification system as follows:[9]

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 at least one year beyond the end of treatment.

3. ***Promising Research Evidence***: Sample criteria include at least one study utilizing some form of comparison (e.g., untreated group, placebo group, matched wait list) that has

established the practice's benefit over the 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.)

For interventions not rated by the CEBC, we also consulted these registries and websites for information:

- Blueprints: http://www.blueprintsprograms.com/
- SAMHSA National Registry of Evidence-Based Programs (NREP): http://www.nrepp.samhsa.gov/
- The Office of Juvenile Justice and Delinquency Prevention's (OJJDP's) Model Programs Guide (MPG): http://www.ojjdp.gov/mpg/Program[10]

The interventions where we found cost-savings data are listed in Table 1 below. In the sections that follow, these programs are briefly summarized.

Table 1. Title IV-E Waiver Interventions for Which We Have Benefit-Cost Analysis Data

Well-Supported by Research Evidence	*Supported by Research Evidence*	*Promising Level of Research Evidence*
• Cognitive Behavioral Therapy (CBT) • Incredible Years (IY) • Interpersonal Psychotherapy • Multi-Dimensional Family Therapy (MDFT) • Multi-Dimensional Treatment Foster Care • Multisystemic Therapy (MST) • Parent-Child Interaction Therapy (PCIT) • Parent Management Training: Oregon Model • Trauma-Focused Cognitive-Behavioral Treatment (TF-CBT) • Triple P Positive Parenting Program or Level Four Triple P	• Dialectical Behavior Therapy • Functional Family Therapy (FFT) • Healthy Families America • Homebuilders model of family-based services • SafeCare	• Alternative Response (AR) or Differential Response • Homebuilders model of family reunification services • Nurturing Parenting Program (NPP) • Parents as Teachers • Parent Child Assistance Program (PCAP) substance abuse treatment for caregivers • Project Connect • Sobriety Treatment and Recovery Teams (START) substance abuse treatment for caregivers • Strengthening Families Program • Legal Guardianship • Wraparound Services

Programs Well-Supported by Research Evidence

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) is a time-limited, evidence-based psychotherapy for treating anxiety disorders and major depressive disorders. It is:

> …an intervention for ameliorating distressing feelings, disturbing behavior, and the dysfunctional thoughts from which they spring. Improvements in target symptoms, such as anxiety and depression, are mediated through identifying and disputing the automatic thoughts that generate those feelings. Behavioral techniques, such as skills training and role-playing, are well-established ways of addressing phobias and posttraumatic reactions. These techniques also help patients develop coping mechanisms for managing the thoughts and feelings identified during the intervention.[11]

Several types of CBT have been highlighted as helpful for child welfare: remote CBT for anxious children, individual CBT for anxious children, parent CBT for anxious children, CBT for depressed adolescents, and trauma-focused CBT (see p.9). [12]

Because treating parents and other caregivers in child welfare is often as important as treating children, we also include results for adults. In terms of adult mental health, as an adjunct to medication, CBT has also demonstrated improved outcomes for adult anxiety, PTSD, depression, schizophrenia/psychosis, and bipolar disorder.[13] For substance-abusing adults, cognitive behavior coping skills therapy and brief cognitive behavioral interventions for amphetamine users also have been shown to be cost-effective.[14]

Incredible Years

Incredible Years (IY) is a training series of multifaceted, developmentally-based curricula for parents, teachers, and/or children. The program is "…designed to promote emotional and social competence and to prevent, reduce, and treat aggression and emotional problems in young children 0 to 12 years old."[15] The IY training model appears to be effective for the kinds of parenting challenges encountered by families whose children ages 2 to 12 are likely to be placed in foster care.

Interpersonal Psychotherapy

Interpersonal Psychotherapy (IPT) is a time-limited and manual-specified psychotherapy developed initially for patients with major depressive disorder but later adapted for other disorders and tested in numerous clinical trials. Delivered by trained mental health professionals, it can also be taught, with adaptations, to health workers with less training. IPT has been used with and without medication. IPT is based on the idea that the symptoms of depression have multiple causes and that the onset of depressive symptoms is usually associated with a trigger in the patient's current personal life. IPT helps the patient to identify and learn how to deal with those personal problems and to understand the relationship between their personal problems and the onset of symptoms.[16]

Multidimensional Family Therapy

Multidimensional Family Therapy (MDFT*)* is a family-centered treatment for teen drug abuse and related behavioral problems that integrates multiple intervention components. MDFT targets a range of adolescent problem behaviors: substance abuse, antisocial and aggressive behaviors, school and family problems, and emotional difficulties. It can be implemented in substance abuse and mental health treatment, child welfare, and juvenile justice systems, including detention centers and juvenile drug courts. It has been well researched, including the gathering of perceptions from teens, parents, therapists, and community collaborators.[17]

Multidimensional Treatment Foster Care

Multidimensional Treatment Foster Care (MTFC) is noteworthy for its ability to improve child behavior so children are more likely to be reunified and less likely to move from placement to placement. The goal of the MTFC program is to decrease problem behavior and to increase developmentally appropriate, normative and pro-social behavior in children and adolescents who are in need of out-of-home placement. Youth come to MTFC via referrals from the juvenile justice, foster care, and mental health systems. The intervention is multifaceted and occurs in multiple settings. The intervention components include:

- Behavioral parent training and support for MTFC foster parents
- Family therapy for biological parents (or other aftercare resources)
- Skills training for youth
- Supportive therapy for youth
- School-based behavioral interventions and academic support
- Psychiatric consultation and medication management, when needed

Three different versions of MTFC have been developed to serve specific age groups ranging from 2-17 years. Each version has been subjected to rigorous scientific evaluations and found to be efficacious. MTFC is being implemented in over 30 communities across the United States and other countries.[18] A special form of MTFC (Project KEEP) is being implemented in child welfare with weekly support to foster parents and training in behavior management. The success of this intervention in helping youth in care to be less disruptive and to exit from foster care more quickly bodes well for large-scale replication by public child welfare agencies.[19]

Multisystemic Therapy

Multisystemic Therapy (MST) is an intensive family- and community-based treatment program that focuses on addressing all environmental systems that impact chronic and violent juvenile offenders, including their families, peers, schools and teachers, and neighborhoods. MST recognizes that each system plays a critical role in a youth's world, and each system requires attention when effective change is needed to improve the quality of life for youth and their families. MST works with youth offenders ages 12 to 17 years who have a very long history of arrests. Program strategies include:

- On-call supportive therapy for youth
- Family therapy, relationship building and skills training for parents (or other caregivers)
- School and skills training for youth

- Use of sports and recreational activities as an alternative to hanging out[20]

A version of MST for families involved in child welfare has been developed called Multisystemic Therapy for Child Abuse and Neglect (MST-CAN):

> MST-CAN is for families with serious clinical needs who have come to the attention of child protective services (CPS) due to physical abuse and/or neglect. MST-CAN clinicians work on a team of 3 therapists, a crisis caseworker, a part-time psychiatrist who can treat children and adults, and a full-time supervisor. Each therapist carries a maximum caseload of four families. Treatment is provided to all adults and children in the family. Services are provided in the family's home or other convenient places. Extensive safety protocols are geared towards preventing re-abuse and placement of children, and the team works to foster a close working relationship between CPS and the family. Empirically based treatments are used when needed and include functional analysis of the use of force, family communication and problem solving, cognitive behavioral therapy for anger management and posttraumatic stress disorder (PTSD), clarification of the abuse or neglect, and reinforcement-based therapy for adult substance abuse.[21]

An additional version of MST for child welfare (Intercept) is currently being implemented as well, primarily by Youth Villages.[22]

Parent-Child Interaction Therapy

Parent-Child Interaction Therapy (PCIT) is an evidence-based treatment for preventing physical abuse for conduct-disordered young children, with emphasis placed on preventing excessive child discipline, improving the quality of the parent-child relationship, and changing parent-child interaction patterns. In PCIT, parents are taught specific skills to establish a nurturing and secure relationship with their child while increasing their child's pro-social behavior and decreasing negative behavior.[23]

PCIT in child welfare applications is primarily a *parent treatment* (i.e., it focuses on reducing maltreating parent behavior), not a child treatment. In this context, the standard PCIT inclusion criteria may not always apply, and some intervention modifications may need to be used. For example, although PCIT was originally developed as a parent-mediated treatment for early childhood disruptive behavior disorders, when used as a parent treatment in child welfare, it is not necessary that the child have any behavior problems nor that the therapist focus on necessarily changing the child's behavior. Instead, a parent's inability to be aware of a child's developmental abilities, his or her need for encouragement, and realistic limit-setting may be the areas of therapeutic work. Because of this, PCIT has been extended beyond the standard PCIT child age limits to include parents of children ages 2 to 12 years in the child welfare studies.[24]

Parent Management Training – Oregon Model™

Parent Management Training – Oregon Model (PMTO) is a group of theory-based parent training interventions that can be implemented in a variety of family contexts. The program aims to teach effective family management skills in order to reduce antisocial and problematic behavior in children ages 3 through 16 years. PMTO is delivered in group and individual family formats, in diverse settings

(e.g., clinics, homes, schools, community centers, homeless shelters), and over varied lengths of time depending on families' needs.[25]

Trauma-Focused Cognitive Behavioral Therapy

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) is a conjoint child and parent psychotherapy approach for children and adolescents who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It has mostly been used and evaluated with youth who were sexually abused or exposed to domestic violence. TF-CBT can also benefit children with depression, anxiety, shame, and/or grief related to their trauma.[26] This psychotherapy model includes parent and child individual and joint sessions in several modules that combine trauma-sensitive interventions with CBT. TF-CBT aims to (1) improve child and parent knowledge and skills related to processing the trauma; (2) manage distressing thoughts, feelings, and behaviors; and (3) enhance safety, parenting skills, and family communication.[27]

Triple P – Positive Parenting Program (Level Four Triple P)

The Triple P – Positive Parenting Program® (Triple P) is designed to prevent and treat behavioral and emotional problems in children and youth through family support systems.[28] The program aims to:

> ...prevent problems in the family, school and community before they arise, and to create family environments that encourage children to realize their potential. Triple P draws on social learning, cognitive behavioral and developmental theory as well as research into risk factors associated with the development of social and behavioral problems in children. It aims to equip parents with the skills and confidence they need to be self-sufficient and to be able to manage family issues without ongoing support. And while it appears successful in improving behavioral problems, more than half of Triple P's 17 parenting strategies focus on developing positive relationships, attitudes and conduct. Triple P is delivered to parents of children up to 12 years, with Teen Triple P for parents of 12- to 16-year-olds. There are also special programs – for parents of children with a disability (Stepping Stones), for parents going through separation or divorce (Family Transitions), for parents of children who are overweight (Lifestyle), and for Indigenous parents (Indigenous).[29]

Programs Supported by Research Evidence

Dialectical Behavior Therapy

Dialectical Behavior Therapy (DBT) is a mindfulness- and acceptance-based cognitive-behavioral therapy adapted for treating people with severe, complex, hard-to-treat multi-diagnostic conditions, in particular borderline personality disorder (BPD). Standard comprehensive DBT comprises four components:

- Individual therapy (approximately 60 minutes/week)
- Group educational skills training (approximately 120 minutes/week)
- Team meeting (approximately 90 minutes/week)
- Unscheduled telephone calls (average duration approximately six minutes)

For this review, we include DBT for Substance Abusers, which was developed by Dr. Linehan and colleagues to treat individuals with co-occurring substance use disorders and BPD. DBT for Substance Abusers focuses on the following five main objectives: (1) motivating patients to change dysfunctional behaviors, (2) enhancing patient skills, (3) ensuring the new skills are used in daily life, (4) structuring the client's environment, and (5) training and consultation to improve the counselor's skills. For substance abusers, the primary target of the intervention is the substance abuse and specific goals include reducing abuse, alleviating withdrawal symptoms, reducing cravings, and avoiding opportunities and triggers for substance use.[30]

Functional Family Therapy

Functional Family Therapy (FFT) is an evidence-based family counseling intervention targeted towards at-risk youth. While FFT is increasingly being used in child welfare, the vast majority of FFT studies are based on programs targeted toward youth who have had previous contact with the juvenile justice system or who are at-risk of delinquency. FFT consists of 12 to 14 therapy sessions over the course of three to four months, during which a clinician meets in the home with the youth and his or her family. During these sessions, the clinician progressively builds protective factors against delinquency while mitigating risk factors. The intermediate program goals focus on improving interpersonal relationships between family members and then building those skills in extra-family relationships.[31]

Healthy Families America

The Healthy Families America (HFA) model is a nationally recognized evidence-based home-visiting program model designed to work with overburdened families who are at-risk for adverse childhood experiences, including child maltreatment. It is the primary home-visiting model equipped to work with families who may have histories of trauma, intimate partner violence, mental health, and/or substance abuse issues. HFA services begin prenatally or right after the birth and are offered voluntarily, intensively, and over the long term (3 to 5 years after the birth).

The HFA model, developed in 1992 by Prevent Child Abuse America, is based upon 12 critical elements derived from more than 30 years of research to ensure that programs are effective in working with families.[32] This strengths-based, intensive home visitation program has the following explicit goals: (1) promoting positive parenting skills and parent-child interaction; (2) preventing child abuse and neglect; (3) supporting optimal prenatal care, as well as child health and development; and (4) improving the parent's self-sufficiency.[33] Note that according to CEBC, the HFA program for child well-being has stronger outcomes than the HFA model for child maltreatment.[34]

Homebuilders Model of Family Preservation Services

The Homebuilders® model of Intensive Family Preservation Services (IFPS) is a preventive intervention that consists of short-term, in-home, intensive family-based services targeted at families facing child removal.[35] The target population for the Homebuilders model is families with children (birth to 18 years) at imminent risk of placement into, or needing intensive services to return home from, foster care, group or residential treatment, a psychiatric hospital, or a juvenile justice facility.[36]

SafeCare

Formerly known as Project 12-Ways, SafeCare is a manualized parent-training curriculum for parents who are at-risk or who have been reported for child maltreatment. Trained professionals work with at-risk families in their home environment to improve parents' skills in several domains, such as planning and implementing activities with their children, responding appropriately to child behaviors, improving home safety, and addressing health and safety issues. SafeCare is generally provided in weekly home visits lasting from 1-2 hours. The program typically lasts 18-20 weeks for each family.[37]

Programs with Promising Research Evidence

Alternative Response or Differential Response

Traditional child protective services focus on investigations of possible maltreatment to determine if children have been or are at-risk of being harmed. This process often involves the juvenile court. Alternative Response allows child welfare agencies to intervene with families in more supportive ways, often by focusing on assessing families' strengths and needs, as well as the provision of community-based services. These programs are also called Differential Response, Family Assessment Response (FAR), Multi-track Response, and Dual-track Response.[38]

Note that Alternative Response is not an intervention, *per se*, but rather it is a policy that enables a family assessment and case assignment to take place. These programs are designed to divert families without severe present or imminent danger and with low risk of future child maltreatment away from formal CPS so that the family can be served by a community-based agency with no juvenile or family court involvement. In states that offer Alternative Response, investigations are still conducted for allegations of severe physical abuse, neglect, and sexual abuse.[39]

Homebuilders Model of Family Reunification Services

This application of the Homebuilders® model of home-based intervention focuses on helping children reunify with birth parents.[40] Program strategies include building family relationships, conducting skills training, addressing concrete needs, and providing in-home support after initial re-entry and reunification process.

Nurturing Parenting Program

The Nurturing Parenting Programs (NPP) are parent education programs primarily based on social learning theory, which supports the widely accepted belief that most parenting patterns are learned during childhood and replicated later in life as the child becomes a parent. The program content centers around parental expectations of the child, empathy toward children's needs, appropriate discipline techniques, parent-child role responsibilities, and children's power and independence. In addition, the NPP incorporates many characteristics associated with positive program outcomes, including teaching emotional communication and behavioral skills training and involving both parents and children so parents can practice skills learned with their child.[41]

Parents as Teachers

Parents as Teachers is a home-visiting model that encourages parental involvement and early intervention. The program works with educators, child care providers, and health providers to support community partnerships with parents to work with young children in order to achieve greater long-term success in school.[42]

Parent-Child Assistance Program

Parent-Child Assistance Program (PCAP) is a substance abuse treatment program where specially trained and closely supervised paraprofessional case managers work with families for three years, beginning during pregnancy or postpartum. Case managers provide regular home visitation and connect previously disengaged mothers to a comprehensive array of services including substance abuse treatment, housing, and mental health services.[43]

Sobriety Treatment and Recovery Teams

Sobriety Treatment and Recovery Teams (START) is a recovery coaching and collaboration model integrating substance abuse, child welfare, and behavioral health services. Families are served using wraparound parenting supports and a system-of-care approach. The intervention pairs specially trained CPS social workers with a family mentor (peer support specialists in recovery) to share a caseload of families who are involved with child welfare for substance abuse reasons. The START team (composed of the CPS caseworker and a family mentor) serve a shared caseload of 12-15 families. Family mentors are people who have been in recovery for at least 3 years and have had prior involvement with child welfare. They meet frequently with the parents, about six times per month, on average, and coordinate closely with the CPS caseworker. The program serves parents with children birth to 5 years with a substantiated incident of abuse and neglect with substance abuse identified as a primary risk factor. Parents are also referred to domestic violence, legal, medical, transportation, parenting, and medical services as needed.[44]

Strengthening Families Program

The Strengthening Families Program (SFP) program is a parenting and family strengthening program originally designed for high-risk families with children 6 to 11 years. SFP is an evidence-based family skills training program found to significantly improve parenting skills and family relationships, reduce problem behaviors, delinquency and alcohol and drug abuse in children and to improve social competencies and school performance. Child maltreatment also decreases as parents strengthen bonds with their children and learn more effective parenting skills. The program has since developed a more universal prevention version, a home-use DVD version, and a version for families with younger children and older teens.[45]

Subsidized Guardianship

The federal Title IV-E Waiver in Illinois allowed the state to pay relatives who were providing guardianship a payment roughly similar to a foster care or adoption subsidy. This approach was very successful, and it showed increases in permanency as well as increased savings estimated in the hundreds of millions of dollars.[46]

Wraparound Services

Wraparound services offer children with serious emotional disturbances and their families better coordinated and stronger linkages to community-based services:

> *Wraparound* is an intensive, individualized care planning and management process that addresses the strengths and needs of children and their families holistically, and seeks to build problem-solving and coping skills and self-efficacy, and to keep children in their homes and communities rather than institutions or other facilities.[47]

In part, the success of Wraparound depends upon the quality of the family interventions and supports that the Wraparound worker links the family to. Investment in this model of intensive care coordination, even at an initial, higher cost, results in per capita cost-savings through reduced use of expensive facility-based care (e.g., inpatient psychiatric hospitalization, residential treatment, emergency room use). Wraparound programs, with intensive care coordination at low caseload ratios, have produced quality outcomes and per capita cost-savings analogous to those expected in the health home option.[48]

III. Benefit-Cost Data for Title IV-E Waiver Practice Strategies

Multiple Types and Dimensions of Economic Data and Cost-Savings

As mentioned earlier, evidence-based practices can create better futures and outcomes for children in at-risk families. But cost savings resulting from the use of these practices and other program reforms need to be reinvested in high-quality and proven services for the parents and children who need services – whether in- or out-of-home.

Title IV-E demonstration experts have emphasized that multiple dimensions of cost and savings need to be considered, and the term *savings* has been used in different ways in various waiver discussions.[49] The primary types of economic analyses are defined next. To introduce these complexities, the types of benefit-cost and other economic analyses are presented in Table 2.

Table 2. Types of Benefit-Cost and Other Economic Analyses[50]

Types of Cost or Economic Analyses
Undertaking cost and outcome analyses—or even simple cost analyses—represents a major contribution to human services. Most of the literature on effective services in these areas assumes that service providers strive to achieve the

best outcomes without regard to budget constraints. Information about effectiveness coupled with cost information enables decision-makers to better understand the tradeoffs involved in selecting various treatment approaches and in preparing budgets.

While benefit-cost analysis is the best known of the class of cost-related analyses, several additional types of analysis also generate valuable insights. These options are presented here in *descending* order of the demands they place on data collection and analysis; i.e., cost-outcomes analyses require the most resources and also require better measures of outcomes and benefits.

Cost-outcomes analysis. This involves comparing services' costs to society to their benefits to society. This comparison generally entails expressing the costs and benefits in dollar terms so they can be compared. Benefit-cost analysis helps indicate whether a program is of value to society at large in terms of generating benefits that outweigh the costs. In a cost-outcomes analysis, however, we can estimate over time the benefits and cost savings of addressing trauma early, including those that are not monetarily defined (e.g., improvements in health outcomes and the related benefit to academic completion, later mental health service use, development of comorbidities, or earning potential). A 1998 RAND study identified that at least four types of significant savings to government are being used in a cost-outcomes analyses:

1. *Increase in tax revenues* from increased employment and earnings by program participants, including state and federal income taxes, Social Security contributions, and state and local sales taxes.
2. *Decrease in government assistance,* including Medicaid, Food Stamps, welfare, and general assistance by counties.
3. *Decrease in expenditures for education, health and other services,* including special education, emergency room visits, and homeless shelters.
4. *Decrease in criminal justice system involvement,* including spending on arrest, adjudication, and incarceration.[51]

Cost-savings analysis. This type of analysis focuses exclusively on the costs and benefits that accrue to government or another specific organization rather than to society as a whole. This kind of analysis is often used to determine whether a publicly provided program "pays for itself" and is thus justified not only by whatever human services it may render but also in financial terms alone.

Cost-effectiveness analysis. The goal of this type of analysis is to estimate the amount of spending required to realize a given outcome level or what level of outcome results from a particular expenditure. Rather than providing a full accounting of all benefits from a program or service, cost-effectiveness analysis generally focuses on one particular type of benefit, a small cluster of benefits, or an index representing multiple benefits, such as the Quality-Adjusted Life Years (QALY) index used in health care research.

A related approach is ***human capital analysis,*** which provides a framework that is consistent with observations about skill formation and helps us predict how various policies would likely affect youth and/or adults. For example, a program that successfully promotes children's human capital development would be more effective if it served children in preschool than if it were delayed until after school entry.[52]

Cost analysis. No benefits are measured as part of cost analysis. Cost analysis helps decision makers benchmark against standards in the industry, informs decision-makers about resource requirements for replicating services or other programs, and assists with other types of resource allocation decisions.

The types of benefit-cost data cited in this research brief are primarily based on program evaluation reports and not special waiver evaluations. In many cases, this is determined by comparing the cost experience of a program group compared with a control group (or other comparison group). These cost savings can be substantial as, for example, when a state with a waiver uses subsidized guardianship to move children from long-term foster care to a guardianship home, when family-finding and early intensive family therapy and permanency efforts reduce the average length of stay for residential treatment, or when timely mental health assessments and evidence-based treatments reduce the number of child placement disruptions.

Of note, these savings can produce significant shifts in foster care and/or residential treatment payments, and substantial numbers of staff hours may then be devoted to other program activities (though child welfare staff members are rarely laid off as a result of these savings). Further, some studies and several national evaluation firms like MDRC (for welfare-to-work programs) approach benefit-cost studies from multiple perspectives:

1. *The family perspective.* This perspective assesses the microeconomic impact on the family receiving the treatment. While this is an important measure of cost savings, it may be less relevant in the context of waiver demonstrations.
2. *Government budgets (federal, state, and/or local).* This perspective is especially relevant in the context of cost-neutrality determinations, and it is also a perspective of great importance to legislative appropriations committees. As noted previously, demonstrating cost neutrality is a requirement of the waiver demonstration projects for the combined set of strategies implemented under the waiver.
3. *The societal perspective.* This perspective accounts for all of the direct and indirect costs and benefits of an intervention. Many of the benefit-cost data from the cited interventions (e.g., some early childhood programs) report savings from this perspective.

Another dimension to consider is the time frame for savings (referred to as the *time horizon* by some economists). Some studies cited in this research brief report cost savings over an extended period of time (e.g., 20 years, through retirement age, a lifetime); other studies focus on a five-year period, and still others use even shorter periods. Note that the benefit-cost data summarized in this research brief reflect differing perspectives, differing methodologies, and different time horizons.

In addition, much discussion of waiver cost-savings is related to two other types of savings that are not discussed in this brief although they are the source of frequent questions from waiver states:[53]

- First, for capped allocation states, a provision in the Terms and Conditions requires that any "savings" resulting from the waiver be used for the further provision of child welfare services. Jurisdictions often want to know what this means and how to determine the amount of

savings. This brief does not address this issue. There is very little official guidance on the definition of *savings*, but essentially this calculation involves comparing expenditures on "traditional" Title IV-E uses of funds with the amount of the jurisdiction's capped allocation. If the traditional expenditures are less than the capped allocations (which conceptually represents what the jurisdiction would have received in the absence of the waiver), then there are savings; otherwise, there are no savings. Ultimately, however, there are no net savings to child welfare because the savings are reinvested in child welfare services. Thus, the provision functions as a sort of maintenance-of-effort requirement.

- Second, in addition to the waiver savings concept, the Children's Bureau has focused on the feasibility of the interventions planned by the jurisdiction, and whether the proposed waiver interventions would be sufficient in scope, quality, and cost to permit implementation. This is basically a feasibility assessment. Some of the information in this research brief may be useful to jurisdictions in gauging the magnitude of potential impacts. This is conceptually similar to looking over a relatively short-term (1- to 3-year) time period from the perspective of the agency's budget.

In summary, there are three or four different ways that the term *savings* is used in waiver planning and evaluation conversations. This research brief presents information that is closest to the cost study that is required in evaluations, with the caution that most of the recent waiver demonstrations are capped allocation waivers, so their evaluations may include other benefit-cost dimensions. For example, there are multiple ways that the term *savings* is used in waivers, and it is important to be precise when various kinds of cost-savings are presented.

Benefit-Cost Data

State-chosen interventions where we could locate any benefit-cost data are listed first in Table 3, with the corresponding data. Note that some of these interventions have not been as widely used and evaluated with child welfare populations, and that many of the benefits used to calculate the benefit-cost ratios are not just foster care savings but also include medical, mental health, employment, criminal justice, and other costs.

Table 3. Waiver Interventions for Which We Have Benefit-Cost Analysis Data

[Note that the Washington State Institute for Public Policy (WSIPP) refers to a cost-savings analysis it conducted to estimate the cost savings of that intervention if it were implemented in Washington. This website (http://www.wsipp.wa.gov/BenefitCost) is updated periodically.]

Waiver Intervention Strategy	Economic Analysis Results
Well Supported by Research Evidence	
Cognitive Behavioral	• *Canada*: In a review of 22 health economic studies of diverse populations around the

Waiver Intervention Strategy	Economic Analysis Results
Therapy (CBT)	world on anxiety, mood, and psychotic and somatoform disorders, CBT costs were lower than the benefits to society.[54] • *Washington WSIPP*: A Washington State Institute for Public Policy (WSIPP) review of studies applied to Washington State found that CBT for *adult* conditions saved the following amounts in relation to costs: amphetamine users ($10,117), anxiety ($38,046), coping skills therapy for substance abuse ($48,611), PTSD ($36,345), depression ($25,914), and schizophrenia/psychosis ($5,915).[55] These ratios imply that for every dollar invested in the program, CBT could save between $5.18 and $189.66 – with most ratios over $100. • For *children*, CBT showed the following savings per child for group therapy for anxiety ($8,322), individual therapy for anxiety ($4,954), remote therapy for anxiety ($25,257), teaching parents who have anxious children ($2,942), depressed adolescents ($55), and trauma ($6,738). These ratios imply that for every dollar invested in the program, CBT could save between $1.11 and $7.56.[56] However, for children with ADHD, CBT has a negative cost savings, returning only $0.77 for every dollar spent.
Incredible Years (IY)	• *Across Trials*: A willingness-to-pay study showed that including multiple components of the IY program was cost-effective compared to none or single components as measured by improvements in child behavior. These results were achieved by combining data from several clinical trials.[57] • *Ireland:* An internal rate of return of 13.3% per family was found in an RCT study.[58] • *Washington WSIPP:* With evaluation results applied to Washington, WSIPP found that the *Incredible Years Parent Training* alone and *Parent Training with Child Training* costs exceeded benefits by $315 and $464 per participant, with a return of $1.19 for every dollar invested, but the child training variation lost money at $0.60 for every dollar invested.[59]
Interpersonal Psychotherapy (IPT)	• *England*: A relatively small improvement in psychological functioning following a brief variation of this psychotherapy (called *Psychotherapy Intervention* or PI) may have had a significant economic impact in the six months following treatment. Namely, brief PI therapy for patients who were high users of psychiatric services resulted in a significant improvement in their psychological status and a substantial reduction in health care utilization and health care costs in the six months following treatment. Costs associated with both primary and secondary care were significantly reduced in the follow-up period.[60]
Multidimensional Family Therapy (MDFT)	• *Multi-site trial (Connecticut, Florida, Illinois, and Philadelphia):* The average weekly costs of MDFT treatment were significantly less for MDFT ($164) than standard treatment ($365). An intensive version of MDFT has been designed as an alternative to residential treatment and provides superior clinical outcomes at significantly less cost (average weekly costs of $384 versus $1,068).[61] • An intensive version of MDFT designed as an alternative to residential treatment

Waiver Intervention Strategy	Economic Analysis Results
	delivers better outcomes at one-third the cost (average weekly costs of $384 vs. $1,138).[62]
Multidimensional Treatment Foster Care (MTFC)	• *Washington WSIPP:* "Overall, taxpayers gain approximately $21,836 in subsequent criminal justice cost savings for each program participant. Adding the benefits that accrue to crime victims increases the expected net present value to $87,622 per participant, which is equivalent to a benefit-to-cost ratio of $43.70 for every dollar spent."[63]
Multisystemic Therapy (MST)	• *Midland County, Michigan:* The benefit-cost ratio ranged from 12.40 to 38.52.[64] *Washington WSIPP:* The direct cost per MST participant is about $7.068 per family.[65] In an early WSIPP study, there was a gain of approximately $31,661 per participant for taxpayers in subsequent criminal justice cost-savings. Crime victims accrue benefits that increase the expected net present value per participant to $131,918. The program generated $28.33 in savings for every dollar spent.[66] In juvenile justice, a WSIPP review of results applied to Washington showed per-family benefits exceeding costs by $15,507 and $19,648 for substance-abusing juvenile offenders, a return of $3.05 to $3.60 for every dollar invested. The child welfare benefit-cost data could not yet be calculated by WSIPP, but for youth with serious emotional disturbance (SED), a WSIPP review of results applied to Washington showed costs *exceeding* benefits by $3,124 per family, for a negative return of $0.53 for every dollar invested.[67] But in juvenile justice, a WSIPP review of results applied to Washington showed per-family benefits exceeding costs by $15,507 and $19,648 for substance-abusing juvenile offenders, a return of $3.05 to $3.60 for every dollar invested.[68]
Parent-Child Interaction Therapy (PCIT)	• *England*: PCIT was calculated to have a benefit-cost ratio of 1.89.[69] • *Washington WSIPP:* A review of studies applied to Washington found that PCIT for families in the child welfare system saves $16,731 per family and has a benefit-cost ratio of $11.55 for every dollar spent.[70] For children with disruptive disorders, the WSIPP review found that PCIT yields savings of $50 per family and $1.04 in savings for every dollar spent.[71]
Parent Management Training- Oregon Model	• *England:* One study found that it reduced the chance that conduct disorder will persist into adulthood, and it saves the public sector funds within 5-8 years under base case conditions. Total savings to society over 25 years were estimated at £16,435 per family, which compares with an intervention cost in the range of £952-£2,078 (2008-09 prices).[72]
Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)	• *Delaware*: One study found that a cost savings of $1,617 per client was realized in a 4-month period.[73] • *Washington WSIPP:* For children with trauma, TF-CBT showed savings of $6,738 per child.[74]
Triple P Positive	• *England:* Evaluations found a benefit-cost ratio of 4.84.[75]

Waiver Intervention Strategy	Economic Analysis Results
Parenting Program or Level Four Triple P	• *South Carolina:* Level four Triple P (the most intensive service level) saves $1,788 per participant by reducing child mental health problems.[76] • *Washington WSIPP:* Level 4 Triple P individual format for child's disruptive behavior could save an additional $1,668 per participant by preventing child abuse and neglect. This amounts to a $1.74 savings for every dollar spent. The Level 4 group program could result in savings of $1,668.[77] • *Washington WSIPP:* A large-scale statewide public-health roll-out for prevention purposes would return $3.22 for every dollar spent.[78]
Supported by Research Evidence	
Dialectical Behavior Therapy (DBT)	• *National estimates:* The American Psychiatric Association reported treatment costs decreased by $26,000/patient in the year of DBT, compared to the year pre-treatment ($46,000 to $20,000); with reductions of 77% in hospitalization days, 76% in partial hospitalization days, 56% in crisis beds, and 80% in emergency room contacts.[79] The Linehan report found that DBT treatment resulted in a cost-savings of $9,000 compared to treatment as usual.[80] • *Sweden:* A Swedish study showed $17,000 fewer costs (320,000SEK vs. 210SEK) comparing costs of year pre-DBT vs. year of DBT (6-18 month period of DBT). Comparing the month before DBT treatment with the 18th month of DBT treatment demonstrated cost savings of $6,000/patient ($8,000 vs. $2,000) (1SEK = 0.1494 US$).[81] • *Washington WSIPP:* A Washington state juvenile offender institution DBT program achieved a $38.05 financial benefit for every dollar spent on the DBT program, and the benefits minus costs savings of $31,243/client after costs of DBT were subtracted (2003 US dollar figures) *(WSIPP, 2004).* Note that the majority of reported cost-savings were from reductions in mental health hospitalization. Adding other service costs (e.g., police, crime reduction, ambulances, social services, housing) and lost income productivity would further enhance the cost-effectiveness analysis.
Functional Family Therapy (FFT)	• *Florida:* Youth recidivism rates are 8% lower and the Florida Redirections project has saved Florida taxpayers $193 million.[82] • *Pennsylvania:* The Commonwealth saves $14.56 for every dollar spent on this program. The potential statewide economic benefit was estimated at $136 million. For 2010, 1,642 youth were served in FFT, which translated into an economic benefit of $67 million.[83] • *Washington, DC:* The expected net benefit per participant of FFT is over $6,900.[84] • *Washington WSIPP*: Overall savings for youth in state institutions on probation were estimated at $34,196 per youth. $11.21 were saved for every dollar spent.[85]
Healthy Families	• *England:* Costs exceed benefits, with an estimated cost benefit ratio of 0.28.[86]

Waiver Intervention Strategy	Economic Analysis Results
America (HFA)	• *New York*: A group of women who received Healthy Families New York (HFNY) had an average savings of $628 (SE=$1,613) in the net cost to government over the women in the control group. Accounting for the net program cost ($4,101) resulted in a recovery of 15% to provide HFNY services. Stated differently, for every dollar invested, the program returned $0.15.[87] • *Washington WSIPP:* A review of studies applied to Washington showed per family costs exceeding benefits by $2,305 per family, a return of $0.51 for every dollar invested.[88] Because Healthy Families evaluation results have been mixed over the past couple of decades, study findings, applications, and methods should be reviewed carefully.[89]
Homebuilders model of family-based services	• *England:* Homebuilders was found to have a benefit-cost ratio of 4.02.[90] • *Washington WSIPP:* The benefit-cost ratio indicates a benefit of $5.84 for every dollar spent per participant. The total cost-savings of the program was $16,332 per participating family.[91]
SafeCare	• *England*: Expected benefits of SafeCare are just over twice as much as the costs of delivering the program.[92] • *Washington WSIPP:* A review of studies applied to Washington found that SafeCare yields savings of $2,753 per family, with a benefit of $16.54 for every dollar spent.[93] • Not much yet is known about the cost-effectiveness of the Project SafeCare augmented model.
Promising Level of Research Evidence	
Alternative Response (AR) or Differential Response (DR)	• *Colorado*: Differences in cost between AR and Investigative response (IR) were not statistically significant.[94] • *Illinois*: AR costs much less than IR cases, based on differences in foster care use.[95] • *Minnesota*: For every dollar spent on a family in Family Assessment Response (FAR), $1.59 was spent on families receiving services as usual over a 39- to 56-month follow-up period. FAR cost an estimated $1,279 less per family for this period.[96] • *Ohio*: In contrast, Ohio found slightly higher costs (a difference of $87 per family) for the non-EPS investigation pathway over a shorter follow-up period that ranged from 10 to 15 months.[97] • *Washington WSIPP*: Analyses using results from the Ohio, Colorado, Illinois, and Minnesota cost studies applied to Washington showed savings of $6.93 per family and a benefit of $3.94 for every dollar spent.[98]
Homebuilders model of family reunification services	• *Washington WSIPP:* The benefit-cost ratio indicates a benefit of $5.84 for every dollar spent per participant. The total cost savings of the program was $16,322 per participating family.[99]
Nurturing Parenting	• *Louisiana*: One statewide study found a benefit-cost ratio of 0.87, which

Waiver Intervention Strategy	Economic Analysis Results
Program (NPP)	demonstrates that the NPP approaches cost neutrality within a short period of 4.5 years, even without the consideration of long-term benefits or benefits to other systems.[100]
Parents as Teachers	• *England:* Costs exceed benefits, with an estimated cost benefit ratio of 0.84.[101] • *Washington WSIPP:* The program returns $1.07 for every dollar spent and has produced savings of $191 per participant.[102]
Parent-Child Assistance Program (PCAP) substance abuse treatment for caregivers	• *Alberta, Canada:* Net monetary benefits range from $13 million to $31 million (lifetime societal costs) from cases of Fetal Alcohol Spectrum Disorder prevented among 366 clients over a 3-year period.[103] • *Washington:* Children of mothers enrolled in PCAP reunify approximately seven months quicker than the statewide average of children age birth to 3 years who exit foster care to reunification.[104] This translates into a potential cost savings of $4,057 per case.[105]
Sobriety Treatment and Recovery Teams (START) substance abuse treatment for caregivers	• *Kentucky*: For every $1 spent on START, Kentucky avoided $2.52 in foster care provision.[106]
Strengthening Families Program	• *Iowa rural counties:* For every dollar invested in the Strengthening Families Iowa Program, $11 are saved.[107] • *Washington WSIPP:* The benefit-cost ratio for the program for parents and youth age 10-14 years indicates a benefit of $3.51 for every dollar spent per participant. The total cost savings of the program was $2,751 per participating family.[108] • Note that "family-centered interventions with a school component generally are more costly than school-based life skills training, but they offer larger benefits per youth assisted. The most effective programs strengthen youth bonds to family, school, and community, increasing protective factors while reducing risk factors. These include Adolescent Transitions, Strengthening Families, Guiding Good Choices, Project Northland, and SOAR."[109]
Subsidized Guardianship (a policy intervention)	• *Washington WSIPP:* A review of studies applied to Washington found that subsidized guardianship saves more than it costs by $7,783 per family.[110]
Wraparound Services (including the Rhode Island model)	• Investment in this model of intensive care coordination results in per-capita cost savings through reduced use of expensive facility-based care (e.g., inpatient psychiatric hospitalization, residential treatment, emergency room use). *Wraparound* programs, with intensive care coordination and low caseload ratios, have produced quality outcomes and per-capita cost-savings analogous to those expected in the health home option, but more child welfare applications need to be tested.[111]

Waiver Intervention Strategy	Economic Analysis Results
	• *Contra Costa County, California:* There was an over 75% reduction in out-of-home days for youth entering Wraparound services (July 2004 –December 2004) when comparing the six months prior to service entry to the six months after enrollment. Maintaining 30 at-risk youth in their homes and supporting them with community-based services can result in cost savings/cost avoidance of over $1 million dollars per year.[112] • *Milwaukee:* The *Wraparound Milwaukee* program has achieved notable results over its 14-year history and reports significant cost-savings. In 2007, the average monthly cost to place a youth at a traditional Wisconsin residential treatment center was more than $8,000. Due to Wraparound's lessened use of residential treatment options, Wraparound's average care cost was nearly $4,000 over the same period. Wraparound cites a drop in residential treatment placements since its inception: from 375 youth placements in 1996 to 90 placements in 2008.[113] • Ohio: Researchers estimated $3.79 million in savings ($1.2m Medicaid, $2.6m Non-Medicaid) as a result of sharing services to reduce the use of costly, intensive out-of-home placements.[114] • *Oklahoma:* A recent study of improved case management in mental health documented substantial cost-savings when Wraparound was included with other innovations.[115]

IV. Waiver Program Interventions That Have Evidence of Effectiveness but Where We Could Not Find Any Benefit-Cost Data

Waiver interventions with evidence of effectiveness but no available benefit-cost data are listed in Table 4. As mentioned earlier, these interventions are rated with asterisks in accordance with the criteria from the California Evidence-Based Clearinghouse for Child Welfare (CEBC).[116] Programs marked with asterisks fall into the three highest levels of effectiveness for the CEBC classification system. One intervention, Father Child Attachment Program, is not listed yet on CEBC but has been evaluated as effective through a randomized control trial or rigorous quasi-experimental design study. It was marked with a "+" instead of asterisks, with more pluses indicating stronger evaluation findings parallel to the CEBC criteria.

Table 4. Waiver Interventions with Effectiveness Data but No Economic Data

▪ Attachment Biobehavioral Catch-up (ABC)***	▪ Parenting with Love and Limits (PLL)**[120]
▪ Brief Strategic Family Therapy**	▪ Parents as Partners.*
▪ Child-Parent Psychotherapy (CPP)**	▪ Permanency Roundtables (PRTs)*+
▪ Circle of Security (COS)*	▪ Project Connect* substance abuse treatment for caregivers with substance use disorders (AODA) [121]
▪ Cognitive Behavioral Intervention for Trauma in Schools (CBITS)*	▪ Residentially based services (RBS) model of group care in California*[a]
▪ Coping Cat***	▪ Reunification services [Many states did not specify a particular model, but one example would be the Intercept model based on Multisystemic Therapy** (MST) used by Youth Villages.]
▪ Eye Movement Desensitization and Reprocessing (EMDR) ***	▪ Temporary Assistance for Needy Families (TANF) (TANF workers provide more than just financial assistance and can help families with concrete services such as referrals to housing, and provision of "flex services" for food, clothing, utilities, etc.)*[122]
▪ Family Connections*	▪ The Seven Challenges*[123]
▪ Family Finding (intensive)*[117]	
▪ Family Group Decision-Making (FGDM)*[118]	
▪ Father Child Attachment Program*+	
▪ Keeping Foster Parents Trained and Supported (Project KEEP)*[119]	
▪ Matrix Model Intensive Outpatient Program (IOP)**	
▪ Motivational interviewing***	

* Promising level of research evidence.

** Supported by research evidence.

*** Well supported by research evidence.

\+ Not listed yet on CEBC but has been evaluated as effective through a randomized control trial or rigorous quasi-experimental design study.

[a]Comparison groups were formed and analyzed for the Residentially Based Services (RBS) model of group care in California in Los Angeles and San Bernardino counties. They showed significantly better youth outcomes in certain areas but no cost-effectiveness studies have been conducted yet. See www.rbsreform.org.

V. Waiver Program Interventions That Are Stated in General Terms or the Interventions Do Not Yet Have Substantial Evidence of Effectiveness and Benefit-Cost Data

Waiver program interventions that are stated in general terms or do not yet have substantial evidence of effectiveness and benefit-cost data are presented in Table 5.

Table 5. Waiver Program Interventions Stated in General Terms or Lacking Outcome and Benefit-Cost Data

• Active Parenting Now (not able to be rated by CEBC) • Aftercare services and post-discharge services • Attachment, Self-Regulation and Competency Behavioral Health-Child Welfare • Child Safety, Permanency and Well-Being Roundtables (CSPAW) • Continuity of treatment approach and providers • Crisis stabilization and crisis response teams • Enhanced caseworker tools and training • Enhanced Family Support Services (EFSS) • Enhanced residential treatment services • Family engagement • Family partners as mentors • Family Team Meetings, including Ohana Family Conferences • Foster parent/birth parent partnerships • Housing vouchers as a form of increasing concrete services to families	• In-home services or therapy (intensive) based on up-front assessment (using the Protective Factors framework) for a period of up to 15 months • Intensive early intervention case management and services • Kinship Navigator services or other kinship supports Mental health services • Neurosequential Model (NMT) and brain-mapping training • Parent café model • Parenting education and support services (IB3) • Positive Indian Parenting • Project Connect • Results-Based Accountability • Relationship-based visitation and parent mentoring • Screening tools and functional assessments (evidence-based) • Solution-focused case management • Targeted foster parent/foster family recruitment • Team decision-making • Transition services for youth in out of home care • Trauma-Informed Care, practices or services

As a summary, Table A.1 in Appendix A lists all the waiver demonstration project interventions using as much specific information as we could find in various state and federal waiver summaries and through outreach to the Title IV-E demonstration coordinator in each state.

VI. Conclusions

Overall, 46 interventions chosen by states and counties with Title IV-E Waivers had evidence of effectiveness at the “well-supported” (14) and “supported” (9) or “promising” (23) levels. Our review finds that nearly all of the states with Title IV-E demonstrations have chosen to begin or expand the use of at least one of the ***25*** evidence-based practices where we found cost-savings data: 15 evidence-based practices are being used that fit the higher two levels of evidence, and an additional 10 interventions have promising levels of evidence.

In addition, states have included other evidence-based and promising interventions where we could not find cost-savings data. If implemented well, both sets of these interventions have the potential to improve child safety and the attainment of emotional and legal permanence, as well as improve child well-being and parent functioning for thousands of families. Positive benefit-cost ratios may also be possible to document someday, but they depend on the context in which the intervention is delivered (to whom and how well), the perspective of the cost study (the family, agency, government, or society), what outcomes are examined (e.g., child welfare involvement, school performance, criminal justice involvement), and over what time period.

More outcome studies with benefit-cost and other forms of economic analysis are badly needed in child welfare.[124] 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. As jurisdictions optimize their array of interventions and consider innovative funding approaches such as pay for success and social impact bonds,[125] studies that go beyond frequency analyses of management information system data will be needed.

Appendix A

Table A.1. Interventions Planned or Underway for the Title IV-E Child Welfare Demonstration States and the District of Columbia

Overview

The Department of Health and Human Services (HHS) was granted the authority to approve ten Title IV-E child welfare demonstration projects in each of FYs 2012 through 2014under Section 1130 of the Social Security Act, as amended by the Child and Family Services Improvement and Innovation Act of 2011 (P.L. 112-34).

In FY 2012, HHS approved nine projects in Arkansas, Colorado, Illinois, Massachusetts, Michigan, Pennsylvania, Utah, Washington, and Wisconsin. In FY 2013, it approved eight more projects in the District of Columbia, Hawaii, Idaho, Montana, Nebraska, New York, Rhode Island, and Tennessee. In FY 2014 the final cohort of nine states including Arizona, Kentucky, Maryland, Maine, Nevada, Oklahoma, Oregon, Texas, West Virginia and one tribal nation (Port Gamble S'Klallam Tribe) were approved. There are also four waiver extension states: California, Florida, Indiana, and Ohio. In March 2015, Montana requested to withdraw from the Waiver. Waiver strategy updates for Nevada and New York have not yet been completed or disseminated publically.

This table lists the major interventions that were identified by each of these states at the time that the following federal summaries were published; they have since been updated, where possible, by the Casey Family Programs Waiver Technical Assistance Team:

- "Terms and Conditions" agreements developed by each waiver state and the U.S. Children's Bureau.
- U.S. Children's Bureau. (2013a). *Profiles of the Title IV-E Child Welfare Waiver Demonstration Projects - Volume II: Demonstrations Active as of Federal Fiscal Year 2013 Volume II.* Washington, DC: Author.
- U.S. Children's Bureau. (2013b). *Summary of the Title IV-E Child Welfare Waiver Demonstrations*. Washington, DC: Author.

State (Approval Year)	Intervention Strategies to Be Implemented as Part of the Child Welfare Demonstration Project
Arizona (2014)	*Assessment:* • Organizational readiness for change • Collaboration *Interventions:* • Motivational Interviewing • Peer-Parent Support • Trauma-Informed Therapy(ies) (strategies not yet specified)
Arkansas (2012)	*Assessment:* • Enhanced clinical and/or functional assessment [e.g., Child and Adolescent Needs and Services Assessment, Emotional

State (Approval Year)	Intervention Strategies to Be Implemented as Part of the Child Welfare Demonstration Project
	Quotient Inventory-Youth Version] • Structured Decision-Making (SDM) *Interventions:* • Alternative/Differential Response • Family Team Decision-Making meetings (engagement)[a] • In-home services (expanding) • Parent education and mentoring (e.g., Nurturing Parents, possibly SafeCare) • Permanency Round Tables (PRTs) • Resource/kinship family recruitment and support in terms of targeted family recruitment • Trauma-informed or other enhanced therapeutic services[b] (e.g., Trauma-Focused Cognitive Behavioral Therapy)
California (Waiver Extension State)	*Assessment:* • Enhanced clinical and/or functional assessment[c] • Up-front assessments of cases at high risk for domestic violence, substance abuse, and mental health issues *Interventions:* • Alternative/Differential Response • Concrete services and supports[d] • Family Team Decision-Making conferences expansion • Family preservation/stabilization • Flexible funding • Independent living/transition services • L.A. County Probation Department (LACPD) enhanced cross-system case assessment and case planning • LACPD expanded use of Functional Family Therapy • LACPD expanded use of Multi-Systemic Therapy • LACPD restructured placement services and increasing utilization of aftercare support services • Mobile crisis teams • Parent education and mentoring • Redesigned group care/residential treatment services (RBS model of group care) • Resource/kinship family recruitment and support • Specialized permanency units focused on family finding and engagement • Trauma-informed or other enhanced therapeutic services
Colorado (2012)	*Assessment:* • Enhanced clinical and/or functional assessment • Trauma-informed child assessment tools *Interventions:* • Adolescent treatment: Multi-Dimensional Family Therapy (MDFT), Multi-Systemic Therapy (MST), Multi-Dimensional Treatment Foster Care (MDTFC) • Adults: Motivational interviewing for substance abuse, cognitive therapy for depression, and interpersonal psychotherapy • Enhanced family engagement via the Family Connections model, training, coaching, peer mentoring, Solution-Based Casework, and the establishment of a standardized Family Meeting model[126]

State (Approval Year)	Intervention Strategies to Be Implemented as Part of the Child Welfare Demonstration Project
	• Enhanced intensive case management • Kinship supports (e.g., referral networks, support groups as well as discretionary funds for non-certified kinship parents) • Parent Training: Parent-Child Interactional Therapy (PCIT), Parent Management Training – Oregon Model, The Incredible Years, Triple P Positive Parenting program • Permanency Roundtables (optional by county) • Resource/kinship family recruitment and support • Trauma-informed child and parent enhanced therapeutic services, such as Coping Cat, Eye Movement Desensitization Reprocessing (EMDR), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
District of Columbia (2013)	*Screening:* • Identify domestic violence situations (where the target population is vulnerable youth) *Interventions:* • Domestic violence services improvement • Homebuilders intensive in-home family preservation services (target population is families with children 0-6 years) • Project Connect intensive in-home family preservation services for families affected by parental substance abuse, domestic violence, and mental health issues (target population is families with children in out-of-home care for 6-12 months who have a goal of reunification) • Expansion of in-home early intervention programs through: o Father-Child Attachment Program o Home visiting (Healthy Families America and Parents as Teachers) o Nurturing Parenting Program o Parent and adolescent support services to families of youth ages 10 to 17 who have committed status offenses o Parent education and support to offer concrete services, home-visiting, and other services • Address the health and mental health needs of youth in foster care (e.g., each child has a medical home, regular wellness medical visits, trauma treatment where indicated) • Prevent foster care entry or re-entry (e.g., family-based substance abuse treatment program)
Florida (Waiver Extension State)	*Assessment:* • Improved needs assessments *Interventions:* FL will continue to expand the array of community-based services through community-based care organizations which may include: • Development and implementation of face-centered evidence-based programs and case management practices • Development of resource family recruitment and training • Early intervention services • Evidence-based, interdisciplinary, and team-based in-home services • Implementation of evidence-based practices to increase effectiveness of mental health and substance abuse screening and treatment • Long-term supports to prevent re-referral • One-time payment for goods or services such as housing or child care • Services that promote expedited permanency through reunification • Strategies to increase access to medical and dental care and to monitor psychotropic medications

State (Approval Year)	Intervention Strategies to Be Implemented as Part of the Child Welfare Demonstration Project
	Other: • Development and deployment of consistent statewide metrics to improve performance in educational outcomes • Expansion of the function of ACCESS (Public Assistance and Supplemental Nutritional Assistance Program) Child in Care Units to ensure connection to Medicaid and public assistance
Hawaii (2013)	Overall: Implement an enhanced crisis response and intensive home-based services system to prevent unnecessary out-of-home placement. Special populations for some of the work are short-stayers (in care for fewer than 30 days) and long-stayers (in care for longer than 60 days). *For short-stayers:* *Assessment:* • Intensive home-based services with rapid assessments conducted using standardized tools, including NCFAS as the family functioning and child well-being assessment tool *Interventions:* • Crisis response team (CRT): A new team of social workers to do in-home assessment of safety and risk that attempt to keep children in home or placed with relatives • Early Family Team Meetings, including 'Ohana Conferences • Increased family visitation (called *increased 'Ohana family visitation time*) – for children who are designated as not likely to return home within two months • Intensive home-based services (IHBS) with rapid assessments conducted using standardized tools (an IHBS will be provided within 4-8 hours of a referral and use several rapid assessment instruments to gather information on strengths and needs with the goal of keeping children safely in the home. IHBS therapists will use North Carolina Family Assessment Survey (NCFAS) as the family functioning and child well-being assessment tool.) *For long-stayers (after 4 months):* *Assessment:* • Rapid assessments conducted using standardized tools (e.g., AARP, CBCL, and CECPS under consideration) *Interventions:* • Early Family Team Meetings, including 'Ohana Conferences • Permanency Roundtables (called *SPAWS*: Safety, Permanency and Well-Being roundtables) • WRAP services (a version of Wraparound services)
Idaho (2013)	Overall: Implement (1) a trauma-informed system of care, (2) evidence-based parent education and support, and (3) Family Group Decision-Making. *Screening:* • Idaho has selected the Child and Adolescent Needs and Services (CANS) as a functional assessment to be implemented as part of the waiver demonstration work. *Assessment:* • Training and other forms of workforce development *Interventions:* • Family Group Decision-Making • The Nurturing Parenting Program

State (Approval Year)	Intervention Strategies to Be Implemented as Part of the Child Welfare Demonstration Project
Illinois (2012)[127]	*Assessment, especially for children ages birth to 3 years:* • Ages and Stages Questionnaire – ASQ (3rd ed.) • Ages and Stages Questionnaire : Socio-Emotional (ASQ-SE) • Child and Adolescent Needs and Services (CANS) • Denver Developmental Screening Test II • Devereaux Early Childhood Assessment for Infants and Children (DECA-I/T) • Infant Toddler Symptom Checklist • Abdin's Parenting Stress Inventory (PSI) *Interventions:* • Child Parent Psychotherapy (expanding) • Enhanced intensive case management • Family preservation/stabilization • Nurturing Parenting Program[128] • Trauma-informed or other enhanced therapeutic services
Indiana[g] (Waiver Extension State)	*Overall:* Indiana's 2012 Waiver extension includes all children served by DCS under the age of 18 as well as their families and provides the State with the flexibility to offer a broader array of services. The extension enables waiver service provision to more closely mirror DCS' practice model and the Safely Home, Families First philosophy, which aims to keep children safely in their own homes or with relatives. *Interventions:* • Family-Centered Treatment (FCT) (strategies not yet specified) • Safely Home[129] • Families First • Child and Family Team Meeting (CFT) Examples of other new programs implemented due to the flexibility of the waiver include: • Children's mental health initiative • Family evaluation/multi-disciplinary team • Child Parent Psychotherapy • Sobriety treatment and recovery teams • Comprehensive home-based services, such as family-centered treatment, motivational interviewing, and trauma-focused cognitive behavioral therapy.
Kentucky (2014)	*Interventions:* Early and Specialized Focus on Permanency (ESFP). ESFP focus will be on prevention of child placement and the reduction in length of stay for those children who may be placed. The department intends to require a minimum of two evidence-based practices (EBPs) that address substance use and domestic violence. The ESFP program will focus on children ages 0-9 years whose parents have substance abuse and/or domestic violence risk factors and whose children are at moderate to imminent risk of entering out-of-home care. Contractors will be required to offer to two EBPs as part of ESFP.[130] The EBPs that may be included are: • Active Parenting Now

State (Approval Year)	Intervention Strategies to Be Implemented as Part of the Child Welfare Demonstration Project
	• Active Parenting Now - Teen • Brief Strategic Family Therapy • Cognitive-behavioral therapy • Dialectical Behavior Therapy • Homebuilders model • Motivational interviewing • Nurturing Parenting Programs • Parent-Child Interaction Therapy (PCIT) • Seven Challenges • Solution-Focused Therapy • Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) • Sobriety Treatment and Recovery Teams (START)[131]
Maine (2014)	*Interventions*: *Implement evidence-based parenting support and trainings:* • Positive Parenting Program or Triple P – Triple P targets parents and caregivers of children and adolescents with moderate to severe behavioral and/or emotional difficulties between the ages of birth to 12 years. *Implement evidence-based substance abuse programs:* • Matrix Model Intensive Outpatient Program (IOP) for substance abuse is a Medicaid-funded, intensive ambulatory level of care, substance abuse treatment service for adults. Currently, the majority of individuals referred for substance abuse treatment from the child welfare system are treated through IOP. IOPs provide an intensive and structured program of alcohol and other drug assessment and group treatment services in a non-residential setting. IOPs include structured clinical and educational sessions.[132]
Maryland (2014)	Maryland is focused on creating a trauma-informed, responsive system. *Screening:* (expand trauma-informed assessments for children 0-8 and 14-17) • Child and Adolescent Needs and Strengths Assessment (CANS MD) and CANS Family (CANS-F) • Maryland Family Risk Assessment (MFRA) (expanding) • Safety Assessment for Every Child (SAFE-C) (expanding) *Interventions*: (Implement evidence-based and evidence-informed programs for children 0-8 and 14-17) • Family Connections/Trauma-Adapted Family Connections. Family Connections is a multifaceted, community-based program that works with families experiencing difficulty in meeting the basic needs of their children and at-risk for child emotional and/or physical neglect. • Functional Family Therapy (FFT). FFT is designed for 11- to 18-year-olds with behavioral health problems including conduct problems and substance abuse problems. It is geared towards improving family relationships by teaching families how to promote the safety of their children, improve communication skills, and improve skills for solving family problems. • Homebuilders. Homebuilders is an intensive family preservation program intended to keep children from being placed out of home. Homebuilders works with the caregivers to provide in-home crisis intervention, counseling, and life skills education over a short period. • Multi-Systemic Therapy (MST). MST is an intensive program that uses an environmental systems approach to work closely with youth with involvement in the juvenile justice system. MST works with 12- to 17-year-olds and their parents and

State (Approval Year)	Intervention Strategies to Be Implemented as Part of the Child Welfare Demonstration Project
	caregivers. • Parent Management Training, Oregon Style (PMTO). PMTO consists of a set of parent training interventions intended to improve parenting practices and to decrease and prevent family coercion, youth conduct problems, substance abuse, internalizing and externalizing behaviors, and other issues among children. • Parent-Child Interaction Therapy (PCIT). PCIT is an evidence-based intervention designed for young children with behavioral and emotional disorders. PCIT is typically conducted through weekly, half-hour parent-child sessions. • Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). TF-CBT is a clinical intervention that includes psycho-education about child trauma and trauma reminders; parenting components; relaxation, affective modulation, and cognitive coping skills tailored to the youth, family and culture; *in vivo* mastery of trauma reminders; and conjoint youth-parent sessions. *Establishment of Specific Programs to Prevent Foster Care Entry or Provide Permanency.* The establishment of one or more of the following programs that are designed to prevent infants, children, and youth from entering foster care or to provide permanency for infants, children and youth in foster care: • An intensive family finding program • A kinship navigator program • A family counseling program, such as family group decision-making, which may include in-home peer support for families • A comprehensive family-based substance abuse treatment program • A program through which special efforts are made to identify and address domestic violence that endangers infants, children, and youth and puts them at-risk of entering foster care. • A mentoring program. *Other:* • Limiting use of residential treatment and group care (congregate care): The development and implementation of a plan that ensures that congregate care is used appropriately and reduces the placement of children and youth in such care. • Plans for addressing health and mental health needs of children in foster care: The development and implementation of a plan for meeting the health and mental health needs of infants, children, and youth in foster care. Title IV-E Guardianship Assistance Program: An amendment to the title IV-E plan that exercises the option to implement a kinship guardianship assistance program. • Preparing youth in transition: The establishment of procedures designed to assist youth as they prepare to transition out of foster care
Massachusetts (2012)	*Assessment:* • Child and Adolescent Needs and Services (CANS) *(*to better track outcomes throughout the intervention and match the appropriate intervention to those in congregate care)[133] *Interventions:* Caring Together Initiative – focused on children and youth in residential care, which includes: • Follow Along: an intensive home-based family intervention for children and youth preparing to return home or to the community from congregate care, performed by a team of high-level social workers. Services continue with the same caseworkers after transition home with continued access to therapy and recreational activities of congregate care and continued access to respite. • Stepping Out Services: transitional services to youth who have transitioned to living independently after receiving pre-independent living and independent living group home services. The focus is on individual supports to achieve independence and build lifelong relationships. Youth are allowed continued access to the services of their former group

State (Approval Year)	Intervention Strategies to Be Implemented as Part of the Child Welfare Demonstration Project
	home setting. • Continuum Services: services provided to children and youth at-risk of residential placement where the family is identified at intake as either able to care for the child at home with intensive support or able to immediately begin intensive work toward reunification. The services are provided through a team of social workers and therapists and include: o Youth and family outreach o Crisis prevention and intervention support o Long-term and short-term out-of-home care if needed • Family Partners: Family partners are parents who have been through the child welfare system and can partner with parents of children in congregate care for support and mentorship. The Family Partners stay with the family through the transition back home from congregate care. *Other:* • MA will also work towards performance-based contracting with congregate care to financially incentivize outcomes.
Michigan (2012)	*Screening:* • Child trauma screening using the Trauma Screening Checklist for children 0-5 years[134] • Family screening using a "family psychosocial screen"[135] *Assessment:* • SDM Safety Planning: The SDM re-assessment tool will be used at each family in-person interaction to better assess safety and match family to appropriate safety services. • Strengthening Families Protective Factors Survey *Interventions:* • Enhanced intensive case management • Concrete assistance: through the use of flexible funds, concrete assistance will be offered in the form of (1) financial support; (2) bus tokens, cab fare; (3) day care; (4) housing assistance; (5) legal fees; (6) essential household needs. • Long-term family engagement[136] • Family engagement and long-term support[137] • Intensive early intervention case management and services • Referrals to appropriate community resources based on screenings and assessments • Safety assessment and planning • Strengthening Families assessment and practice framework[138] • Strengthening Families Program (SFP). SFP is an evidence-based family skills training program found to significantly reduce problem behaviors, delinquency, and alcohol and drug abuse in children and to improve social competencies and school performance. *Other:* • Performance-based contracting
Nebraska (2013)	*Overall:* Implement (1) an Alternative Response system and (2) results-based accountability into the State's performance and contract monitoring system. *Assessment* • SDM screening tool *Interventions:*

State (Approval Year)	Intervention Strategies to Be Implemented as Part of the Child Welfare Demonstration Project
	• *Alternative Response*[139] The Alternative Response system will include: o A comprehensive assessment of child safety and well-being, and of family strengths and needs o The provision of concrete supports and voluntary services such as meeting basic needs, housing assistance, child care, and mental health and substance abuse treatment o Referral to an expanded array of EBP, which may include: ▪ Parent-Child Interaction Therapy (PCIT): PCIT is an evidence-based approach to improving parental capacity and child/parent interactions. ▪ Positive Parenting Program (Triple P): The overall Triple P program is a multi-tiered system of five levels of education and support for parents and caregivers of children and adolescents. ▪ Wraparound services
Nevada (2014)	Note that waiver strategy updates for Nevada have not yet been completed or disseminated publically. *Assessment:* • Safety Plan Determination (SPD), which assesses how to achieve the least intrusive and most effective means for protecting children by "ruling in" or "ruling out" in-home safety management. Interventions: • Implement a safety management services model called *Safety Assessment Family Evaluation* (SAFE), which includes safety management services, in-home safety plans, community resources to assist Division of Child and Family Services (DCFS) in meeting in-home safety management objectives, and more effective use of family network resources.[140]
New York (2013)	*Overall:* New York State will seek to improve outcomes for children in out-of-home care and in aftercare subsequent to placement. New York City (ACS) will implement Strong Families NYC as its IV-E Waiver project. The initiative will promote greater stability, permanency and well-being for children in family foster care, and their families. *Screening*: As part of Strong Families NYC, every child in family foster care and their caregiver are screened for trauma and resilience as well as mental health, educational and behavioral health needs using the CANS–NY. Better assessments and trauma screening will improve planning and service delivery. *Interventions:* Strong Families NYC will implement trauma-focused and evidence-based behavioral health interventions within a framework that strengthens the knowledge and practice of child welfare staff and increases collaboration between child welfare and mental health services. • Partnering for Success (PfS) builds new bridges between foster care caseworkers and mental health clinicians in order to improve the coordination and delivery of behavioral and mental health care for children and families. The intervention includes the full suite of Cognitive Behavioral Therapies (CBT+), an evidence-based model proven effective in addressing anxiety, depression, behavioral issues and trauma. It also includes training and coaching that supports skills for parent engagement, and promotion of family and child well-being. • Attachment Biobehavioral Catch-up (ABC): Provides young children and their caregivers with a 10-week evidence-based intervention that improves the caregiver's ability to respond to infants' and toddlers' emotional and behavioral cues, encouraging secure attachment and the child's long-term self-regulation of stress.

State (Approval Year)	Intervention Strategies to Be Implemented as Part of the Child Welfare Demonstration Project
	Other: • As part of a structural reform, Strong Families NYC reduces the caseloads of caseworkers and supervisors. Reduced caseloads allow caseworkers to provide more intensive, higher quality services and more detailed assessments. Reduced caseloads also improve worker retention and reduce turnover.
Ohio (Waiver Extension State)	*Note that the Ohio waiver may be ending soon.* *Interventions:* • Enhanced visitation • Family Team Meetings • Flexible funding • Kinship family recruitment and support[141] • Trauma-informed or enhanced therapeutic services
Oklahoma (2014)	The Oklahoma waiver efforts focus on children ages 0-12 year who are at-risk of entering or re-entering the foster care system, or who are in the foster care system. *Assessment:* During investigation, assessments include: • Assessments of child safety • Family inventory of needs determination • Family Resources Scale (Dunst) Interventions: • Short-term, intensive home-based services for domestic violence, parental depression, home safety and environment, and substance abuse -- called *Intensive Safety Services* (ISS) (no particular HBS model specified but the following interventions below will be offered). • Cognitive behavior therapy • Healthy Relationships – a domestic violence program • Managing child behavior modules • Motivational interviewing ISS workers will link families with community-based services, including: • Parent Child Interaction Therapy (PCIT) • Trauma-focused CBT • Substance abuse services: Sobriety Treatment and Recovery Teams(START) or Parent Child Advocacy Program (PCAP) • Psychiatric services (not specified) Establishment of specific programs to prevent foster care or increase permanency including: • Intensive Family Finding • Kinship Navigator

State (Approval Year)	Intervention Strategies to Be Implemented as Part of the Child Welfare Demonstration Project
	• Family Group Decision Making • Substance abuse services (specific model not specified yet) • A program to identify and address domestic violence (specific model not specified yet) • A mentoring program (specific model not specified yet) Limit use of congregate care: Development and implementation of a plan to ensure congregate care placements are used appropriately, and reduce use of congregate care
Oregon (2014)	*Interventions:* Intensive Family Engagement Strategy*:* The intervention includes a structured set of services to support the following: • Family find (family finding) • Family meetings • Family Navigators (The Family Navigator Program assists eligible families in navigating the child welfare and human services to promote better accessibility and coordination of services.)[142]
Pennsylvania (2012)	*Overview - New 3 Stage Approach to Child Welfare Services:* Engagement: through the use of Family Group Decision Making (FGDM), Family Team Conferencing (FTC*),* and county-specific strategies Assessment: Use of CANS, FAST, and county-specific strategies Evidence-based interventions*: to be determined during the first year of waiver for all counties* *Alleghany County:* Engagement: FTC for all children Assessment: CANS for 5- to 17-year-olds, and FAST (still under development) *Dauphin County:* Engagement: County-specific strategy that includes (1) pre-court meeting, (2) family engagement meeting, (3) family group conferencing, (4) blended perspectives meeting, (5) team meetings, and (6) restorative practices Assessment: FAST for all families; CANS for children over the age of 5 years with a high FAST score; and Ages and Stages for 0 to 5-year-olds Evidence-based interventions: *to be determined during the first year of waiver for all counties* *Lackawanna County:* Engagement: County-specific strategy that includes (1) family finding; (2) family group decision making (FGDM); (3) family team meetings; (4) teaming meetings Assessment: FAST for all families; CANS for children over the age of 5 years Evidence-based interventions: *to be determined during the first year of waiver for all counties* *Philadelphia County:* Engagement: family group decision making (FGDM), family team conferencing (FTC), and county-specific strategies

State (Approval Year)	Intervention Strategies to Be Implemented as Part of the Child Welfare Demonstration Project
	Assessment: CANS and FAST countywide Interventions: Evidence-based practices *to be determined* *Venango County:* Engagement: family group decision making (FGDM), family team conferencing (FTC), and county-specific strategies Assessment: FAST and CANS for those with a high FAST score Interventions: Evidence-based practices *to be determined*
Port Gamble S'Klallam Tribe (2014)	*Interventions:* • Positive Indian Parenting[143] • Family Group Decision Making[144]
Rhode Island (2013)	Overall: Rhode Island's core intervention for purposes of the demonstration is Wraparound services. Their goal is to reinvest funding from a reduction in the utilization of residential treatment into increasing the array of evidence-based community services. This is pending and is being negotiated with HHS. *Interventions:* • Wraparound services
Tennessee (2013)	Overall: Tennessee's waiver demonstration project is designed to reduce both admissions into foster care and length of stay in foster care.. [145] *Assessment:* To reduce admissions into care, Tennessee will use a standardized assessment tool, the Family Advocacy and Support Tool (FAST), to better understand needs and to inform which services are most appropriate for families. *Interventions:* • An evidence-informed parenting program will be implemented to increase parenting skills and nurturing environments for children in order to help children remain safely at home. • Assessment, investigations, and in-home staff will also be trained to better engage and support families to engage in services. • To reduce length of stay in care, Tennessee will use the evidence-informed parenting program in an effort to increase the likelihood and speed of reunifications, alongside Project KEEP to better support foster parents and help children stabilize in their foster homes. Staff will also be trained to increase their own engagement skills.
Texas (2014)	*Interventions:* • Keeping siblings together: For infants, children, and youth in out-of home placements, substantially increasing the number of cases of siblings who are in the same foster care, kinship guardianship, or adoptive placement, above the number of such cases in fiscal year 2008. • Multi-Dimensional Treatment Foster Care (MDTFC) • Parent Management Training -- Oregon Model (PMTO) • Project KEEP (Keeping Foster Parents Trained and Supported) • SafeCare • Triple P – Level 4

State (Approval Year)	Intervention Strategies to Be Implemented as Part of the Child Welfare Demonstration Project
Utah (2012)	Overall, Utah is focusing on caseworker tools and training[146] and bolstering community resources through expansion of evidence-based programming. *Interventions:* • Strengthening Families Program (SFP): SFP is an evidence-based family skills training program. • Systematic Training for Effective Parenting (STEP), a multi-component parenting education curriculum *Other:* • National Child Traumatic Stress Network (NCTSN) child welfare training curriculum to ensure that staff can recognize and properly address trauma in children, youth, and families. • Inventory of DCFS contracts and community resources for in-home services to understand the availability of EPB
Washington (2012)	*Assessment:* • Enhanced child and family clinical and functional assessment (e.g., child's safety and family strengths and needs) *Interventions:* • Alternative Response (Family Assessment Response- FAR) • Concrete services and supports as well as voluntary services such as housing vouchers, food, clothing, utility assistance, mental health services, drug and alcohol treatment, and employment assistance • Homebuilders family preservation/stabilization • Incredible Years parenting program • Project Safe Care • Triple P - Positive Parenting Program
West Virginia (2014)	*Overall:* Safe at Home West Virginia will implement Wraparound model and enhanced service array to decrease frequency and duration of congregate care. *Assessment:* • West Virginia Child and Adolescent Needs and Strengths (CANS-WV) for all children involved in the child welfare system (trauma-informed assessments for youth and their families • Comprehensive assessment and planning • Family functioning assessment • Youth behavioral evaluation • EPSDT • Protective Capacity Family Assessment • Casey Life Skills (CLS) *Interventions:* (may include) • Appropriate treatment planning that involves children and families • Evidence-informed and evidence-based services and supports
Wisconsin (2012)	*Overall:* A re-entry prevention predictive risk model designed for the waiver will be used to target the waiver intervention to families at highest risk of re-entry. *Interventions:* • Solution-focused case management services

State (Approval Year)	Intervention Strategies to Be Implemented as Part of the Child Welfare Demonstration Project
	• May include the following interventions: o Child Parent Psychotherapy o Parent-Child Interaction Therapy o Trauma-focused cognitive behavioral therapy • Enhance access to services such as: o Crisis stabilization o Community-based Parent Cafés o In-home therapy o Peer parent mentors o Respite care o Substance abuse and mental health treatment for parents o Transportation

[a]Examples, depending upon the particular state, include family finding and kinship navigator services.

[b]Examples, depending upon the particular state, include parent-child interaction therapy, trauma-focused cognitive behavioral therapy, and multi-systemic therapy.

[c]Examples, depending upon the particular state, include the Child and Adolescent Needs and Strengths (CANS) assessment and the Ages and Stages Questionnaire.

[d]Examples, depending upon the particular state, include refer to time-limited, case-specific concrete services and supports such as assistance with transportation, child care, utilities, rent, etc.

[e]Six states (California, Florida, Indiana, North Carolina, Ohio, and Oregon) have received title IV-E waivers to implement what were referred to broadly as "flexible funding" waiver demonstrations. While varying widely in terms of scope, service array, organizational structure, and payment mechanisms, all of these demonstrations shared the core concept of allocating fixed amounts of title IV-E dollars to local public and private child welfare agencies in an effort to provide new or expanded services that prevent out-of-home placement and/or facilitate permanency. The fundamental assumption underlying flexible funding demonstrations was that the cost of these services would be offset by subsequent savings in foster care expenditures.

[f]Examples, depending upon the particular state, include family team meetings (FTMs) and family group decision making (FGDM).

[g]The identification of specific programs and services to be implemented through Indiana's waiver is pending the finalization of contracts.

VIII. Endnotes

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

[3] See for example:

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- 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.

[4] 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.

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[9] See http://www.cebc4cw.org/.

[10] The Office of Juvenile Justice and Delinquency Prevention's (OJJDP's) Model Programs Guide (MPG) contains information about evidence-based juvenile justice and youth prevention, intervention, and reentry programs. It is a resource for practitioners and communities about what works, what is promising, and what does not work in juvenile justice, delinquency prevention, and child protection and safety. MPG uses expert study reviewers and CrimeSolutions.gov's program review process, scoring instrument, and evidence ratings. The two sites also share a common database of juvenile-related programs.

[11] Rotter, M., & Carr, A. (2010). *Targeting criminal recidivism in justice-involved people with mental illness: Structured clinical approaches*. Washington, DC: The CMHS National GAINS Center. Retrieved from: http://gainscenter.samhsa.gov/cms-assets/documents/69181-899513.rottercarr2010.pdf.

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[14] For adult benefit cost data on CBT for adults across various conditions, see: http://www.wsipp.wa.gov/BenefitCost, pp. 6-7.

[15] From Incredible Years FAQ. Retrieved from http://incredibleyears.com/about/incredible-years-series/.

[16] Retrieved April 2, 2015 from http://www.cebc4cw.org/program/interpersonal-psychotherapy/detailed

[17] For more information about MDFT, see http://www.mdft.org/MDFT-Program/What-is-MDFT and Liddle, H. A. (2013). Multidimensional family therapy for adolescent substance abuse: A developmental approach. *Interventions for Addiction, 3*, 87-96.

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[19] See:

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[20] See http://www.mstservices.com/what-is-mst.

[21] See http://www.cebc4cw.org/program/multisystemic-therapy-for-child-abuse-and-neglect/.

[22] See http://www.youthvillages.org/what-we-do/intensive-in-home-treatment/intercept.aspx#sthash.DZsU0gvJ.dpbs.

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- Herschell, A. D., Calzada, E. J., Eyberg, S. M., & McNeil, C. B. (2002). Parent-Child Interaction Therapy: New directions in research. *Cognitive and Behavioral Practice, 9*, 9-16.

[24] Personal communication, Mark Chaffin, October 18, 2010. These changes may add real value. A new study in a child welfare setting found that a combination of PCIT with a motivational enhancement pre-

treatment was critical for obtaining reductions in child maltreatment recidivism. In the most compelling study of the effectiveness of PCIT in preventing physical abuse, Chaffin et al. (below) reported improved parenting competence, and lowered rates of repeated reports and re-investigations for child abuse and neglect in Oklahoma. Success was greatest when therapists had strong ongoing coaching and supervision and when parents were not exposed to multiple interventions and were allowed, instead, to focus on learning how to use positive parenting and discipline methods. See Chaffin, M., Funderburk, B., Bard, D., Valle, L. A., & Gurwitch, R. (2011). A combined motivation and Parent-Child Interaction Therapy package reduces child welfare recidivism in a randomized dismantling field trial. *Journal of Consulting and Clinical Psychology, 79*(1), 84-95.

[25] Typically with the Parent Management Training – Oregon Model, sessions are one week apart to optimize the opportunity for learning and rehearsing new practices. The number of sessions provided in parent groups ranges from 6 to 14; in clinical samples, the mean number of individual treatment sessions is 25. The central role of the PMTO therapist is to teach and coach parents in the use of effective parenting strategies, namely skill encouragement, setting limits or effective discipline, monitoring, problem solving, and positive involvement. In addition to the core parenting practices, PMTO incorporates the supporting parenting components of identifying and regulating emotions, enhancing communication, giving clear directions, and tracking behavior. Promoting school success is a factor that is woven into the program throughout relevant components. See SAMHSA NRPP website: http://www.blueprintsprograms.com/evaluationAbstracts.php?pid=c837307a9a2ad4d08ca61a4f1bd848ba3d6890fc

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

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

[28] The U.S. Triple P - Positive Parenting Program system population trial in South Carolina found that making Triple P available to all parents in a county (not just those parents at-risk) led to: (a) Fewer hospitalizations from child abuse injuries (17% lower); (b) Fewer out-of-home placements (16% lower); and (c) Slowed growth of confirmed child abuse cases (22% lower)This was when these counties were compared with counties without access to Triple P. In a further analysis of this trial, Foster et al. (below) reported that the cost of delivering Triple P universally would be recovered in a single year by a 10% reduction in the number of families in which abuse and neglect occurred. See:

- Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2009). Population-based prevention of child maltreatment: The U.S. Triple P system population trial. *Prevention Science*, *10*(1), 1-12.
- Foster, E. M., Prinz, R. J., Sanders, M. R., & Shapiro, C. (2008). The costs of a public health infrastructure for delivering parenting and family support. *Children and Youth Services Review*, *30*, 493-501.

[29] See http://www.triplep.net/glo-en/find-out-about-triple-p/triple-p-in-a-nutshell/.

[30] Abstracted from:

- Krawitz, R. (201). *Financial cost-effectiveness of, and other dialectical behavior therapy information, for funders, administrators and providers of services for people with borderline personality disorder.* Waikato District Health Board, Hamilton, New Zealand. Abridged version retrieved from http://behavioraltech.org/downloads/Financial-Cost-Effectiveness-DBT.pdf
- http://www.wsipp.wa.gov/BenefitCost/Program/339

[31] Taxy, S., Liberman, A. M., Roman, J. K., & Downey, M. (2012). *The costs and benefits of Functional Family Therapy for Washington, DC*. Washington, DC: District of Columbia Crime Policy Institute and the

Urban Institute. Retrieved from http://www.urban.org/UploadedPDF/412685-The-Costs-and-Benefits-of-Functional-Family-Therapy-for-Washington-DC.pdf. For additional information, see http://www.fftllc.com.

[32] See http://www.healthyfamiliesamerica.org/about_us/

[33] Kirkland, K., & Mitchell-Herzfeld, S. (2012). *Evaluating the effectiveness of home visiting services in promoting children's adjustment in school: Final report*. Washington, DC: Pew Charitable Trusts.

[34] Outcome study results have been very mixed for *Healthy Families America*.

[35] Previous IFPS evaluations have questioned the ability of the intervention to prevent foster care placements. Research experts, however, have pointed to some of the methodological challenges of these earlier studies, which included problems with model fidelity, and the difficulty systems have with identifying families with imminent risk of child removal. A few recent studies have shown more positive results. WSIPP concluded that programs that strictly adhered to the components of the Homebuilders® model significantly reduced out-of-home placement compared to programs that did not adhere closely to the model. See:

- Nelson, K., Walters, B., Schweitzer, D., Blythe, B. J., & Pecora, P. J. (2009). *A ten-year review of family preservation research: Building the evidence base.* Seattle, WA: Casey Family Programs.
- Washington State Institute for Public Policy. (2006). *Intensive family preservation programs*: *Program fidelity influences effectiveness.* Olympia, WA: Author. Retrieved from http://www.wsipp.wa.gov/pub.asp?docid=06-02-3901.

[36] See http://www.cebc4cw.org/program/homebuilders/detailed.

[37] See http://www.wsipp.wa.gov/ReportFile/1494. For additional information, see the SafeCare website: http://safecare.publichealth.gsu.edu/.

[38] See https://www.childwelfare.gov/responding/iia/alternative/.

[39] See https://www.childwelfare.gov/responding/iia/alternative/.

[40] A randomized control group study (RCT) of the Homebuilders reunification program was conducted in Utah with a six-year follow-up. The researchers randomly assigned the cases of foster children to (1) a control group of 53 children whose families received routine agency services as a component of an overall foster care plan, or (2) an experimental group of 57 children whose families received intensive reunification services, with the goal of family preservation. The experimental group receiving intensive services was more likely to be reunited successfully with their families than those in the control group receiving routine services. These differences proved to be statistically significant at the conclusion of treatment as well as during the six-year follow-up period. See:

- Walton, E. (1998). In-home family-focused reunification: A six-year follow-up of a successful experiment. *Social Work Research, 22*, 205-214.
- Walton, E., Fraser, M. W., Lewis, R. E., Pecora, P. J., & Walton, W. K. (1993). In-home family-focused reunification: An experimental study. *Child Welfare, 72*(5), 473-487.

[41] Bavolek, S. (2005). *Research and validation report of the Nurturing Parenting programs.* Asheville, NC: Family Development Resources. Retrieved from http://nurturingparenting.com/images/cmsfiles/nppvalidationstudiesnew1-3-14.pdf. See also Bavolek, S., & Dellinger-Bavolek, J. (1985). *Increasing the nurturing parenting skills of families in Head Start: Validation of the Nurturing Parenting program for parents and children birth to five years*. Asheville, NC: Family Development Resources. Retrieved from http://www.nurturingparenting.com/images/cmsfiles/validation_b-5_program.pdf.

[42] http://www.parentsasteachers.org/about http://www.parentsasteachers.org/about

[43] See http://depts.washington.edu/pcapuw/inhouse/PCAP_Cost_Savings_Brief_Feb_2013.pdf.

[44] See http://www.state.in.us/children/files/Practice_Digest_Substance_Use_11_13.pdf.

[45] http://www.strengtheningfamiliesprogram.org/

[46] Center for the Study of Social Policy. (2010). *Reducing foster care safely saves public dollars and promotes family stability* (Policymakers' Fact Sheet Series 2010-10). Washington, DC: Author.

[47] National Wraparound Initiative. (2012). *What is wraparound?* Portland, OR: Portland State University. Retrieved from http://www.nwi.pdx.edu/wraparoundbasics.shtml#whatiswraparound.

[48] A recent study in Oklahoma of improved case management in mental health documented substantial cost-savings when Wraparound was included with other innovations. See:

- Pires, S. A., & Human Services Collaborative. (2013). *Customizing health homes for children with serious behavioral health challenges*. Rockville, MD: U.S. Substance Abuse and Mental Health Services Administration.
- Strech, G., Harris, B., & Vetter, J. (2011). *Evaluation of the care management oversight project*. Norman, OK: College of Continuing Education, University of Oklahoma.

[49] Personal communication, Don Winstead, March 7, 2014, and Joan Smith, March 11, 2014.

[50] See:

- Child Welfare Information Gateway. (2014). *Making an economic case*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children & Families. Retrieved from https://www.childwelfare.gov/preventing/evaluating/economic.cfm.
- Kilburn, M. R. (2011). Cost and outcomes analysis of child well-being. In J.L. Magnabosco & R.W. Manderscheid (Eds.), *Outcomes measurement in the human services: Cross-cutting issues and methods in the era of health reform* (2nd ed., pp. 283-295). Washington, DC: NASW Press.
- Kilburn, M. R., & Karoly, L.A.. (2008). *The economics of early childhood policy: What the dismal science has to say about investing in children*. Santa Monica, CA: RAND Corporation and Seattle, WA: Casey Family Programs. Retrieved from http://www.rand.org/pubs/occasional_papers/OP227.html.

[51] Karoly, L. A., Greenwood, P. W., Everingham, S. S., Hoube, J., Kilburn, M. R., Rydell, C. P.,… Chiesa, J. (1998). *Investing in our children: What we know and don't know about the costs and benefits of early childhood interventions*. Santa Monica, CA: RAND.

[52] Kilburn, M. R., & Karoly, L.A.. (2008). *The economics of early childhood policy: What the dismal science has to say about investing in children*. Santa Monica, CA: RAND Corporation and Seattle, WA: Casey Family Programs. Retrieved from http://www.rand.org/pubs/occasional_papers/OP227.html.

[53] Personal communication, Don Winstead, March 7, 2014.

[54] Myhr, G., & Payne, K. (2006). Cost-effectiveness of cognitive-behavioural therapy for mental disorders: Implications for public health care funding policy in Canada. *Canadian Journal of Psychiatry*, *51*(10), 662-670.

[55] For adult benefit cost data on CBT for adults across various conditions, see: http://www.wsipp.wa.gov/BenefitCost, pp. 6-7. Note that we think, however, that the actual costs of the intervention are likely understated at about $352 to $1,421.

[56] Retrieved March 30, 2014 from http://www.wsipp.wa.gov/BenefitCost, p. 5.

[57] Foster, M. E., Olchowski, A. E., & Webster-Stratton, C. H. (2007). Is stacking intervention components cost-effective? An analysis of the Incredible Years program. *Journal of the American Academy of Child and Adolescent Psychiatry, 46,* 1414-1424.

[58] See O'Neill, D. O., McGilloway, S., Donnelly, M., Bywater, T., & Kelly, P. (2010). *A cost-benefit analysis of early childhood intervention: Evidence from an experimental evaluation of the Incredible Years parenting program* (Working Paper Series No. 207-10). Maynooth, Ireland: Department of Economics, Finance and Accounting, National University of Ireland. Retrieved from: http://www.atlanticphilanthropies.org/sites/all/modules /filemanager/files/A_Cost-benefit_Analysis_of_Early_Childhood_Intervention_Evidence_from_an_Experimental_Evaluation_of_the_Incredible_Years_Parenting_Program_2.pdf.

[59] Retrieved from http://www.wsipp.wa.gov/BenefitCost, p. 5.

[60] Guthrie, E., Moorey, J., Margison, F., Barker, H., Palmer, S., McGrath, G., Tomenson, B., Creed, F. (1999). Cost-effectiveness of brief psychodynamic-interpersonal therapy in high utilizers of psychiatric services. *Archives of General Psychiatry*, *56*(6), 519-526. doi: 10-1001/pubs.Arch Gen Psychiatry-ISSN-0003-990x-56-6-yoa8378.

[61] The economic evidence base of MDFT is limited. See French, M. T., Roebuck, M. C., Dennis, M., Godley, S., Liddle, H. A., & Tims, F. (2003). Outpatient marijuana treatment for adolescents: Economic evaluation of a multisite field experiment. *Evaluation Review, 27,* 421-459 and Liddle, H. A. (2013). Multidimensional family therapy for adolescent substance abuse: A developmental approach. *Interventions for Addiction, 3*, 87-96. Quote is from p. 94.

[62] Liddle, H. A. (2013). Multidimensional family therapy for adolescent substance abuse: A developmental approach. *Interventions for Addiction, 3*, 87-96. Economic summary is on p. 94. Strattion, P. (2011). *The evidence base of systemic family and couples therapies.* Warrington, UK: Association of Family Therapy, p. 19. Retrieved from http://www.aft.org.uk/SpringboardWebApp/userfiles/aft/file/Training/EvidenceBaseofSystemicFamilyandCouplesTherapies(Jan2011).pdf Retrieved from http://www.aft.org.uk/SpringboardWebApp/userfiles/aft/file/Training/EvidenceBaseofSystemicFamilyandCouplesTherapies(Jan2011).pdf

[63] MDTFC cost-effectiveness research is abstracted from page 19 of Aos, S., Phipps, P., Barnoski, R., & Lieb, R. (2001). The comparative costs and benefits of programs to reduce crime. (Document #01-05-1201). Olympia, WA: Washington State Institute for Public Policy. Retrieved from http://www.wsipp.wa.gov/ReportFile/756 .

[64] For MST savings in Midland County, Michigan, see http://mstservices.com/annualreport2009.pdf.

[65] For recent MST per family cost data, see: http://www.blueprintsprograms.com/programCosts.php?pid=cb4e5208b4cd87268b208e49452ed6e89a68e0b8

[66] Aos, S., Phipps, P., Barnoski, R., and Lieb, R. (2001). The comparative costs and benefits of programs to reduce crime. Olympia, WA: Washington State Institute for Public Policy. Retrieved from http://www.wsipp.wa.gov/ReportFile/756

[67] Retrieved from http://www.wsipp.wa.gov/BenefitCost, p. 1.

[68] Retrieved from http://www.wsipp.wa.gov/BenefitCost, p. 1.

[69] Edovald, T. (2012). Investing in children: child protection and social care. Social Research Unit: Dartington, UK. Retrieved from: http://dartington.org.uk/wp-content/uploads/2012/11/IIC-Child-Protection-1-November-2012.pdf

[70] See http://www.wsipp.wa.gov/BenefitCost. (Retrieved February 16, 2015; this website is periodically updated.)

[71] Retrieved from http://www.wsipp.wa.gov/BenefitCost.

[72] Bonin**,** E., Stevens**,** M.**,** Beecham, J.**,** Byford**,** S., & Parsonage, M. (2011). Costs and longer-term savings of parenting programmes for the prevention of persistent conduct disorder: A modelling study. *BMC Public Health*, *11*, 803. Retrieved from http://www.biomedcentral.com/1471-2458/11/803

[73] Greer, D., Damion J., Grasso, D. J., Cohen, A., & Webb, C. (2013). *Trauma-focused treatment in a state system of care: Is it worth the cost?* Research presented at the 26th Annual Children's Mental Health Research & Policy Conference, Tampa, FL. Retrieved from http://cmhconference.com/files/2013/cmh2013-46a.pdf.

[74] Retrieved from http://www.wsipp.wa.gov/BenefitCost.)

[75] Edovald, T. (2012). Investing in children: child protection and social care. Social Research Unit: Dartington, UK. Retrieved from: http://dartington.org.uk/wp-content/uploads/2012/11/IIC-Child-Protection-1-November-2012.pdf

[76] Lee, S., Aos, S., Drake, E., Pennucci, A., Miller, M., & Anderson, L. (2012). *Return on investment: Evidence-based options to improve statewide outcomes, April 2012* (Document No. 12-04-1201). Olympia, WA: Washington State Institute for Public Policy. Retrieved from http://wsipp.wa.gov/Reports/322.

[77] Retrieved from http://www.wsipp.wa.gov/BenefitCost.

[78] Retrieved from http://www.wsipp.wa.gov/BenefitCost.

[79]Linehan, M. M., & Heard, H. L. (1999). Borderline personality disorder: Costs course and treatment outcomes. In N. Miller and K. Magruder (Eds.), *The cost-effectiveness of psychotherapy: A guide for practitioners* (pp. 291-305). New York, NY: Oxford University Press.

[80]Linehan, M. M., Armstrong, H., Suarez, L., &, Allmon, D. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48*,1060-1064.

[81] Perseius,. K., Samuelsson, M., Andersson, E., Berndtsson, T., Gotmatk, H., Henriksson, F., Kaver, A.,… & Asberg, M. (2004). Does dialectical behavioural therapy reduce treatment costs for patients with borderline personality disorder: A pilot study? *Vard I Norden*, 72, 27-30.

[82] See http://www.fftllc.com/about-fft-training/project-outcomes.html and http://www.evidencebasedassociates.com/ featured_projects/redirectionQ4_11.pdf.

[83] See http://www.episcenter.psu.edu/sites/default/files/resources/2010%20Evidence-based%20Intervention%20Outcome%20Summary_9-16-11.pdf. See also: http://www.fftllc.com/about-fft-training/ project-outcomes.html.

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

[85] Retrieved from http://www.wsipp.wa.gov/BenefitCost. Also see: http://www.fftllc.com/documents/latest%20WISPP%20report%20with%2018.98.pdf.

[86] Edovald, T. (2012). Investing in children: child protection and social care. Social Research Unit: Dartington, UK. Retrieved from: http://dartington.org.uk/wp-content/uploads/2012/11/IIC-Child-Protection-1-November-2012.pdf

[87] For the Healthy Families New York cost savings information, see http://ocfs.ny.gov/main/reports/NIJ%20ReportFINAL%20REPORT%2011-29-2010.pdf.

[88] Retrieved from http://www.wsipp.wa.gov/BenefitCost.

[89] Chaffin, M. (2004). Is it time to rethink Healthy Start/Healthy Families? *Child Abuse & Neglect*, *28,* 589-595.

[90] Edovald, T. (2012). Investing in children: child protection and social care. Social Research Unit: Dartington, UK. Retrieved from: http://dartington.org.uk/wp-content/uploads/2012/11/IIC-Child-Protection-1-November-2012.pdf

[91] Retrieved from http://www.wsipp.wa.gov/BenefitCost.

[92] Edovald, T. (2012). Investing in children: child protection and social care. Social Research Unit: Dartington, UK. Retrieved from: http://dartington.org.uk/wp-content/uploads/2012/11/IIC-Child-Protection-1-November-2012.pdf

[93] Retrieved from http://www.wsipp.wa.gov/BenefitCost. See also:

- http://www.wsipp.wa.gov/rptfiles/3900.SafeCare.pdf
- http://www.wsipp.wa.gov/rptfiles/12-04-1201.pdf

[94] National Quality Improvement Center on Differential Response in Child Protective Services. (2014). Final report: QIC-DR cross-site evaluation. Available from: www.differentialresponseqic.org.www.differentialresponseqic.org.

[95] National Quality Improvement Center on Differential Response in Child Protective Services. (2014). Final report: QIC-DR cross-site evaluation. Available from: www.differentialresponseqic.org.www.differentialresponseqic.org.

[96] Siegel, G., & Loman, L. A. (2006). *Extended follow-up study of Minnesota's family assessment response.* St. Louis, MO: Institute of Applied Research. Retrieved from http://www.iarstl.org/papers/FinalMNFARReport.pdf.

[97] Loman, L. A., Filonow, C. S., & Siegel, G. (2010). *Ohio alternative response evaluation final report.* St. Louis, MO: Institute of Applied Research.

[98] See http://www.wsipp.wa.gov/BenefitCost. (Retrieved February 16, 2015; this website is periodically updated.)

[99] WSIPP presented a single benefit-cost analysis for Homebuilders®-style Intensive Family Preservation Service (IFPS) programs. In their meta-analytic table, they presented effect size estimates in three ways: (1) for IFPS programs that focused on reunification of children already placed out of home, (2) for programs focused on preventing children from being removed from home, and (3) for all IFPS programs. The benefit-cost estimates were nearly identical for the reunification and prevention programs, so we have summarized them here. See:

- Washington State Institute for Public Policy. (2013). *Benefit-cost results*. Olympia, WA: Author. Retrieved from http://www.wsipp.wa.gov/BenefitCost. (Retrieved February 14, 2014; this website is periodically updated.)
- Lee, S., Aos, S., & Miller, M. (2012). *Return on investment: Evidence-based options to improve state-wide outcomes* (Document No. 12-04-1201). Olympia, WA: Washington State Institute for Public Policy. Retrieved from http://www.wsipp.wa.gov/rptfiles/12-04-1201.pdf.
- Lee, S., Aos, S., & Miller, M. (2008). *Evidence-based programs to prevent children from entering and remaining in the child welfare system: Benefits and costs for Washington* (Report No. 08-07-3901). Olympia, WA: Washington State Institute for Public Policy. Retrieved from http://www.wsipp.wa.gov/pub.asp?docid=08-07-3901.

[100] Maher, E. J., Corwin, T. W., Hodnett, R., & Faulk, K. (2012). A cost-savings analysis of a statewide parenting education program in child welfare. *Research on Social Work Practice, 22*, 615-625.

[101] Edovald, T. (2012). Investing in children: child protection and social care. Social Research Unit: Dartington, UK. Retrieved from: http://dartington.org.uk/wp-content/uploads/2012/11/IIC-Child-Protection-1-November-2012.pdf.

[102] See http://www.wsipp.wa.gov/BenefitCost (Retrieved February 23, 2015; this website is periodically updated).

[103] Thanh, N.X., Jonsson, E., Moffatt, J., Dennett, L., Chuch, A. W., & Birchard, S. (2015). An economic evaluation of the Parent-Child Assistance Program for Preventing Fetal Alcohol Spectrum Disorder in Alberta, Canada. *Administration and Policy in Mental Health, 42,* 10 – 18.

[104] Washington State Department of Social & Health Services, Children's Administration. (2012). *Washington State AFCARS files.* Seattle, WA: Casey Family Programs Data Advocacy Department. (Used with permission.)

[105] Casey Family Programs and the University of Washington. (2013). *Parent-child assistance program outcomes suggest sources of cost savings for Washington State*. Seattle, WA: Authors. Retrieved from http://depts.washington.edu/pcapuw/inhouse/PCAP_Cost_Savings_Brief_Feb_2013.pdf.

[106] See *Courier Journal*. Also see Huebner, R. A., Willauer, T. & Posze, L. (2012). The impact of Sobriety Treatment and Recovery Teams (START) on family outcomes. *Families in Society, 93,* 196-203.

[107] Spoth, R. L., Guyll, M., and Day, S. X. (2002). Universal family-focused interventions in alcohol-use disorder prevention: Cost-effectiveness and cost-benefit analyses of two interventions. *Journal of Studies on Alcohol,* 63(2), 219-228.

[108] See http://www.wsipp.wa.gov/BenefitCost (Retrieved February 23, 201; this website is periodically updated).

[109] Miller, T. & Hendrie, D. (2008). *Substance abuse prevention dollars and cents: A cost-benefit analysis.* DHHS Pub. No. (SMA) 07-4298. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, p. 24. Retrieved from http://www.samhsa.gov/sites/default/files/cost-benefits-prevention.pdf

[110] See http://www.wsipp.wa.gov/BenefitCost (Retrieved February 23, 2015; this website is periodically updated). Note that WSIPP does have a summary of Title IV-E waivers in North Carolina and Oregon at http://www.wsipp.wa.gov/ReportFile/1020.

[111] See http://www.nwi.pdx.edu/wraparoundresearch.shtml.

[112] For more information on the Contra Costa Wraparound services evaluation, see http://humanservices.ucdavis.edu/resource/uploadfiles/Contra%20Costa%20Wrap.pdf.

[113] The Wraparound Milwaukee program argues that reduced utilization of costly inpatient and often last-resort services allows mental health workers to focus more on improved treatment. Clinical scores incorporating feedback from youth, families, and clinicians note an average 20-point improvement of clinical health indicators of treated youth. See http://county.milwaukee.gov/WraparoundMilwaukee/WraparoundAward.htm.

[114] Caution is warranted in reviewing these data as other services and initiatives may be accounting for some of the reductions in out-of-home care and resulting cost-savings. See http://fcf.ohio.gov/Portals/0/Home/Initiatives/ENGAGE/ENGAGEWraparoundSummary.pdf

[115] Strech, G., Harris, B., & Vetter, J. (2011). *Evaluation of the care management oversight project*. Norman, OK: College of Continuing Education, University of Oklahoma. See http://www.nwi.pdx.edu/pdf/Care-Management-Oversight-Report-Final.pdf

[116] See http://www.cebc4cw.org.

[117] At least one rigorous study of Family Finding is underway.

[118] Results on the most rigorous FGDM outcomes studies have been mixed but there is a great possibility for major cost-savings in terms of placement avoidance or use of less restrictive placement settings. See http://www.americanhumane.org/assets/pdfs/children/advocacy/111th-fgdm.pdf.

[119] A special form of multi-dimensional treatment foster care (*Project KEEP*) is being implemented in child welfare by providing weekly support to foster parents and training in behavior management. The success of this intervention in helping youth in care exit foster care more quickly in a less disruptive manner bodes well for large-scale replication by public child welfare agencies. Preliminary analyses of cost-effectiveness due to averted mental health conditions and increased placement stability indicate the promise of substantial cost-savings. See:

- http://www.keepfostering.org/
- Goldhaber-Fiebert, J. D., Bailey, S. L., Hurlburt, M. S., Zhan, J., Snowden, L. R., Wulczyn, F.,… Horwitz, S. M. (2012). Evaluating child welfare policies with decision-analytic simulation models. *Administration and Policy in Mental Health and Mental Health Services Research*, *39*(6), 466-477.

[120] Parenting with Love and Limits (PLL) combines group therapy and family therapy to treat children and adolescents age 10 to 18 who have severe emotional and behavioral problems (e.g., conduct disorder, oppositional defiant disorder, and attention deficit/hyperactivity disorder) and frequently co-occurring problems such as depression, alcohol or drug use, chronic truancy, destruction of property, domestic violence, or suicidal ideation. See: http://www.gopll.com/; and http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=45.

[121] Project Connect works with high-risk families who are affected by parental substance abuse and are involved in the child welfare system. The program offers home-based counseling, substance abuse monitoring, nursing, and referrals for other services. The program also offers home-based parent education, parenting groups, and an ongoing support group for mothers in recovery. While the goal for

most Project Connect families is maintaining children safely in their homes, when this is not possible, the program works to facilitate reunification. The target population is high-risk, substance-affected families involved in the child welfare system. Family risks may include the following: poly-substance abuse and dependence, domestic violence, child abuse and neglect, criminal involvement and behavior, physical and mental health conditions, poverty, inappropriate housing, lack of education, poor employment skills, and impaired parenting. Most of the families served are ethnically diverse, have a low household income, and are headed by single mothers.

Project Connect staff include individuals with experience and professional licensure in the fields of substance abuse, child welfare, mental health, and/or substance abuse; the program develops individual training plans for the development of skills in areas where staff have less experience. Services provided by Project Connect can also be reimbursed by Medicaid. Substance abuse by parents is often a significant factor in the risk of child abuse or neglect. "An independent evaluation determined that 45% of children whose families were served by *Project Connect* were reunited after an average of five months. Of families that did not participate, only 18% of children were reunited after ten months. Evaluations continue to show high levels of family or participant satisfaction and a significant rate of improved commitment to recovery for those completing *Project Connect* services." (From http://www.cfsri.org/projectconnect.html)

[122] TANF and other anti-poverty strategies are under-researched but some have promise. For example, Slack and Berger in their study of a Milwaukee economic support intervention had preliminary findings showing a 25% reduction in child maltreatment re-reports to CPS. See:

- Colorado TANF benefit cost analysis at https://peerta.acf.hhs.gov/uploadedFiles/CLP%20C-B%20Analysis.pdf.
- Malcolm, M. (2012). Can buy me love: The effect of child welfare expenditures on maltreatment outcomes. *Applied Economics, 44*, 3725-3736.
- Paxson, C., & Waldfogel, J. (2003). Welfare reforms, family resources, and child maltreatment. *Journal of Policy Analysis and Management, 22*, 85-113.
- Slack, K. S., Holl, J. L., Lee, B. J., McDaniel, M., Altenbernd, L., & Stevens, A. B. (2003). Child protective intervention in the context of welfare reform: The effect of work and welfare on maltreatment reports. *Journal of Policy Analysis and Management, 22*, 517-536.
- Shook, K. S., & Testa, M. (1997). *Cost-savings evaluation of the Norman Program: Final report to the Department of Children and Family Services.* Chicago, IL: Illinois Department of Children and Family Services.

[123] The Seven Challenges program is designed specifically for adolescents with drug problems, to motivate a decision and commitment to change, and to support success in implementing the desired changes. The program simultaneously helps young people address their drug problems as well as their co-occurring life skill deficits, situational problems, and psychological problems. The challenges provide a framework for helping youth think through their decisions about their lives and their use of alcohol and other drugs. Counselors using **7C** teach youth to identify and work on the issues most relevant to them. In sessions, as youth discuss the issues that matter most, counselors seamlessly integrate the Challenges as part of the conversation. Retrieved from http://www.cebc4cw.org/program/the-seven-challenges/. See Schwebel, R. (2004). *The Seven Challenges manual.* Tucson, AZ: Viva Press.

[124] 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.

[125] 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

[126] The Colorado standardized Family Meeting model includes caregivers and their families as key decision makers in the development of case and safety plans. The State will also modify non-safety certification regulations of relative foster family homes to facilitate the placement of children with relatives when out-of-home placement is necessary.

[127] "Illinois's parenting support demonstration constitutes the state's fourth title IV-E waiver demonstration. An earlier demonstration focused on enhanced child welfare staff training ended in June 2005 while a subsidized guardianship demonstration ended in October 2009 with the establishment of a statewide Guardianship Assistance Program. A third demonstration focused on the provision of enhanced alcohol and other drug abuse (AODA) services continues under a long-term waiver extension." James Bell Associates, Inc. (2013). *Profiles of the Title IV-E child welfare waiver demonstration projects: Volume II: Demonstrations active as of federal fiscal year 2013* (p. 25). Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, and Families, Children's Bureau. Retrieved from http://www.acf.hhs.gov/sites/default/files/cb/waiver_profiles_vol2.pdf.)

[128] Illinois "…will implement a version of NPP known as the Nurturing Program for Parents & Their Infants, Toddlers & Preschoolers that is focused specifically on the biological parents of children aged 0–5. In addition, the State will use a version of the NPP designed for the foster caregivers of children aged 0–5 known as the NPP-Caregiver Version." (James Bell Associates, Inc., 2013, p. 26).

[129] For Indiana, the waiver target population is Title IV-E eligible and ineligible children who are (1) children and families who have substantiated cases of abuse and/or neglect that will likely develop into an open case with an Informal Adjustment (IA) or Child in Need of Services (CHINS) status; (2) children and their families who have an Informal Adjustment or children who have the status of CHINS or Juvenile Delinquency Juvenile Status Offense (JD/JS); and (3) children with the status of CHINS or JD/JS and their foster/kinship families with whom they are placed.

[130] Children currently in Kentucky foster care will not be eligible for ESFP; however, if children are placed in foster care while their families are receiving ESFP services they will be allowed to continue in the program.

[131] Kentucky is expanding the Sobriety Treatment and Recovery Teams (START) program. START is an attempt to meld what we know about addiction-services treatment, good child welfare practice, and family preservation practice into a model that can work with the special needs of these families. These teams have all of the responsibility that regular intake and social workers have. They provide in-home services and ongoing protective services. Where indicated, they can take custody and place children out of the home, working with the family on reunification or developing an alternate permanency plan for the children. As part of START, each regional community health center has adopted one or more evidence-based programs for delivering treatment.

[132] Experimental design studies have been conducted to evaluate the Matrix Model Intensive Outpatient Program. The model is listed on the SAMHSA evidence-based registry, with modest rigor of the studies noted. See http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=87

[133] Massachusetts will expand its use of CANS to better track outcomes throughout the intervention and match the appropriate intervention for those in congregate care.

[134] In Michigan "…the Trauma Screening Checklist will be administered to all households with children aged 0–5 years. When eligible and appropriate, these households will be linked to trauma-focused, evidence-based mental health interventions, such as Trauma-Focused Cognitive Behavioral Therapy, Parent-

Child Interaction Therapy, or other interventions deemed appropriate, including Early Head Start or Parent-Infant Psychotherapy. In addition, children aged 3–5 years with a positive history of trauma will be screened using the Trauma Symptom Checklist for Young Children and will also be referred for these mental health interventions" (James Bell Associates, 2013, p. 36).

[135] The Michigan "Family Psychosocial Screening uses a screening tool for caregivers to make appropriate referrals: substance abuse assessment and treatment, legal aid and advocacy, DV shelter and support, batterer's intervention, mental health treatment, Early Head Start, day care, preschool, parenting groups, EBP in home visiting, and informal respite care.

[136] Michigan's long-term family engagement uses a 3 phase approach towards family engagement practices that includes: Phase 1 – engagement and case planning; Phase 2 – service provision and collaborative monitoring; and Phase 3 – aftercare with step-down in level of engagement and intervention.

[137] In Michigan, "…long-term Family Engagement and Support will provide an array of services and supports for a 15-month period and include three phases: (1) engagement and case planning, (2) service provision and collaborative monitoring, and (3) aftercare with step-down of engagement and intervention." (James Bell Associates, 2013, p. 36).

[138] In Michigan, "…a protective factors framework, will be integrated through which contracted agencies will be responsible for establishing a link to resources in order to build the following factors: (1) social connections, (2) parental resilience, (3) knowledge of parenting and child development, (4) concrete support in times of need, and (5) social and emotional competence of children." (James Bell Associates, 2013, p. 36).

[139] In Nebraska, Alternative Response will be phased in using a five-5 county pilot followed by statewide implementation for all children 0-18 who are screened in to an Alternative Response system utilizing the SDM screening tool.

[140] Nevada, as part of implementing its Safety Assessment Family Evaluation (SAFE) model:

- Will expand, enhance, and support safety management services as part of the practice model.
- Develop in-home safety plans to keep the child safely in home.
- Assign safety managers to each family.
- Involve community resources to assist DCFS in meeting in-home safety management objectives by developing in-home safety services, which otherwise would not be available.
- Increase oversight and more effective use of family network resources employed for safety management within in-home safety plans.
- Provide training, professional development, coaching, and support to contracted safety service managers, providers, and child welfare staff.
- Strengthen the limited safety service resources that currently exist and develop new safety service resources.
- Develop and strengthen collaborative relationships and case management approaches that maximize the involvement of safety service managers with DCFS ongoing services caseworkers.
- Determine the extent to which in-home safety management contributes to and enhances.

[141] In Ohio, "kinship supports, which increase attention to and support for kinship caregivers and their families, ensuring that kinship caregivers have the support they need to meet the child's physical, emotional, financial, and basic needs. The strategy includes a set of core activities specifically related to the kinship caregiver including home assessment, needs assessment, support planning, and service referral and provision." (James Bell Associates, 2013, p. 39).

[142] Oregon *Family Navigator s*ervices will include but are not limited to:

- Assisting with transportation to and from appointments.
- Helping decrease parents' fear and anxiety about their circumstances and interfacing with multiple human services systems.

- Assisting with life skills development.
- Assisting the family in completing necessary paperwork to access services.
- Assisting the family in maximizing the effectiveness of their interactions with child welfare and other human services agencies.

[143] Port Gamble will implement Positive Indian Parenting (PIP). PIP is an Indian parenting curriculum developed by the National Indian Child Welfare Association that emphasizes addressing historical trauma and tradition cultural teaching as a base for effective parenting. The Port Gamble S'Klallam Tribe will use Title IV-E funding flexibly to train family care coordinators and child welfare staff in PIP and to expand the use of this curriculum in the service area.

[144] Port Gamble Family Group Decision Making (FGDM) will be expanded to include the use of an FGDM coordinator and will be fully implemented with all cases involved with the child welfare system. Additional child welfare staff may be trained to be FGDM coordinators in the future.

[145] The In-Home Tennessee Initiative involves a coordinated community care model, which will move the state away from contracting with multiple community providers with multiple assessments and services plans to contracting with a single provider to manage the services and create a coordinated service plan. The Family Advocacy and Support Tool (FAST) will be given to all children through the age of 17 and their families. For those with in-home services, the FAST will be used to place families in one of three tiers of intensive in-home services, based on their risk factors in the FAST. Intensive in-home services will be expanding:

- ✓ Tier 1: Low-risk for out-of-home placement and receive short-term concrete services
- ✓ Tier 2: Moderate-risk for out-of-home placement and receive support and stabilization services for a moderate amount of time
- ✓ Tier 3: High-risk for out-of-home placement and receive immediate and intensive services for longer duration

The Wraparound service model will be expanding statewide to ensure a coordinated service plan for in-home services and access to more in-home services, which may include :

- ✓ ARC (Attachment, Self-Regulation, and Competency*):* a recognized promising practice that offers a framework for working with youth and families who have experienced multiple and/or prolonged traumatic stress
- ✓ Teen Outreach Program (TOP) is viewed as an evidence-based youth development program (but it is not rated by CEBC).

[146] In Utah, "caseworker training, skills, and tools will be developed and implemented that focus on trauma-informed practice and strengthening parents' protective and promotive factors. Specific interventions include the infusion of the Strengthening Families Program to build protective factors within families and utilization of the National Child Traumatic Stress Network's child welfare training curriculum to improve caseworker skills related to recognizing and addressing trauma." (James Bell Associates, 2013, p. 49).