PREPARING FOR FAMILY FIRST PREVENTION SERVICES ACT IMPLEMENTATION IN TEXAS

APRIL 2020

A STATEWIDE SERVICE CAPACITY ASSESSMENT

TABLE OF CONTENTS

EXECUTIVE SUMMARY 4

INTRODUCTION AND BACKGROUND 7

- FFPSA Prevention Services 8
  - *Eligibility* 8
  - *Evidence Ratings* 10
- The Family First Transition Act 12
- FFPSA Implementation 13

STUDY OBJECTIVES 14

METHODOLOGY 14

- Survey Development and Data Collection 14
- Data Elements 15
- Analytic Sample 16
- Response Rate 16

FINDINGS 17

- Services by Region 17
- Agency Perceptions about Services 18
- Client CPS Involvement 19
- Agency Characteristics: Size, Capacity, and Provider Credentials 19
- Funding 21
- Programs and Interventions in Use among Providers 22
  - *Mental Health Services (n=257)* 22
  - *Substance Abuse Services (N=137)* 24
  - *In-home Parent Training Services (N=105)* 26
- Expanding Services: Capacity and Service Array 29

LIMITATIONS 30

DISCUSSION AND RECOMMENDATIONS 30

- Major Findings 30
- Recommendations 32

LIST OF TABLES AND FIGURES

Table 1: FFPSA Overview 7

Table 2: Eligibility Criteria for Clearinghouse Inclusion 9

Table 3: Approved Programs 12

Table 4: Programs Under Review 12

Table 5: Service Categories 17

Table 6: Most Common MH Programs by Region, excluding CBT and TF-CBT 23

Table 7: Most Common SA Programs by Region, excluding MI 25

Table 8: Most Common In-Home PT Programs by Region 28

Figure 1: Responding Agencies by Region 17

Figure 2: Providers by Category and Region 18

Figure 3: Perceptions about Services 18

Figure 4: CPS Involvement 19

Figure 5: Agency Size 19

Figure 6: Number of Clients Served 20

Figure 7: Education Credentials 21

Figure 8: Funding for Services 21

Figure 9: State Contracts 22

Figure 10: Mental Health Programs 22

Figure 11: Substance Abuse Programs 24

Figure 12: In-Home Parent Training Programs 27

Figure 13: Capacity Barriers 29

EXECUTIVE SUMMARY

The Family First Prevention Services Act (FFPSA) of 2018 is a new federal law intended to prevent children from entering foster care, reduce the use of group residential care in favor of family-like, and strengthen support for kinship care. Recognizing that children do best when maintained safely in their own homes, the law provides additional federal resources to states to prevent children from entering foster care by increasing access to critical services for children and their caregivers.

Under FFPSA, states are able to draw down federal Title IV-E funding to pay for mental health, substance abuse, and parent training services for families whose children are at imminent risk of removal. Prevention services under FFPSA can be provided for children and/or their caregivers for up to 12 months, but only for programs that have been designated as an evidence-based practice (EBP) by a federal Clearinghouse established to conduct research reviews and assign evidence ratings. Implementation of the law, which will take effect in Texas in October 2021, requires careful planning and coordination among state agencies, policymakers, philanthropic funders, and the community of service providers throughout the state.

In collaboration with the Texas Department of Family and Protective Services (DFPS), the Texas Health and Human Services Commission (HHSC), and Casey Family Programs, the Texas Center for Child and Family Studies (the Center) created and deployed a statewide survey to community organizations providing mental health, substance abuse, and parent training services in Texas. The survey was designed to answer these research questions:

1. What are the mental health, substance abuse, and in-home parent training services currently available for child welfare-involved families in the state?

2. To what extent do services currently being provided in these categories meet criteria for being evidence-based, according to current federal guidelines?

3. What are the barriers to expanding the state's capacity to serve additional clients? What are the barriers to expanding providers' service arrays to include more qualifying EBPs?

The critical finding of this study is that **there are significant gaps between the services currently being offered by community providers in the state and the programs that have been approved to date as FFPSA-qualifying EBPs**. Other key findings from the survey responses are briefly highlighted:

- Among mental health providers, only one intervention in wide use (Trauma-Focused Cognitive Behavior Therapy) has been approved as an EBP, but at the lowest level of evidence, which restricts the amount of funding that the state can draw down for it.

- Among substance abuse treatment providers, only one modality in wide use (Motivational Interviewing) has been approved as an EBP at the highest evidence level, but it is an approach to increasing motivation to engage in behavior change, not a clinical intervention to treat substance abuse.

- Among in-home parent training providers, the most common program approved as an EBP at the highest evidence level (Parents as Teachers) is used by only 18 percent of providers. No other programs approved for in-home parent training are in wide use among providers who responded to the survey.[1]

- Across service categories, a large majority of providers indicated willingness to augment or modify their service arrays to include more FFPSA-qualifying EBPs. Most organizations, however, would need the state to pay all or most of their upfront expansion costs, which could include the cost of purchasing new programs, training existing staff, hiring new staff, and/or obtaining additional physical space.

Based on the findings from the survey, there are seven recommendations for the state to consider as it moves toward FFPSA implementation:

1. *Strategically invest in expanding the supply of Clearinghouse-approved evidence-based programs throughout the state.* Realizing the intended goal of preventing entries to care will require thoughtful decision-making about which programs to select for investment among the state's supply of community service providers.

2. *Establish efficient methods for scaling up EBPs statewide.* Strategies for building service capacity will need to work for urban and rural providers of all sizes throughout the state.

3. *Localize data for decision-making.* Demand, capacity, and population needs should be examined at the catchment level to determine the appropriate mix of services.

4. *Create a reliable mechanism for educating local providers on the changes that will be required for FFPSA implementation.* To prepare for implementation, providers need access to reliable and up-to-date information about FFPSA and the actions being taken at the state level that have downstream implications for their operations.

5. *Convene stakeholders from state agencies, the philanthropic community, and the provider community to ensure that funding for services is sufficient and systemically coordinated.* A small collaborative comprised of these public and private stakeholder groups can maximize the collective impact of all available resources.

6. *Situate the services that will be provided under FFPSA within a full continuum of care. Texas*. As FFPSA targets a relatively narrow spectrum of vulnerable children and families, it is important to ensure sustained support for a full continuum of services for families with more intensive and less intensive needs.

7. *Equip providers with the resources to collect their own data for program evaluation.* EBPs do not always have the desired impact once implemented, so the state should ensure providers have the skills and funding to evaluate outcomes to inform ongoing considerations for program selection.

[1] The parent training providers represented in the survey responses include agencies that are contracted to provide primary and secondary prevention services through the Prevention and Early Intervention (PEI) division of DFPS, as well as agencies who are providing non-contracted services in the community to clients already involved in CPS cases. Internal data from PEI indicates that both Parents as Teachers and Nurse Family Partnership are in fairly wide use for primary and secondary prevention among the subset of PEI contracted providers. This is discussed on page 30 of the report.

The Family First Prevention Services Act presents an unprecedented opportunity for the state to leverage federal support to invest in services to maintain children in their own homes. The services that will be available to families under FFPSA may allow more families to maintain their children in their care, prevent the trauma of removal for children who can safely remain at home, reduce the burden on the foster care system, and coalesce community-based providers around the mission of family preservation. Thoughtful planning and implementation will help the state maximize the intended benefits for vulnerable Texas children and families.

INTRODUCTION AND BACKGROUND

The Family First Prevention Services Act of 2018 (FFPSA) represents the most significant federal child welfare reform in over two decades. Recognizing that children do best when maintained safely in their own homes, the law provides additional federal resources to states to prevent children from entering foster care by expanding access to critical services.

Nationally, there are some 437,000 children in foster care.[2] In Texas, there were 31,408 children in substitute care as of August 1, 2019.[3] Though both of these figures are slightly lower than the previous year, they represent an overall trend of increases in the number of children in foster care that started in the mid-2010s.[4] Research suggests that, at a national level, the recent uptick in foster care cases is at least partially attributable to the rise in drug use, and in particular the opioid epidemic, over the past decade.[5] FFPSA is part of a federal response to this problem, putting more resources into the prevention of foster care entries among families affected by drug abuse and other issues. Through providing additional support for vital services to families, FFPSA is an attempt to prevent the need for foster care and maintain more children in their homes.

In addition to the provisions of FFPSA that are intended to prevent entries to care, other parts of the law are meant to reduce the use of group care placements in favor of family-like settings for children in substitute care, and to promote and strengthen kinship care so that children can safely reside with family members when they cannot remain at home. Table 1 provides broad information about the three core provisions of FFPSA.[6]

Table 1: FFPSA Overview

MAJOR PROVISIONS OF FFPSA	
Prevention Services	FFPSA allows states to access federal Title IV-E funding to pay for services intended to prevent children who are at imminent risk of removal from entering substitute care. Services for mental health, substance abuse, and in-home parent training are eligible for federal funding, but eligible programs must be designated as "evidence-based" by a federal clearinghouse. Services can be provided to children and/or their caregivers. Pregnant and parenting youth and kinship care families are also qualified to receive these services, even if the youth are not considered at imminent risk of removal.

[2] This figure is based on the most recent statistics available from the Children's Bureau, which reflects fiscal year 2018 data. https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport26.pdf
[3] DFPS Data Book *CPS Conservatorship: Children in DFPS Legal Responsibility on August 31*: https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/Conservatorship/Activity_on_August_31.asp
[4] Increases in entries to care started in 2012 at the national level, and in 2015 in Texas. In FY 2019 data, the number of entries in Texas dropped back down to just under the 2016 level.
[5] Radel, L., Baldwin, M., Crouse, G., Ghertner, R., & Waters, A. (2018). *ASPE research brief: Substance use, the opioid epidemic, and the child welfare system: Key findings from a mixed methods study.* Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.
[6] A more detailed summary of all sections of FFPSA can be found on the DFPS FFPSA webpage: https://www.dfps.state.tx.us/Child_Protection/Family_First/default.asp

Reducing Congregate Care	In order to encourage more placements in family-like settings, and to address concerns about over-reliance on group residential care, FFPSA creates requirements for qualified residential treatment programs (QRTPs). Upon implementation of FFPSA, residential treatment centers (RTCs), emergency shelters, and other general residential operations (GROs) will have to be designated as a QRTP for the state to use federal funds for foster care maintenance payments beyond 2 weeks. To be designated as a QRTP, the facility must be accredited, use a trauma-informed model, have licensed or registered staff, be inclusive of the child's family in planning and programming, and have a plan for after-care for at least 6 months upon a child's discharge from the placement. These requirements do not apply to group placements for pregnant or parenting youth, supervised independent living for emancipating youth, or residential facilities for minors who have been sex trafficked or who are at high risk for sex trafficking.
Strengthening Kinship Care	Funding under FFPSA can be used to implement kinship navigator programs, which are meant to provide enhanced support for relative caregivers to meet the needs of children placed in their care. Kinship navigator programs provide caregivers with education, information, and referrals to community services toward the goal of maximizing caregivers' capacity to provide a safe and stable home.

FFPSA PREVENTION SERVICES

Eligibility

This report is focused specifically on the prevention services component of FFPSA, which allows states to use Title IV-E funds for up to 12 months to pay for services intended to prevent children from entering substitute care. There are three categories of services eligible for funding under FFPSA: 1) mental health, 2) substance abuse, and 3) in-home[7] skill-based parent training. Services must be provided by a qualified clinician and use a trauma-informed approach to be eligible for FFPSA funding.[8]

Only certain individuals are eligible to receive services through FFPSA Title IV-E funding. Qualified recipients include children who the state designates as candidates for foster care, their caregivers, parenting or pregnant youth in foster care, and/or children in kinship care and their caregivers. Candidates for foster care are children who the state considers at imminent risk of removal. In Texas, a child is defined as a foster care candidate when 1) at any time a child is the subject of a safety plan and absent preventative services the plan is removal, or 2) a child is not the subject of a safety plan but is at high or very high risk of abuse or neglect, and absent preventative services the plan is removal.[9] If the children of families receiving prevention services

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[7] Per the Title IV-E Prevention Services Clearinghouse, "in-home" does not mean that the services necessarily have to be provided at the residence of the caregivers. See Table 2.

[8] Per federal guidance, "qualified clinician" and "trauma informed approach" are not being further defined. https://www.cwla.org/wp-content/uploads/2018/12/ACYF-CB-PI-18-09-State-FFPSA-Prevention-PI.pdf

[9] Child Protective Services Handbook, section 12550: https://www.dfps.state.tx.us/handbooks/CPS/Files/CPS_pg_x12000.asp

under FFPSA enter substitute care at any point, federal reimbursement for services for that family will stop. An at-a-glance table summarizing key prevention services requirements is included as Appendix A.

Just as only certain individuals are eligible to receive FFPSA-funded prevention services, only certain programs and interventions are eligible to be included in the Clearinghouse of approved services. Table 2 describes the characteristics that make programs eligible, and ineligible, for inclusion in the Clearinghouse.

Table 2: Eligibility Criteria for Clearinghouse Inclusion

FFPSA CLEARINGHOUSE PROGRAM ELIGIBILITY CRITERIA		
Mental Health	**Substance Abuse**	**In-Home Parent Training**
Eligibility Criteria		
Programs that aim to reduce or eliminate behavioral and emotional disorders or risk for such disorders. Programs and services may target any mental health issue. It is not required that participants in the program or service have a diagnosis. Programs and services can be delivered to children and youth, adults, or families; can employ any therapeutic modality, including individual, family, or group; and may have any therapeutic orientation.	Programs that have an explicit focus on the prevention, reduction, treatment, remediation, and/or elimination of substance use, misuse, or exposure in general. Programs can target any specific type of substance, multiple substances, or aim to address substance use or misuse in general. Programs and services targeting use or misuse of alcohol, marijuana, illicit drugs, or misuse of prescription or over-the-counter drugs. Services can be delivered to children and youth, adults, or families; can employ any therapeutic modality, including individual, family, or group; and may have any therapeutic orientation.	Programs that are psychological, educational, or behavioral interventions or treatments that involve direct intervention with a parent or caregiver. Services must be provided directly to the parent(s) or caregiver(s); children may be present or involved, but are not required to be present. Contact may be face-to-face, over the telephone or video, or online. Programs may be explicitly delivered as in-home interventions or can be interventions for which delivery in-home is a possible or recommended method to administer the intervention. This may include residential facilities, shelters, or prisons if that is where the parent(s) or caregiver(s) resides.
Exclusion (Ineligibility) Criteria		

Programs and services that rely on psychotropic medications or screening procedures without a counseling or behavioral therapeutic component.	Programs and services aimed solely at reducing, treating, or remediating tobacco use. Programs and services that are directed only at collateral persons or caregivers, or systems interventions. Programs and services that are pre-clinical programs and that do not themselves involve prevention or treatment.	Programs for which in-home delivery is not possible. Public service campaigns that do not involve services provided directly to caregivers.

Evidence Ratings

The federal funding available for services to prevent entries to care is also restricted to interventions, programs, or modalities determined to be "evidence-based." The designation of which interventions are evidence-based is determined by the Title IV-E Prevention Services Clearinghouse ("the Clearinghouse") established by the Administration for Children and Families (ACF) division of the U.S. Department of Health and Human Services. The Clearinghouse developed a manualized systematic review process for assessing research on intervention effectiveness and assigning evidence ratings based on the strength of existing empirical research.

The Clearinghouse reviews evidence on programs in the three eligible service categories of mental health, substance abuse, and in-home skill-based parent training. There are four ratings that can be assigned by the Clearinghouse: *does not currently meet criteria, promising*, *supported*, and *well-supported*. Programs rated promising, supported, and well-supported are eligible for Title IV-E funding under FFPSA. By fiscal year 2024, however, at least 50 percent of the Title-IV funds spent on these services must be spent on programs with well-supported ratings.

The Clearinghouse employs a stringent, manualized process to systematically assess programs and therapeutic interventions to determine evidence ratings. The process is a six-step review method that is outlined in the Title IV-E Prevention Services Clearinghouse Handbook of Standards and Procedures:[10]

1. **Identify programs and services for review**: Relevant candidate programs are recommended by stakeholders.

2. **Select and prioritize programs and services for review**: The Clearinghouse assesses candidate programs to determine whether they are eligible to be reviewed. This determination is based on whether programs fall into one of the three service categories and whether there is a book or manual outlining a practice protocol. Programs are prioritized based on whether they target relevant outcomes, are in active use, and have implementation support.

3. **Literature search**: Clearinghouse reviewers conduct systematic searches for existing empirical research on each program under review.

[10] https://www.acf.hhs.gov/sites/default/files/opre/psc_handbook_v1_final_508_compliant.pdf

4. **Study eligibility screening and prioritization**: Each study found on a program that is under review is screened for eligibility for inclusion in the review, based on the publication date and source, study design, and target outcomes. If there are more than 15 eligible studies on a program, the studies are scored on quality measures, and the top-scoring 15 studies are accepted for review.

5. **Evidence review**: Using pre-specified standards outlined in the handbook, trained reviewers analyze each study to assess design and scientific rigor for making causal determinations. Studies meeting an acceptable threshold for inclusion are then reviewed to determine the effect size of the findings.

6. **Program and service ratings**: Programs are assigned one of the four Clearinghouse ratings. Well-supported programs demonstrate positive outcomes beyond a year after the introduction of the intervention. Supported programs demonstrate positive outcomes for at least six months after the end of the intervention. Programs earning the promising rating show statistically significant results without requiring follow-up measures.

The Clearinghouse review process has been slower than anticipated, especially in light of the implementation timeline. To address this issue, the ACF approved a route for states to receive transitional funding on a temporary basis for programs that have not yet been reviewed by the Clearinghouse. To claim transitional funding, states must conduct their own independent reviews, using the same review methods used by the Clearinghouse, on programs and services they for which they wish to receive temporary reimbursement. If the ACF approves the submitted documentation of the independent review, states can receive transitional funding on these programs for up to 5 years, or until the Clearinghouse reviews and rates the programs. If the Clearinghouse reviews a transitionally approved program and assigns a rating of *does not meet criteria*, the payments for that program will cease.

As of the publication of this report, 15 programs/modalities have been approved by the Clearinghouse (Table 3)[11], and 6 programs are currently under review (Table 4). An additional program (Family Centered Treatment) has not been reviewed by the Clearinghouse but has been approved for transitional payments after an independent review was submitted to the Children's Bureau by the state of Arkansas. A matrix containing a wide range of relevant information for each approved program (e.g., target population, outcome goal, practitioner requirements, etc.) is included as Appendix B.

In addition, the Clearinghouse has assigned ratings of *does not meet criteria* to several programs, meaning that they are not eligible for Title IV-E funding: Multisystemic Therapy for Child Abuse and Neglect (under mental health), Nurturing Parenting (under parent training), Solution Based Casework (under parent training), Family Behavior Therapy (under substance abuse) and Seeking Safety (under substance abuse). The Clearinghouse also reviews evidence for Kinship Navigator programs; to date, none have met criteria for an evidence-based rating. Appendix C provides more detailed information about the programs that have been reviewed but do not meet criteria.

[11] Table 3 is color-coded. Dark green=well-supported; light green=supported; yellow=promising.

Table 3: Approved Programs

CLEARINGHOUSE APPROVED PROGRAMS[12]		
Mental Health	**Substance Abuse**	**In-Home Parent Training**
Multisystemic Therapy	Multisystemic Therapy	Healthy Families America
Parent-Child Interaction Therapy	Motivational Interviewing	Nurse Family Partnership
Brief Strategic Family Therapy	Brief Strategic Family Therapy	Parents as Teachers
Family Centered Treatment*	Families Facing the Future	Brief Strategic Family Therapy
Functional Family Therapy	Methadone Maintenance Therapy	Homebuilders
Trauma-Focused CBT		SafeCare
Child-Parent Psychotherapy		

* This program was approved for *transitional* payments following an independent review submitted by the state of Arkansas; it may be used by any state for transitional payments.

Table 4: Programs Under Review

PROGRAMS UNDER CLEARINGHOUSE REVIEW[13]		
Mental Health	**Substance Abuse**	**In-Home Parent Training**
• Attachment and Biobehavioral Catchup • Incredible Years • Interpersonal Psychotherapy • Multidimensional Family Therapy • Triple P – Positive Parenting Program	• Multidimensional Family Therapy • The Seven Challenges	• Attachment and Biobehavioral Catchup • Multidimensional Family Therapy

THE FAMILY FIRST TRANSITION ACT

In December 2019, the president signed the Family First Transition act – a new federal law providing additional resources to states to help with the start-up costs associated with FFPSA implementation. The law provides $500 million for one-time, flexible payments to states and tribes to cover some of the costs of transitioning to FFPSA-qualified programs and placements. Texas is expected to receive approximately $50 million in Transition Act funds, which must be spent within five years. The state is currently developing strategies for using Transition Act funds to support implementation in Texas.

The law also makes changes to the prevention services implementation timeline. Under FFPSA, 50 percent of Title IV-E funds used on evidence-based prevention services must be spent on programs with well-

[12] As of March 2020.

[13] As of March 2020.

supported ratings. With the passage of the Family First Transition act, evidence thresholds are being phased-in gradually. In fiscal years 2022-2023, 50 percent of expenditures must be on well-supported *or* supported programs. The requirement that 50 percent of expenditures go to well-supported programs will not go into effect until fiscal year 2024.

FFPSA IMPLEMENTATION

States could opt to begin implementation of FFPSA as early as October 2019, however many states, including Texas, opted to delay implementation. FFPSA will go into effect in Texas in October 2021. According to the Texas Department of Family and Protective Services (DFPS)[14], the main reasons cited for delaying implementation were not having enough providers in the state who offer evidence-based services, a lack of QRTPs in the state, and a need for further federal guidance on which programs will qualify for federal funding. The state is examining outcomes and costs for serving children in FFPSA-approved congregate care settings, implementing QRTPs, and training in evidence-based modalities. DFPS is also creating partnerships to assist with capacity building, determine the allocation of funds once FFPSA is implemented, and explore the development of a kinship navigator program. In September 2020, Texas must provide the Texas Legislature with a strategic plan for FFPSA implementation.

As FFPSA is a complex new federal law altering a broad swath of child welfare functions and funding mechanisms, state implementation of the law requires careful planning and preparation. A recently published technical guide on FFPSA implementation, prepared by the Children's Defense Fund in collaboration with several other national child welfare organizations, identifies guiding principles critical for successful implementation by states and tribes.[15] These principles will be relevant for all aspects of child welfare service delivery as Texas moves toward implementation.

- **Implementation will require strong and sustained partnerships among multiple stakeholders.** Many entities must coordinate and collaborate to ensure effective implementation, including state and federal government agencies, community-based providers of residential and non-residential services, philanthropic organizations, accreditation bodies, the judiciary, and service consumers.

- **Implementation is a long game.** Implementation of FFPSA requires a fundamental shift in how the child welfare system is organized and funded and will require child welfare agency staff, judges, attorneys and contracted provider agencies to be aligned in their approaches to child welfare. This transition will take time and will include a period of planning, education, resource alignment, and system re-balancing to maximize its intended impact.

- **Implementation measures must always be centered on the ultimate impact on children and their families**. Stakeholders must keep the impact of the law on children, youth, and families at the center of planning and implementation. Regular review of data, even for programs designated as evidence-based, and consistent inclusion of diverse families in planning and implementation, is critical to ensure that FFPSA provisions are having the desired impact.

- **Implementation will require intensive coordination among stakeholders**. Implementation of FFPSA will require strong communication between ACF, the state child welfare agency, and local

[14] Texas Department of Family and Protective Services. Family First Prevention Services Act. https://www.dfps.state.tx.us/Child_Protection/Family_First/default.asp

[15] Children's Defense Fund. Implementing the Family First Prevention Services Act: A Technical Guide for Agencies, Policymakers, and Other Stakeholders: https://www.childrensdefense.org/wp-content/uploads/2020/02/FFPSA-Guide.pdf.

stakeholders who have the most knowledge about the needs of children and families in their communities.

- **FFPSA is a starting point for reform.** FFPSA cannot overcome all of the challenges that child welfare agencies experience in improving outcomes for children and families. Implementation of FFPSA will require careful consideration of resources that are available to help families before they ever become involved in the child welfare system. It will also require child welfare stakeholders to continue working to overcome workforce challenges, build an adequate supply of placements, support kinship families, and create a full spectrum of services and supports.

STUDY OBJECTIVES

This study focuses specifically on the prevention services component of FFPSA, which establishes eligibility requirements for services to be reimbursed by the federal government through Title IV-E. Because of the requirement that reimbursable services be designated as evidence-based, child welfare stakeholders in Texas have raised concerns that many community providers are not currently equipped to comply with the requirements related to qualifying prevention services.

To better understand the current statewide capacity of potentially reimbursable mental health, substance abuse, and in-home parent training services, the Texas Center for Child and Family Studies (the Center) partnered with Casey Family Programs, the Department of Family and Protective Services, and the Texas Health and Human Services Commission (HHSC) to empirically address the following questions:

1. What are the mental health, substance abuse, and in-home parent training services currently available for child welfare-involved families in the state?

2. To what extent do services currently being provided in these categories meet criteria for being evidence-based, according to current federal guidelines?

3. What are the barriers to expanding the state's capacity to serve additional clients? What are the barriers to expanding providers' service arrays to include more qualifying EBPs?

METHODOLOGY

SURVEY DEVELOPMENT AND DATA COLLECTION

The study objectives were carried out through a statewide survey of community providers likely to be offering services in at least one of the service categories eligible for FFPSA funding.

The survey was developed by the Texas Center for Child and Family Studies based on ongoing input and oversight from a steering committee consisting of members from major FFPSA stakeholder groups: the Prevention and Early Intervention (PEI) and Child Protective Services (CPS) divisions of DFPS, the Behavioral Health Services division of HHSC, Casey Family Programs, and the Texas Alliance of Child and Family Services (TACFS). The survey was pilot tested by the committee, members of the DFPS data and analytics team, and external providers from the membership of TACFS. The steering committee approved the final version of the survey in July 2019. The full survey instrument is available from the Texas Center for Child and Family Studies.[16]

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[16] A PDF of the survey is available by request from the Texas Alliance of Child and Family Services: www.tacfs.org

Survey recipients reflect the distribution lists of the contracted mental health, substance abuse, and parent training service providers of HHSC Behavioral Health Services, PEI, and CPS, as well as Children's Advocacy Centers and members of the Texas Council of Community Centers. In addition to contracted providers, the CPS Regional Directors compiled lists of all non-contracted parent training providers from each region and these organizations were added to the CPS distribution list.

The survey was open from July 16, 2019 to August 16, 2019. The link to the survey was sent via email with a jointly signed message from DFPS Associate Commissioner for CPS Kristene Blackstone, DFPS Associate Commissioner for PEI Sasha Rasco, and HHSC Behavioral Health Services Associate Commissioner Trina Ita. Two pre-deployment emails were sent informing recipients of the upcoming survey and its purpose, and two reminder emails were sent while the survey was open. The survey instructions requested that the survey be completed by only one individual within each organization with the title of Clinical Director or higher.

DATA ELEMENTS

The survey collected general agency information as well as information specific to mental health, substance abuse, and/or parent training services currently offered.[17] [18] The data elements are briefly described below.

General agency information:

- Region of headquarters
- Regions in which services are provided
- Existing service contracts (DFPS, HHSC, other state agencies, etc.)
- Number of full-time staff
- Agreement that services are trauma-informed
- Agreement that services are evidence-based
- Interest in serving larger numbers of clients
- Interest in providing new or different programs
- Proportion of costs state would have to pay to for expansion of clients or service arrays
- Barriers to expansion of capacity

Information from agencies currently providing services in each eligible category:[19]

- Screening questions to ensure services currently provided are eligible under FFPSA category definitions
- Populations of clients served
- Programs/modalities/interventions offered[20]
- Provider qualifications

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[17] These questions were asked for each category of services. Respondents only saw these questions if they answered "yes" to a prompting question for each category asking if they were currently providing services in that category.

[18] For each service category, the list of programs included for respondents to select from was guided by the Casey Family Programs publication Interventions with Special Relevance for the Family First Prevention Services Act (FFPSA) (2nd ed.). https://caseyfamilypro-wpengine.netdna-ssl.com/media/Family-First-Interventions-Catalog.pdf

[19] Where there were multiple responses from a single agency, the response from the individual with the most senior title was retained and the others were removed. In the case that the titles were equivalent, or it was unclear which was more senior, the response with more missing data was removed.

[20] Once respondents indicated that they did not provide services in any of the eligible categories, they were exited from survey without seeing any subsequent questions.

- Primary funding source for category-specific services
- Number of clients served
- Client CPS involvement

ANALYTIC SAMPLE

There were 411 respondents originally recorded in the data prior to excluding ineligible responses. This number, however, contained both agency-level duplicates and empty responses, in which a recipient opened the survey but did not answer any questions.

To create the final sample, the following exclusions were made, resulting in a final sample of N=315 unique, valid responses:

- *28 duplicate responses were removed.* Only one respondent per agency was allowed, as conveyed in the survey communications and on the survey consent page, but in some instances more than one respondent at an agency took the survey. The data set was de-duplicated at the individual and agency levels.[21]
- *44 empty responses were removed.* In these instances, respondents opened the survey but did not answer any questions. This exclusion category includes entries in which respondents provided only agency information (name, title, service regions, etc.) but did not answer any further questions.
- *21 responses were removed from agencies not providing any services in eligible categories.* To be eligible for inclusion, responding agencies had to provide services in at least one of the categories of mental health, substance abuse, or parent training.[22]
- *3 responses were removed for miscellaneous ineligibility issues.* These removals were responses from staff members in state government agencies. The eligible population for the survey was community-based service providers.

After removing agency duplicates and empty responses, the final study sample represents N=315 unique, unduplicated agency responses from community providers of mental health treatment services, substance abuse treatment services, and/or parent training services.

RESPONSE RATE

In an attempt to estimate the number of unique agencies who received the survey so that a response rate could be calculated, the research team from the Center obtained the distribution lists from the largest distributors: HHSC, CPS, PEI, and TACFS. The researchers were not able to obtain the distribution list for the Texas Council of Community Centers (TCCC), so the overlap between this list and the other recipient lists is unknown.

After compiling the HHSC, CPS, PEI, and TACFS distribution lists, the research team de-duplicated email addresses, then de-duplicated again at the agency level using the organization names in respondents' email addresses. Email addresses that used personal or non-organizational addresses (such as @yahoo or @gmail) could not be de-duplicated at the agency level. Given the two pieces of missing information (the recipient

[21] Numbers exceed the total sample size because agencies could select multiple service types they provide.

[22] Once respondents indicated that they did not provide services in any of the eligible categories, they were exited from survey without seeing any subsequent questions.

list from the TCCC and the unknown affiliations of recipients using personal email addresses), the *best approximation* of unique recipients at the agency level is N=915, reflecting a response rate of 37 percent.

FINDINGS

Of respondents who do provide services in one of the eligible categories, the largest number of agencies provide mental health services, followed by parent training then substance abuse (Table 5).

Table 5: Service Categories[23]

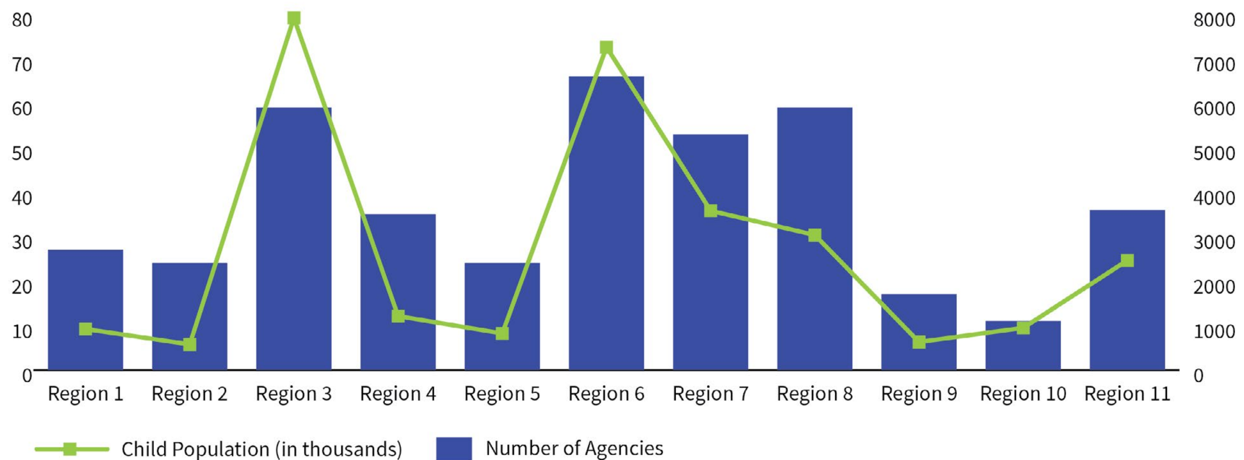
MENTAL HEALTH	PARENT TRAINING[24]	SUBSTANCE ABUSE
N= 257	N=189	N=137

Among agencies who responded to the survey, 46 (14.6%) are Child Advocacy Centers (CACs).[25] Of the CACs in the survey, 42 provide mental health services, while 5 provide substance abuse services, and 6 provide in-home parent training services.

SERVICES BY REGION

Responding agencies provide services throughout the state as shown in Figures 1 and 2.[26] The distribution of responding agencies roughly aligns with the child populations of the HHSC/DFPS service regions (Figure 1), which is an indication that the survey responses are at least somewhat representative of the statewide population of community provider agencies.

Figure 1: Responding Agencies by Region



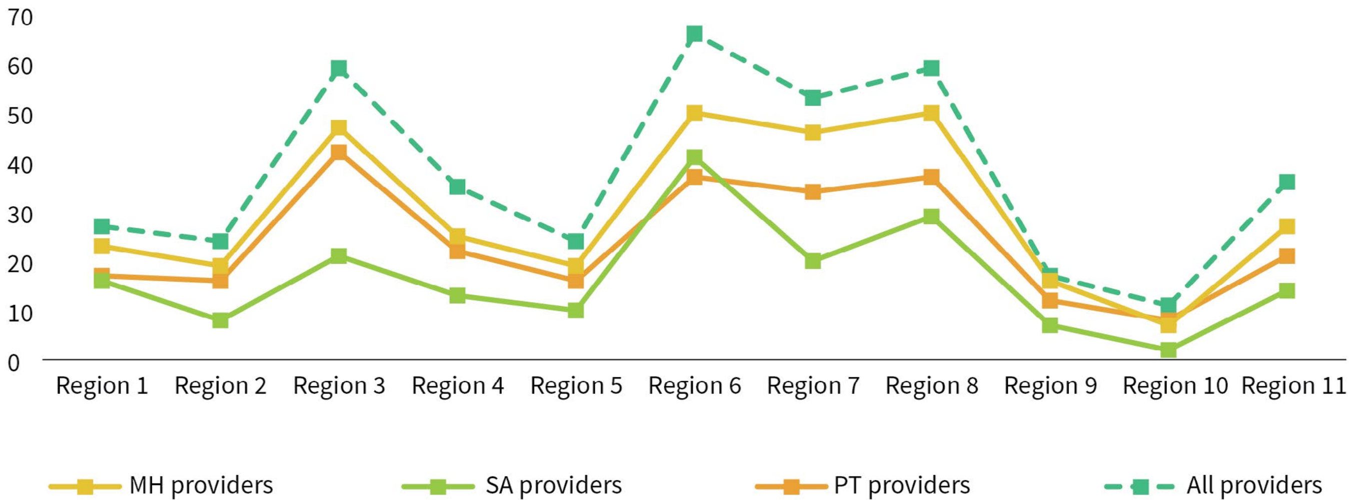
[23] Numbers exceed the total sample size because agencies could select multiple service types they provide.

[24] The full number of parent training providers represented in this section includes providers who currently offer classroom-based, but not in-home, parent training. Though these providers may not be currently offering FFPSA-eligible services in this category, they represent a pool of providers whose services could be adapted to build in-home parent training capacity. In the section below dedicated to findings regarding parent training providers, responses are split into those currently offering in-home (n=105) and those currently offering only classroom-based (n=84).

[25] Fifty-seven respondents answered *yes* to the question, "Is your agency a Child Advocacy Center." The list of these agencies was cross-referenced with the list of local CAC programs, and 11 were not on the list of CACs in Texas. These were removed from the count of Child Advocacy Center providers but retained in the data set.

[26] Numbers exceed total sample size because agencies could select all that apply.

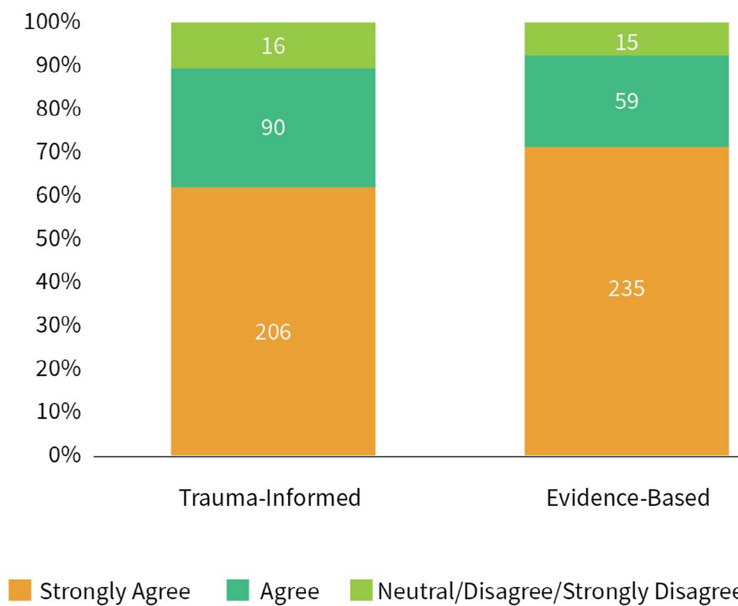
Figure 2: Providers by Category and Region[27]



Agency Perceptions about Services

FFPSA requires that qualifying prevention services be evidence-based and use a trauma-informed approach. Survey respondents were asked, in two separate items, to indicate their agreement that the services provided by their agency are evidence-based and trauma informed. For each question, nearly 95 percent of those who answered agree or strongly agree that the services they provide are trauma-informed and evidence based (Figure 3).

Figure 3: Perceptions about Services[28]



[27] Throughout the report, MH=mental health, SA=substance abuse, and PT=parent training.

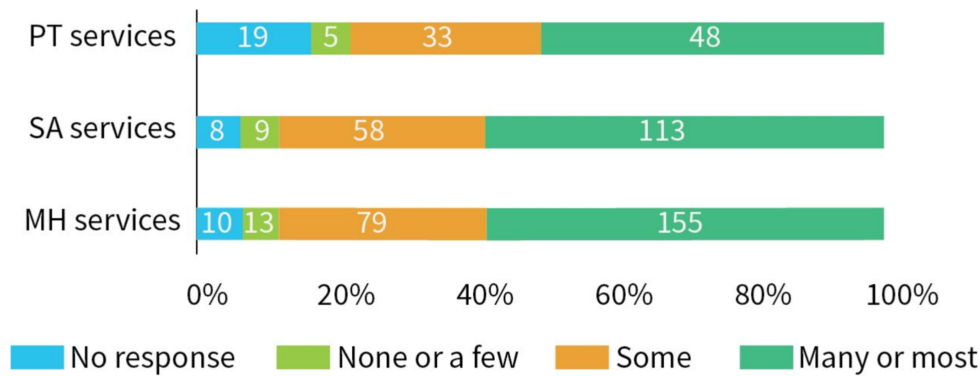
[28] For all figures in the report, the data labels reflect the number (not percent) of agencies who selected that response option. Responses may not equal the full number of providers, or the number of providers within each service category, because of respondents who did not answer that item.

Client CPS Involvement

Because FFPSA prevention services are available for child welfare involved families whose children are candidates for foster care, survey respondents were asked to *estimate* the proportion of their clients who have an open CPS case (at any stage of service) within each service category (Figure 4).[29] For mental health and substance abuse service categories, more than half of providers estimate that many or most of their clients have an open CPS case. For in-home parent training providers, slightly under half say that many or most are estimated to have an open CPS case.

Figure 4: CPS Involvement

Providers' Estimates of Clients with Active CPS Involvement

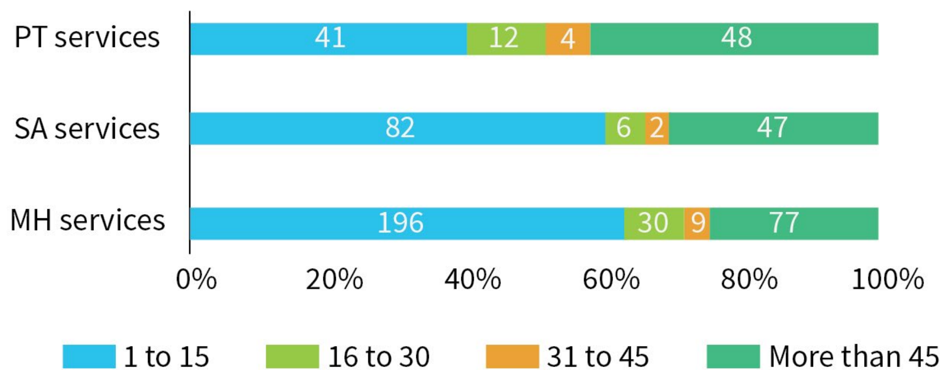


Agency Characteristics: Size, Capacity, and Provider Credentials

For mental health and substance abuse providers, the majority are small agencies, with 15 or fewer full-time staff, as shown in Figure 5. In-home parent training providers are evenly split between larger agencies with more than 30 full-time staff, and smaller agencies with 30 or fewer full-time staff.[30]

Figure 5: Agency Size

Full-Time Staff Positions

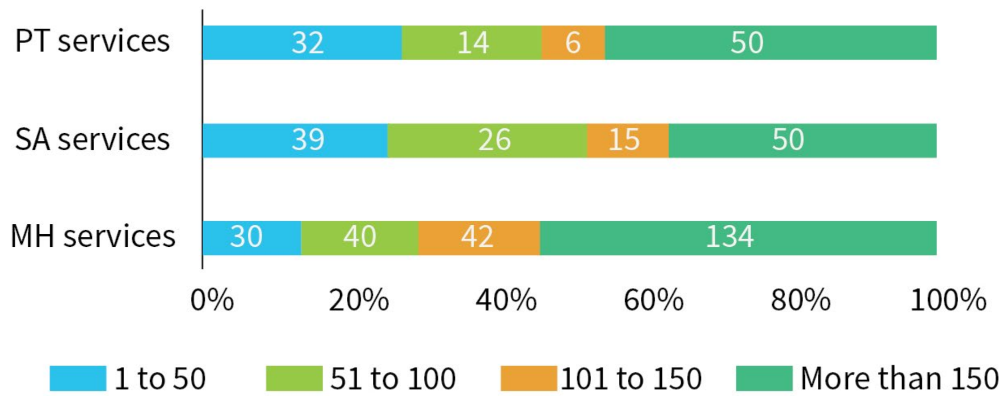


[29] This item excludes classroom-based parent training providers; only in-home providers are reflected.

[30] This item excludes classroom-based parent training providers; only in-home providers are reflected.

Across service categories, the majority of providers served more than 100 clients last year, and for mental health providers, a majority served over 150 (Figure 6). The number of providers who served 50 or fewer clients last year is only 12 percent for mental health providers, but nearly one third for in-home parent training and substance abuse providers.[31]

Figure 6: Number of Clients Served



Within each service category, the survey asked respondents to identify the credentials of the staff delivering the interventions and programs.[32] Across categories, master's-level providers were most common, as shown in Figure 7.[33] [34] Licensed Professional Counselors (LPCs) are the most common master's-level degree across all categories; 84 percent of mental health providers, 63 percent of substance abuse providers, and 35 percent of in-home parent training providers are reported having LPCs providing direct services.

Compared to mental health providers, substance abuse and in-home parent training providers are using higher numbers of professionals with bachelor's degrees (or less) delivering services. Among substance abuse providers, Licensed Chemical Dependency Counselor (LCDC[35]) is the most common education credential at any level; 65 percent of substance abuse provider agencies use LCDCs to deliver services. In-home parent training providers also rely on many professionals without advanced degrees; the "other bachelor's degree" option was the most common response among less advanced degrees in this service category.

There was also an open-ended option for respondents to give answers outside of the choices listed. Across service categories, most common write-in responses were nurses (RNs and nurse practitioners), Licensed Sex Offender Treatment Providers, and various master's-level interns.

[31] This item excludes classroom-based parent training providers; only in-home providers are reflected.

[32] This item excludes classroom-based parent training providers; only in-home providers are reflected.

[33] These numbers exceed the total sample for each service category because respondents could select all that apply.

[34] Doctoral-level answer choices: PhD, PsyD, MD; Master's-level answer choices: LMSW, LCSW, LMFT, LPC; Bachelor's or lower-level answer choices: BSW, other bachelor's degree, and LCDC.

[35] Only an associate degree is required for an LCDC.

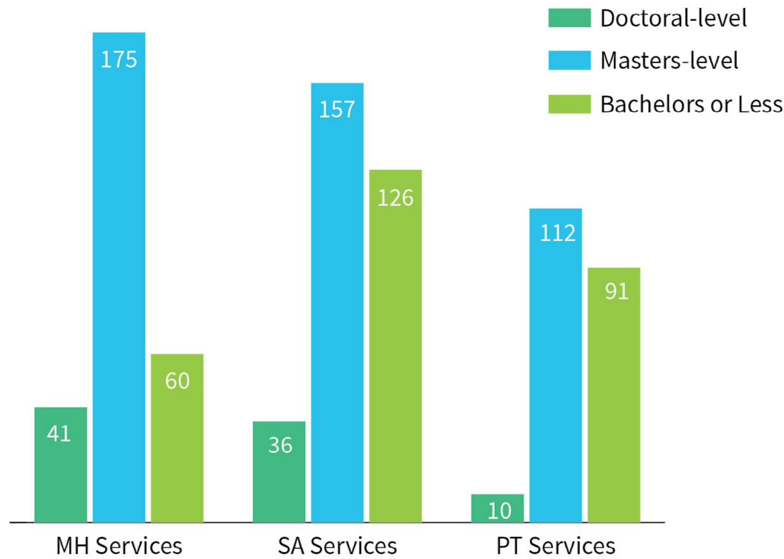


Figure 7: Education Credentials

Funding

For the in-home parent training[36] and substance abuse service categories, state contracts are providers' primary funding source of funding, followed by Medicaid, as shown in Figure 8[37]. For mental health providers, a slightly lower proportion get most of their funding from state contracts, and a slightly higher proportion have Medicaid as the primary funding source compared to the other service categories.

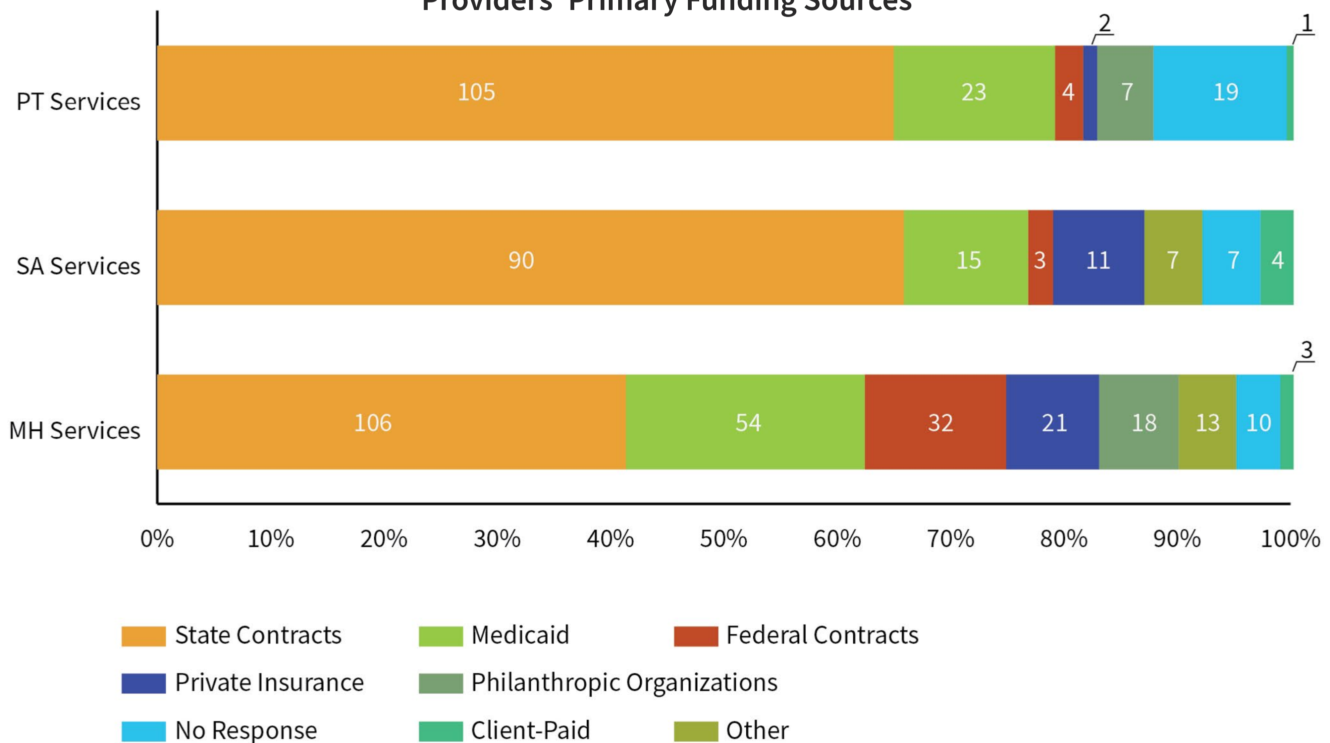


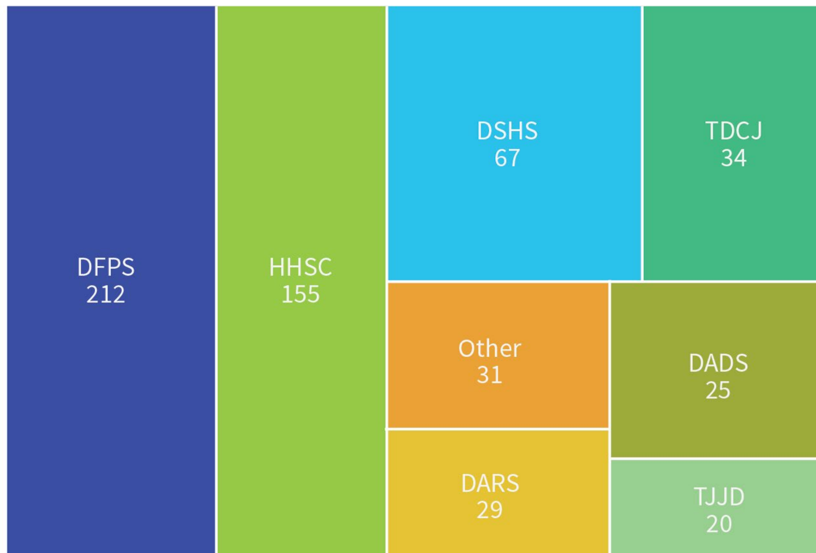
Figure 8: Funding for Services

[36] This item excludes classroom-based parent training providers; only in-home providers are reflected.

[37] For readability, data labels are only included for the four most prevalent responses.

Providers who had funding from state contracts were asked about the agencies they contract with. Among all providers, DFPS and HHSC are the largest sources of state contracts (Figure 9).[38]

Figure 9: State Contracts



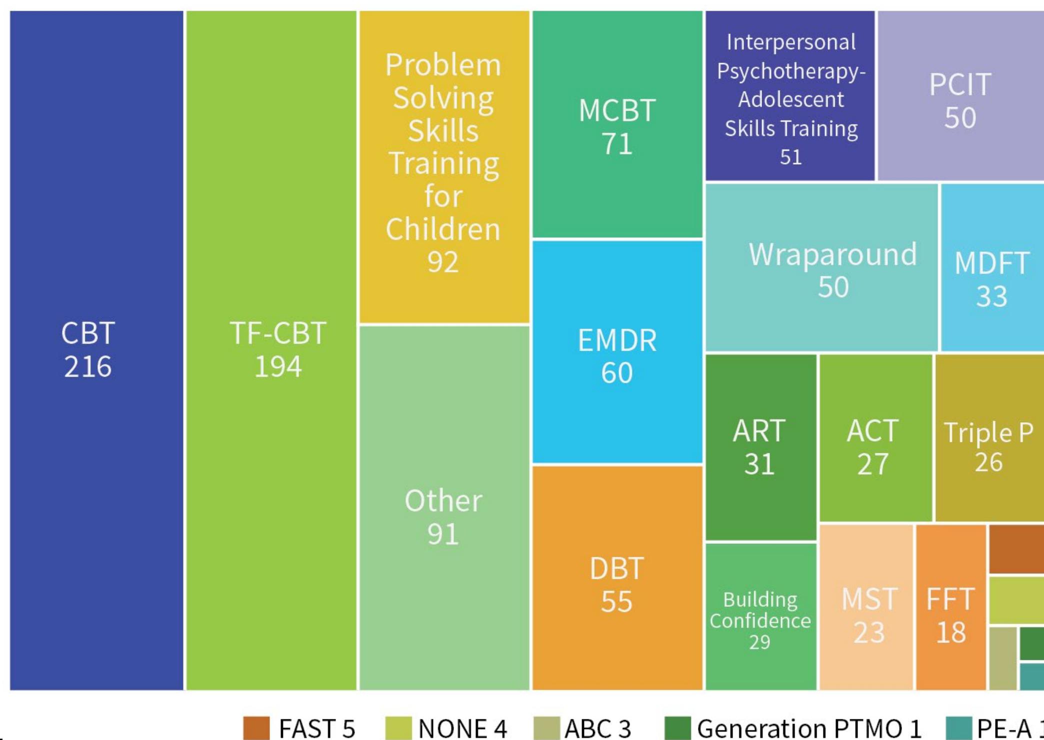
Programs and Interventions in Use among Providers

Mental Health Services (n=257)

Providers offering mental health services are serving a broad range of clients: 96 percent of respondents provide individual mental health services, and 86 percent provide family mental health services. Further, 93 percent of providers offer services to both adults and children/ youth.

Responding agencies were asked to select all that applied from a list of programs and interventions that have the potential to receive high evidence ratings from the Clearinghouse. As shown in Figure 11, Cognitive Behavioral Therapy (CBT) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) are the most commonly used mental health treatments by a large margin.[39]

Figure 10: Mental Health Programs



[38] Numbers exceed total sample size because agencies could select all that apply.

[39] Numbers exceed total sample size because agencies could select all that apply.

Cognitive Behavioral Therapy, used by 84 percent of mental health providers in the survey, has not yet been reviewed by the Clearinghouse and is not one of the programs under review. Trauma-Focused CBT, used by 76 percent of providers, has been designated as an EBP by the Clearinghouse, but only at the promising level of evidence. This is relevant because at the start of implementation, 50 percent of qualifying spending has to be at the supported or well-supported level, and at the well-supported level starting in fiscal year 2024.

Among the other programs already approved by the Clearinghouse, none are in considerably wide use by mental health providers who responded to the survey.

Well-supported:

- Multisystemic Therapy: 9% of providers
- Parent-Child Interaction Therapy: 20% of providers
- Brief Strategic Family Therapy: not a survey response option
- Family Centered Treatment: not a survey response option

Supported:

- Functional Family Therapy: 7%

Promising:

- Child-Parent Psychotherapy: not a survey response option under mental health[40]

Some programs that have been rated by the Clearinghouse were not response options on the survey, so their usage is unknown. In the case of Child-Parent Psychotherapy (CPP), it is unknown how widely it might be in use as a mental health intervention because it was not a survey response option in this category.[41] However, it was included as an intervention in the parent training service category; 19 percent of parent training providers reported using CPP as an in-home parent training intervention, though it has not been reviewed or scheduled for review in that service category.

Of the 91 write-in responses for the "other" category, the most common responses were play therapy, Seeking Safety (since reviewed by the Clearinghouse and rated as does not meet criteria), and Cognitive Processing Therapy.

Regionally, the predominant program type varies somewhat if CBT and TF-CBT (overwhelmingly the most used modalities in every region) are taken out of the analysis. Table 5 shows which mental health programs are offered by the highest number of responding agencies within each region, *excluding CBT and TF-CBT*.

Table 6: Most Common MH Programs by Region, excluding CBT and TF-CBT

	MENTAL HEALTH PROGRAMS
Region 1	Problem Solving Skills Training for Children
Region 2	Mindfulness-based Cognitive Behavioral Therapy

[40] Child-Parent Psychotherapy was included as a response option under In-Home Parent Training, per the guidance of the Casey Family Programs' Family First Interventions Catalog: https://caseyfamilypro-wpengine.netdna-ssl.com/media/Family-First-Interventions-Catalog.pdf
[41] Per the categorization of this program in the Casey Family Programs' Family First Interventions Catalog.

Region 3	Problem Solving Skills Training for Children
Region 4	Problem Solving Skills Training for Children
Region 5	Problem Solving Skills Training for Children
Region 6	Problem Solving Skills Training for Children
Region 7	Eye Movement Desensitization and Reprocessing
Region 8	Problem Solving Skills Training for Children
Region 9	Eye Movement Desensitization and Reprocessing
Region 10	Tie: Eye Movement Desensitization and Reprocessing, Dialectical Behavioral Therapy and Problem Solving Skills Training for Children
Region 11	Problem Solving Skills Training for Children

Substance Abuse Services (N=137)

A large proportion of providers (93 percent) serve adults, but fewer provide treatment to youth (80 percent), and even fewer (64 percent) offer family-based treatment. These findings also show that there may be gaps along a continuum of acuity needs. Only 15 percent of respondents provide residential/inpatient substance abuse services. Further, only 39 percent offer intensive outpatient programming, while 59 percent offer supportive outpatient programming. Only 7 agencies provide inpatient treatment allowing caregivers to have their children with them. The survey captured the majority of agencies who provide this specialized service; there are only 10 such facilities in the state.[42]

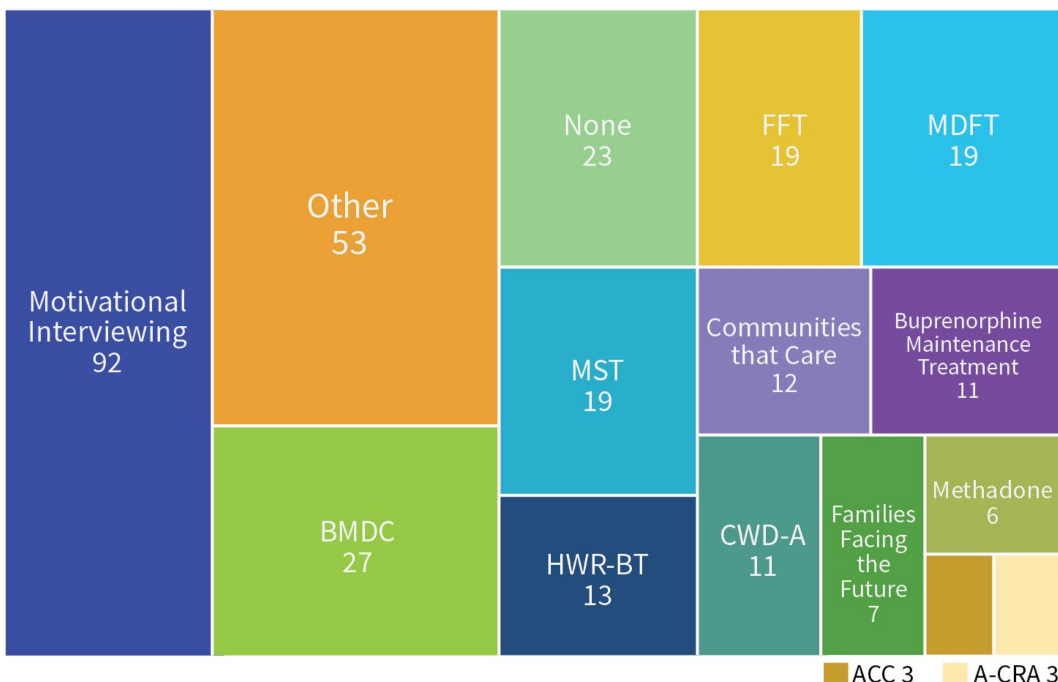


Figure 11:
Substance Abuse Program
Substance Abuse Interventions

[42] https://www.voa.org/pdf_files/family-based-residential-treatment-directory

Asked to select which programs and interventions are used in their agencies (Figure 12)[43], respondents indicated that Motivational Interviewing (MI) is by far the most commonly used modality; 92 providers (67%) reported using MI in their programs.

Of the other programs that have already been Clearinghouse-approved for substance abuse, none are in wide use by respondents. Some programs that have been rated by the Clearinghouse were not response options on the survey, so their usage is unknown.

Well-supported:
- Multisystemic Therapy: 14% of providers
- Brief Strategic Family Therapy: not a survey response option

Supported:
- Families Facing the Future: 5% of providers

Promising:
- Methadone Maintenance Therapy: 4% of providers

Among the write-in responses for the “other” category, the most common response was CBT, followed by Seeking Safety (since reviewed by the Clearinghouse and rated as does not meet criteria), and the Matrix Model (not reviewed or scheduled for review).

Though Motivational Interviewing is the most commonly used modality for substance abuse in every region, there is considerable variation in the predominant program type within each region if MI is excluded. Table 6 displays the substance abuse programs *other than MI* offered by the highest number of responding agencies within each region.

Table 7: Most Common SA Programs by Region, excluding MI

	SUBSTANCE ABUSE PROGRAMS
Region 1 *	Multisystemic Therapy
Region 2 *	Tie: Buprenorphine Maintenance, Brief Marijuana Dependency Counseling, Families Facing the Future, and Helping Women Recover
Region 3	Multidimensional Family Therapy
Region 4 *	Tie: Functional Family Therapy and Multidimensional Family Therapy
Region 5	Tie between Communities that Care, Buprenorphine Maintenance, Brief Marijuana Dependency Counseling, Functional Family Therapy, and Helping Women Recover
Region 6	Brief Marijuana Dependency Counseling

[43] Numbers exceed total sample size because agencies could select all that apply.

Region 7	Brief Marijuana Dependency Counseling
Region 8	Tie: Communities that Care, Adolescents Coping with Depression, Brief Marijuana Dependency Counseling, and Multisystemic Therapy
Region 9 *	Tie: Buprenorphine Maintenance and Helping Women Recover
Region 10	Buprenorphine Maintenance
Region 11	Brief Marijuana Dependency Counseling

*The most common answer for these regions would have been "none of these" if that response option were included in this table

The Texas Health and Human Services Commission contracts with community providers for many of the substance abuse programs in the state. Though usage numbers were not available, Appendix D describes the services that HHSC contracts for through community procurement for these services throughout the state.

In-home Parent Training Services (N=105)

There were 189 total respondents who indicated that they provide parent training services. Of these providers, 105 provide in-home services, and 84 provide only classroom-based services.

There are two different focus populations among the parent training providers in the survey. Parent training providers who received the survey as part of the PEI distribution list are providing services for primary prevention; they are largely serving families who are not formally involved with CPS, in order to prevent cases of maltreatment from occurring. In contrast, parent training providers who received the survey as part of the CPS distribution list are largely serving families already actively involved with CPS in a family preservation or conservatorship case. Some number of providers in the survey data may be providing services to both of these populations within a single agency. This blend of two target populations may inform the finding from Figure 4 showing that nearly half of parent training providers estimate that many or most of their clients have open CPS cases: some parent training providers (PEI contracted agencies) are serving populations with few families actively involved with CPS, while other parent training providers (CPS referral agencies) are serving populations with most families actively involved with CPS.

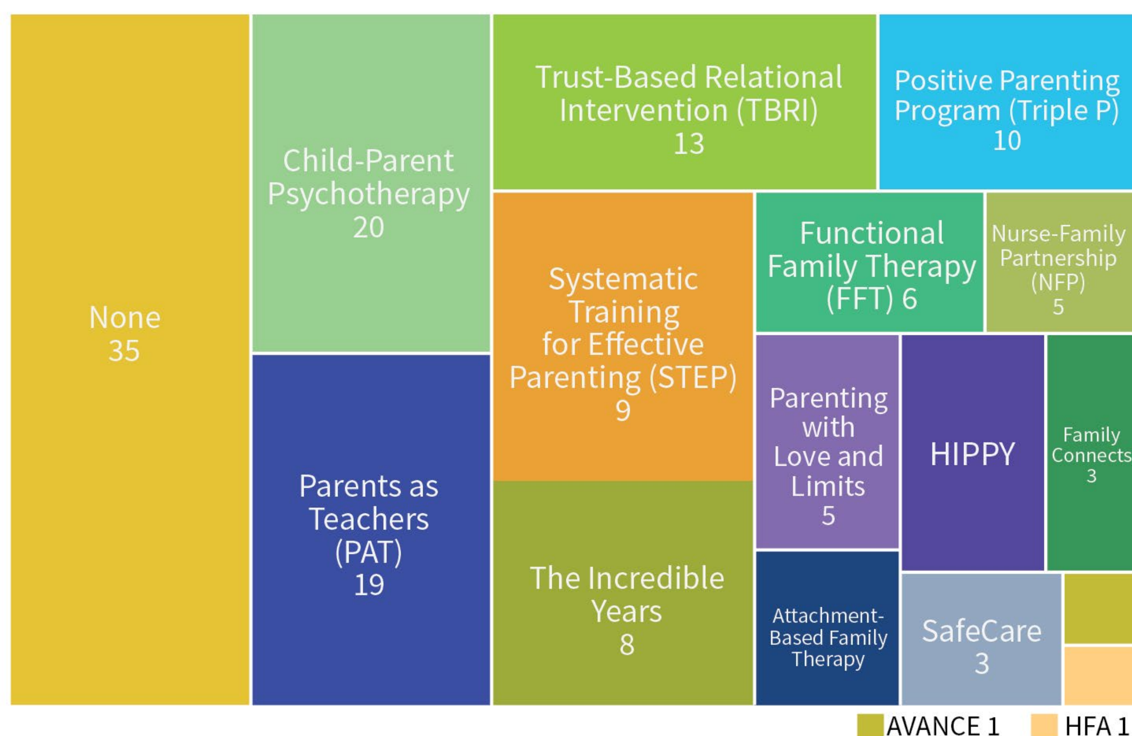
Among the 84 providers who only offer classroom-based services, 50 (60%) indicated that they would be interested in expanding their scope to offer in-home services in the future. Over half of these, however, stated that the state would have to pay 100 percent of the upfront costs for expanding or changing their service array.

The 105 providers offering in-home parent training services were asked to select which programs and interventions they offer, and the largest number of respondents (33%) said that they are not providing any of the programs available for selection, as shown in Figure 14.[44]

[44] Numbers exceed total sample size because agencies could select all that apply.

Figure 12: In-Home Parent Training Programs

In-Home Parent Training Interventions



Programs that have already been approved by the Clearinghouse for in-home parent training are not in substantially wide use.

Well-supported:

- Healthy Families America: 1% of providers
- Nurse Family Partnership: 5% of providers
- Parents as Teachers: 18% of providers
- Brief Strategic Family Therapy: not a survey response option

Supported:

- SafeCare: 3% of providers

Some programs that have been rated by the Clearinghouse were not response options on the survey, so their usage is unknown. Child-Parent Psychotherapy (CPP) was Clearinghouse-approved as a mental health intervention, but it was not reviewed as a parent training intervention. This means that, despite 19 percent of in-home parent training providers using CPP, it is currently not approved to receive federal reimbursement in this service category.

Of the write-in responses for the “other” category, Nurturing Parenting was the most common by a large margin, representing over half of write-in answers. Nurturing Parenting has since been reviewed by the Clearinghouse and rated as does not meet criteria.

Regionally, there is some slight variation in the predominant program type offered by providers. Table 7 shows which in-home parent training programs are offered by the highest number of responding agencies within each region, with the "none of these" answer choice excluded. This data is encouraging, since Parents as Teachers is already approved at the well-supported level.

Table 8: Most Common In-Home PT Programs by Region

	PARENT TRAINING PROGRAMS
Region 1	Parents as Teachers
Region 2	Parents as Teachers
Region 3	Trust-Based Relational Intervention
Region 4	Tie: Parents as Teachers and Trust-Based Relational Intervention
Region 5	Parents as Teachers
Region 6	Child-Parent Psychotherapy
Region 7	Trust-Based Relational Intervention
Region 8	Parents as Teachers
Region 9	Child-Parent Psychotherapy
Region 10	Incredible Years
Region 11	Parents as Teachers

In interpreting the findings about the use of in-home parent training programs in the state, it is important to consider that the agencies who responded to the survey are providing services to a broad spectrum of clients, from those involved in voluntary primary prevention programs in the community, to those intensively involved with CPS due to maltreatment. Because of this mix of providers who are serving different populations, the survey findings may not accurately reflect the use of EBPs when looking exclusively at either end of the service continuum.

For example, internal data from PEI indicates that both Parents as Teachers and Nurse Family Partnership (both approved at the well-supported level) are in fairly wide use for primary and secondary prevention among the subset providers who have PEI contracts. Further, SafeCare (approved at the supported level) is in use in by PEI contracted providers in four Texas communities. To augment the data from all parent training providers in the survey, and to give a fuller picture of the parent training prevention services currently provided in the state, Appendix E displays all parent training and home visiting programs offered through PEI contracted community providers, along with numbers of families served in each program during fiscal year 2019. Parent training providers that are not contracted with PEI are not reflected in this table.

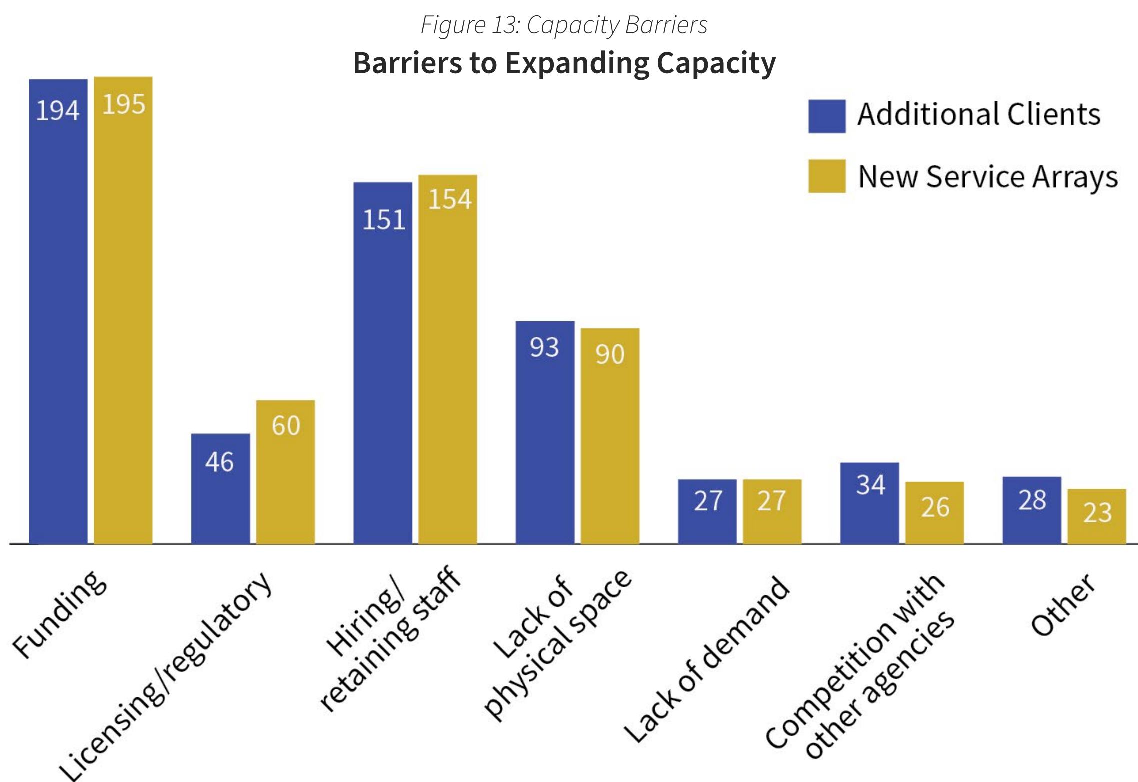
Expanding Services: Capacity and Service Array

The survey asked respondents two separate but related questions regarding service capacity. The first is whether their agency would be interested in expanding to serve more clients if needed, since FFPSA provides states with financial supports to expand services to families. The second is whether they would consider augmenting or modifying their service arrays if needed to comply with FFPSA requirements, especially regarding the use of Clearinghouse-approved programs.

The responses to these two items were substantially similar: 84 percent of respondents are interested in expanding to serve more clients, and 83 percent would consider expanding or changing their service arrays as needed. However, a hurdle to these changes is the upfront costs of expansion. For both questions, almost exactly half of providers indicated that that the state would have to pay 100 percent of the upfront costs, and the remainder said the state would have to pay at least 25 to 50 percent.

In fact, for both questions, respondents identified remarkably similar barriers to enacting these changes, with funding as the most commonly selected answer option, followed closely by hiring and retaining a qualified workforce (Figure 10).[45]

Figure 13: Capacity Barriers



Respondents were also given open-ended opportunities to comment on other barriers they might face in regard to expanding capacity. The majority of responses were just comments on the answer choices reflected in Figure 10, however, a few notable themes emerged.

- There were many comments specific to rural provider issues. Several providers discussed the special challenges of providing services in a rural area, including transportation costs for staff and for clients, the expense of having to travel to larger areas to get trainings for staff, and the difficulty of attracting a qualified workforce.

[45] Numbers exceed total sample size because agencies could select all that apply.

- There were multiple comments related to the costs of purchasing proprietary EBPs and training staff to learn new programs or interventions.

- There were a number of comments related to the need for reimbursement rates to be higher to make the changes that would be required to offer new service arrays.

- Finally, many respondents noted that allowing LPC or MSW interns to serve CPS clients would facilitate capacity building.

LIMITATIONS

As with all research, this study has limitations that should be considered when examining the findings. A key limitation of this study is the unknown generalizability of the survey findings to the full population of child and youth serving providers throughout the state. Participation in the study was voluntary, and those who responded may not be fully representative of those who did not.

Another limitation, common to all survey research, is that respondents could only choose from the response options available for any closed-ended questions. The research team made every effort to ensure survey response choices reflected exhaustive answers, however there are still instances in which the answer options were not sufficient to capture all desired data.

DISCUSSION AND RECOMMENDATIONS

Major Findings

The critical finding of this study is that there are significant gaps between the services currently being offered by community providers in the state and the programs that have been approved to date as FFPSA-qualifying evidence-based practices.

Though the overwhelming majority of providers who took part in the survey report that they are providing evidence-based programming, the majority of interventions they are providing have not been approved as EBPs by the federal Clearinghouse.[46] The divide between services that are available in Texas and services that are reimbursable under FFPSA is not static; the Clearinghouse continues to review and rate programs, so new programs will continue to become FFPSA-eligible over time. In the meantime, as Texas moves closer to the deadline for submitting a plan for FFPSA implementation, the gap between available services and FFPSA-reimbursable services will have implications for the state's ability to maximize federal funding for services to prevent foster care entries.

The extent and nature of the gaps in available and FFPSA-qualified services differ by service category.

Mental Health Services

Among mental health providers, the most common treatment interventions by a wide margin are Cognitive Behavioral Therapy (84% of providers) and Trauma-Focused Cognitive Behavioral Therapy (75% of

[46] As of March 2020

providers).[47] Of these, TF-CBT has been approved by the Clearinghouse, but with the important caveat that it is only approved at the promising evidence rating. This is relevant because 50 percent of qualifying spending on prevention services has to be at the supported or well-supported levels at the start of implementation, and at the well-supported level starting in fiscal year 2024. Of further concern is the possibility that the Clearinghouse will not review CBT at all because it may not meet the requirement of being a manualized intervention.

The most widely used program that is approved at the well-supported level is Parent-Child Interaction Therapy, which is used by 20 percent of providers. There are two other well-supported mental health programs – Brief Strategic Family Therapy and Family Centered Treatment – but neither was an answer option on the survey, so it is unknown how widely they are in use (though neither was mentioned by any providers in the open-ended "other" comment box).

Substance Abuse Services

The snapshot of substance abuse services in the state reveals several potential targets for capacity building. Of the 137 survey respondents who provide substance abuse services, only 15 percent offer residential inpatient services. There may also be other gaps in the substance abuse service continuum, given the scope of the opioid epidemic and other substance use; for example, only 39 percent of respondents offer intensive outpatient services.

Since the purpose of FFPSA is preventing entries to foster care through additional services, a potentially important issue is having a supply of inpatient substance abuse providers that allow caregivers to bring their children to reside with them during treatment. Currently, there are only 10 facilities in the state who offer this service, seven of which are captured in the survey.

Among the 137 substance abuse providers in the survey, Motivational Interviewing (MI) is by far the most commonly used intervention modality.[48] The next most common survey selection was the "other" option, where the most prevalent write-in responses were CBT, which is subject to the same concerns discussed above, and Seeking Safety, which has since been reviewed by the Clearinghouse and rated as does not meet criteria. The most commonly used intervention that has Clearinghouse approval is Multisystemic Therapy, which is only in use by 14 percent of substance abuse providers. Of further concern is that 17 percent of substance abuse providers reported using *none* of the interventions available to select from in the survey.

The fact that MI is overwhelmingly the most used intervention among substance abuse providers may be cause for some concern in relation to treating substance abuse disorders that may lead to children entering care. While MI has strong evidence of effectiveness and is approved for substance abuse at the well-supported level, it is not actually a clinical intervention to treat substance use disorders. Rather, it is a modality used across many service sectors to increase clients' motivation to engage in behavior change. In other words, MI may increase the likelihood that clients will engage in treatment, but it cannot clinically treat a substance use disorder.

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[47] See Figure 11 for all MH programs in use by respondents.

[48] See Figure 12 for all SA programs in use by respondents

In-Home Parent Training

The responses from in-home parent training providers further contribute to the divide between available services and Clearinghouse-approved EBPs. Among the 105 providers of in-home parent training, the most commonly selected response from the list of programs was "none"; a full one-third of providers reported that they do not offer any of the interventions that were available for selection in this category.[49]

The next two most common responses were Child-Parent Psychotherapy (19%), which has not been reviewed or scheduled for review by the Clearinghouse as a parent training intervention, and Parents as Teachers (18%), which has been approved at the well-supported level. Over half of respondents who wrote-in responses in the "other" category reported using the Nurturing Parenting program; however, this has since been reviewed by the Clearinghouse and assigned a rating of does not meet criteria.

To maximize federal funding under FFPSA, there is a need for capacity building on two fronts: building capacity for agencies to serve higher numbers of clients to meet demand for expanded prevention services after implementation, and building new service arrays so that there are FFPSA-qualified evidence-based programs available throughout the state in each service category. The findings suggest promising capacity-building opportunities. Among all providers, 84 percent are interested in expanding to serve more clients, and 83 percent would consider augmenting or modifying their service arrays to include more approved EBPs from the Clearinghouse. Further, over half of providers offering classroom-based parent training are interested in shifting or expanding their services to offer in-home parent training.

There are, however, substantial barriers to these expansions at the provider level. Most organizations indicated that the state would have to pay all or most of their upfront costs to build out capacity. Providers need funding for retraining staff, hiring additional staff, and obtaining more physical space to house staff and serve clients, among other needs. These barriers are even more pronounced for providers in rural areas, who have travel and transportation costs that are more prohibitive than those of providers in urban areas. Further, rural providers may have difficulty even finding staff in areas where there is not an available pool of qualified clinicians or administrators.

Recommendations

The following recommendations are based on the findings of the capacity assessment as applied to implementing the provisions of FFPSA in Texas.

1. *Strategically invest in expanding the supply of Clearinghouse-approved evidence-based programs throughout the state.*

To realize the intended goal of preventing substitute care entries, more Clearinghouse-approved EBPs must be offered throughout the state, and they must have sufficient diversity to ensure the right services are available to meet the diverse needs of families. This capacity assessment shows that there are shortages of FFPSA-qualified programs in all service categories, and particularly in substance abuse and in-home parent training. This will require thoughtful decision-making about which programs to select for investment among the state's community service providers.

[49] See Figure 13 for all in-home PT programs in use by respondents

The Family First Transition Act will provide approximately $50 million in funds, which must be spent within five years, to assist with FFPSA implementation. With those funds, the state could choose an initial round of programs covering each service category and assist local providers throughout the state in adding the programs to their service arrays. Investing in a smaller set of EBPs at the outset (rather than a wide array of programs) may be optimal because of the substantial provider resources needed to learn and implement a new intervention. After the first two years of implementation, additional programs will have been approved by the Clearinghouse, giving the state and providers more options for drawing down federal funding for prevention services.

Determining what interventions to select for initial implementation in child and family serving agencies is a complicated and important decision involving multiple factors. The Texas Alliance of Child and Family Services has created a matrix of approved services that allows for quick and easy comparison of program characteristics that may be useful for considering potential interventions.[50] The following are recommendations for how the state could strategically invest in building the right array of EBPs:

Choose a mix of proprietary and non-proprietary interventions. Proprietary programs are typically more expensive to purchase, but the real cost involves expanding the use of the program. Proprietary programs usually involve a contract between the owner of the program model and a provider. With a proprietary model, Texas could not perpetuate the growth and use of the program using their own resources because all training in the model is disseminated by the owner. The state should consider which proprietors could help Texas implement interventions in the most cost-effective way.

Choose a mix of programs with different practitioner requirements. Programs have different minimum qualifications for the professionals who deliver the intervention. Of the programs already approved by the Clearinghouse, six require that the practitioner have a master's degree and be licensed, one allows practitioners to have only a bachelor's degree, four have no minimum qualifications (high school diploma or equivalent and some experience working with children and families), and two require a nurse or physician. Choosing some programs with less advanced qualifications will give agencies more staffing flexibility and may be particularly beneficial for rural providers.

Consider the costs of program training requirements. The time and expense of trainings for providers to learn an intervention can widely vary. At least one of the programs already approved by the Clearinghouse has training delivered entirely online. Some trainings are available in the community and easy to access, some programs will send a trainer to local communities to provide training, and others require practitioners to travel out-of-state to receive training. Further, some proprietary models have a cap on the number of people who can be trained at one time; this ranges widely, from 5 to 30 or more. Having at least some interventions that can be trained in larger numbers will maximize efficiency.

Choose at least one or two programs with more affordable start-up costs to balance out the costs of the more expensive ones. Start-up costs for Clearinghouse-approved interventions vary widely, from $300 to over $35,000. It is important to consider both start-up and ongoing costs, as well as what the cost includes. Does it include training and use of the model only? Does it cover the cost of certification? Does it cover written materials and instruments in various languages? Does it cover support/guidance as needed? Is there a cap on the amount of support the proprietors offer within that price? All of these factors should be considered in calculating the affordability of a new program.

50 See Appendix B.

Select interventions that have high relevance for CPS-involved families. Some of the interventions were specifically designed for families in maltreatment has occurred[51], so these should get special consideration. The state should also consider interventions that specifically target neglect, since more than 70 percent of confirmed allegations in Texas are for neglectful supervision.[52]

Ensure that interventions have a feasible level of intensity. Approved interventions vary widely in intensity level, which has implications for the ability of providers to deliver them to fidelity. Low intensity models involve 1-3 sessions total with sessions lasting approximately 30-50 minutes. High intensity models require 2-3 sessions per week with sessions lasting two or more hours. The state should avoid selecting interventions that are all high intensity, as community agencies are unlikely to have the staff or capacity to carry these out.

Select interventions that cover wide range of ages, while focusing appropriate resources on age groups with the highest need. Clearinghouse-approved interventions target both parents and children from defined ranges. Only one approved intervention targets all children ages 0-17. In 2019, half of children receiving services through Family-Based Safety Services (FBSS) were age 5 or younger[53], so a similar proportion of selected interventions should target this age range.

2. *Establish efficient methods for scaling up EBPs statewide.*

Once programs are selected, there are multiple options for how to get them up and running statewide. The state could create regional cohorts of providers who can consolidate to make training costs more efficient (for example, purchasing training materials in bulk). Trainers for each selected intervention could be embedded in each region to travel to various communities for training. Alternately, the state could contract with a single organization to organize, coordinate, and/or directly provide trainings throughout the state for selected programs.
There may also be opportunities for increasing capacity for evidence-based prevention services by leveraging existing infrastructure, especially in resource-scarce areas. Since the congregate care provisions of FFPSA may reduce the number of residential facilities in the state, it is possible that some current providers of residential services could adapt new business models. For example, with assistance from the state, an emergency shelter could be repurposed as an evidence-based residential substance abuse facility for families.

3. *Localize data for decision-making.*

The state should examine the needs of the FFPSA-eligible population by catchment area to determine the mix of service needs in specific communities. Demand, capacity, and service utilization should also be tracked at the catchment level.

[51] See the Clearinghouse Matrix in Appendix B for information on the target outcomes for each intervention.
[52] DFPS Data Book. (2019). Child Protective Investigations: Alleged and Confirmed Types of Abuse: https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Investigations/Investigations/Types_of_Abuse.asp
[53] DFPS Data Book. (2019). CPS Family Preservation: Children Served. https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/Family_Preservation/Children_Served.asp

4. *Create a reliable mechanism for educating local providers on the changes that will be required for FFPSA implementation.*

DFPS is already engaged in keeping the provider community informed through webinars, website information, and public hearings, among other methods. This work should be continued so that providers have solid information on which to base their strategic planning for FFPSA implementation. Providers, as well as other community child welfare stakeholders, need access to reliable and up-to-date information, both on the provisions of FFPSA, as well as the actions being taken at the state level that have downstream implications for their operations. To the extent possible, information should be disseminated in person at the local community level to give providers and stakeholders the ability to ask questions and speak directly to those with the most knowledge of the law and its implementation in Texas.

5. *Convene stakeholders from state agencies, the philanthropic community, and the provider community to ensure that funding for services is sufficient and systemically coordinated.*

Active collaboration between DFPS and HHSC (Medicaid) will be essential for managing the state and federal funding streams for services across all categories. Further, since many providers rely on philanthropic dollars in addition to state contracts to operate community programs, state agencies should work purposefully with the private philanthropic and provider communities to coordinate funding. A small collaborative comprised of these public and private stakeholder groups can provide the broadest view of statewide service needs and coordinate funding to maximize the collective impact of all available resources.

6. *Situate the services that will be provided under FFPSA within a full continuum of care.*

As important as FFPSA is for promoting children's safety, permanency, and wellbeing, it targets only one segment of vulnerable children and families in Texas. As the state builds up services under FFPSA, it should also ensure that there is a full continuum of services for families with more intensive and less intensive needs. The state can continue to build this continuum through sustained support for primary prevention services, conservatorship services, and aftercare services.

A broad-based strategy for reducing entries to care requires that local communities come together to create safety nets for families before children are at imminent risk of removal. Toward this goal, the state should engage the faith-based and non-paid provider communities to augment the work of paid providers. Entities such as Alcoholics Anonymous, Narcotics Anonymous, food banks, and baby pantries can play an essential role in meeting the needs of families outside of the network of professional providers. Family Resource Centers – community-based facilities that offer a wide array of supportive services to strengthen family functioning – may also play a role in creating a comprehensive array of services in the community outside of formal involvement with DFPS or other state systems.

7. *Equip providers with the resources to collect their own data for program evaluation.*

Even when using EBPs that are approved by the Clearinghouse, effectiveness will vary. This variation can be due to differences in local populations, providers, or methods of delivery. Interventions that are selected from the Clearinghouse may not have the desired impact once implemented, so agencies should evaluate outcomes to inform ongoing considerations for program selection. In fact, under FFPSA, states are required to evaluate any EBPs that are below the well-supported Clearinghouse rating, so facilitating data collection at the local agency level will provided needed information to inform evaluation at the state level. Program

evaluation requires both specialized skills and funding, however, so the state will need to create ways to support agencies toward the evaluation of outcomes at the provider level.

These recommendations were provided based on the best-known information at the time the report was written.[54] There are three important considerations that qualify these recommendations.

- The state's definition of foster care candidacy could change prior to FFPSA implementation. Changes to the definition of candidacy will directly affect the state's service capacity needs. The more broadly that candidacy is defined, the more service capacity will be needed to serve the eligible population.

- The willingness and ability of community providers to adapt to the requirements of FFPSA will depend on the state's approach to procurement upon implementation, as well as the sufficiency of funding to make necessary changes. If the state requires that providers offer FFPSA-qualifying EBPs as a condition for contracting, providers who want to pursue or maintain contracts will be compelled to make these changes. Conversely, if providers can maintain their contracts without changing their services, there may be less motivation to make expensive reforms such as hiring new staff, purchasing new space, or adopting new programs.

- The full impact of the COVID-19 pandemic on the child welfare system remains to be seen. The pandemic could have considerable effects on the state's available resources to support FFPSA implementation.

In summary, the Family First Prevention Services Act presents an unprecedented opportunity for the state to leverage federal support to invest in services to maintain children in their own homes. The services that will be available to families under FFPSA may allow more families to maintain their children in their care, prevent the trauma of removal for children who can safely remain at home, reduce the burden on the foster care system, and coalesce community-based providers around the mission of family preservation. The law, however, is only as good as the state's ability to implement it in a manner that maximizes its benefits. This capacity assessment hopes to inform the state's plan for successful implementation toward supporting vulnerable children and families.

[54] March 2020

APPENDIX A

FFPSA TITLE IV-E PREVENTION SERVICES REQUIREMENTS AT-A-GLANCE[1]	
Effective Date	The Title IV-E Prevention Program is optional, but state and tribal agencies were able to take up the option as of October 1, 2019. Texas opted to delay implementation until October 1, 2021.
Eligible Individuals	1. Children who are candidates for foster car 2. A child in foster care who is a pregnant or parenting youth, and/or 3. Parents or kin caregivers of a candidate for foster care or a pregnant or parenting foster youth. There is no income requirement to qualify.
Eligible Services and Programs	1. Mental health services provided by a qualified clinician 2. Substance abuse prevention and treatment services provided by a qualified clinician, and 3. In-home parent skill-based programs, which include parenting skills training, parent education and individual and family counseling, which do not have to be delivered in the home.
Duration	Eligible services and programs may be used for up to 12 months and for additional contiguous 12-month periods when justified on a case-by-case basis. There is no lifetime limit on accessing these prevention services.
Evidence-Based Requirements	All eligible services and programs must meet evidence-based requirements based on the definitions of "promising," "supported," or "well supported" practices defined in Family First. Tribal Title IV-E agencies do not have to meet these practice standards.
Trauma-Informed	All eligible services and programs must be trauma informed.
Written Prevention Plan	Title IV-E agencies must maintain a written prevention plan for each child that describes the services and programs that will be provided to the child or on their behalf.

[1] This table was adapted from *Implementing the Family First Prevention Services Act: A Technical Guide for Agencies, Policymakers, and Other Stakeholders* published by the Children's Defense Fund: https://www.childrensdefense.org/wp-content/uploads/2020/02/FFPSA-Guide.pdf. The contents reflect inclusion of provisions from the Family First Transition Act of 2019.

Data Reporting Requirements	Title IV-E agencies must submit child-specific data to the Children's Bureau related to the specific services provided, total expenditure for the services, duration of the services, and whether or not the child entered foster care.
State Plan Component	Title IV-E agencies must submit a five-year plan that details the services they plan to use, how they will monitor and oversee the safety of children receiving the prevention services, plans for evaluation of the program, consultation and coordination among other agencies, steps to support and train the child welfare workforce, and other requirements specified in FFPSA.
Maintenance of Effort	State Title IV-E agencies must maintain at least the same level of "state foster care prevention expenditures" each year as the amount the agency spent in FY2014 (or an alternate applicable year) for services with similar characteristics. Tribal Title IV-E agencies do not have to meet this requirement.
Federal Reimbursement	From FY2020 – FY2026, costs of the Title IV-E prevention services are reimbursable at 50 percent. Beginning in FY2027, Title IV-E prevention services are reimbursable at the Federal Medical Assistance Program (FMAP) rate. Beginning in FY2020, administrative and training costs associated with the Title IV-E Prevention Program will be reimbursed at 50 percent.
Well-Supported Practices Requirement	In FY2022 and FY2023, at least 50 percent of the total expenditures by the State for the Title IV-E Prevention Program must be for services that meet the "supported" or "well-supported" evidence-based practice criteria. In FY2024 and beyond, at least 50 percent of the total expenditures by the State for the Title IV-E Prevention Program must be for services that meet the "well-supported" evidence-based practice criteria. Tribal Title IV-E agencies do not have to meet this requirement.

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APPENDIX B

Title IV-E Prevention Services Clearinghouse: Evidence-Based Services And Programs Matrix

	Approved for	Target	Frequency	Setting	Primary Goal	Average Length	Practitioner	Practitioner Requirements	Variations & Approx. Training Cost
Well-Supported									
Brief Strategic Family Therapy (BSFT)	Mental Health Substance Abuse In-home Parent Skill-based Training	Whole families with youth 6 – 17-years-old with problem behaviors	Medium: One, 60 – 90 minute, in-person session per week	Multiple Home, school, community centers or clinic	Work with the whole family to improve family functioning, prevent and treat youth substance abuse and decrease youth behavior problems	3 – 5 months	Master's level therapist - exceptions can be made for Bachelor level professionals with extensive experience	Attend a 4 day training at their agency. Providers then participate in weekly video supervision for 4 – 6 months and record and submit family therapy sessions. The site, not the therapist, is certified	Yes: approved for mental health, substance abuse and parenting training and there is specific evidence of effectiveness for African American and Hispanic families $35,000 +
Multisystemic Therapy (MST)	Mental Health Substance Abuse	At-risk youth ages 12 – 17 and their families	High: Multiple visits per week	Multiple Home, school or in the community	Promote pro-social behavior and reduce criminal activity	3 – 5 months	Master's level therapist - exceptions can be made for Bachelor level professionals with extensive experience	Therapist must attend a 5 day training out of state and be on an MST team with a certified MST supervisor who attends 12 days of training	Yes: multiple and specifically for child abuse and neglect and PTSD $26,000 +
Functional Family Therapy (FFT)	Mental Health	Whole families with youth 11 – 18-year-olds with behavioral issues	Medium: One, 90-minute, in-person session per week + one phone call per week	Multiple In the therapy office, home, school or other community setting	Decrease conflict in the home, improve family functioning, help youth make positive change	2 – 4 months	Master's level therapist - exceptions can be made for Bachelor level professionals with extensive experience	Therapist must attend a multi-day training and be on a FFT team. Full certification can take up to 3 years	Yes: child welfare, gang involvement and probation and parole $36,000 +
Parent-Child Interaction Therapy (PCIT)	Mental Health	2 – 7-year-olds with behavior problems and their families	Medium: One, in-person session per week or one session every other week	Play-room therapy office with one-way mirror	Parents learn behavior management, child's behavior improves and parent/child relationship improves	3 – 5 months	Licensed Master's level therapist	40 hours of training (30 in-person) with a PCIT certified therapist – found all over the country	No, but studies have shown it to be effective for children with autism and past trauma $14,000 +
*** Family Centered Treatment (FCT)**	Mental Health	Whole families with youth birth – 17-year-olds	High: Two, in-person, multi-hour sessions per week	In-home	Family therapy aimed at positive individual behavior change and improving family functioning to prevent out of home placement	6 months	Licensed Master's level therapist	Certification is required and consists of an online, 100-hour course and field-based competency requirements	No $10,000 +

Motivational Interviewing (MI)	Substance Abuse	10-years-old – adults with an addiction to drugs/alcohol and/or nicotine	Low: One – three sessions total, each session lasts approximately 30 – 50 minutes	Multiple School, therapy office, community agency or in home	Encourage and promote behavior change to improve physiological, psychological, and lifestyle outcomes	1 – 6 weeks	No minimum qualifications	Complete a 1 day, on-line or in-person training – usually found locally	Yes: can be used to help change any unhealthy behavior $600 +
Healthy Families America (HFA)	In-home Parent Skill-based Training	Pregnant women/ Families with children age newborn – 5-years-old	Medium: One weekly visit	In-home	Strengthen the parent/child relationship, enhance family functioning	6 months +	No minimum qualifications	H.S. diploma and attend a 4-day training, likely in house or found locally	No, but supplemental books and manuals can be provided to families $4,000 – 10,000 +
Nurse Family Partnership	In-home Parent Skill-based Training	Pregnant women/ Families with children age newborn – 2-years-old	Medium: One weekly visit for the first month, then can taper down	In-home or somewhere in the parent's community	Improve the health of the children and their families	2 years	Registered Nurse (RN) with a bachelor's degree	Participate in educational session with the NFP National Service Office	No $30,000
Parents as Teachers (PAT)	In-home Parent Skill-based Training	Pregnant women/ Families with children age newborn – starts Kindergarten	Low: Every other week or monthly	In-home Can also be provided in child-care setting	Improve the health of children, prevent child abuse, teach parenting skills, detect/ prevent developmental delays	3 years	No minimum qualifications	H.S. diploma and attend a 5-day PAT training held throughout the nation including Texas	No $2,500 +
Homebuilders	In-home Parent Skill-based Training	Families with children ages newborn – 18-years-old	High: An average of 10 hours a week + 24 hour on-call availability + regular telephone check-ins	In-home	Help families identify strengths and problems associated with child safety and deliver intensive family therapy in order to preserve and/or reunify families	1 – 2 months	Master's Degree or Bachelor's level professional	Attend initial 4-day core training. After using the model, attend 10 days total of advanced training	No Cost could not be estimated based on current, publicly available information on Homebuilders
Supported									
Families Facing the Future (FFF) (formerly Focus on Family)	Substance Abuse	Parents in substance abuse recovery with Methadone treatment and their families	High: Contact made three times per week	Combination Outpatient clinic and in-home	Parents learn relapse prevention skills, decrease stress in the home, improve family functioning	4 – 6 months	Master's level therapist	Attend a 3-day training in Washington State	Yes: can be used for other substance dependence and alcohol dependence $4,500 +
SafeCare	In-home Parent Skill-based Training	Families with children age newborn – 5-years-old who are at-risk for or have a history of child neglect and/or abuse	Medium: One weekly 60 – 90 minute visit	In-home	Home-visiting program that promotes positive parent-child interaction and children's health and home safety and reduces child maltreatment/abuse	5 months	No minimum qualifications	32 hours of training and 2 months of using the model	No Cost could not be estimated based on current, publicly available information on SafeCare

Promising									
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	Mental Health	Youth ages 4-18 who have PTSD symptoms and their caregivers	Medium: One weekly session	Therapy office	Address traumatic experience, youth learns self-regulation skills, caregivers learn behavioral management skills	3 – 4 months	Licensed Master's level therapist	Preferred that therapist has certification but not required. For certification, attend a 2-day training (available in TX), take exam and have monthly supervision (can be by phone) for 6 months	Yes: can be done either with just the youth or the youth and their caregiver $300 – 2,500
Child-Parent Psychotherapy (CPP)	Mental Health	Youth ages birth – 5-years-old who have experienced a trauma and their caregivers	Medium: One, 60 – 90 minute, weekly session	Multiple In the therapy office or In-home	Help children express their feelings through play, strengthen parent-child relationships, deepen parents' understanding of their child's behaviors, help families heal and grow after stressful experiences and identify supports for the family	5 – 11 months	Master's level therapist	Attend an initial 3-day training. 6 – 12 months after initial training, providers participate in two 2-day competency building workshops and participate in bi-monthly consultation calls for 18 months	No $25,000 +
Methadone Maintenance Therapy	Substance Abuse	Adults with heroin/opioid addiction	High: Daily contact	In a clinic	Reduce heroin/opioid addiction through medication assisted treatment	1 year +	Licensed physician and Licensed nurse	Attend training through SAMHSA Clinic must be SAMHSA certified	No $450 +

*Family Centered Treatment has been transitionally approved for FFPSA prevention services payments based on an independent review submitted by the state of Arkansas.

Any state may receive transitional payments for a program after approval of an independent review. However, if the Clearinghouse reviews the program at a later date, the findings of the official review will override the transitional approval if they differ.

Currently Under Review				
	Mental Health	**Substance Abuse**	**In-home Parent Skill-based Programs**	**Kinship Navigator**
Multidimensional Family Therapy	X	X	X	
Attachment and Biobehavioral Catch-Up	X		X	
Interpersonal Psychotherapy	X			
Incredible Years	X			
Positive Parenting Program - Triple P	X			
*Sobriety Treatment & Recovery (START)		X		
The Seven Challenges		X		
YMCA Kinship Support Services				X

*This program has been independently reviewed by the state of Kentucky and submitted to the Children's Bureau for transitional approval. If approved, any state can receive transitional payments for the program pending an official review by the Clearinghouse.

APPENDIX C

Title IV-E Prevention Services Clearinghouse:
Evidence-Based Services and Programs Reviewed but Not Approved

	Reviewed for	Date Research Evidence Last Reviewed	Reason Program/Service Does Not Currently Meet Criteria
Nurturing Parenting For Parents & their Infants, Toddlers & Preschoolers For Parents & Their Scholl Age children 5 to 11 Years	In-home Parent Skill-based Training	March 2020	Did not meet criteria to receive a rating because no studies of the program achieved a rating of moderate or high on design and execution
Solution-Based Casework	In-home Parent Skill-based Training	March 2020	Did not meet criteria to receive a rating because no studies met eligibility criteria for review
Multisystemic Therapy for Child Abuse and Neglect	Mental Health	June 2019	Did not meet criteria because no studies of the program that achieved a rating of moderate or high on design and execution demonstrated a favorable effect on a target outcome
Seeking Safety	Substance Abuse	March 2020	Did not meet criteria because no studies of the program that achieved a rating of moderate or high on design and execution demonstrated a favorable effect on a target outcome
Family Behavior Therapy Adolescent Adult	Substance Abuse	March 2020	Did not meet criteria because no studies met eligibility criteria for review
Family Behavior Therapy Adult with Child Welfare Supplement	Substance Abuse	March 2020	Did not meet criteria because no studies of the program achieved a rating of moderate or high on design and execution

Kinship Interdisciplinary Navigation Technologically-Advanced Model (KIN-Tech)	Kinship Navigator Programs	June 2019	Did not meet criteria to receive a rating because no studies of the program achieved a rating of moderate or high on design and execution
Children's Home Society of New Jersey Kinship Navigator Model	Kinship Navigator Programs	June 2019	Did not meet criteria to receive a rating because no studies of the program achieved a rating of moderate or high on design and execution
Ohio's Kinship Supports Intervention / ProtectOHIO	Kinship Navigator Programs	March 2020	Did not meet criteria to receive a rating because no studies of the program achieved a rating of moderate or high on design and execution

APPENDIX D

HEALTH AND HUMAN SERVICES COMMISSION CONTRACTED SUBSTANCE USE SERVICES		
Intervention Services: Services to reduce the effects of symptoms of substance by providing case management, home visits, and educational services to at-risk or high-risk target population.		
Program	Description	Eligibility
Pregnant, Postpartum Intervention (PPI)	PPI assists pregnant and parenting females reduce the effects of substance use for themselves and their children by providing case management (i.e., needs assessments, referrals to community resources), home visits, and education.	Pregnant or postpartum women who have, or are at risk for having, a substance use disorder. Women referred or involved with child welfare with children under age 6.
Parenting Awareness and Drug Risk Education (PADRE)	PADRE provides community-based, gender specific intervention services through case management (i.e., needs assessment, referral to community resources), home visits, and education to expectant fathers and fathers involved with Child Welfare who have substance use disorders (SUD)or are at risk for developing SUD.	Men referred or involved with child welfare as having, or being at risk of having, a substance use disorder and who have a child under the age of 6.
Rural Border Intervention Program (RBI)	RBI programs provide community-based and home-based substance use prevention and intervention services in remote rural border areas through increase knowledge of community resources, support, and necessary services.	Men and women in Texas who live in rural border counites within 62 miles of the Texas-Mexico Border.
Outreach, Screening, Assessment, and Referral (OSAR) Centers	OSAR Centers provide outreach / engagement, screening and assessments for substance use disorders, and referral to community resources.	Texas residents.

Treatment Services: Services provided by licensed substance abuse disorder treatment facilities and other community agencies to deliver services to the target population. The priority populations must be admitted to state-funded treatment services in the following order of priority: a) injecting pregnant women, b) pregnant women, c) injecting drug users, d) individuals referred by DFPS, and e) high risk for overdose.		
Program	Description	Eligibility
Treatment for Adults (TRA)	TRA Programs operate five service types include: Residential Detoxification, Ambulatory Detoxification, Intensive Residential, Supportive Residential, and Outpatient Treatment Services.	Adult Texas residents who meet clinical and financial eligibility.
Treatment for Females (TRF)	TRF Programs operate seven service types include: Residential Detoxification, Ambulatory Detoxification, Intensive Residential, Supportive Residential, and Outpatient Treatment Services. In addition, TRF Programs operate Women and Children's Intensive and Supportive Residential programs.	Texas residents who are adult pregnant women or women with dependent children who meet clinical and financial eligibility.
Treatment for Co-Occurring Psychiatric and Substance Use Disorders (TCO)	Adjunct services for persons with substance use and mental health issues where coordinated resources and care help people achieve recovery.	Individuals identified as having a mental health and substance use issue.
Recovery Support Services: Services to increase long-term recovery and recovery through peer engagement.		
Program	Description	Eligibility
Community Based Organization (CBO)	A community-based organization who provides recovery support services to individuals seeking long-term recovery from substance use disorders.	N/A

Treatment organization (TO)	A licensed substance use disorder treatment program that incorporates recovery support services and peer recovery coaching.	N/A
Youth Recovery Communities (YRC)	A community-based or licensed substance use disorder treatment facility to provide recovery services for youth aged 13-21 who want a substance-free environment that supports their life goals. The program supports long-term recovery and provides engagement and support through peers.	N/A

APPENDIX E

DFPS Prevention and Early Intervention Contracted Parent Training and Home Visiting Providers			
	Number Served in FY2019*	**Program Type**	**FFPSA Clearinghouse Status**
24/7 Dad	722	Parenting	Not reviewed
Abriendo Puertas	54	Parenting	Not reviewed
AVANCE	288	Parenting	Not reviewed
Effective Black Parenting Program	45	Parenting	Not reviewed
Healthy Families America	35	Home visitation	Well-supported
Home Instruction for Parents of Preschool Youngsters	1,566	Home visitation	Not reviewed
Incredible Years	73	Parenting	Under review (in the category of mental health)
Nurse Family Partnership	5,015	Home visitation	Well-supported
Nurturing Parenting Program	792	Parenting	Does not meet criteria
Nurturing Fathers Program	272	Parenting	Not reviewed, but likely under Nurturing Parenting which does not meet criteria
Nurturing Skills for Families	38	Parenting	Not reviewed, but likely under Nurturing Parenting which does not meet criteria
Parent-Aide Model	93	Parenting	Not reviewed

Parenting Wisely	44	Parenting	Not reviewed
Parents as Teachers	4,834	Home visitation	Well-supported
SafeCare	579	Home visitation	Supported
STAR+STAR Express	25,280	Youth and family: counseling, parenting	Not reviewed
Strong Families, Strong Forces	61	Youth and family: counseling, parenting	Not reviewed
Systematic Training for Effective Parenting	395	Parenting	Not reviewed
Triple P Levels 2-5	929	Parenting	Under review (in the category of mental health)
Trust-Based Relational Intervention	962	Parenting	Not reviewed

*Counts may include duplicate enrollments served during the fiscal year.