July 20, 2018

Naomi Goldstein

Deputy Assistant Secretary for Planning Research and Evaluation
United States Department of Health and Human Services
Administration for Children and Families
330 C Street, SW
Washington, DC 20201


Dear Ms. Goldstein,

On behalf of the Institute for Child and Family Well-being (ICFW), we appreciate the opportunity to provide comments on the development of the Clearinghouse of Evidence-Based Practices in Accordance with the Family First Prevention Services Act (FFPSA). We believe this law will transform how this nation serves at-risk children and families by promoting early interventions and evidence-based prevention services to avoid foster care placements and maintain family stability.

ICFW is a collaboration between Children’s Hospital of Wisconsin (Children’s) and the Helen Bader School of Social Welfare at the University of Wisconsin-Milwaukee with a mission to improve the lives of children and families by designing and implementing effective programs, conducting cutting-edge research and evaluation and promoting change through policy and advocacy.

By way of background, Children’s is the largest not-for-profit, community-based agency serving children and families in the state of Wisconsin, providing community services to more than 15,000 children and families annually. In partnership with the Division of Milwaukee Child Protective Services, Children’s is responsible for the ongoing case management of approximately 1,450 children, which represents half of the youth and families involved in out-of-home care in Milwaukee County. Additionally, Children’s provides family preservation and support, child and family counseling, child welfare, child advocacy and protection, and adoption services throughout the state of Wisconsin.

ICFW brings together researchers and Children’s practitioners to accelerate the process of translating knowledge into direct practices, programs and policies that promote health and well-being. In addition, ICFW provides training, consultation and technical assistance to help human service agencies implement and replicate best practices. ICFW looks forward to engaging with the Department of Health and Human Services (the Agency) and other stakeholders to implement this transformational law.

Types of Programs and Services (2.2.1)
At a minimum, we urge to the Agency to include in the FFPSA Clearinghouse of Evidence-Based Practices (Clearinghouse) the programs, services and interventions that are included in existing evidence-based clearinghouses, including the California Evidence-Based Clearinghouse for Child Welfare (CEBC), the Administration for Children and Families’ Home Visiting Evidence of Effectiveness and The Substance Abuse and Mental Health Service Administration’s National Registry of Evidence Based-Programs and Practices (NREPP). Given the complexity of the behavioral, physical and emotional issues that at-risk children and families experience, we encourage the Agency to provide states with access to a wide array of comprehensive programs and services to
allow them to best serve target populations. Foster care placement has multifactorial causes, thus the need for breadth in service delivery options is critical as child welfare-involved families’ needs vary widely.

Additionally, we encourage the Agency to provide tools and resources to states and child welfare agencies to effectively prepare the child welfare workforce to adapt to focus on prevention services. Quality training, reasonable caseloads and processes to recognize and address secondary trauma will be essential in operationalizing FFPSA. Another critical component of implementation is ensuring that all eligible at-risk children and adults receive age-appropriate routine screening, assessment and referral to appropriate evidence-based services.

In Appendix A, you will find the programs and services that ICFW requests the Agency to prioritize for inclusion in the Clearinghouse. These recommendations include programs which have a research evidence base, or forthcoming evidence base, and experience utilizing these interventions to serve vulnerable children and families. Where applicable, we have referenced the CEBC rating to support our recommendation of the program’s categorization as “well-supported, supported or promising.” This is not an exhaustive list, but one that includes services that we believe are important for Children’s and other providers in the state to appropriately serve FFPSA eligible children and families.

**Target Population of Interest (2.2.2)**

We appreciate the Agency’s interest in identifying populations “similar” to those involved in the child welfare system for the purposes of prioritizing programs and services. In developing the Clearinghouse, we urge you to ensure that the studies included for consideration are not limited solely to the population of families involved with the child welfare system. These vulnerable families share many characteristics with other vulnerable populations. For example, we know that housing instability and homelessness rates are high among families that are reported to child protective services and that these families are similar to the families who ultimately enter the child welfare system. Based on Children’s experience caring for and serving vulnerable children and families, we believe the following should also be considered similar populations: children with high truancy or school mobility rates; children with Individual Educational Plans; children who have experienced homelessness; children who have experienced eviction; children with mental health or behavioral health assessments with identified risk; and children in the juvenile justice system.

**Target Outcomes (2.3.2)**

We agree that target outcomes that “prevent child abuse and neglect and reduce likelihood of foster care placement by supporting birth families and kinship families and improving targeted supports for pregnant and parenting youth and their parents” are critically important. We encourage the Agency to also consider short-term outcomes that are critical factors for improving the health and well-being of children and better positioning them to thrive in adulthood. For instance, programs that are designed to help children build resilience and meet developmental milestones such as secure attachment and self-regulation are vital. In addition, it is important to measure functional outcomes that follow healthy development, including school attendance and performance, positive physical and mental health status and prosocial behavior. Additionally, improvements in parents’ ability to cope with stress, parenting skills and adult core capabilities should be measured given the influence that these have on child functioning, home stability and long-term well-being. Finally, we believe that the Agency should reconsider its position that the Clearinghouse will not assess any outcomes related to access to services, satisfaction or referral to programs. Interventions with strong outcomes can ultimately fail if they suffer from an inability to facilitate access to needed services or results in low satisfaction that could affect intervention fidelity. These indicators are also vital to understanding how a program works and whether it can effectively scale to reach the population it is designed to serve.
**Implementation and Fidelity Support (2.2.6)**

We appreciate FFPSA’s focus on the utilization of evidence-based programs to serve at-risk children and families. We are committed to helping providers implement programs with fidelity and assess outcomes. At the same time, we believe that there continues to be a need in the field for innovating and finding solutions for practice. A priority for ICFW is to work with human service agencies and practitioners to adapt evidence-based practices to better serve populations.

For example, despite its proven efficacy, Parent Child Interactive Therapy (PCIT) often does not reach children in the child welfare system. To increase its availability and accessibility, Drs. Joshua Mersky and Dimitri Topitzes of University of Wisconsin-Milwaukee adapted and tested a group-based PCIT model that can be delivered routinely within a foster care context. Specifically, they modified PCIT from a dyadic treatment averaging 12-14 weekly clinic sessions to a group-based training model consisting of two to three full-day workshop sessions. Among the many advantages, the adaptation reduces participation burden and stigma for foster parents; provides social learning opportunities; and contains costs which increases the likelihood of agency uptake and sustainability.

We encourage the Agency to provide states and the child welfare field with the flexibility to innovate to facilitate broad adoption of evidence-based practices and better serve at-risk children and families. FFPSA requires states to “continuously monitor its provision of these prevention services and programs and use the information learned to refine and improve its practices (sec. 50711).” We encourage the Agency to support this refinement and allow-for innovative and adaptive practices and interventions.

Sincerely,

Amy Herbst, MSSW, APSW
Vice President, Child Well-Being

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2 See “Integrating PCIT into Child Welfare Services
[https://uwm.edu/icfw/parent-child-interaction-therapy/]
Appendix: A

Mental Health and Substance Abuse Prevention and Treatment Services

1. Parent Child Interaction Therapy (PCIT) and Project Connect (PCIT adapted to be provided in a group setting)

Per the California Evidence-Based Clearinghouse (CEBC): Parent-Child Interaction Therapy (PCIT) is a dyadic behavioral intervention for children (ages 2.0 – 7.0 years) and their parents or caregivers that focuses on decreasing externalizing child behavior problems (e.g., defiance, aggression), increasing child social skills and cooperation, and improving the parent-child attachment relationship. It teaches parents traditional play-therapy skills to use as social reinforcers of positive child behavior and traditional behavior management skills to decrease negative child behavior. Parents are taught and practice these skills with their child in a playroom while coached by a therapist. The coaching provides parents with immediate feedback on their use of the new parenting skills, which enables them to apply the skills correctly and master them rapidly. PCIT is time-unlimited; families remain in treatment until parents have demonstrated mastery of the treatment skills and rate their child’s behavior as within normal limits on a standardized measure of child behavior. Therefore treatment length varies but averages about 14 weeks, with hour-long weekly sessions. **Scientific Rating: 1 (Well-supported by research evidence)**

Per The Institute for Child and Family Well-being (ICFW): ICFW has adapted PCIT for foster care and child welfare in group (Project Connect) and in-home settings. During the past two years, five ICFW therapists have served over 120 children and their caregivers in nearly 1100 sessions of PCIT. Since its development and implementation in 2014, ICFW therapists have served 79 children and their caregivers in 15 different offerings of Project Connect. PCIT is an empirically validated treatment for externalizing behavior problems in young children. Foster children are at a especially high risk of developing externalizing problems, difficulties that their foster parents are not often trained to manage effectively. PCIT is typically delivered by therapists in 12-14 individual, weekly sessions. Although efficacious, standard PCIT is resource intensive, so it is unlikely to be adopted as a routine service by child welfare agencies. Therefore, the objective of this study was to implement and test the efficacy of a novel adaptation of PCIT with foster families using group-based and in-home treatment.

Results showed that PCIT can be implemented successfully in a community setting with foster families using group-based training and follow-up in-home activities. The proposed intervention built on existing child welfare service structures, thereby increasing the likelihood of successful (a) implementation of the intervention, (b) replication in future effectiveness trials, and (c) integration into the child welfare service system.

Published journal article on PCIT and Project Connect

- **Translating evidence-based treatments into child welfare services through community-university partnerships: A case example of parent-child interaction therapy** Joshua P. Mersky, James Topitzes, & Katelyn Blair

Published journal article supporting home-based PCIT

- **Home-Based vs. Clinic-Based Parent–Child Interaction Therapy: Comparative Effectiveness in the Context of Dissemination and Implementation** Timothy R. Fowles, Joshua J. Masse, Lucy McGoron, Ryan M. Beveridge, Ariel A. Williamson, Marissa A. Smith, Brendt P. Parrish
  - [https://link.springer.com/article/10.1007/s10826-017-0958-3](https://link.springer.com/article/10.1007/s10826-017-0958-3)
2. Keeping Foster and Kin Parents Supported and Trained (KEEP)
Per CEBC: “The objective of KEEP is to give parents effective tools for dealing with their child's externalizing problems, trauma, and other behavioral and emotional problems and to support them in the implementation of those tools. Curriculum topics include framing the foster/kin parents' role as that of key agents of change with opportunities to alter the life course trajectories of the children placed with them. Foster/kin parents are taught methods for creating a safe environment, encouraging child cooperation, using behavioral contingencies, strategies for self-regulation, effective limit setting, and balancing encouragement and limits. There are also sessions on dealing with difficult problem behaviors including covert behaviors, promoting school success, encouraging positive peer relationships, and strategies for managing stress brought on by providing foster care. There is an emphasis on active learning methods; illustrations of primary concepts are presented via role-plays and videotapes.” Scientific Rating: 3 (Promising research evidence)

3. EMDR
Per CEBC: EMDR therapy is an 8-phase psychotherapy treatment that was originally designed to alleviate the symptoms of trauma. During the EMDR trauma processing phases, guided by standardized procedures, the client attends to emotionally disturbing material in brief sequential doses that include the client’s beliefs, emotions, and body sensations associated with the traumatic event while simultaneously focusing on an external stimulus. Scientific Rating: 1 (Well-supported by research evidence)

Per Children’s Hospital of Wisconsin Community Services’ Well-being program (Children's Well-being program) and ICFW: At Children's Well-being program and ICFW, we are integrating EMDR into our TF-CBT practice when client is experiencing significant obstacles to accessing trauma narrative.

4. Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)
Per CEBC: TF-CBT is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles. Scientific Rating: 1 (Well-supported by research evidence)

Per Children’s Well-being program and ICFW: At Children’s Well-being program, we are providing TF-CBT to children and youth in clinical, school and in-home settings.

5. Child Parent Psychotherapy (CPP)
Per CEBC: CPP is a treatment for trauma-exposed children aged 0-5. Typically, the child is seen with his or her primary caregiver, and the dyad is the unit of treatment. CPP examines how the trauma and the caregivers’ relational history affect the caregiver-child relationship and the child's developmental trajectory. A central goal is to support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health. Treatment also focuses on contextual factors that may affect the caregiver-child relationship (e.g., culture and socioeconomic and immigration related stressors). Targets of the intervention include caregivers’ and children’s maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child’s mental health. Over the course of treatment, caregiver and child are guided to create a joint narrative of the psychological traumatic event and identify and address traumatic triggers that generate dysregulated behaviors and affect. Scientific Rating: 2 (Supported by research evidence)

Per Children’s Well-being program and ICFW: At Children’s Well-being program, we are providing CPP to children and caregivers in the dyad in clinical and in-home settings.
6. **Motivational Interviewing (MI)**

*Per CEBC:* MI is a client-centered, directive method designed to enhance client motivation for behavior change. It focuses on exploring and resolving ambivalence by increasing intrinsic motivation to change. MI can be used by itself, as well as in combination with other treatments. It has been utilized in pretreatment work to engage and motivate clients for other treatment modalities. **Scientific Rating: 1 (Well-supported by research evidence)**

*Per Children's Well-being program and ICFW:* MI is an essential tool for our Well-being Assessment and clinical intake and engagement processes.

7. **Child and Family Traumatic Stress Intervention (CFTSI)**

*Per CEBC:* CFTSI is a brief early intervention model for children and adolescents 7-18 that is implemented soon after exposure to a potentially traumatic event, or in the wake of disclosure of physical and sexual abuse. Developed at the Yale Child Study Center, CFTSI fills a gap between acute responses/crisis intervention and evidence-based, longer-term treatments designed to address traumatic stress symptoms and disorders that have become established. The goal of this family-strengthening model is to improve the caregiver's ability to respond to, and support, a child who has endorsed at least one posttraumatic symptom. By raising awareness of the child's symptoms, increasing communication and providing skills to help master trauma reactions, CFTSI aims to reduce symptoms and prevent onset of posttraumatic stress disorder (PTSD). In addition, CFTSI offers an opportunity to assess which children and families need longer-term treatment. CFTSI is provided by master's-level clinicians who have been trained by CFTSI master trainers. **Scientific Rating: 3 (Promising research evidence)**

**In-Home Parent Skill-based Programs**

1. **Together Facing the Challenge (TFTC)**

*Per CEBC:* TFTC is a training/consultation approach to improving practice in treatment foster care (TFC). The intervention was built from a naturalistic study of “usual care” TFC to determine what practice components were related to improved outcomes for youth. It also incorporates elements from existing evidence-based treatments to fill identified gaps in usual care practice. The resulting model includes training/consultation for TFC staff as well as training for treatment foster parents. TFTC is designed as a train-the-trainer approach, so that TFC administrative/supervisory personnel can learn the model and train treatment foster parents. **Scientific Rating: 2 (Supported by research evidence)**

*Per Children’s Hospital of Wisconsin Community Services’ Out of Home Care programs:* In January, 2012 CHWCS implemented a new evidence-based TFC model entitled “Together Facing the Challenge.” This model, researched during a multi-year study conducted through Duke University, found that the three factors largely responsible for helping children in treatment foster care succeed are:

- Supportive and involved relationships between TFC social workers and treatment foster parents
- Effective use of behavior management strategies by treatment foster parents that are trauma informed
- Supportive and involved relationships between treatment foster parents and the youth in their care

Through a 7-session curriculum and home based 1:1 coaching exercises and tools, this model supports relationship development and teaches effective trauma-informed behavior management strategies to bring practical solutions to everyday problems. All TFC foster parents licensed with CHWCS are required to complete the Together Facing the Challenge curriculum as part of their first year education requirements.
2. **Healthy Families America (HFA)**

*Per CEBC:* HFA is a home visiting program model designed to work with overburdened families who are at-risk for child abuse and neglect and other adverse childhood experiences. It is designed to work with families who may have histories of trauma, intimate partner violence, mental health issues, and/or substance abuse issues. HFA services are offered voluntarily, intensively, and over the long-term (3 to 5 years after the birth of the baby). **Scientific Rating: 1 (Well-supported by research evidence)**

*Per Children’s Hospital of Wisconsin Community Services’ Family Support and Preservation programs:* HFA is delivered by Family Support and Preservation programs and is often complemented by the Parents as Teachers curriculum.

3. **Parents as Teachers (PAT)**

*Per CEBC:* Parents as Teachers is an early childhood parent education, family support and well-being, and school readiness home visiting model based on the premise that “all children will learn, grow, and develop to realize their full potential.” Based on theories of human ecology, empowerment, self-efficacy, attribution, and developmental parenting, Parents as Teachers involves the training and certification of parent educators who work with families using a comprehensive curriculum. Parent educators work with parents to strengthen protective factors and ensure that young children are healthy, safe, and ready to learn. An agency may choose to use the Parents as Teachers model to focus services primarily on pregnant women and families with children from birth to age 3 or through kindergarten. **Scientific Rating: 3 (Promising research evidence)**

*Per Children’s Hospital of Wisconsin Community Services’ Family Support and Preservation program:* Parents as Teachers is delivered in home visiting services and complements HFA well.

4. **Triple P**

*Per CEBC:* As a prevention program, System Triple P helps parents learn strategies that promote social competence and self-regulation in children. Parents become better equipped to handle the stress of everyday child rearing and children become better able to respond positively to their individual developmental challenges. As an early intervention, System Triple P can assist families in greater distress by working with parents of children who are experiencing moderate to severe behavior problems. Throughout the program, parents are encouraged to develop a parenting plan that makes use of a variety of System Triple P strategies and tools. System Triple P practitioners are trained, therefore, to work with parents’ strengths and to provide a supportive, non-judgmental environment where a parent can continually improve their parenting skills. **Scientific Rating: 1 (Well-supported by research evidence)**

*Per Children’s Hospital of Wisconsin Community Health Early Childhood programs:* During the past 12 months, 31 families received Triple P Level 3 Primary Care.

_Triple P Level 3 Discussion Groups_  
Two-hour small group sessions, targeting a specific problem behavior or issue. Each discussion group can be taken as a stand-alone session or as part of a series. There are four topics for parents of children 0–12 (Dealing with disobedience; Managing fighting and aggression; Developing good bedtime routines; and Hassle-free shopping with children). We have three accredited Discussion Group providers: two community services providers and one provider in behavioral health. To date, there has been 6 total discussion groups completed, a total of 61 parents/caregivers served.

_Triple P Level 2 Selected Seminars_  
An introduction to the strategies of positive parenting and Triple P. Parents attend any number of three 90-minute seminars (Power of Positive Parenting; Raising Confident, Competent Children; and Raising Resilient Children) or
any of the three seminars. We have 7 accredited seminar providers: two community services providers, four primary care providers and one behavioral health provider. To date, there has been 32 total seminars facilitated, a total of 257 parents/caregivers served.

5. **Nurturing Parenting**

*Per CEBC:* The Nurturing Parenting Program for Parents and their Infants, Toddlers and Preschoolers is a family-centered program designed for the prevention and treatment of child abuse and neglect. Both parents and their children birth to five years participate in home-based, group-based, or combination group-based and home-based program models. Lessons are competency-based ensuring parental learning and mastery of skills. **Scientific Rating: 3 (Promising research evidence)**

*Per Children’s Hospital of Wisconsin Community Services’ programs:* Nurturing Parenting is delivered in a group setting in our Child Welfare and Family Support and Preservation programs.

6. **The Community Response Program**

*The Community Response Program* (CRP) was created in 2006 to fill a gap in the child maltreatment prevention continuum. CRP provides voluntary supports to families reported to county child protective services (CPS) for alleged child abuse or neglect who are not receiving services because the referral is either screened out or the referral is screened in for further assessment, but the case is closed due to a finding that the report could not be substantiated.

The overall goal is to strengthen families, prevent child abuse and neglect, and reduce re-referrals to CPS. CRP is a short-term (20 week maximum) voluntary prevention program that includes:

- Case Management
- Home Visits
- Collaborative Goal Setting
- Comprehensive Assessment
- Flexible Funds

CRP staff work with the families to identify immediate needs and assist families in connecting to formal and informal resources to meet these needs (e.g., parenting supports, mental health treatment, child health and development). CRP works not only to mitigate risk factors, but also to identify and build protective capacities of parents and caregivers.

*Per Children’s Hospital of Wisconsin Community Services’ Family Support and Preservation programs:* Wisconsin just went through a rigorous evaluation and the findings are pending. We encourage the Agency to consider for Clearinghouse placement once evaluation is released.

7. **ACT Raising Safe Kids Program**

*Per CEBC:* ACT Raising Safe Kids Program is a universal parenting program designed to promote positive parenting and prevent child maltreatment by fostering knowledge and skills that change or improve parenting practices. The program is delivered by trained and certified ACT Facilitators in 9 sessions of 2-hour each on average. The ACT program has a universal public health approach and aims to reach to all parents of young children in a given community. The ACT program addresses parents’ use of effective, nonviolent discipline and nurturing behaviors. It addresses parental knowledge of child development, discipline methods, and media literacy. It also addresses parents’ anger management, social problem solving skills and their ability to teach/model these skills to children. By promoting effective parenting practices, the program also addresses children’s aggression and behavior problems. ACT also provides a supportive community of parents who help and support each other during and after the program: it builds community. **Scientific Rating: 3 (Promising research evidence)**
8. **Period of PURPLE Crying**

*Per CEBC:* The Period of PURPLE Crying program is the name given to the Shaken Baby Syndrome (SBS) prevention program developed by National Center on Shaken Baby Syndrome. The program educates parents and caretakers on normal infant crying, the most common trigger for shaking an infant. It was designed to be used primarily in universal, primary prevention settings, but is applicable to secondary prevention as well. **Scientific Rating: 3** *(Promising research evidence)*