Considerations for Scaling Evidence-Based Prevention Programs under the Family First Prevention Services Act

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Introduction

The federal Family First Prevention Services Act of 2018 (Family First Act) seeks to keep children safely with their families through the provision of evidence-based services to prevent foster care entry.[1] States and tribes preparing for and implementing the Family First Act can benefit from lessons learned in jurisdictions such as New York City (NYC) that were early adopters of evidence-based prevention services. In this brief, we present two evidence-based models (EBMs), implemented in NYC, as case studies: Brief Strategic Family Therapy (BSFT) and Child Parent Psychotherapy (CPP). Drawing on interviews with the purveyors of the two EBMs, as well as community-based provider agencies implementing these EBMs in NYC, we identify four key factors that influence the scale-up of EBMs in child welfare. We conclude with considerations for jurisdictions preparing to implement prevention services under the Family First Act as they seek to build a service continuum that better meets the needs of children and families.

Our findings are organized using the framework developed by the Society for Prevention Research's Mapping Advances in Prevention Science (MAPS) IV Translation Research Task Force. The MAPS IV Task Force identified six common factors that influence scale-up of EBMs in public systems, including child welfare systems: (1) developer[2] and funder capacity, (2) public awareness and support for EBMs, (3) community engagement and capacity, (4) leadership and support for EBMs, (5) skilled workforce, and (6) data monitoring

Key Terminology

Evidence-based model (EBM): In the context of the Family First Act, an intervention that seeks to prevent entry into foster care (i.e., mental health, substance abuse, and in-home parenting services) or provides kinship navigation services. The Title IV-E Prevention Services Clearinghouse rates EBMs as promising, supported, or well-supported. While they are often referred to as evidence-based programs or interventions (as in the Clearinghouse), we use the term "model" throughout this brief. The term model encompasses a standardized intervention that is implemented through individual programs at the community level.

Intermediary: An entity that supports the implementation of multiple EBMs and/or builds capacity within agencies and systems to implement and sustain EBMs (Proctor et al., 2019).

Provider: The entity that delivers services to children and families using an EBM. The provider may be the public child welfare agency, or this role may be contracted out to community-based providers (as is the case in NYC).

Public agency: The public child welfare agency.

Purveyor: The disseminator of an EBM that is responsible for increasing program effectiveness, ensuring fidelity, and promoting scale (Neuhoff, Loomis, & Ahmed, 2017). The purveyor may be the original developer of the EBM or a separate entity.

[1] The Family First Act includes several other provisions. For an overview of the Act and additional resources, see www.FamilyFirstAct.org.
[2] Fagan and colleagues (2019) use the term "developer" throughout their framework. For BSFT and CPP, developer and purveyor can be used interchangeably, since the entity that developed the intervention continues to support implementation. We use purveyor in this brief.

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and evaluation capacity (Fagan et al., 2019). We highlight findings from our interviews across four of these factors—purveyor capacity, skilled workforce, data monitoring and evaluation capacity, and leadership and support—and include lessons from the literature for each of these factors.

Background

Development and implementation of EBMs takes time and involves several partners (e.g., model developers, community partners, evaluators, purveyors, etc.). In a traditional phased approach, EBM developers design and test their models to ensure that they positively affect the children and families served. Then the developer or a separate entity (purveyor and/or intermediary) may work to expand the use of the EBM to new locations by providing training, technical assistance, and fidelity monitoring to program providers.[3] While many stakeholders are involved in the multiple steps from design to widespread use of an EBM, this brief focuses primarily on the needs of the purveyors responsible for disseminating EBMs. EBMs cannot be scaled without sufficient purveyor capacity to partner with public agencies and providers to support high-quality delivery and optimal outcomes for children and families.

Public policy that requires or recommends and funds the implementation of EBMs has been identified as the most important factor for successfully scaling evidence-based prevention services (Fagan et al., 2019). The Family First Act is therefore an important development in the child welfare field, as it provides federal funding for the implementation of prevention and kinship navigator program models that meet specific evidence requirements. To draw down these funds, states must submit and receive approval for a plan that includes a certain share of expenditures on EBMs with the highest evidence rating. The Title IV-E Prevention Services Clearinghouse (Clearinghouse) conducts systematic reviews of available research evidence to rate services as promising, supported, well-supported, or does not currently meet criteria. States may select an EBM rated by the Clearinghouse, and they may also conduct their own independent reviews to identify models meeting eligibility criteria for federal funding.[4] However, the evidence base for child welfare program models lags behind that of other fields, and the Clearinghouse's time-intensive reviews are constrained by available resources. As of November 2020, only 21 program models met the criteria for a rating of promising or above.[5] We therefore anticipate that the purveyors of program models that meet the evidence criteria will experience increased demand, while the purveyors of program models not yet rated or with lower evidence ratings will seek to continue building the evidence for their models.

States and tribes preparing to increase their investments in evidence-based prevention services can learn from NYC's process for selecting and installing EBMs. In NYC, planning began in 2011, and 11 evidence-based and evidence-informed program models were implemented by 2013 (Clara, Garcia, & Metz, 2017). Lessons learned from this implementation informed the re-competition and expansion of new prevention services contracts in NYC in 2020.

Methodology and Data

To inform our case studies of the CPP and BSFT models, we conducted interviews with staff at two provider agencies in NYC and with the two model purveyors.[6] Data collection focused primarily on purveyor capacity—the first factor in Fagan and colleagues' (2019) framework—although we also gleaned

[3] Many current program developers are adopting various methods of designing, testing, and disseminating programs that are more inclusive of community members than the phased approach and may therefore lend themselves better to scaling up (Fagan et al., 2019).
[4] For more information on the evidence requirements under the Family First Act and Family First Transition Act, see Applying the Research and Evaluation Provisions of the Family First Prevention Services Act and The Family First Transition Act Provides New Implementation Supports for States and Tribes.
[5] Three additional programs have been approved for transitional payments through independent systematic reviews.
[6] Two purveyors support the implementation of BSFT: the Brief Strategic Family Therapy® Institute, and the Family Therapy Training Institute of Miami. The former supports implementation in NYC and was interviewed for this brief.

information related to other factors (e.g., data and evaluation capacity). Selecting these two models from the suite of EBMs being implemented in NYC allowed us to include variation in current evidence ratings on the Title IV-E Prevention Services Clearinghouse, target population age range, and type of program model. NYC's child welfare agency assisted with identifying one provider that was awarded a contract in 2020 to continue or expand service delivery in the each of these two models.

Limitations

While the CPP and BSFT case studies highlight important considerations pertaining to the scale-up of EBMs, the context of NYC may not be generalizable to other jurisdictions, due to a myriad of factors including cost of living, and the size and demographics of the population. Furthermore, we only examined two program models and one provider operating each model due to limited resources. Additional findings would likely emerge from interviews with additional purveyors and implementing providers.

Overview of the Program Models

Child Parent Psychotherapy (CPP)

This mental health intervention serves caregivers with children ages 0 to 5 who have experienced trauma and/or are exhibiting attachment, mental health, or behavioral challenges (National Child Traumatic Stress Network, 2012). The Clearinghouse rated CPP as promising, and the purveyor views this rating as a risk to adoption and possible funding since states may tend to implement and fund models with higher evidence ratings.

Brief Strategic Family Therapy (BSFT)

This mental health and substance abuse intervention serves families with children ages 6 to 17 who currently engage in or are at risk for developing behavior problems, including substance abuse (University of Miami Miller School of Medicine, 2020). The Clearinghouse rated BSFT as well-supported, and the purveyor reported receiving initial inquiries from child welfare agencies as jurisdictions engage in their Family First Act planning.

More detailed information on these program models is available in the Appendix.

Case Study Findings: Essential Factors for EBM Scale-up

Purveyor capacity

Because purveyors have exclusive rights to their program model, they are key partners in states' efforts to successfully scale EBMs. Purveyors play a central role in training and certifying providers, and in providing consultation and ongoing implementation support. In our interviews, four areas of purveyor capacity needs emerged: purveyor staffing, business model development, navigating the constraints of operating within a university environment (if applicable), and navigating the needs and expectations of provider and public agency partners, including through program adaptations.

Purveyor capacity needs

- Purveyor staffing
- Business model development
- Navigating university settings, if applicable
- Navigating the needs and expectations of implementation partners

Purveyors require adequate staffing at the national and local levels to support implementation. At the national level, purveyors require adequate internal staffing across core positions to support implementation. The CPP purveyor noted that their team would benefit from adding staff members specializing in data and technology and administrative support. The CPP purveyor would also like to build out regional leadership to provide an additional layer of support to local jurisdictions and to disseminate practice changes. However, securing initial and ongoing funding for these roles has proven challenging; one purveyor that operates out of a university setting noted that their university requires guaranteed funding for three years to hire for a new staff position.

At the local level, the purveyors use model managers (BSFT) or consultants (CPP) to guide implementation. Both purveyors require these staff to be trained in the model and certified by the purveyor; however, staffing structures vary. BSFT directly hires its model managers as employees of the purveyor organization and, where possible, hires model managers from the local jurisdiction. While the current BSFT model manager is not local to NYC, the BSFT provider noted the value of having local consultants to support implementation for other EBMs. CPP consultants operate independently of the purveyor organization, with local consultants providing on-the-ground support to providers. The CPP provider noted the value of having consultants who were steeped in the local NYC context and child welfare system. For both program models, providers reported strong, collaborative relationships with their model managers/consultants.

Both the CPP and BSFT providers experienced delays in finding appropriate replacements when there was turnover in their model manager/consultant position. In each instance, the provider was looking for a replacement with specific qualities: a NYC-based consultant for CPP, and a model manager bilingual in Spanish for BSFT. Both providers noted that transitions in their model manager/consultant position led to delays in staff training.

Purveyors should establish a business model that generates sufficient revenue to provide high-quality support. Both providers and purveyors emphasized that purveyors need a strong business model; however, they also recognized that developing such a model can be challenging for many purveyors whose background is in clinical work, not business management. One provider appreciated that the purveyor sought to keep costs low to make the program more affordable and accessible but

Lessons from the literature: Purveyor capacity

Many programs are not designed with scaling in mind. The traditional phased approach to developing and evaluating an EBM may make the model less culturally relevant and appealing to consumers and more difficult to implement in the real world. Developers may also be more interested in research and development than dissemination and implementation support. Moreover, developers and purveyors often lack needed skillsets for dissemination (e.g., marketing and management), and they may also lack adequate staffing, sufficient funding, and incentives to expand their model's reach. Further, few EBMs were designed specifically for the child welfare context and may require adaptations to better meet the needs of families and systems.

For implementation partners seeking to scale EBMs, recommendations from the literature include:

- Engage communities in the design and testing of EBMs.
- Develop business and pricing models that are sustainable and promote long-term implementation with fidelity.
- Build implementation tools that can be easily scaled (e.g., self-guided tools, online learning communities).
- Invest in marketing that uses consumer research to inform branding, packaging, and distribution of EBMs.
- Build partnerships (e.g., with intermediaries) that support dissemination.
- Develop feedback loops for community stakeholders and providers to strengthen the program model and implementation supports.
- Localize expertise in the model in a way that balances a sense of ownership with ongoing engagement with the purveyor.

Sources: Aarons & Chaffin, 2013; Fagan et al., 2019; Kreuter & Bernhardt, 2009; Neuhoff, Loomis, & Ahmed, 2017; Supplee & Metz, 2015

noted that purveyors should seek to balance setting affordable prices with building appropriate infrastructure to spread and scale the intervention. The BSFT purveyor emphasized the importance of establishing a transparent and sustainable menu of costs for each service provided.

In addition to pricing structures, purveyors' organizational infrastructure and approach to disseminating and supporting their program model are key components of their overall business strategy. One provider highlighted that purveyors' business models should be grounded in understanding the day-to-day realities of program providers, and recognizing that the purveyor cannot "air drop" an intervention into a new location; instead, the purveyor must have processes for understanding the local and provider agency context to ensure successful implementation.

Training emerged as a key consideration for purveyors' planning, with an emphasis on the importance of building adequate training resources that account for provider agency staff turnover. While providers were eager for new staff to begin their formal training in the models, purveyors reported that they needed to adjust their training plans to accommodate the frequency of new hires. One purveyor reported a financial loss due to having to provide more training to meet the demand. To build internal training capacity, the CPP provider developed a new train-the-trainer approach—CPP Agency Mentorship Program (CAMP)—which builds provider capacity to train and supervise staff in the model. Provider agencies noted an increase in the availability of online training supports within the context of the COVID-19 pandemic and hoped that this type of flexible training option will remain available in the future.

Beyond the need for initial training, both purveyors emphasized the importance of providing ongoing implementation supports as part of their business models, with one purveyor citing a common misconception among providers that implementation support ends with training. Both purveyors described building supportive, ongoing relationships with providers to build capacity and ensure fidelity.

Purveyors located within university settings face unique circumstances. The purveyors of both CPP and BSFT operate out of universities. Providers perceived that purveyors located within universities tended to move more slowly than their counterparts in other settings and hypothesized that this is due to greater bureaucracy within universities (e.g., when processing contracts). Reflecting on all EBMs, one provider noted that universities' overhead rates, focus on studying and testing interventions rather than building business operations, and other restrictions may all pose barriers to scaling implementation of EBMs.

Purveyors must navigate the needs and expectations of their implementation partners. All purveyors and providers discussed the challenges they faced and the strategies they employed to align the differing needs and expectations of purveyors, providers, and public agencies. They noted that many EBMs were not initially designed for implementation in the child welfare context, or that the child welfare agency's expectations may conflict with the program model. Examples of tensions between program models and public agency expectations include:

- The child welfare agency requires that children be present during home visits to assess the child's safety; however, this may prevent the clinician from adequately addressing the caregiver's trauma experiences, as a therapist would in a one-on-one session.
- Many prevention providers serve dual clinical and case management roles, which can make it challenging for the clinician to build rapport with the family.
- The child welfare agency's performance metrics for providers include metrics around caseload and utilization. Clinicians may avoid having difficult therapeutic conversations with clients out of fear that the client will disengage and stop services.

To address these and other challenges, providers and purveyors viewed early and ongoing collaboration and communication between all three implementation partners (purveyor, provider, child welfare agency) as essential. The provider has often served as the central communicator, drawing on their clinical knowledge and understanding of the local child welfare agency policies. Clear contractual relationships,

including a direct contract between the child welfare agency and the purveyor, have also helped the partners navigate the responsibilities of each entity with clearly established roles and expectations. Other strategies have included having weekly meetings between the provider and model manager/consultant (BSFT); developing an integration team to address implementation challenges at the system and provider levels in real time (CPP); and hiring case managers to partner with the clinicians, allowing clinicians to focus more on clinical work.

Prior to implementation, purveyors and providers identified strategies to promote successful coordination and partnership. One provider highlighted the importance of reconciling differences between child welfare agency policies/procedures and model requirements prior to implementation to promote alignment and clear messaging. Relatedly, purveyors and providers noted the importance of pre-implementation planning (prior to training) between the provider and purveyor to build engagement and identify and address barriers to successful implementation.

Finally, one provider highlighted the importance of aligning quality assurance procedures across the purveyor and provider to support model fidelity and streamline processes. The provider viewed the purveyor's quality assurance procedures as a benefit to implementing EBMs, allowing the provider to embed the purveyor's quality assurance tools into their agency's processes, rather than building their own.

As purveyors and child welfare agencies work toward alignment and seek to address the local community's needs and experiences, program adaptations may result. Providers gave examples of child welfare agency requirements they needed to bring back to the purveyors to determine whether and how they fit into the program model (e.g., incorporating new protocols such as domestic violence screenings). The providers felt supported by their consultant/model manager in discussing these changes, although one provider noted that vetting the proposed change with purveyor leadership can be time-consuming. Program adaptations may also be made to better serve different racial and ethnic groups in the local child welfare context. However, in the case of BSFT and CPP, neither purveyor reported making cultural adaptations to their model, and both emphasized that their interventions were developed to work with different racial/ethnic groups and are suitable for implementation in different cultural contexts.

Skilled provider workforce

High turnover rates among provider staff can impede EBM scale-up. Purveyors reported that, relative to other jurisdictions in which they had worked, frontline social services staff in NYC move more frequently between positions, seeking higher salaries. Clinicians may also experience secondary trauma in their work and must balance multiple requirements to align their services with the program model and child welfare agency expectations. The resulting high levels of attrition raise concerns for

Lessons from the literature: Skilled provider workforce

Implementation of EBMs requires sufficient provider agency staff with the credentials, training, and support necessary to deliver services. Staff turnover, which is common in child welfare, can inhibit efforts to scale. From the clinician perspective, organizational implementation barriers include high productivity demands and limited time for learning and supervision.

For implementation partners seeking to scale EBMs, recommendations from the literature include:

- Invest more time and resources in intensive training for new staff in anticipation of turnover.
- Provide ongoing supervision and coaching by the purveyor or an intermediary.
- Create a culture that embraces and incentivizes best practices in EBMs.
- Build staff members' cultural competency.
- Develop partnerships with universities to integrate knowledge of EBMs into coursework and develop future clinicians' skills through field experiences.

Sources: Bertram, Collins, & Elsen, 2020; Eslinger, Sprang, Ascienzo, & Silman, 2020; Fagan et al., 2019; Marlowe, Cannata, Bertram, Choi, & Kerns, 2020

both model fidelity and family engagement, since new clinicians must be trained on and develop expertise in the program model, and families must form new relationships when clinicians leave the provider agency. To foster a supportive community for its clinicians and combat turnover, the CPP provider agency holds support groups and community-building activities.

Purveyors and providers can strengthen recruitment strategies and hiring processes. Providers identified recruitment challenges, including finding clinicians with needed credentials and competition among different program models. For example, BSFT requires culturally and linguistically competent clinicians and does not allow the use of interpreters, and it can be challenging to recruit bilingual staff for these positions. Further, new graduates may be less familiar with BSFT or CPP than with other interventions, such as Multisystemic Therapy and Functional Family Therapy, making it more difficult to recruit new clinicians. To build a direct pipeline of clinicians in other jurisdictions, the CPP purveyor has developed internship sites with universities.

To ensure a successful match between candidates and the program model, the BSFT purveyor developed a hiring toolkit, with input from the provider's human resource team to foster their engagement and support. Providers receive intensive training on how to use this toolkit. The CPP provider has also developed interview questions to recruit best-fit candidates.

Data monitoring and evaluation capacity

While providers and purveyors highlight the importance of data in their work, purveyors may face challenges building data systems. Providers and purveyors described data collection on fidelity measures and expressed a desire for stronger capacity to collect family-level data. For example, one provider described a database that another EBM purveyor developed and used and indicated that having access to similar data on families' treatment outcomes would be helpful for their program. However, purveyors' ability to develop these systems may be impeded by financial and capacity limitations. For example, one purveyor discussed the difficulty of establishing and maintaining a cost-effective, accessible, user-friendly, and comprehensive database across multiple implementation sites.

Furthermore, one purveyor reported that it can be challenging to identify consistent measures for analysis and reporting. More specifically, CPP requires sites to report on specific domains but does not require specific measures, given that there is a lack of free assessment tools available for use with young children. This leads to inconsistency in data gathered across sites implementing CPP but allows providers to select and use the measures that best align with their needs and/or their local child welfare agency's reporting requirements.

Lessons from the literature: Data and evaluation capacity

Data on program implementation (e.g., to track adaptations), model fidelity, and short- and long-term participant outcomes remain crucial as programs scale up. The Family First Act also requires ongoing evaluation of prevention programs implemented with federal funding.

For implementation partners seeking to scale EBMs, recommendations from the literature include:

- Conduct ongoing research on how to optimize EBMs to be portable and scalable.
- Evaluate whether and how program adaptations influence outcomes.
- Utilize precision research methods to refine program models to be more efficient and effective.

Sources: Fagan et al., 2019; McKlindon, 2019; Rolls Reutz, Kerns, Sedivy, & Mitchell, 2020; Supplee & Duggan, 2019

Independent evaluations can promote credibility in research findings, but are limited by available funding. Both purveyors view ongoing evaluation and evidence-building as crucial and report that these activities are often done through external research partnerships. The BSFT purveyor values the increased credibility gained through independent evaluations. The CPP purveyor also values independent evaluations but pointed to challenges in evaluation

funding amounts and timelines that limit opportunities for ongoing trials, particularly for interventions with a relatively long duration such as CPP. The costs of hiring clinicians for program implementation and researchers for program evaluation pose additional barriers, particularly in jurisdictions with a high cost of living.

Leadership and support

Public agency leadership's understanding of and support for specific EBMs facilitates sustainable scaling. The CPP purveyor provided examples from other states in which state child welfare agency leaders completed CPP training and, in some cases, took on caseloads to fully understand the model. One provider emphasized the value of having in-house expertise on program models within child welfare agencies. Staff who understand the nuances of the models can help public agencies ensure that EBMs are being implemented as intended in real time, instead of needing to wait for fidelity scores from the purveyors. Finally, recognizing that changes in agency leadership can threaten the continuity of EBM implementation, one purveyor highlighted the value of public-private partnerships to ensure ongoing funding for EBMs and promote accountability for sustained implementation.

Lessons from the literature: Leadership and support

The engagement of supportive leaders at the child welfare agency is essential for both adopting and sustaining EBMs and garnering support from staff and the general public.

For implementation partners seeking to scale EBMs, recommendations from the literature include:

- Identify innovative partnerships between child welfare administrators and social work programs.

Source: Fagan et al., 2019

Considerations

Findings from NYC's experience implementing these two EBMs provide helpful considerations for states that are preparing for and implementing EBMs through the Family First Act:

- **Strong purveyor infrastructure and capacity will be needed to meet the expanded demand for evidence-based prevention programs**. Purveyors require strong business models with pricing structures that cover the true costs of supporting jurisdictions to implement their program models with fidelity. By collecting and monitoring cost data, purveyors can set appropriate price structures, and agencies can budget appropriately to implement EBMs at scale. While provider agencies should work to support and retain qualified clinicians, purveyors should also build sustainable, flexible training options into their business models to realistically account for expected clinician turnover. Purveyor business models should also include the infrastructure for data collection and management. Purveyors must be adequately staffed at their national offices to fulfill key functions and build out the capacity and localized expertise of their model managers/consultants to provide responsive and tailored support to providers.

  A variety of creative solutions may help purveyors build their capacity. Purveyors may contract with management experts from the private sector to develop and refine their business models and enhance their marketing strategies. Intermediary organizations with expertise in program implementation and local context may help jurisdictions implement one or more EBMs. For example, intermediaries can develop coaching resources and implementation support tools tailored to the local community context.

  Purveyors located within universities may face additional barriers to scale and may learn from the experiences of program models such as Multisystemic Therapy (MST), which moved out of the university setting to a for-profit purveyor organization (MST Services; Neuhoff, Loomis, & Ahmed, 2017). University-based developers can also leverage cross-departmental expertise by partnering with colleagues from their business departments, and some universities have developed offices to support dissemination (e.g., the University of Illinois' Office of Technology Management; Supplee & Metz, 2015).

One provider recommended a peer support model in which model purveyors who have successfully scaled their models would serve as consultants to other purveyors and local jurisdictions to plan for and implement EBMs. Such an approach would require funding, which may be an opportunity for public and/or private investment. This approach could pose challenges, however, in that model purveyors may potentially be in competition with one another for new business.

- **Successfully embedding EBMs into child welfare systems requires strong and sustained relationships across model purveyors, public child welfare agencies, and program providers**. When public child welfare agencies contract with program providers for service delivery, providers may find themselves stuck in the middle between the purveyor's model expectations and the child welfare agency's practice requirements. In its latest round of prevention services contracts, NYC's child welfare agency has addressed this challenge by establishing its own contracts with purveyors and building learning cohorts where providers, purveyors, and the child welfare agency regularly convene. Jurisdictions can promote alignment and shared understanding by identifying and resolving discrepancies between child welfare agency and model requirements prior to implementation, and by maintaining open channels of communication between the purveyor, child welfare agency, and provider.
- **As EBMs are adapted for, and implemented within, a myriad of cultural and agency contexts, robust and ongoing data collection is required to monitor program implementation and child and family outcomes**. Data are essential for planning, implementing, monitoring, evaluating, and adapting EBMs to better serve children and families. Providers are eager for additional data to guide their programming, and all partners should consider how data can be used in real time to strengthen program implementation. However, many child welfare agency data systems are not designed to monitor program implementation and model fidelity. There are several ways to address this issue, as well as the need to measure long-term impacts. Purveyors may partner with researchers to strengthen their collection and use of data; data sharing agreements may help facilitate the tracking of outcomes across public systems; and/or customizable EBM-specific data systems, such as those described by Weaver and DeRosier (2019), can promote data-driven decision making with families and within provider agencies.

  The two models included in this brief were developed for use with different racial/ethnic groups. However, this is not true of all EBMs, and equity issues must be considered by all purveyors and their implementation partners. We expect that program adaptations will need to be made to ensure culturally relevant services for different racial/ethnic groups. Data collection will therefore be necessary to ensure that program impacts endure within new populations and in new jurisdictions. Purveyors can strategically partner with child welfare agencies and evaluators to design rigorous evaluations that meet the Family First Act's evaluation requirements and build evidence in the field. States can claim reimbursement for 50 percent of the costs to evaluate prevention services implemented under the Family First Act, opening up new fiscal resources for evaluation (U.S. Department of Health and Human Services, 2019).

The Family First Act presents an opportunity for purveyors and child welfare stakeholders to learn from and with one another. As purveyors prepare for expanded demand under the Family First Act, they can leverage the lessons learned from NYC's long-term implementation of EBMs. Planful implementation and cooperative partnerships between purveyors, public agencies, and providers will better position systems, programs, children, and families for success.

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Appendix: Program Snapshots

	Child Parent Psychotherapy	Brief Strategic Family Therapy
Program description & target population	A mental health program that serves caregivers with children ages 0-5 who have experienced trauma and/or are exhibiting attachment, mental health, or behavioral challenges. Services are delivered through weekly sessions lasting, on average, one year.	A mental health and substance abuse program that serves families with children ages 6-18 who currently engage in or are at-risk for developing behavior problems, including substance abuse. Services are delivered through 12-16 weekly sessions.
Evidence rating (Title IV-E Prevention Services Clearinghouse)	Promising	Well-supported
History	Developed by Alicia Lieberman and Patricia Van Horn in the late 1990s at the Child Trauma Research Program at the University of California San Francisco and manualized in 2005. Fidelity measures created by Chandra Ghosh Ippen. Theoretical principles influenced by Selma Fraiberg's Infant-Parent Psychotherapy, attachment theory, and trauma-informed principles.	Developed by researchers, led by Jose Szapocznik and Olga Hervis at the Center for Family Studies at the University of Miami during the 1970s.
Reach	Providers have been trained in 32 states and internationally.	Providers have been trained in over 30 states and internationally.
Training and technical assistance	Mental health professionals may be trained through one of three paths: (1) 18-month CPP Learning Collaborative (comprised of didactic training, active learning, mentorship, and agency support; (2) the CPP Agency Mentorship Program (CAMP) through which organizations already trained in CPP complete an 18-month train-the-trainer process; or (3) an endorsed CPP internship. Consultants approved by CPP provide ongoing model implementation support.	A site readiness process is used to evaluate and prepare the site before BSFT training begins. Training is comprised of workshops, followed by ongoing weekly supervision and review. BSFT model managers provide initial supervision and ongoing implementation support.
Fidelity monitoring	A range of fidelity tools are used to assess and support treatment fidelity, consultation fidelity, and supervision fidelity.	Provider agencies must meet fidelity requirements for licensure. Model fidelity is monitored through weekly supervision using videos from family sessions. A panel of BSFT experts rate provider competence, and supervisors receive related training.

Sources: California Evidence Based Clearinghouse for Child Welfare, 2019; Child Parent Psychotherapy, 2018; National Child Traumatic Stress Network, 2012; purveyor interviews; University of Miami Miller School of Medicine, 2020; Youth.Gov, 2020.

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