

Scaling Evidence-Based Programs in Child Welfare



Scaling Evidence-Based Programs in Child Welfare: Successes, Challenges, and Opportunities Under the Family First Prevention Services Act

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FOREWORD

On behalf of the IBM Center for The Business of Government, we are pleased to present this report, *Scaling Evidence-Based Programs in Child Welfare*, by Patrick Lester, Director, Social Innovation Research Center.

An enduring challenge for government policymakers involves how to scale up a pilot or a program that has been demonstrated as being successful in its early stages. This report discusses governments addressing this challenge in three different program areas—those highlighted in the 2018 Family First Prevention Services Act as important to reducing child maltreatment by increasing investments in three kinds of prevention services—home visiting, mental health services, and substance abuse services.

Lester points to two key factors that influence success or failure in scaling evidence-based programs:

- Successful scaling requires active and targeted support from sponsoring federal and state agencies.
- Supportive management infrastructure and sufficient resources can ensure quality and fidelity to core program components.

The author describes a series of success stories and lessons learned in evidence-based prevention interventions for home visiting, mental health services, and substance abuse services.

We hope this report helps federal, state, and local officials in developing their plans to implement the 2018 Family First Prevention Services Act. More broadly, the insights and recommendations in the report can inspire public managers with insights on how to scale evidence-based pilot programs in serving individuals and communities in need.



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EXECUTIVE SUMMARY

In 2018, Congress enacted the Family First Prevention Services Act (Family First), a new law intended to reduce child maltreatment through increased investments in prevention services.

Under the act, states may use entitlement funds under Title IV-E of the Social Security Act to support evidence-based interventions in three primary categories of prevention programs: home visits to improve parenting skills, mental health treatment, and substance abuse disorders.

All three categories of services have interventions backed by significant research, several of which have been scaled in many states. This analysis reviews previous efforts to scale these programs, including challenges, successes, and other lessons learned. It concludes with the following recommendations for officials charged with implementing the new law.

- **Recommendation One: States and local jurisdictions should provide appropriate, targeted funding for eligible evidence-based services.** Evidence-based interventions are rarely scaled on a systemwide basis without significant and targeted public support. States should fully use the opportunities offered by Family First to invest in the law's designated evidence-based prevention services.
- **Recommendation Two: States and local jurisdictions should proactively plan to cover the full cost of quality implementation.** Evidence-based interventions sometimes involve additional costs, with training, fidelity monitoring, data systems, and ongoing consultation among the most common additional expenses. To ensure that these programs are administered effectively, states should include details about how they will cover the full cost of implementation in their federally-required five-year prevention plans.
- **Recommendation Three: States and local jurisdictions should consider using performance-based contracts, value-based payments, evidence mandates, and pay-for-success funding.** Performance-based contracts and similar arrangements may provide additional incentives to scale evidence-based programs effectively.
- **Recommendation Four: States should adopt evidence-informed budgeting, cost-benefit evaluations, and outcomes monitoring to help scale these programs.** Where they have been adopted, such process changes have helped support scaling efforts. More states should consider these reforms.
- **Recommendation Five. States and federal agencies should help expand the child welfare evidence base.** Although there has been significant research on home visiting and behavioral health programs, the overall evidence base for other child welfare-related services is weak, with just a small number of interventions meeting the highest research standards. States should partner with local researchers and use federal administrative funds available under Family First to cover the costs of additional research.

While these recommendations apply specifically to Family First, there are broader lessons for evidence-based policy in general. These include: (1) the need for dedicated federal research funding, (2) providing federal and state support for scaling, and (3) ensuring the quality of implementation.

INTRODUCTION

Each year, millions of allegations of child abuse and neglect are reported to state or local child protective services agencies, usually by medical professionals, teachers, social services personnel, or law enforcement.

In 2017, there were an estimated 4.1 million referrals involving approximately 7.5 million children.¹ Approximately 270,000 children were removed from their homes and entered foster care. Most (70 percent) of these cases were attributable to parental substance abuse, mental illness, family violence, parental criminal activity, or extreme poverty.²

Child protective services are costly and they often produce poor outcomes for the children in their care. Nearly \$30 billion in federal, state, and local funds were spent on child welfare programs in 2016.³ Only a small fraction of that amount, however, was spent on evidence-based interventions that have, through rigorous research, been shown to improve child safety, permanence, or well-being.⁴

Reasons for this low use of evidence-based services include:

- **Gaps in the Research:** Most child welfare interventions have not been sufficiently validated by rigorous studies. Of the 482 programs catalogued by the California Evidence-Based Clearinghouse for Child Welfare, only 35 (seven percent) meet its criteria for being well supported by research.⁵ The number of programs meeting this threshold has increased only slightly since 2010, when there were twenty. Most of these interventions were not originally or specifically designed for child welfare populations.
- **Knowledge and Attitudinal Barriers:** Another barrier is informational. A recent survey found that only 14 percent of public child welfare directors had heard of the California Evidence-based Clearinghouse.⁶ Researchers and practitioners often suggest that it takes an average of 17 years for research results to find their way into practice.⁷ As a result, other practices

1. U.S. Department of Health and Human Services, Administration for Children and Families, "Child Maltreatment 2017," 2019. <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>.

2. Moira Szilagyi, et al., "Health Care Issues for Children and Adolescents in Foster Care and Kinship Care," *Pediatrics*, 2015. <https://pediatrics.aappublications.org/content/136/4/e1142>.

3. Congressional Research Service, "Child Welfare: Purposes, Federal Programs, and Funding," 2019. <https://fas.org/sgp/crs/misc/IF10590.pdf>.

4. Sarah McCue Horwitz, et al., "Exploration and Adoption of Evidence-based Practice by US Child Welfare Agencies," *Children and Youth Services Review*, 2014. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3960081/>.

5. Communication with California Evidence-Based Clearinghouse, October 31, 2019.

6. Sarah McCue Horwitz, et al., "Exploration and Adoption of Evidence-based Practice by US Child Welfare Agencies," *Children and Youth Services Review*, 2014. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3960081/>.

7. Cindy L. Munro and Richard H. Savel, "Narrowing the 17-Year Research to Practice Gap," *American Journal of Critical Care*, May 2016. <http://ajcc.aacnjournals.org/content/25/3/194.full>; Zoë Slote Morris, Steven Wooding, and Jonathan Grant, "The Answer is 17 years, What is the Question: Understanding Time Lags in Translational Research," *Journal of the Royal Society of Medicine*, December 16, 2011. <http://journals.sagepub.com/doi/ful/10.1258/jrsm.2011.110180>.

that have been shown to be ineffective can remain in use for years.⁸ For child welfare workers, risk avoidance may be another contributing factor. A combination of limited resources and substantial legal oversight may inhibit innovation in the field.⁹

- **Political Hurdles:** Taking any public program to scale, including those that are evidence-based, can be costly.¹⁰ A recent survey found that most community mental health clinic executives (87 percent) view increased costs as a major obstacle to using evidence-based programs.¹¹ Such costs may also generate political resistance and other obstacles, including partisan opposition, interest group politics, bureaucratic politics, budgetary politics, and legal barriers.¹²
- **Replication Challenges:** Even when they are implemented, evidence-based interventions sometimes fail to produce the hoped-for effects, often because of insufficient resources, poor execution, or local conditions that differ from those in the original research.¹³ One review of nearly 500 child and adolescent programs found that those that were well-implemented produced effects that were two to three times greater than those that were not.¹⁴
- **Scaling Challenges:** Taking a program to scale poses additional logistical challenges. Studies of widely implemented federal programs like Head Start, education, or job training initiatives regularly produce findings of little or no impact, even when previous studies had suggested that some programs were effective.¹⁵ Poor or variable implementation when programs go to scale is a common contributor to poor performance.

How can these barriers be overcome? What does it take to scale evidence-based programs successfully? This report answers these larger questions by focusing on two related sub-questions:

1. Given that most child welfare-related programs are publicly funded, what combination of federal, state, and local **public policy changes** (legal, regulatory, or funding mechanisms) are needed to successfully scale evidence-based programs?
2. What **management strategies and resources** are needed to scale these programs effectively?

8. David Epstein and Propublica, "When Evidence Says No, but Doctors Say Yes," *The Atlantic*, February 22, 2017. <https://www.theatlantic.com/health/archive/2017/02/when-evidence-says-no-but-doctors-say-yes/517368/>; Justin Timbie, et al., "Five Reasons That Many Comparative Effectiveness Studies Fail to Change Patient Care and Clinical Practice," *Health Affairs*, October 2012. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2012.0150>; Austin Frakt, "Information Overload," *The Incidental Economist*, January 27, 2012. <http://theincidentaleconomist.com/wordpress/information-overload/>; Victor R. Fuchs and Arnold Milstein, "\$640 Billion Question — Why Does Cost-Effective Care Diffuse So Slowly?", *New England Journal of Medicine*, May 26, 2011. <http://www.nejm.org/doi/full/10.1056/NEJMp1104675>.

9. Sonya J. Leathers, et al., "Use of Evidence-based Interventions in Child Welfare: Do Attitudes Matter?" *Children and Youth Services Review*, 2016. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6221194/>.

10. Patrick McCarthy "The Road to Scale Runs Through Public Systems," *Stanford Social Innovation Review*, 2014. https://ssir.org/articles/entry/the_road_to_scale_runs_through_public_systems.

11. Lawrence A. Palinkas, "Adoption of Innovative and Evidence-based Practices for Children and Adolescents in State-supported Mental Health Clinics: A Qualitative Study," *Health Research Policy and Systems*, 2017. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5372256/>.

12. Patrick Lester, "Managing Toward Evidence: State-Level Evidence-Based Policymaking and the Results First Initiative," *Annals of the American Academy of Political and Social Science*, 2018. http://socialinnovationcenter.org/wp-content/uploads/2018/01/Managing_Toward_Evidence.pdf; Patrick Lester, "Policy Drivers: Putting the Politics Back in Implementation," Social Innovation Research Center, 2018. <http://www.socialinnovationcenter.org/archives/3012>.

13. Mary Ann Bates and Rachel Glennerster, "The Generalizability Puzzle," *Stanford Social Innovation Review*, Summer 2017. https://ssir.org/articles/entry/the_generalizability_puzzle#.

14. Joseph A. Durlak and Emily P. DuPre, "Implementation Matters: A Review of Research on the Influence of Implementation on Program Outcomes and the Factors Affecting Implementation," *American Journal of Community Psychology*, 2008. <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.470.834&rep=rep1&type=pdf>.

15. Arnold Ventures, "When Congressionally-authorized Federal Programs are Evaluated in Randomized Controlled Trials, Most Fall Short. Reform is Needed," *Straight Talk on Evidence*, 2018. <https://www.straighttalkonevidence.org/2018/06/13/when-congressionally-authorized-federal-programs-are-evaluated-in-randomized-controlled-trials-most-fall-short-reform-is-needed/>.

This report examines these questions within the context of the Family First Prevention Services Act (Family First). This new law provides federal matching funds for evidence-based mental health services, and substance abuse treatment, and in-home parenting programs for children at risk of entering the child welfare system.¹⁶ To qualify as evidence-based, the underlying research for eligible services must first be reviewed and approved by the newly created Title IV-E Prevention Services Clearinghouse, which was launched by the U.S. Department of Health and Human Services' (HHS) Administration for Children and Families (ACF) in late 2018.¹⁷ States must also submit five-year prevention plans to ACF's Children's Bureau for review and approval. At least ten states are expected to seek funding for these services in the first fiscal year, which began October 1, 2019. As of January 1, 2020, two jurisdictions (Utah and the District of Columbia) have had their plans approved.

What will it take for states to scale these programs successfully? To answer this question, this report reviews the history of scaling evidence-based programs for each the three sets of prevention services covered by the law—in-home parenting, mental health, and substance use disorder programs.¹⁸ It also draws on interviews with experts in child welfare, home visiting, and behavioral health and with several model developers (see box). It concludes with recommendations.

EVIDENCE-BASED MODEL DEVELOPERS UNDER FAMILY FIRST

Most evidence-based interventions approved for funding under Family First were first developed by academics and later scaled by model developer organizations, sometimes referred to as “purveyors” in the literature. These support organizations, which are usually nonprofits, provide consultation, training, and other assistance to other nonprofits or organizations that are implementing the evidence-based intervention, or “model.”

This report profiles the research, innovation, and scaling efforts of the following eight model developers, each of which oversees a model that has been rated as “well-supported” by evidence by the Title IV-E Prevention Services Clearinghouse and/or California Evidence-based Clearinghouse.

- **Home Visiting:** Healthy Families America, Nurse-Family Partnership, Parents as Teachers
- **Mental Health:** Functional Family Therapy, Multisystemic Therapy, Parent-Child Interaction Therapy
- **Substance Use Disorder:** Multidimensional Family Therapy, Multisystemic Therapy

16. Patrick Lester, “Evidence-based Child Welfare Legislation Enacted,” Social Innovation Research Center, February 9, 2018. <http://www.socialinnovationcenter.org/archives/3153>; Children's Defense Fund, “Implementing the Family First Prevention Services Act: A Technical Guide for Agencies, Policymakers and Other Stakeholders,” 2019. <https://www.childrensdefense.org/policy/policy-priorities/child-welfare/family-first/implementing-the-family-first-prevention-services-act>.

17. Patrick Lester, “Roll Out Begins for Family First Evidence Provisions,” *Child Welfare Evidence & Innovation Blog*, October 4, 2019. <http://childwelfareevidence.org/?p=28>.

18. The law also provides funding for evidence-based kinship navigator programs, which are not covered in this analysis.

Home Visiting: A Model for Family First



Of the three types of prevention programs funded by Family First, in-home parenting is the category with the most significant track record of scaling evidence-based programs. This success is primarily attributable to the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, housed at HHS, which has historically provided significant financial and technical support for scaling and improving home visiting programs.

Like Family First, MIECHV established a federally funded review process to rate programs and determine eligibility for funding. It also required states to submit scaling plans before financing their initiatives. However, MIECHV is more ambitious than Family First in other ways. The program provides substantial support for ongoing research. It has developed a dedicated infrastructure for continuous improvement that Family First lacks.

Background

Poor parenting and child maltreatment can produce severe and long-lasting effects. A child's brain is significantly affected by both prenatal factors (such as maternal nutrition, exposure to toxic substances, and stress) and postnatal factors in the home (such as neglect or physical abuse early in life when a child's brain is experiencing its most rapid development).¹⁹ Adverse childhood experiences have been associated with poor outcomes later in life, such as diminished academic achievement, unstable work histories, increased criminal involvement, heightened risk of mental illness, drug abuse, and suicide.²⁰

Home visiting programs can help prevent child abuse and neglect. Although they vary substantially in their design, most of these programs use trained professionals to provide an array of in-home services such as: (1) child and parent screenings and assessments; (2) training on home safety, health, or parenting skills; and/or (3) referrals to other services where necessary.

These programs have been the subject of considerable research to determine their effectiveness. Clinical trials have been conducted to determine their impact on maternal health, birth outcomes, immunization rates, breastfeeding, children's dietary practices, lead levels, parenting practices, accidental injury, and child maltreatment.²¹

Replication and Scale

Home visiting as a general service strategy has a long track record. Its origins trace back more than a century to the settlement house movement and public health nursing, both of which emerged in the late 1800s.²² The earliest programs were supported by philanthropy. Limited taxpayer support began with the Maternal and Child Health Program enacted by Congress in 1935.

Home visiting took a significant leap forward after MIECHV was created in 2010 as part of the Affordable Care Act.²³ The program's status as an evidence-based initiative drew signifi-

19. Center on the Developing Child, "From Best Practices to Breakthrough Impacts: A Science-Based Approach to Building a More Promising Future for Young Children and Families," Harvard University, 2016. <https://developingchild.harvard.edu/resources/from-best-practices-to-breakthrough-impacts/>.

20. Centers for Disease Control and Prevention, "Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence," 2019. <https://www.cdc.gov/violenceprevention/pdf/preventingACES-508.pdf>.

21. Sarah A. Avellar and Lauren H. Supplee, "Effectiveness of Home Visiting in Improving Child Health and Reducing Child Maltreatment," *Pediatrics*, November 2013. https://pediatrics.aappublications.org/content/132/Supplement_2/S90#ref-13.

22. Karen Moran Finello, "A Brief History of Home Visiting in the United States," California Center for Infant-Family and Early Childhood Mental Health. <http://cacenter-ecmh.org/wp/a-brief-history-of-home-visiting-in-the-united-states/>.

23. Ron Haskins and Greg Margolis, *Show Me the Money: Obama's Fight for Rigor and Results in Social Policy* (The Brookings Institution: 2015), pp.31-66.

cant bipartisan support.²⁴ The idea of evidence-based home visiting programs prompted early interest from the Bush administration, which had become a proponent of using evidence to justify programs in the federal budget.²⁵

Although it is not the only source of funding, MIECHV has played a major role in scaling home visiting programs. Prior to the law's enactment, estimates of annual funding from all sources ranged from \$500-750 million.²⁶ Today annual funding from all sources is over \$1.5 billion. MIECHV covers about a quarter of that figure, with states and other federal programs like the Maternal and Child Health Block Grant Program, Temporary Assistance to Needy Families (TANF), Medicaid, and the Child Abuse Prevention and Treatment Act (CAPTA) providing the balance.²⁷ Most of the widely-scaled home visiting models have received positive ratings in the federal home visiting evidence clearinghouse.²⁸

Although evidence-based home visiting programs have expanded significantly in recent years, there is further room to grow. Census estimates of the number of pregnant women and children living in poverty suggest that home visiting programs currently only reach about six percent of the eligible population.²⁹

The largest evidence-based models achieved scale in different ways. Clinical trials for the Nurse-Family Partnership (NFP) began in the late 1970s with federal research funding from HHS. Much of its early funding was drawn from the federal Maternal and Child Health Block Grant.³⁰ Other common federal funding streams include MIECHV, Medicaid, TANF, and Title IV-B child and family services grants. Today NFP operates in 41 states and serves more than 50,000 families each year.

Another evidence-based model, Healthy Families America, was launched in 1992 with private funding and drew much of its early support from TANF funds.³¹ It currently operates in 38 states and serves over 70,000 families per year. Parents as Teachers launched in 1981 with funding from the Missouri Department of Elementary and Secondary Education and The Danforth Foundation.³² In 1987, it established a National Center to oversee its growing network. Drawing on a variety of funding sources (Title I and IDEA education funds, TANF, and CAPTA), the program expanded to all 50 states by the mid-1990s. It is also now operational in six other countries.

24. The Congressional Budget Office (CBO) nearly rated the proposed law as producing net cost savings for the federal government, which would have helped smooth its way to enactment, but disagreements over evidence standards among activists and on Capitol Hill undermined CBO's confidence in the its projection. In the end, MIECHV was included in the Affordable Care Act.

25. Donald P. Moynihan, "Advancing the Empirical Study of Performance Management: What We Learned from the Program Assessment Rating Tool," February 20, 2013. Available at: <http://www.lafollette.wisc.edu/images/publications/workingpapers/moynihan2013-003.pdf>.

26. Ibid.; Pew Charitable Trusts, "States and the New Federal Home Visiting Initiative: An Assessment from the Starting Line," August 24, 2011. <https://www.pewtrusts.org/en/research-and-analysis/reports/2011/08/24/states-and-the-new-federal-home-visiting-initiative-an-assessment-from-the-starting-line>.

27. National Home Visiting Resource Center, "Home Visiting Primer," 2018. https://www.nhvr.org/wp-content/uploads/NHVR_C_Primer_FINAL.pdf; National Home Visiting Resource Center, "2018 Home Visiting Yearbook," pp. 12-13. <https://nhvr.org/yearbook/>.

28. Home Visiting Evidence of Effectiveness (HomVEE). See: <https://homvee.acf.hhs.gov/>.

29. Heather Sandstrom, "Early Childhood Home Visiting Programs and Health," Health Affairs, April 2019. <https://www.healthaffairs.org/doi/10.1377/hpb20190321.382895/full/>.

30. Emilie Stoltzfus and Karen E. Lynch, "Home Visitation for Families with Young Children," Congressional Research Service, 2009, pp. 19-20. https://www.everycrsreport.com/files/20091023_R40705_9180cd7c853cfa09567961616dabaa2777187472.pdf.

31. Ibid., p. 19.

32. Parents as Teachers, "Who We Are." Accessed October 2019. <https://parentsasteachers.org/who-we-are-index>.

Quality, Innovation, and Improvement

Although most home visiting programs are backed by rigorous research, there remains room for improvement. Studies suggest that the impact on targeted outcomes for most programs is modest.³³

This assessment was underscored by MIECHV's national evaluation, released in early 2019.³⁴ Consistent with past studies it found positive, but modest, impact for each of the models it reviewed and for the program as a whole. The largest effects for each model tended to be those that were aligned with its primary programmatic focus. For example, the Nurse-Family Partnership produced the largest reduction in child emergency room visits. Parents as Teachers produced larger improvements in parental supportiveness.

Research suggests that continuous quality improvement (CQI) could improve these modest results.³⁵ HHS is supporting several related efforts including innovation grants,³⁶ a federally-sponsored network of state CQI administrators,³⁷ and a network of home visiting researchers.³⁸ A quarter of existing grants under MIECHV are reserved for funding and evaluating new home visiting models, which could spur innovation.³⁹ Additional research is being conducted on individual program components (or "active ingredients") to more quickly identify which core components of existing models should be replicated faithfully and which may be adapted to address the needs of new or different populations.⁴⁰

Model developers are also working to improve their own programs. The Nurse-Family Partnership (NFP) oversees proposed adaptations to its model, pilot testing them before subjecting them to more formal quasi-experimental and experimental evaluations to determine their effectiveness. Validated improvements are frequently integrated into the model.⁴¹

Parents as Teachers (PAT) permits adaptations outside of its four model components. Its Research Council advises on projects and partnerships. Recent research has examined PAT's impact on child protective services recidivism, substantiated cases of child maltreatment, strategies for improved parental engagement using technology, maternal sensitivity, child behavior and developmental outcomes, child academic outcomes, suspensions and absenteeism in the middle school years, diabetes, and obesity prevention.

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33. Effect sizes average about 0.10. Sarah A. Avellar and Lauren H. Supplee, "Effectiveness of Home Visiting in Improving Child Health and Reducing Child Maltreatment," *Pediatrics*, November 2013. https://pediatrics.aappublications.org/content/132/Supplement_2/S90#ref-13; kk; Ann Easterbrook, "Limiting Home Visiting Effects: Maternal Depression as a Moderator of Child Maltreatment," *Pediatrics*, November 2013. https://pediatrics.aappublications.org/content/132/Supplement_2/S126.
34. MDRC, "Impacts on Family Outcomes of Evidence-Based Early Childhood Home Visiting: Results from the Mother and Infant Home Visiting Program Evaluation," OPRE Report 2019-07. Washington, DC. <https://www.acf.hhs.gov/opre/resource/impacts-family-outcomes-evidence-based-early-childhood-home-visiting-results-mother-infant-home-visiting-program-evaluation>.
35. Neera K. Goyal, et al., "Using Quality Improvement to Promote Implementation and Increase Well Child Visits in Home Visiting," *Child Abuse and Neglect*, 2016. <https://daneshyari.com/article/preview/344535.pdf>.
36. HRSA, "HHS Awards \$17 Million to Support Innovations to Strengthen the Federal Home Visiting Program," November 29, 2016. <https://www.hrsa.gov/about/news/press-releases/2016-11-29-home-visiting-innovation.html>; National Home Visiting Resource Center, "Promoting Family Engagement in Home Visiting: An Overview of Innovative Efforts," December 2017. https://www.nhvr.org/wp-content/uploads/NHVR-Brief-1229_FINAL.pdf.
37. Home Visiting Collaborative Innovation and Improvement Network (CoINN). <https://hv-coiin.edc.org/>.
38. Home Visiting Applied Research Collaborative (HARC), <https://www.hvresearch.org/>; Anne Duggan, et al., "Creating a National Home Visiting Research Network," *Pediatrics*, 2013. https://pediatrics.aappublications.org/content/132/Supplement_2/S82.
39. OPRE, "Grantee-Led Evaluations: The Maternal, Infant, and Early Childhood Home Visiting Program – Overview and Profiles," OPRE Report #2016-78, October 2016. <https://www.acf.hhs.gov/opre/resource/grantee-led-evaluations-maternal-infant-early-childhood-home-visiting-program-overview-profiles>.
40. Peggy Nygren, et al., "What's Happening During Home Visits? Exploring the Relationship of Home Visiting Content and Dosage to Parenting Outcomes," *Maternal Child Health Journal*, 2018. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6153727/>; Lauren H. Supplee and Anne Duggan, "Innovative Research Methods to Advance Precision in Home Visiting for More Efficient and Effective Programs," *Society for Research in Child Development*, July 2019. <https://srcd.onlinelibrary.wiley.com/doi/full/10.1111/cdep.12334>.
41. David Olds, et al., "Improving the Nurse-Family Partnership in Community Practice," *Pediatrics*: Volume 132, Supplement 2, November 2013. http://pediatrics.aappublications.org/content/pediatrics/132/Supplement_2/S110.full.pdf.

Healthy Families America (HFA) was developed to prevent child abuse and neglect, but it has also been the subject of ongoing research. One adaptation for pregnant and parenting youth in care was piloted in Illinois and evaluated by Chapin Hall at the University of Chicago.⁴² Lessons learned from the pilot were incorporated into an optional child welfare adaptation that was announced nationally in 2018.

Finally, states are beginning to implement several system-wide improvements. More emphasis is being placed on integrating home visiting programs with existing state early childhood education programs and health initiatives.⁴³ The recent federal reauthorization of MIECHV also included a new home visiting outcomes-based payment option.⁴⁴

Conclusion

Of the three primary types of evidence-based prevention programs supported by Family First, home visiting programs have the strongest history of research and dissemination of evidence-based models. Most of the nation's largest home visiting programs are evidence-based as determined by a federal clearinghouse, the Home Visiting Evidence of Effectiveness. MIECHV provides a variety supports for research and continuous improvement that should serve as a model for Family First.

STATE EFFORTS ARE KEY TO SCALING EVIDENCE-BASED RESULTS

Federal laws like the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program and Family First are helping to scale evidence-based interventions, but the federal government is not acting alone. States are also playing a leading role.⁴⁵ Some of their most promising strategies include:

Evidence Reviews in State Budgeting Processes: Some states now incorporate evidence reviews in their budget processes. For example, Colorado requires state agencies that request new funding to summarize and cite the research on program outcomes and to conduct a cost-benefit analysis⁴⁶. Minnesota has instituted similar requirements.⁴⁷ Cost-benefit analyses by the Washington State Institute for Public Policy have helped that state scale many of its evidence-based programs.⁴⁸

42. Amy Dworsky, et al., "Home Visiting for Pregnant and Parenting Youth in Care: Final Report," Chapin Hall, 2019. <http://igrowillinois.org/wp-content/uploads/2019/07/HV-PIlot-Evaluation-final-report.pdf>.

43. Child Trends, "Child Trends Selects Five States to Participate in Initiative to Connect Home Visiting Information with Other Early Childhood Data," November 2017. <https://www.childtrends.org/news-release/child-trends-selects-five-states-participate-initiative-connect-home-visiting-information-early-childhood-data>; Nurse-Family Partnership, "Medicaid and Health Care Integration." <https://www.nurse-familypartnership.org/public-policy/medicaid-health-care-integration/>.

44. Patrick Lester, "Home Visiting Extension Authorizes Pay-for-Outcomes Transactions," Social Innovation Research Center, February 9, 2019. <http://www.socialinnovationcenter.org/archives/3188>.

45. For more information, see: Pew-MacArthur Results First Initiative, <https://www.pewtrusts.org/en/projects/pew-macarthur-results-first-initiative>; Results for America, "2019 Invest in What Works: State Standard of Excellence," 2019. <https://2019state.results4america.org/>.

46. Pew-MacArthur Results First, "States Should Prioritize Evidence in Budgeting to Promote Positive Outcomes," 2018. <https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2018/07/states-should-prioritize-evidence-in-budgeting-to-promote-positive-outcomes>.

47. Minnesota Department of Management and Budget, "Using Evidence in Policymaking," undated. <https://mn.gov/mmb/evidence/>.

48. Pew-MacArthur Results First, "States' Use of Cost-Benefit Analysis," 2013. <https://www.pewtrusts.org/en/research-and-analysis/reports/2013/07/29/states-use-of-costbenefit-analysis>.

STATE EFFORTS ARE KEY TO SCALING EVIDENCE-BASED RESULTS CONT.

Mandates to Invest in Evidence: Some agencies have mandatory evidence targets established by state law that require them to spend a certain percentage of their funding on evidence-based programs. For example, Oregon passed a law in 2003 directing five state agencies to spend at least 25 percent of their funds on evidence-based programs by 2007. The threshold rose steadily thereafter, reaching 75 percent in 2011.⁴⁹

Leveraging Medicaid Spending Flexibilities: Medicaid is a substantial source of funding for many child welfare-related services. Some states, like Louisiana and Minnesota, have established Medicaid payment codes for evidence-based interventions, sometimes with enhanced (higher) payment rates. South Carolina has used Medicaid waiver authority to establish a pay-for-success program that has expanded Nurse-Family Partnership services in the state.⁵⁰

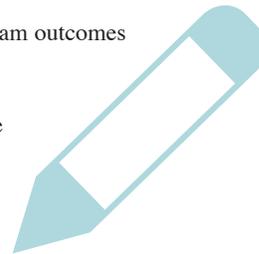
Contract and Grant Requirements to Adopt Evidence-Based Approaches: Some state and local agencies direct providers to adopt evidence-based interventions through contract and grant requirements.⁵¹ Performance-based contracts, which are common in many states, may also help scale evidence-based interventions.⁵²

Training and Technical Assistance for Evidence-Based Approaches: Some states have funded programs that defray the costs of training and technical assistance for evidence-based programs. Examples include the Child Health and Development Institute (CHDI) of Connecticut and the EPISCenter in Pennsylvania.

Monitoring Program Fidelity: Some states, like Tennessee and Washington, track and report on the fidelity of program implementation, sometimes relying on inspections and audits for information.⁵³

Monitoring Program Outcomes: Some states, like New Mexico, monitor program outcomes to track their progress over time.⁵⁴

Funding Pilots and Evaluations: Some states, such as Iowa and Colorado, have helped to further build the evidence base by providing funding for local pilots and evaluations.⁵⁵



49. Pew-MacArthur Results First, “States Can Set Funding Thresholds That Promote Evidence-Based Programs,” 2019. <https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2019/02/states-can-set-funding-thresholds-that-promote-evidence-based-programs>.

50. South Carolina Department of Health and Human Services, “Fact Sheet: South Carolina Nurse-Family Partnership Pay for Success Project,” 2016. https://www.scdhhs.gov/sites/default/files/2-16-16-SC-NFP-PFS-Fact-Sheet_3.pdf.

51. Pew-MacArthur Results First Initiative, “How Evidence Can Inform Contracting for State, Local Governments,” 2019. <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2019/03/how-evidence-can-inform-contracting-for-state-local-governments>.

52. California Evidence-based Clearinghouse, “Contracting Evidence-Based Practices for Families Involved in Child Welfare,” 2017. <https://www.cebc4cw.org/files/CEBCCContractingEBPsForFamiliesInvolvedInCW.pdf>; Pew-MacArthur Results First Initiative, “How to Use Evidence in the Contracting Process,” 2016. <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2016/12/how-to-use-evidence-in-the-contracting-process>; Patrick Lester, “Building Performance Systems for Social Service Programs,” IBM Center for the Business of Government, 2016. <http://www.businessofgovernment.org/sites/default/files/Building%20Performance%20Systems%20for%20Social%20Service%20Programs.pdf>.

53. Pew-MacArthur Results First, “How Policymakers Prioritize Evidence-Based Programs Through Law,” 2017. <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2017/04/how-policy-makers-prioritize-evidence-based-programs-through-law>; Pew-MacArthur Results First Initiative, “Implementation Oversight for Evidence-Based Programs: A Policymaker’s Guide to Effective Program Delivery,” 2016. <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2016/05/implementation-oversight-for-evidence-based-programs>.

54. Jessica Reno and Deborah Altschul, “New Mexico MST Outcomes Tracking Project,” New Mexico Children, Youth & Families Department and the Center for Effective Interventions, 2018. https://cdn2.hubspot.net/hubfs/295885/MST%20Redesign/Marketing%20Collateral/Case%20Study%20and%20Reports/NM_MST_2017AnnualReport.FINAL.pdf.

55. Descriptions and case studies of Results First work in specific states can be found at <http://www.pewtrusts.org/en/projects/pew-macArthur-results-first-initiative/where-we-work>.

Mental Health: Strong Research but Insufficient Scale



With over a billion dollars in federal funds spent annually on research for mental health treatment, the evidence for the effectiveness of these programs is more advanced than for most other child welfare-related services. Few children, however, receive such evidence-based care. Although individual model developers have grown their networks, system-wide scaling has been hampered by a lack of consistent federal and state financial funding for research-backed treatments.

Background

Mental health disorders are common among children and families either in, or in danger of entering, the child welfare system. Up to 80 percent of children who enter the foster care system suffer a diagnosable mental health condition such as depression, anxiety, attention-deficit/hyperactivity disorder, or other behavioral problems.⁵⁶ Parents often suffer from similar disorders, which can lead to a child's removal from the home.⁵⁷

Psychology has a long history, but research on effective treatments began to accelerate after the creation of the National Institute of Mental Health (NIMH) in 1949.⁵⁸ This had dramatic effects on the field. Studies in the 1950s began to cast doubt on prevailing psychoanalytical techniques of the era.⁵⁹ Empirically-backed interventions like cognitive-behavioral therapy and family therapy soon emerged to take their place.⁶⁰ The shift from institutionalized care in mental hospitals to community-based treatment also gained speed during this period.⁶¹ Since then, a broad range of psychosocial interventions backed by hundreds of randomized controlled trials and several meta-analyses have been developed.⁶²

Replication and Scale

Despite the existence of these evidence-based models and a high level of demonstrated need, few children or parents who come into contact with the child welfare system receive effective, evidence-based mental health services. Surveys of state behavioral health systems indicate that no more than 1-3 percent of youth with serious behavioral health disorders receive evidence-based care.⁶³ The majority of children who receive community-based mental health services consequently show no improvement.⁶⁴

56. Moira A. Szilagyi, et al., "Health Care Issues for Children and Adolescents in Foster Care and Kinship Care," *Pediatrics*, 2015. <https://pediatrics.aappublications.org/content/136/4/e1142>; Kristin Turney and Christopher Wildeman, "Mental and Physical Health of Children in Foster Care," *Pediatrics*, 2016. <https://pediatrics.aappublications.org/content/138/5/e20161118>.

57. M. Ann Easterbrooks, et al., "Limiting Home Visiting Effects: Maternal Depression as a Moderator of Child Maltreatment," *Pediatrics*, 2013. https://pediatrics.aappublications.org/content/132/Supplement_2/S126.

58. Ramya Sundararaman, "The U.S. Mental Health Delivery System Infrastructure: A Primer," Congressional Research Service, 2009, pp. 3-5. <https://fas.org/sgp/crs/misc/R40536.pdf>.

59. Joel Paris, "Is Psychoanalysis Still Relevant to Psychiatry?", *Canadian Journal of Psychiatry*, 2017. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5459228/>.

60. Courtney L. Benjamin, et al., "History of Cognitive-Behavioral Therapy (CBT) in Youth," *Child and Adolescent Psychiatric Clinics of North America*, 2012. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3077930/>; Janice M. Rasheed, "The History of Family Therapy" in *Family Therapy: Models and Techniques* (Sage Publishing, 2010). https://www.sagepub.com/sites/default/files/upm-binaries/35408_Chapter1.pdf.

61. Gerald N. Grob, "Mental Health Policy in America: Myths and Realities," *Health Affairs*, 1992. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.11.3.7>.

62. Mary Jane England, et al., *Psychosocial Interventions for Mental and Substance Use Disorders: A Framework for Establishing Evidence-Based Standards* (National Academies Press: 2015), pp. 1-11. https://www.integration.samhsa.gov/news/Psychosocial_Interventions_for_Mental_and_Substance_Use.pdf.

63. Eric Bruns, "Research, Data, and Evidence-Based Treatment Use in State Behavioral Health Systems, 2001-2012," *Psychiatric Services*, 2015. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5107263/>.

64. Ann Garland, et al., "Improving Community-Based Mental Health Care for Children: Translating Knowledge into Action," *Administration and Policy in Mental Health and Mental Health Services Research*, 2013. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3670677/>.

A major barrier is cost. Most evidence-based treatments have been developed and validated in academic and clinical settings which focus on demonstrating a statistically significant effect—and where cost and practical scaling considerations are less important. Many evidence-based treatments have unrealistic staffing or dose requirements that do not mesh well with the practical business realities of community-based care.⁶⁵ Cost considerations are rarely discussed or included in published studies. Most of these issues are subsequently addressed by model developers, but nearly every evidence-based model still features substantial personnel, training, technology, record-keeping, and supervision requirements—all of which can increase costs.⁶⁶

The funding to cover these costs is limited. Medicaid is the largest source of funding for community-based mental healthcare, but Medicaid payment rates for services are often below those found in the private market.⁶⁷ Most Medicaid-funded mental health services are overseen by managed care organizations (MCOs) that often work to further reduce costs. Limitations imposed by MCOs can include substituting other mental health personnel for trained psychiatrists or restricting other practices that may interfere with the implementation of evidence-based treatment. Payment methods such as fee-for-service or capitation rates are often structured in a way that further shift costs to the provider, which can encourage high-volume, low-quality care.⁶⁸

The numbers we serve at the Child Guidance Center with an evidence-based model are relatively small because it requires such extensive staff training and consultation,” wrote one behavioral health provider in Connecticut. “None of the state grants we receive to implement and sustain evidence-based practices comes close to covering the costs of these practices.⁶⁹

Although much of the funding for mental health services originates at the federal level, federal agencies play only a limited role in encouraging the use of evidence-based care, usually permitting but not mandating specific interventions. For example, Medicaid permits states to request cost-neutral waivers that could be used to create and test integrated systems of care that may encourage the use of evidence-based treatment.⁷⁰ The Substance Abuse and Mental Health Services Administration (SAMHSA) provides modest encouragement for the use of evidence-based services in its grants.⁷¹

65. Kelsie H. Okamura, et al., “The Price per Prospective Consumer of Providing Therapist Training and Consultation in Seven Evidence-Based Treatments within a Large Public Behavioral Health System: An Example Cost-Analysis Metric,” *Frontiers in Public Health*, 2018. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5766669/>.

66. Rebecca E. Stewart, “The Perfect Storm: Collision of the Business of Mental Health and the Implementation of Evidence-Based Practices,” *Psychiatric Services*, 2016. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4790728/>.

67. Christina Andrews, “Lessons from Medicaid’s Divergent Paths on Mental Health and Addiction Services,” *Health Affairs*, 2015. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4831618/#R5> ; Kaiser Commission on Medicaid and the Uninsured, “Mental Health Financing in the United States: A Primer,” 2011. <https://www.kff.org/medicaid/report/mental-health-financing-in-the-united-states/>.

68. Nicole Schmidt Hackbarth, “Financing Integrated Care for Adults with Serious Mental Illness in Community Mental Health Centers,” RAND, 2015. https://www.rand.org/content/dam/rand/pubs/working_papers/WR1000/WR1084/RAND_WR1084.pdf.

69. Eliot Brenner, “The Crisis of Youth Mental Health.” *Stanford Social Innovation Review*, 2019. https://ssir.org/articles/entry/the_crisis_of_youth_mental_health.

70. Genevieve Graaf and Lonnie Snowden, “The Role of Medicaid Home and Community-Based Services Policies in Organizing and Financing Care for Children with Severe Emotional Disturbance.” Elsevier, 2017. <https://rc.library.uta.edu/uta-ir/bitstream/handle/10106/28288/HCBS%20Waiver%20Description.pdf>.

71. Patrick Lester, “Evidence-based Opioids Treatment and Prevention,” *Social Innovation Research Center*, 2018. <http://www.socialinnovationcenter.org/archives/3328>.

However, under the Trump administration, SAMHSA's support for evidence-based prevention and treatment services has shifted away from supporting proprietary evidence-based models and toward more general training in evidence-based practices.⁷²

States have played a somewhat stronger, but varied role.⁷³ The most common form of state support for evidence is training and technical assistance, but the effectiveness of these efforts is unclear.⁷⁴ An analysis of a system-wide training program in Philadelphia, for example, found that it generated only modest improvements in the use of evidence-based practices.⁷⁵ In a recent survey, most state mental health directors rated training programs as less effective than enhanced reimbursement rates and paying for better outcomes.⁷⁶

Some states and local jurisdictions have provided such financial support. For example, Delaware and Louisiana have both designated evidence-based models (such as Multisystemic Therapy or Functional Family Therapy) in their Medicaid reimbursement policies.⁷⁷ Oregon requires 75 percent of its funding for mental health programs to be spent on evidence-based treatments.⁷⁸ Los Angeles County requires community-based providers that receive county prevention funds to choose from a list of approved evidence-based and promising programs.⁷⁹

Although they only reach a small fraction of the eligible population, the nation's largest evidence-based providers have frequently leveraged such initiatives to grow. For example, although early research on Functional Family Therapy (FFT) dates back to the 1970s, it did not begin to grow substantially until the late 1990s when two states, Pennsylvania and Washington, began investing in research-backed programs for justice-involved youth.⁸⁰ (See Box: Scaling Evidence-Based Prevention Programs). The model has since grown to 350 sites in 40 states and ten nations. It serves 50,000 families annually.

72. Ibid.

73. Pew-MacArthur Results First, "4 Ways Implementation Support Centers Assist in the Delivery of Evidence-Based Programs," 2017. <https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2017/07/4-ways-implementation-support-centers-assist-in-the-delivery-of-evidence-based-programs>.

74. Rebecca E. Stewart, "State Adoption of Incentives to Promote Evidence-Based Practices in Behavioral Health Systems," *Psychiatric Services*, 2018. <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201700508>.

75. Rinad Beidas, et al., "A Repeated Cross-sectional Study of Clinicians' Use of Psychotherapy Techniques During 5 years of a System-wide Effort to Implement Evidence-based Practices in Philadelphia," *Implementation Science*, 2019. <https://implementation-science.biomedcentral.com/articles/10.1186/s13012-019-0912-4>.

76. Rebecca E. Stewart, "State Adoption of Incentives to Promote Evidence-Based Practices in Behavioral Health Systems," *Psychiatric Services*, 2018. <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201700508>.

77. Genevieve Graaf and Lonnie Snowden, "The Role of Medicaid Home and Community-Based Services Policies in Organizing and Financing Care for Children with Severe Emotional Disturbance." Elsevier, 2017. <https://rc.library.uta.edu/uta-ir/bitstream/handle/10106/28288/HCBS%20Waiver%20Description.pdf>; Louisiana Healthcare Connections, "LDH to Begin Tracking Evidence-Based Practices," 2019. <https://www.louisianahealthconnect.com/newsroom/2019-20--ldh-to-begin-tracking-evidence-based-practices.html>.

78. Pew-MacArthur Results First, "States Can Set Funding Thresholds That Promote Evidence-Based Programs," 2019. <https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2019/02/states-can-set-funding-thresholds-that-promote-evidence-based-programs>.

79. Sara Dube and Priya Singh, "Los Angeles County Provides Strong Oversight of Mental Health Programs," Pew Charitable Trusts, 2019. <https://www.pewtrusts.org/en/research-and-analysis/articles/2019/06/27/los-angeles-county-provides-strong-oversight-of-mental-health-programs>.

80. EpisCenter, "History of Pennsylvania's EBP Initiative," December 2012. <http://www.episcenter.psu.edu/sites/default/files/resources/History%20of%20EBI%20in%20PA.pdf>; Washington State Institute for Public Policy, "Washington State's Implementation of Functional Family Therapy for Juvenile Offenders: Preliminary Findings," 2002. http://www.wsipp.wa.gov/ReportFile/803/Wsipp_Washington-StatesImplementation-of-Functional-Family-Therapy-for-Juvenile-Offenders-PreliminaryFindings_Full-Report.pdf.

SCALING EVIDENCE-BASED VIOLENCE PREVENTION PROGRAMS:

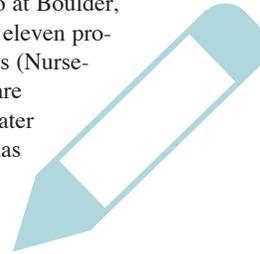
The story of Blueprints for Healthy Youth Development

Cost is a major barrier to scale for most publicly funded programs, but prevention-focused programs may have certain advantages. They may generate budget savings that fully or partially offset initial costs, thereby generating a pathway to scale if the associated budgetary savings are reinvested.

For example, it is estimated that substance use disorders impose hundreds of billions of dollars per year in economic, health, and incarceration costs, some of which could be avoided through more effective prevention and treatment.⁸¹ A recent report from RAND indicated that child maltreatment prevention and kinship care programs like those funded by Family First could produce net taxpayer savings.⁸² Social determinants of spending on health and mental health programs are also receiving increased scrutiny as a way to reduce costs.⁸³

Similar cost savings have helped pave the way for increased spending on evidence-based juvenile violence prevention programs. Starting in the 1970s, a series of reports from the Surgeon General and the Centers for Disease Control and Prevention (CDC) began to portray violence as a public health problem.⁸⁴ In the 1990s, the CDC provided grants for rigorous evaluations of programs that prevented youth violence, including several that used randomized controlled trials. Such studies were later used to demonstrate that funding evidence-based juvenile violence prevention programs could reduce incarceration costs and save money.⁸⁵

In 1996, four organizations – the CDC, Office of Juvenile Justice and Delinquency Prevention (OJJDP) at the U.S. Department of Justice, Colorado Division of Criminal Justice, and Pennsylvania Commission on Crime and Delinquency – collaborated to launch Blueprints for Violence Prevention.⁸⁶ This initiative, housed at the University of Colorado at Boulder, reviewed the literature on youth violence prevention programs and designated eleven programs as models that met its highest evidence standards. Three of these models (Nurse-Family Partnership, Multisystemic Therapy, and Functional Family Therapy) are also rated highly by the Prevention Services Clearinghouse today. Blueprints later received funding from OJJDP to scale up the model programs. The initiative has since rebranded as Blueprints for Healthy Youth Development.



81. Austin Frakt, “Spend a Dollar on Drug Treatment, and Save More on Crime Reduction,” *The New York Times*, April 2017. <https://www.nytimes.com/2017/04/24/upshot/spend-a-dollar-on-drug-treatment-and-save-more-on-crime-reduction.html>.

82. Jeanne Ringel, et al., “Improving Child Welfare Outcomes: Balancing Investments in Prevention and Treatment,” RAND, 2018. https://www.rand.org/pubs/research_reports/RR1775-1.html.

83. Len M. Nichols and Lauren A. Taylor, “Social Determinants as Public Goods: A New Approach to Financing Key Investments in Healthy Communities,” *Health Affairs*, 2018. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0039>; Gail Steketee, et al., “Health Outcomes and Costs of Social Work Services: A Systematic Review,” *American Journal of Public Health*, 2017. <https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2017.304004>; Margarita Alegría, et al., “Social Determinants of Mental Health: Where We Are and Where We Need to Go,” *Current Psychiatry Reports*, 2017. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6181118/>.

84. Linda Dahlberg and James Mercy, “The History of Violence as a Public Health Issue,” Centers for Disease Control and Prevention, 2009. <https://stacks.cdc.gov/view/cdc/24078>; Brittany L. Rhoades, et al., “The Role of a State-Level Prevention Support System in Promoting High-Quality Implementation and Sustainability of Evidence-Based Programs,” *American Journal of Community Psychology*, 2012. <https://www.researchgate.net/publication/221970539>.

85. National Juvenile Justice Network, “Cost-Benefit Analyses for Juvenile Justice: A Guide and Examples,” undated. <http://www.njjn.org/our-work/juvenile-justice-reform-cost-benefit-analyses-a-guide-and-samples>.

86. Sharon Mihalic, “Successful Program Implementation: Lessons from Blueprints,” *Juvenile Justice Bulletin*, 2004. <https://www.ncjrs.gov/pdffiles1/ojjdp/204273.pdf>.

SCALING EVIDENCE-BASED VIOLENCE PREVENTION PROGRAMS:

The story of Blueprints for Healthy Youth Development cont.

Several states have used Blueprints to launch their own programs. Pennsylvania, one of the initiative's founding partners, began funding its model programs in 1998.⁸⁷ In 2008, the state funded the Evidence-based Prevention and Intervention Support Center (EPISCenter) to provide implementation and training support. The Blueprints and Pennsylvania initiatives have spurred similar efforts in other states and helped scale several of the existing evidence-based models that will be funded by Family First.

Parent-Child Interaction Therapy (PCIT), which traces its early development back to the 1970s, began to be adopted in the 1990s in a few states such as California, where it received state funding. It has been scaled most significantly, however, in Pennsylvania. Implementation began in 2009 with pilot programs in Philadelphia and Allegheny County. The program's subsequent scale-up was helped significantly when three of the state's five behavioral health managed care organizations, which oversee Medicaid funded programs, offered enhanced (higher) payments for PCIT services. MCOs have also helped fund training programs. Currently there are PCIT providers practicing in 62 of the state's 67 counties.

Multisystemic Therapy (MST) followed a similar path to scale (see Figure 1). Early research for the model began in the late 1970s at Memphis State University. Its developer, Scott Henggeler, later established a research center at the Medical University of South Carolina and received funding from the state to develop training programs. Two support organizations, MST Services and the MST Institute, were created in 1996 to oversee training and quality assurance with initial programs in Tennessee, California and Louisiana. The following year the program expanded into Washington state, Colorado, New York and Nebraska. Today, MST operates in 34 states and 15 nations.

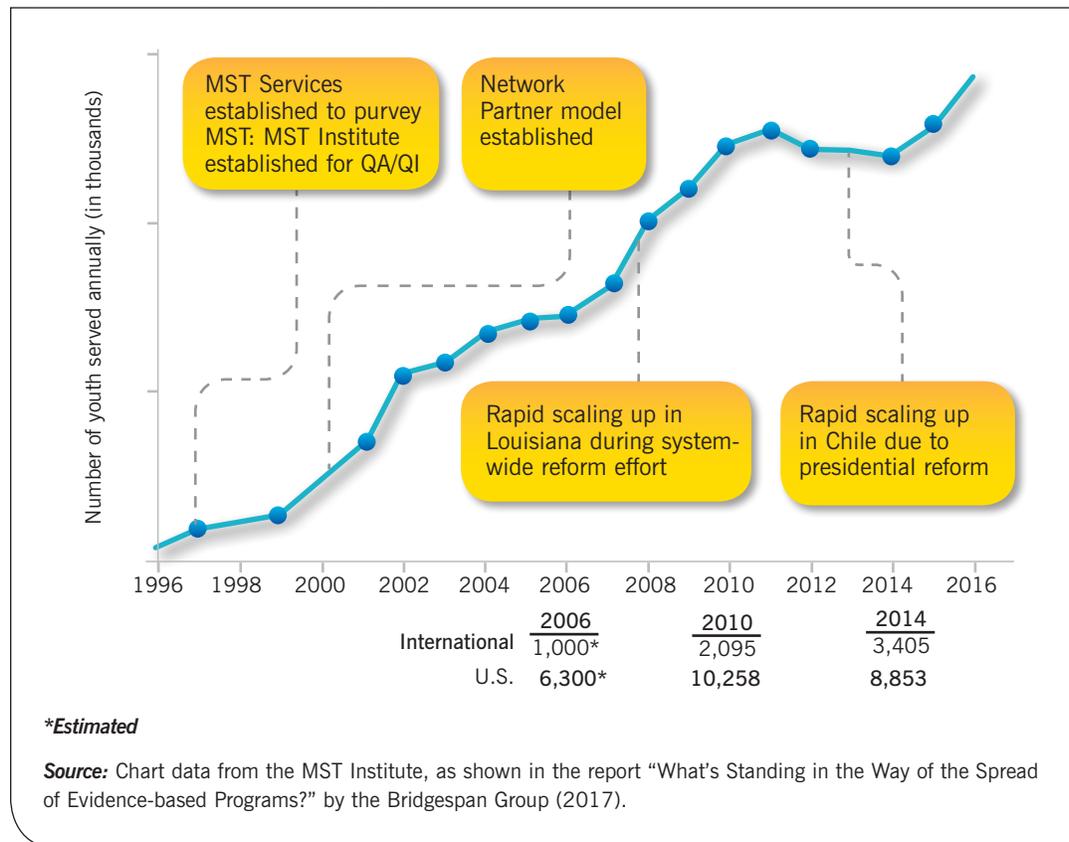
Quality, Innovation, and Improvement

Years of funding from NIMH and the National Institute on Drug Abuse (NIDA) has made mental health one of the better-researched child welfare-related fields. Nevertheless, the need for continued research was highlighted by two major developments over the past five years. In 2015, researchers from the Center for Open Science announced that they were able to successfully replicate the findings of just 39 of 100 peer-reviewed studies that had been published in high-ranking psychology journals.⁸⁸ Reproducibility is a cornerstone of scientific research and evidence-based policy. Unfortunately, replication failures have been an issue in numerous fields in the sciences and social sciences.⁸⁹

87. Liz Campbell and Brian Bumbarger, "Looking Back, Moving Forward: The History & Current State of Evidence-based Intervention in Pennsylvania," Penn State EPISCenter, 2012. <http://www.episcenter.psu.edu/EBIReports/lookingbackmovingforward>.

88. Open Science Collaboration, "Estimating the Reproducibility of Psychological Science." *Science*, August 2015. <https://science.sciencemag.org/content/349/6251/aac4716.full>; Monya Baker, "First Results from Psychology's Largest Reproducibility Test," *Nature*, April 2015. <https://www.nature.com/news/first-results-from-psychology-s-largest-reproducibility-test-1.17433>.

89. Patrick Lester, "Addressing the Research 'Replication Crisis': Evidence-based Policy's Hidden Vulnerability," Social Innovation Research Center, January 2018. <http://www.socialinnovationcenter.org/archives/2906>.

Figure 1: Multi-Systemic Therapy: How It Scaled Over Time

A related development occurred in 2017, when the Trump administration terminated the contract for SAMHSA’s evidence clearinghouse, the National Registry of Evidence-based Programs and Practices (NREPP).⁹⁰ NREPP had been criticized for approving models backed by weak evidence.⁹¹ Many of these criticisms appeared to be due to policy decisions made by SAMHSA in 2015, not any flaws inherent to a well-implemented federally-sponsored clearinghouse.⁹²

SAMHSA later replaced the clearinghouse with a resource center that provides more general information on evidence-based practices. The effectiveness of general treatment guidelines like those included in resource center is unclear, however.⁹³ The Prevention Services Clearinghouse, launched under Family First, is now filling NREPP’s previous evidence review role for child welfare prevention services.⁹⁴

90. Patrick Lester, “Trump Administration Terminates SAMHSA Evidence Clearinghouse Amid Questions About Its Objectivity,” Social Innovation Research Center, January 2018. <http://www.socialinnovationcenter.org/archives/2771>.

91. Dennis M. Gorman, “Has the National Registry of Evidence-based Programs and Practices (NREPP) lost its way?,” *International Journal of Drug Policy*, July 2017. <https://www.sciencedirect.com/science/article/abs/pii/S0955395917301147>.

92. Sharon Green-Hennessy, “Suspension of the National Registry of Evidence-Based Programs and Practices: The Importance of Adhering to the Evidence,” *Substance Abuse Treatment, Prevention, and Policy*, 2018. <https://substanceabusepolicy.biomedcentral.com/articles/10.1186/s13011-018-0162-5>; Jason T. Burkhardt, et al., “An Overview of Evidence-Based Program Registers (EBPRs) for Behavioral Health,” *Evaluation and Program Planning*, February 2015. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4413923/>.

93. Irene Bighelli, et al., “Implementation of Treatment Guidelines for Specialist Mental Health Care,” *Cochrane Database of Systematic Reviews*, 2016. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6463846/>; Substance Abuse and Mental Health Services Administration. Evidence-Based Practices Resource Center. <https://www.samhsa.gov/ebp-resource-center>.

94. Administration for Children and Families, Title IV-E Prevention Services Clearinghouse. <https://preventionservices.abtsites.com/>.

Together, these developments demonstrate the value of continued research to replicate and build on earlier studies. Funding for mental health research comes from a wide range of governmental, philanthropic, and other sources.⁹⁵ Federal support for such research is significant, totally \$1.6 billion in 2019.⁹⁶ However, only a small portion of this funding is devoted to research on child and adolescent interventions.⁹⁷

Practical, replicated, field-based research is one of the strengths of model developers, many of which can point to multiple replications of their earlier studies. For example:

- Multisystemic Therapy has been successfully replicated in at least 26 randomized controlled trials.⁹⁸ Several variations of the core model have also been subjected to successive stages of testing to determine their effectiveness before they were rolled out.⁹⁹
- Parent-Child Interaction Therapy was developed to address disruptive behavior problems among young children by altering parent-child interactions and disciplinary practices, but ongoing research has led to several adaptations, including those intended to reduce child maltreatment.¹⁰⁰ The intervention uses discrete modules that can be included depending on the needs of a particular child. Tailored adaptations have been developed for military families, Native Americans, and Latino families, among others.
- Functional Family Therapy, originally designed for justice-involved youth aged 11-18, has also been adapted for other populations, including children and parents with a documented history of abuse or neglect. The model's child welfare adaptation includes two variants: a low-cost, less intensive version for low-risk clients and a higher cost, more intensive version for those who are higher risk.¹⁰¹ With research funding provided by NIDA, this adaptation was successfully tested in all five boroughs of New York City.¹⁰²

Conclusion

Mental health research has benefitted from substantial and consistent financial support from NIH. Unfortunately, a failure to mandate or even substantially incentivize the use of evidence-based treatment means that few people who need these services receive them. The history of evidence-based mental health treatment demonstrates the importance of federal incentives like those included in Family First.

95. Alexandra Pollitt et al., "Project Ecosystem: Mapping the Global Mental Health Research Funding System," RAND Corporation: Santa Monica, California, 2016. https://www.rand.org/content/dam/rand/pubs/research_reports/RR1200/RR1271/RAND_RR1271.pdf.

96. National Institute of Mental Health, "FY 2020 Budget - Congressional Justification," 2019. <https://www.nimh.nih.gov/about/budget/fy-2020-budget-congressional-justification.shtml>.

97. Kimberly Eaton Hoagwood, et al., "Trends in Children's Mental Health Services Research Funding by the National Institute of Mental Health From 2005 to 2015: A 42% Reduction," *Journal of the American Academy of Child and Adolescent Psychiatry*, 2018. [https://jaacap.org/article/S0890-8567\(17\)31777-X/fulltext](https://jaacap.org/article/S0890-8567(17)31777-X/fulltext).

98. MST Services, "Multisystemic Therapy Research at a Glance 2019." <http://www.mstservices.com/mst-whitepapers>; Gregorio Melendez, "Estimating the Reproducibility of Psychological Science," MST Services, September 3, 2015. <http://info.mstservices.com/blog/reproducibility-of-psychological-science>.

99. MST Services, "Multisystemic Therapy® (MST®) Adaptations: Pilot Studies to Large-Scale Dissemination 2019." <http://www.mstservices.com/mst-whitepapers>.

100. Larissa Niec, *Handbook of Parent-Child Interaction Therapy: Innovations and Applications for Research and Practice*. (New York, NY: Springer Nature); PCIT International, "PCIT Research," undated. <http://www.pcit.org/pcit-research.html>.

101. Function Family Therapy, "FFT Child Welfare (FFT-CW)," undated. <https://www.fftllc.com/fft-child-welfare/>.

102. Charles W. Turner, et al., "Summary of comparison between FFT-CW and Usual Care Sample from Administration for Children's Services," *Child Abuse & Neglect*, 2017. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5541769/>.

Substance Use Disorder: Insufficient Research and Scale



Substance use disorders experienced by parents or youth can contribute to an unsafe home environment and lead to the removal of a child from the home. As is the case with mental health, some evidence-based substance use prevention and treatment interventions have been researched and developed, often with funding from the National Institutes of Health (NIH) or philanthropy.

Like mental health, however, few who need these services receive them. Federal funding for substance use disorder programs, primarily provided through Medicaid or the Substance Abuse and Mental Health Services Administration (SAMHSA), does little to encourage the use of evidence-based interventions. The scaling of these programs has consequently been limited to a few leading states, with low utilization overall.

Background

Substance abuse is a major contributor to child maltreatment and neglect. In 2017, almost a third of child abuse victims were reported with a parent or other caregiver who was misusing drugs or alcohol.¹⁰³ The number of children placed in foster care has been rising since 2012 at least in part because of the growing opioid epidemic.¹⁰⁴

Prevention and treatment are two components of a larger strategy that usually includes prescription drug monitoring, regulation, and law enforcement.¹⁰⁵ For prevention and treatment, public health officials usually recommend a comprehensive continuum-of-care strategy that emphasizes community and school-based education, targeted prevention, early detection and screening, and treatments that are evidence-based.¹⁰⁶

Most of the evidence-based substance abuse interventions addressing the needs of child welfare-involved populations are family-based. Such interventions can provide services to parents and their children and often rely on relationships with siblings and extended family for monitoring and support. Examples of evidence-based interventions include Multisystemic Therapy, Multidimensional Family Therapy, Motivational Interviewing, and Families Facing the Future.¹⁰⁷

Opioid-addicted patients often experience better outcomes with medication-assisted treatment (MAT), which pairs FDA-approved medications with therapy to reduce illicit drug use and co-occurring mental health disorders.¹⁰⁸ Methadone Maintenance Therapy, which must be administered by federally certified and licensed treatment programs, has been rated as promising by the Prevention Services Clearinghouse.¹⁰⁹

103. U.S. Department of Health and Human Services, Administration for Children and Families, "Child Maltreatment 2017," 2019. Retrieved from <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>.

104. ASPE, Substance Use, the Opioid Epidemic and the Child Welfare System: Key Findings from a Mixed Methods Study, March 2018. <https://aspe.hhs.gov/pdf-report/substance-use-opioid-epidemic-and-child-welfare-system-key-findings-mixed-methods-study>.

105. The President's Commission on Combatting Drug Addiction and the Opioid Crisis, "Final Report," November 1, 2017. https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf.

106. Patrick Lester, "Evidence-based Opioids Treatment and Prevention," Social Innovation Research Center, 2018. <http://www.socialinnovationcenter.org/archives/3328>.

107. Each has been rated as supported or well-supported for substance use disorder either by the Prevention Services Clearinghouse or the California Evidence-based Clearinghouse.

108. Pew Charitable Trusts, "Medication-Assisted Treatment Improves Outcomes for Patients with Opioid Use Disorder," p. 5, November 2016. http://www.pewtrusts.org/~media/assets/2016/11/medicationassistedtreatment_v3.pdf; Kenneth Anderson and April Smith, "Seven Countries That Beat an Overdose Crisis," *The Fix*, May 18, 2017. <https://www.thefix.com/seven-countries-beat-overdose-crisis>
Richard P. Mattick, "Methadone Maintenance Therapy Versus No Opioid Replacement Therapy for Opioid Dependence," *Cochrane Database of Systematic Reviews*, July 8, 2009. http://www.oregon.gov/oha/HSD/AMH/docs/Methadone_maintenance_therapy_review.pdf.

109. Title IV-E Prevention Services Clearinghouse, "Methadone Maintenance Therapy." <https://preventionservices.abtsites.com/programs/122/show>.

Other interventions, such as Multidimensional Family Therapy, have protocols for populations that are using prescribed medications such as opioid-related MAT.¹¹⁰

Unfortunately, few adults or youth who need such treatment receive it. Fewer receive services that have been proven to be effective.¹¹¹ A 2016 Surgeon General review of 600 alcohol and drug prevention programs rated only 42 as evidence-based.¹¹² Fewer than half of addiction treatment providers have professional degrees or formal credentials for addiction treatment.¹¹³ While research suggests that patients achieve better outcomes with medication-assisted treatment, most substance abuse treatment facilities do not offer this combination of services.¹¹⁴ Patients commonly suffer from co-occurring mental health disorders, but half of treatment facilities do not provide comprehensive mental health assessments or diagnosis.¹¹⁵

Replication and Scale

As is the case for other evidence-based services, a primary barrier to scale for evidence-based substance use disorder programs is insufficient funding. Federal spending on substance use disorder has increased substantially in recent years, but other than increased support for medication-assisted treatment, little of it has been earmarked for programs that are evidence-based.¹¹⁶

Medicaid is now the largest funder for such programs, but discretion over which interventions are funded is left to the states.¹¹⁷ As noted earlier, SAMHSA has moved away from endorsing specific evidence-based models and has instead focused on issuing guidelines and providing funding for generalized training.¹¹⁸

In most states, decisions about which services are provided are determined in contracts with providers.¹¹⁹ Unfortunately, this process has usually produced low utilization of evidence-based services, but a few states—including South Dakota, New Mexico, Connecticut, New Mexico, and Rhode Island—have provided higher levels of financial support.¹²⁰

For example, Connecticut helped spur the growth of Multidimensional Family Therapy (MDFT), an evidence-based model rated as well-supported by the California Evidence-based Clearinghouse. In the late 1990s, the state began to shift its juvenile mental health funding from expensive residential placements to community mental health centers, which provided a

110. Interview with MDFT representative, October 25, 2019.

111. U.S. Department of Health & Human Services, Office of the Surgeon General, "Facing Addiction in America: The Surgeon General's Spotlight on Opioids," September 2018, p. 8. <https://addiction.surgeongeneral.gov/>.

112. U.S. Department of Health and Human Services, "Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health," 2016, Appendices A and B. <https://addiction.surgeongeneral.gov/table-of-contents>.

113. Christina Andrews, "Lessons from Medicaid's Divergent Paths on Mental Health and Addiction Services," *Health Affairs*, 2015. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4831618/#R5>; Kaiser Commission on Medicaid and the Uninsured, "Mental Health Financing in the United States: A Primer," 2011. <https://www.kff.org/medicaid/report/mental-health-financing-in-the-united-states/>.

114. SAMHSA, "National Survey of Substance Abuse Treatment Services (N-SSATS): 2016," July 2017, pp. 2, 12-13, 39, 41, 67. https://www.samhsa.gov/data/sites/default/files/2016_NSSATS.pdf.

115. *Ibid.*, pp. 20, 47.

116. Bipartisan Policy Center, "Tracking Federal Funding to Combat the Opioid Crisis," March 2019. <https://bipartisanpolicy.org/wp-content/uploads/2019/03/Tracking-Federal-Funding-to-Combat-the-Opioid-Crisis.pdf>.

117. Colleen M. Grogan, et al., "Survey Highlights Differences in Medicaid Coverage for Substance Use Treatment And Opioid Use Disorder Medications," *Health Affairs*, 2017. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5304419/>.

118. Elinore F. McCance-Katz, "The Substance Abuse and Mental Health Services Administration (SAMHSA): New Directions," *Psychiatric Services*, August 2018. <https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201800281>.

119. Traci Rieckmann, et al., "A Longitudinal Study of State Strategies and Policies to Accelerate Evidence-Based Practices in the Context of Systems Transformation," *Health Services Research*, 2015. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4545350/>.

120. Peter Greenwood, "Ranking States in Their Use of Evidence-Based Programs for Juvenile Offenders: A 20-Year Progress Report," *Berkeley Journal of Criminal Law*, 2018. <https://scholarship.law.berkeley.edu/cgi/viewcontent.cgi?article=1136&context=bjcl>.

growth opportunity for several evidence-based interventions.¹²¹ MDFT began operations in the state in 2001, initially with support from a SAMHSA grant and later with state funds. The model later expanded to South Carolina and other locations.

Multisystemic Therapy (MST) also has a strong footprint in Connecticut. According to the state's Department of Children and Families, 77 percent of the youth served by MST from 2007-2013 were drug-free in the last 30 days of the intervention and 98 percent had no new drug-related offenses.¹²² Significant scaling in Connecticut and several other states, including Louisiana, was partly attributable to the Models for Change initiative, a juvenile justice-focused effort supported by the John D. and Catherine T. MacArthur Foundation.¹²³ In 2006, the year the initiative started, there were just four MST teams in Louisiana serving 47 families annually. By 2014, after Medicaid funding became available for MST, there were 40 teams serving over 1,700 families per year.¹²⁴ MST has also experienced significant expansions in New Mexico, North Carolina, Pennsylvania, and Ohio.¹²⁵

Further growth will probably require similar levels of targeted support. Family First could spark significant state expansions. Increased federal and state spending on medication-assisted treatment could also provide opportunities if it is tied to therapies that are evidence-based.¹²⁶ Drug courts, both adult and juvenile, could be another potential source of growth. Following a series of targeted trainings, Louisiana's juvenile drug courts substantially increased their use of research-supported services.¹²⁷

Quality, Innovation, and Improvement

Although existing evidence-based programs are largely underutilized, more research is needed to improve their effectiveness. A 2016 review of the psychosocial interventions most commonly used for opioid addiction treatment indicated that there were significant gaps in the research.¹²⁸ Information is lacking about which combinations of medications and therapy are most appropriate for which populations. Additional research is also needed on prevention, workforce issues, and technology-based solutions such as telehealth.¹²⁹

In 2017, NIH spent approximately \$116 million on opioid-related research, primarily through NIDA.¹³⁰ Most of this research was dedicated to developing or improving medication-based treatments, overdose antidotes, and alternative pain medications. In 2019, NIH announced a

121. Eboni Howard, "Statewide Implementation of Child and Family Evidence-Based Practices: Challenges and Promising Practices," 2012. http://familyinvolvementcenter.org/phocadownloadpap/Articles_and_Research/Evidence-Based_Practice_Brief_Final_03022012.pdf.

122. MST Services, "Multisystemic Therapy (MST) and Teenage Substance Abuse." <http://info.mstservices.com/white-paper/substance-abuse-treatment>.

123. MacArthur Foundation, "Evaluation of the Models for Change Initiative," October 2018. <https://www.macfound.org/press/evaluation/evaluation-models-change-initiative/>.

124. Alex Neuhoff, et al., "What's Standing in the Way of the Spread of Evidence-based Programs?", Bridgespan Group, 2017. <https://www.bridgespan.org/bridgespan/Images/articles/spread-of-evidence-based-programs/spreading-evidence-based-programs.pdf>.

125. MST Services, "State Success Guides." <https://cdn2.hubspot.net/hubfs/295885/MST%20Redesign/Marketing%20Collateral/Guides/State%20Success%20Guides%2006262018.pdf>.

126. Susan K. Urahn, "The Next Step States Need to Take to Combat the Opioid Crisis," *Governing*, June 2019. <https://www.governing.com/columns/smart-mgmt/col-states-opioid-use-disorder-medication-assisted-treatment.html>.

127. Stephen W. Phillippi, Jr., et al., "Advancing Evidence-Based Practices for Juvenile Justice Reform Through Community Development," *Journal of Community Practice*, 2013. https://www.researchgate.net/publication/270831886_Advancing_Evidence-Based_Practices_for_Juvenile_Justice_Reform_Through_Community_Development.

128. Karen Dugosh, et al., "A Systematic Review on the Use of Psychosocial Interventions in Conjunction with Medications for the Treatment of Opioid Addiction," *Journal of Addiction Medicine*, March/April 2016. <https://journals.lww.com/journaladdictionmedicine/Pages/articleviewer.aspx?year=2016&issue=04000&article=00004&type=Fulltext>.

129. Patrick Lester, "Evidence-based Opioids Treatment and Prevention," Social Innovation Research Center, 2018. <http://www.socialinnovationcenter.org/archives/3328>.

130. Elizabeth O'Brien, "Here's What It Would Cost to Fix the Opioid Crisis, According to 5 Experts," *Money*, November 27, 2017. <http://time.com/money/5032445/cost-fix-opioid-crisis/>.

significant expansion of its funding (to \$945 million) for new research on prevention, treatment, pain management, and technology.¹³¹

NIH grants like these have been used to test adaptations and improvements for several existing evidence-based models. For example, Multidimensional Family Therapy (MDFT) has been the subject of eight published randomized clinical trials, and additional research is ongoing.¹³² Two randomized trials are currently underway in Florida for an adaptation focused on parental substance use and child maltreatment. Another recent study compared the effectiveness of MDFT to resident treatment.¹³³ Additional sources of research funding have included SAMHSA, the Administration for Children and Families, the Laura and John Arnold Foundation, and the European Union (for clinical trials in Europe).

MST has also been the subject of extensive research.¹³⁴ This has included replications with new populations varying in race, gender, socioeconomic status, and age. Implementation research has investigated the importance of model fidelity, training programs, and quality assurance systems. Several adaptations of the original model have also been developed, including those focused on child maltreatment and substance abuse. Recent evaluations of the adaptation for substance abusing youth have examined the effects of incorporating contingency management, an evidence-based substance abuse intervention, into the core model.¹³⁵

Conclusion

Like mental health, substance use programs have benefitted from substantial federal investments in research through NIH. Unfortunately, most of this research has been focused on medications and pain management, with little devoted to therapies and other supportive services. There are also few requirements or incentives that encourage the use of these evidence-based treatments.

Like mental health, the history of substance use disorder programs demonstrate that proactive federal support is necessary for evidence-based interventions to be successfully developed and brought to scale.

131. National Institutes on Drug Abuse, "NIDA Announces New NIH HEAL Initiative Awards to Address the Opioid Crisis," September 26, 2019. <https://www.drugabuse.gov/about-nida/horas-blog/2019/09/nida-announces-new-nih-heal-initiative-awards-to-address-opioid-crisis>.

132. Multidimensional Family Therapy, "MDFT Scientific Publications." <http://www.mdft.org/mdft/media/files/Documents/MDFT-Publications.pdf>.

133. Howard Liddle, et al., "Multidimensional Family Therapy as a Community-based Alternative to Residential Treatment for Adolescents with Substance Use and Co-occurring Mental Health Disorders." *Journal of Substance Abuse Treatment*, 2018. [http://www.mdft.org/mdft/media/files/Publications/Liddle-et-al-\(2018\)-MDFT-Alternative-to-Residential-Treatment.pdf](http://www.mdft.org/mdft/media/files/Publications/Liddle-et-al-(2018)-MDFT-Alternative-to-Residential-Treatment.pdf).

134. Scott Henggeler and Cindy Schaeffer, "Multisystemic Therapy: Clinical Overview, Outcomes, and Implementation Research," *Family Process*, 2016. http://www.mstuk.org/sites/default/files/mst/resource-files/Henggeler_et_al-2016-Family_Process.pdf.

135. Kristyn Zajac, "Multisystemic Therapy for Externalizing Youth," *Child and Adolescent Psychiatric Clinics of North America*, 2016. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4475575/>.

The Role of Model Developers



While going to scale is largely the domain of the public sector, scaling evidence-based interventions with quality usually requires additional support—from the domains of academia and nonprofits. Most evidence-based interventions are initially developed and evaluated by academics, but scaling usually requires a separate organization (usually nonprofit) to provide ongoing support for implementation. The academic(s) who initially developed the model usually maintain a relationship with the organization, often as lead researchers, advisors, or CEO.

Most model developers (sometimes referred to as purveyors) offer a baseline set of services, including extensive experience with their model, technical manuals, training, and fidelity monitoring. The best developers often offer additional services, including familiarity with the funding and legal terrain, validated measurement tools, large networks that are using the same model, professional certifications, organizational accreditation, data systems, specialized consulting, ongoing model research, and support for continuous quality improvement (CQI).

Most funding for implementation comes from governmental sources, including grants and contracts to frontline nonprofit service providers. The expenses of model developers are commonly covered by a combination of fees charged to organizations that implement the models and/or through public or private grants made directly to the model developers.¹³⁶

By leveraging economies of scale that come from large networks, model developers are often able to offset capacity constraints among partner organizations that would otherwise hinder successful implementation. Some of the most common activities and services provided by model developers include the following:

Marketing: Scaling evidence-based interventions is partly an exercise in marketing. For most health and social services interventions, the demand side of this market can be traced to the public sector, where funding and regulatory decisions are made.¹³⁷ However, nonprofit providers, who frequently receive grants and contracts to implement these services, are a common additional focus of these marketing efforts.¹³⁸

Broadly defined, marketing can include relatively passive dissemination activities such as publishing journal articles, making conference presentations, and conducting public education efforts.¹³⁹ Marketing can also include more active diffusion activities, which can include in-person meetings and negotiations with prospective partner organizations.¹⁴⁰ Surprisingly few developers are this proactive, however. A 2017 review of model developers in child welfare and juvenile justice found that just under half (46 percent) actively recruited new sites.¹⁴¹ Most of the significant scaling for these developers, when it occurred, was attributable to external demand, including foundation and government investments and related public policies changes.

136. Enola Proctor, et al., "Intermediary/purveyor Organizations for Evidence-based Interventions in the US Child Mental Health: Characteristics and Implementation Strategies," *Implementation Science*, 2019. <https://implementationscience.biomedcentral.com/articles/10.1186/s13012-018-0845-3>.

137. Abigail A. Fagan, et al., "Scaling up Evidence-Based Interventions in US Public Systems to Prevent Behavioral Health Problems: Challenges and Opportunities," *Prevention Science*, 2019. <https://link.springer.com/article/10.1007/s11221-019-01048-8>.

138. Patrick Lester, "Using Evidence in Child Welfare," Social Innovation Research Center, 2017. <http://socialinnovationcenter.org/wp-content/uploads/2017/02/Using-Evidence-in-Child-Welfare.pdf>.

139. Jane Macoubrie and Courtney Harrison, "Human Services Research Dissemination: What Works?," OPRE, 2013. <https://www.acf.hhs.gov/sites/default/files/opre/litreview.pdf>.

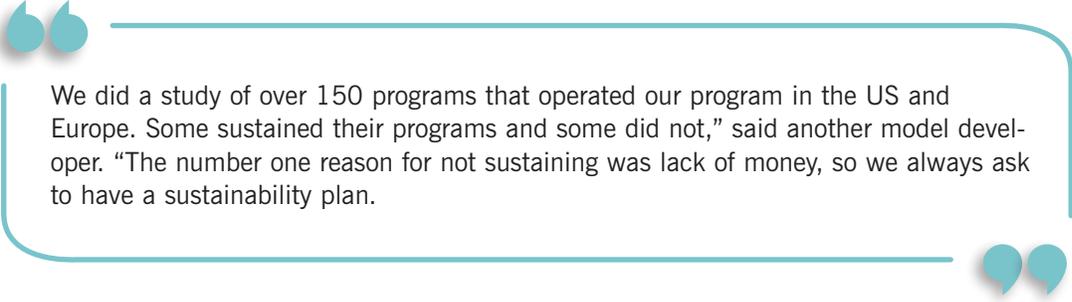
140. Patrick Lester, "Investing in Innovation (i3): Strong Start on Evaluating and Scaling Effective Programs, But Greater Focus Needed on Innovation," Social Innovation Research Center, 2017. pp. 46-48. <http://www.socialinnovationcenter.org/archives/2482>.

141. Alex Neuhoff, et al., "What's Standing in the Way of the Spread of Evidence-based Programs?," Bridgespan Group, 2017. <https://www.bridgespan.org/bridgespan/Images/articles/spread-of-evidence-based-programs/spreading-evidence-based-programs.pdf>.

For example, Parent-Child Interaction Therapy's rapid growth in Pennsylvania demonstrates the impact of a more proactive approach to marketing that balances supply and demand. Its scale up in the state was partly attributable to a growing network of state and local trainers who acted as champions and advocates for the model. Commonly used marketing strategies included word-of-mouth endorsements, the development of marketing materials, and attending community events.¹⁴² The network's growth was also largely due to demand-side changes in payment rules instituted by the state's largest managed care organizations.

Planning: After a new intervention has been selected, sites often go through an initial planning phase that can take several months.¹⁴³ Common activities during this period can include budgeting, establishing internal organizational policies (such as purchasing, billing, staff caseloads, safety, communication, and staff remuneration), and stakeholder engagement to ensure buy-in. Sometimes sites will start slowly, piloting an initiative before rolling it out more broadly.

For example, Functional Family Therapy has developed an application process to ensure that its model is a good fit for prospective sites. After a new site has been approved, a planning, readiness, and training process is implemented to move it toward self-sufficiency. Sustainability is a key focus of early planning efforts, including ensuring that sufficient reimbursement rates and referral processes are in place.



We did a study of over 150 programs that operated our program in the US and Europe. Some sustained their programs and some did not," said another model developer. "The number one reason for not sustaining was lack of money, so we always ask to have a sustainability plan.

Site Launch: After the planning stage, the next step is to make the intervention operational. This includes hiring staff with appropriate academic backgrounds, experience, certifications and licensing. Other activities include procuring tangible assets like equipment, practice manuals, appropriate workspace, and data systems. Private philanthropy and government grants can often cover these one-time startup costs.

Fidelity: Fidelity is the degree to which an evidence-based program or practice is being implemented in a manner that is consistent with the model's core components. Core components are those aspects of an intervention must be included for it to work as intended. They are usually described in treatment manuals, toolkits, or other guidelines published by the model developer. They can include critical practice elements, dose and duration of the program, personnel qualifications, training, equipment, and other materials.

142. Ashley T. Scudder, et al., "A Mixed-methods Study of System-level Sustainability of Evidence-based Practices in 12 Large-scale Implementation Initiatives," *Health Research Policy and Systems*, 2017. <https://health-policy-systems.biomedcentral.com/articles/10.1186/s12961-017-0230-8>.

143. Lawrence A. Palinkas, et al., "Agency Leaders' Assessments of Feasibility and Desirability of Implementation of Evidence-Based Practices in Youth-Serving Organizations Using the Stages of Implementation Completion," *Frontiers in Public Health*, 2018. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5987031/>.

In most cases, perfect fidelity is not necessary. There are often tradeoffs between fidelity and adaptations that may be necessary to tailor a model to local conditions.¹⁴⁴ This balance is often achieved with guidance from the developer and it is commonly implemented in a way that preserves adherence to the model's core components.

Apart from developer-approved adaptations, failure to implement an evidence-based intervention with fidelity can undermine its effectiveness. Insufficient fidelity is a reason why many scale-up efforts for evidence-based interventions fail to achieve expected results. For example, a study of the implementation of Functional Family Therapy in Washington state found that it more effectively reduced recidivism for juvenile offenders when it was administered with fidelity.¹⁴⁵ Increased therapist adherence has also been linked to improved youth outcomes in Multisystemic Therapy.¹⁴⁶

Fidelity can falter for a variety of reasons. One is insufficient funding to cover all the necessary components. Fidelity can also slip if there is insufficient buy-in among staff.¹⁴⁷ It may also decline over time if there is insufficient training, monitoring, or other support.

High-capacity model developers often have research-validated metrics and tools for tracking fidelity. Such measures may specify staff caseloads, frequency of staff interaction, treatment dosage, task checklists, assessments of treatment quality (including through third-party observations), and staff education, training, and certifications.¹⁴⁸ This information is frequently incorporated into organizational data systems, which site managers and model developers can use to monitor performance.

Personnel/Workforce: In most cases, personnel issues remain important beyond the launch phase, when most initial hiring and training occurs. Annual turnover for social services agencies in child welfare and behavioral health organizations often ranges from 20-40 percent.¹⁴⁹ Major contributors to personnel turnover can include low pay, high stress, and difficult working conditions.

144. Gregory Aarons, et al., "Dynamic Adaptation Process to Implement an Evidence-based Child Maltreatment Intervention," *Implementation Science*, 2012. <https://implementationscience.biomedcentral.com/articles/10.1186/1748-5908-7-32>; Dennis Pérez, et al., "A Modified Theoretical Framework to Assess Implementation Fidelity of Adaptive Public Health Interventions," *Implementation Science*, 2016. <https://implementationscience.biomedcentral.com/articles/10.1186/s13012-016-0457-8>.

145. Robert Barnoski, "Washington State's Implementation of Functional Family Therapy for Juvenile Offenders. Preliminary findings," Washington State Institute for Public Policy, 2002. http://www.wsipp.wa.gov/ReportFile/803/Wsipp_Washington-StatesImplementation-of-Functional-Family-Therapy-for-Juvenile-Offenders-PreliminaryFindings_Full-Report.pdf.

146. Scott Henggeler, et al., "Multisystemic Therapy with Violent and Chronic Juvenile Offenders and Their Families: The Role of Treatment Fidelity in Successful Dissemination," *Journal of Consulting and Clinical Psychology*, 1997. <https://psycnet.apa.org/doiLanding?doi=10.1037%2F0022-006X.65.5.821>.

147. Traci Rieckmann, et al., "Legislating Clinical Practice: Counselor Responses to an Evidence-Based Practice Mandate," *Journal of Psychoactive Drugs*, 2013. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3721513/>.

148. Mathematica Policy Research, Chapin Hall, "Making Replication Work: Building Infrastructure to Implement, Scale-up, and Sustain Evidence-Based Early Childhood Home Visiting Programs with Fidelity," U.S. Department of Health and Human Services, 2014, pp. 25-76. https://www.chapinhall.org/wp-content/uploads/EBHV_MakingReplication_Final-1.pdf; Justice Research and Statistics Association, "Implementing Evidence-based Practices", December 2014. pp. 11-15. https://ncwwi.org/files/Evidence_Based_and_Trauma-Informed_Practice/Implementing_Evidence-based_Practices.pdf. Sarah Bearman, et al., "From Practice to Evidence in Child Welfare: Model Specification and Fidelity Measurement of Team Decisionmaking," *Children and Youth Services Review*. 2014. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4205920/>.

149. Casey Family Programs, "How Does Turnover Affect Outcomes and What Can Be Done to Address Retention?", 2017. <https://www.casey.org/turnover-costs-and-retention-strategies/>.



It's a really, really difficult job," said one state child welfare administrator in an interview. "I would say that individuals investigating abuse and neglect might have the hardest job in state government. Every single day they're going out, they're investigating situations—could be abuse, could be neglect, could be a family that needs certain services—some really, really tough situations.¹⁵⁰



Workforce challenges can undermine the implementation of evidence-base interventions, which often have stringent requirements for professional credentials and manageable caseloads.¹⁵¹ Staff turnover results in lost expertise and necessitates continuous training, which increases costs. In some settings, particularly rural areas, recruiting enough qualified staff can be an insurmountable barrier to scale.

Hiring staff who are sufficiently committed to implementing an intervention with fidelity can also be a challenge. "We don't get crazy about fidelity," one agency leader told interviewers for a study in Philadelphia.¹⁵² "I try to teach these rigid protocols to my therapists and they say, 'This won't fly with my guys.'"

Model developers can specify personnel qualifications, but usually they have limited control over hiring decisions by their local partner organizations. In some cases, however, they may contract directly with a state or local jurisdiction to provide services.

For example, the Parents as Teachers National Center is the nonprofit grantee for Wyoming's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. It subcontracts with two local agencies to deliver services to 200 families in six counties. The national office also operates an affiliate in St. Louis. "This really provides us an opportunity to 'walk the walk' and to live out what we ask our affiliate organizations to do with families. It has been an incredible learning laboratory opportunity," said Allison Kemner, Vice President of Research and Quality Improvement.¹⁵³

Training: Most evidence-based interventions require staff to be trained to implement them effectively. Insufficient training can undermine performance. A 2017 Substance Abuse and Mental Health Services Administration (SAMHSA) survey of state substance abuse and mental health agencies found that 96 percent cited insufficient provider readiness as a barrier to implementing evidence-based practices in their states.¹⁵⁴ Without sufficient training that is coupled with quality assurance, monitoring, and ongoing support, many staff may fail implement an intervention with fidelity.¹⁵⁵

150. MST Services, "Shortage of Child Welfare Workers Straining the System," August 2019. <http://info.mstservices.com/blog/shortage-child-welfare-workers>.

151. James Bell and Heidi Melz, "Findings and Implications for Evidence Building from a Cross-Site Implementation Study," January 2018. <https://sswr.confex.com/sswr/2018/webprogram/Paper31818.html>.

152. Rebecca E. Stewart, "Non-participants in Policy Efforts to Promote Evidence-based Practices in a Large Behavioral Health System," *Implementation Science*, 2017. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5445384/>.

153. Interview, October 22, 2019.

154. SAMHSA, "Funding and Characteristics of SSAs and SMHAs, 2015." 2017, pp. 65-69 <https://store.samhsa.gov/system/files/sma17-5029.pdf>.

155. Rinad Beidas and Philip C. Kendall, "Training Therapists in Evidence-Based Practice: A Critical Review of Studies from a Systems-Contextual Perspective," *Clinical Psychology*, 2010. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2945375/>.

Most model developers offer such training.¹⁵⁶ Training can be provided onsite where the evidence-based intervention is delivered, offsite at a training facility, or online.¹⁵⁷ Sometimes it is supplemented with on-the-job coaching that pairs new staff with consultants or more experienced staff that can act as mentors. Research suggests that active training that includes supervision and feedback is usually more effective than traditional training methods that couple workshops with written materials.¹⁵⁸ Many developers also offer individual and organization-wide certifications.

Technology: Technology can sometimes be used to increase the effectiveness or efficiency of an evidence-based intervention. Possible uses can include integration into case management, service delivery, and training. It can also be used to monitor fidelity, outcomes, and performance gaps.¹⁵⁹

Model developers often incorporate technology as a core component of their models. Some evidence-based family-based therapy programs have used technology to reduce training costs, improve fidelity and service delivery, and overcome transportation and scheduling barriers that impede family engagement.¹⁶⁰ For example, Parent-Child Interaction Therapy has tested a variety of technology-based enhancements, including the use of video conferencing to connect frontline therapists to trainers who can directly observe parent-child interactions and offer real-time consultation and feedback. Such technology-based solutions have been tested in randomized trials to confirm their effectiveness compared to clinic-based care.¹⁶¹

Telehealth is also drawing increased attention among home visiting programs, where it is viewed as an alternative when geographic or scheduling barriers prevent an in-person visit. About half of the counties served in the MIECHV program are rural, which can pose accessibility challenges. Telehealth is also an option when families move out of a program's normal service area. Parents as Teachers and the Nurse-Family Partnership have both tested telehealth-based visits to determine their effectiveness.¹⁶²

156. Alex Neuhoff, et al., "What's Standing in the Way of the Spread of Evidence-based Programs?", Bridgespan Group, 2017. <https://www.bridgespan.org/bridgespan/Images/articles/spread-of-evidence-based-programs/spreading-evidence-based-programs.pdf>.

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159. Michael Corrigan, "Building CCWIS is as Easy as 1, 2, 3," *Chronicle of Social Change*, 2019. <https://chronicleofsocialchange.org/child-welfare-2/building-comprehensive-child-welfare-information-system/33426>; Paul Lanier, "Preventing Infant Maltreatment with Predictive Analytics: Applying Ethical Principles to Evidence-Based Child Welfare Policy," *Journal of Family Violence*, 2019. http://www.caichildlaw.org/Misc/Lanier_et_al-2019-Journal_of_Family_Violence.pdf.

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161. J. S. Comer, et al., "Remotely Delivering Real-time Parent Training to the Home: An Initial Randomized Trial of Internet-delivered Parent-Child Interaction Therapy (I-PCIT)," *Journal of Consulting and Clinical Psychology*, 2017. <https://www.ncbi.nlm.nih.gov/pubmed/28650194>.

162. National Home Visiting Resource Center, "Technology in Home Visiting: Strengthening Service Delivery and Professional Development Using Virtual Tools," 2017. https://www.nhvr.org/wp-content/uploads/NHVR-Brief-1108_FINAL.pdf; Dorian E. Traube, et al., "Advancing Home Based Parenting Programs through the Use of Telehealth Technology," *Journal of Child and Family Studies*, 2019. <https://doi.org/10.1007/s10826-019-01458-w>; David Olds, et al., "Cluster Randomized Controlled Trial of Intervention to Increase Participant Retention and Completed Home Visits in the Nurse-Family Partnership," *Prevention Science*, 2015. <https://www.ncbi.nlm.nih.gov/pubmed/25999201>.

Conclusions and Recommendations



Although there are many potential contributors to the success or failure of any scaling effort, two factors stand out for evidence-based programs.

First, successful scaling of such interventions appears to require active and targeted support from government agencies. They—and usually only they—have the financial resources and legal authority necessary to scale public programs significantly. This is true in social services, education, and even healthcare, where the actions of private entities like managed care organizations are substantially governed by public regulatory authorities. Surprisingly, the influence and comparative effectiveness of various public policy strategies has received insufficient attention in much of the academic research on implementation. More rigorous research is needed on the specific array of policy choices that will help scale evidence-based interventions successfully.

Second, while public policy decisions may be the critical drivers of scale, the key ingredient to *effective* scaling appears to be a supportive infrastructure that assures quality and fidelity to core components. Some states have met these needs with publicly supported training institutes, but well-resourced model developers are another critical resource that has received too little attention.

Lacking more systematic research on these subjects, policymakers and practitioners must instead turn to recent history and practical experience. Overall, the scaling of these prevention programs prior to Family First has been modest, but there have been enough success stories and lessons learned to inform the implementation of this new law. As states and federal officials continue their efforts to scale evidence-based programs under the program, they should consider the following recommendations.



Recommendation One: States and local jurisdictions should provide appropriate, targeted funding for eligible evidence-based services. The primary barriers to scale for most evidence-based interventions are increased costs compared to standard (often ineffective) care and insufficient funding to cover those costs. The importance of targeted funding can be seen in the differing levels of scale experienced by evidence-based home visiting programs (where targeted support has been provided) compared to mental health and substance abuse programs, where there has been less targeted funding and proportionately fewer children and families who receive these services.

By incorporating evidence requirements into a major federal entitlement, Title IV-E of the Social Security Act, Family First represents a significant departure from past federal policy that has usually left such decisions to the states. Family First nevertheless leaves states with substantial discretion, particularly over funding decisions. States should fully use this opportunity to invest in evidence-based prevention services.



Recommendation Two: States and local jurisdictions should proactively plan to cover the full cost of quality implementation. Evidence-based interventions often entail activities that improve their effectiveness but can be costly – including extensive training, consulting, continuous quality improvement (CQI) activities, data systems, performance management, and more. States and local jurisdictions will need to think creatively about ways to subsidize or cover these costs. Failure to do so may undermine the effectiveness of these services.

Some states and Medicaid managed care organizations have addressed this issue through enhanced reimbursement rates for evidence-based interventions. Some have created centralized training centers. Some have subsidized other provider costs, such as data systems or fidelity monitoring. Many states and model developers have

been creative about seeking multiple sources of funding for different aspects of the interventions, in some cases braiding different funding streams to pay for the full cost of services. As states develop their five-year prevention plans under Family First and submit them to HHS for review, they should include details describing how they will address the full cost of quality implementation.



Recommendation Three: States and local jurisdictions should consider using performance-based contracts, value-based payments, evidence mandates, and pay-for-success funding. Some states such as Oregon have already adopted evidence mandates. Performance-based contracts or similar incentive-based payments are relatively common in child welfare.¹⁶³ Value-based payments, a related concept, are becoming increasingly common in Medicaid. Such tools may help grow interventions that are more effective. As these policies are developed, however, care must be taken to avoid cream-skimming and other pitfalls that have commonly confronted similar efforts in the past.¹⁶⁴



Recommendation Four: States should adopt evidence-informed budgeting, cost-benefit evaluations, and outcomes monitoring to scale effective programs. Because federal, state, and local revenues are finite, greater investments in evidence-based programs may require reallocating existing resources from other less effective services and/or rely on studies that demonstrate cost savings for prevention-based services. Some states have adopted budgetary and other policy innovations that should serve as models for other states. Examples include evidence-informed budgeting (Minnesota and Colorado), cost-benefit research (Washington), and outcomes monitoring (New Mexico).



Recommendation Five: States and federal agencies should help expand the child welfare evidence base. Each of the three categories of evidence-based prevention programs covered by Family First already has interventions that will qualify for funding under the law. This is not an accident. All three have drawn substantial research investments from federal agencies and programs like NIMH, NIDA, and MIECHV.

Unfortunately, similar resources are not available for other child welfare-related programs. A recent analysis by the California Evidence-based Clearinghouse identified several categories of services where there were few—or no—interventions backed by rigorous research.¹⁶⁵ Examples include child welfare workforce development, commercial sexual exploitation prevention, and anger management for adults, among others.

The Office of Planning, Research & Evaluation (OPRE) at ACF provides some support for evidence building, but it is limited. For example, OPRE cohosted a conference on evaluation with ACF's Children's Bureau in 2019.¹⁶⁶ It has also provided funding for evaluation assistance from the Urban Institute, Child Trends, and Chapin Hall.¹⁶⁷ More support for evidence building is needed.

163. Patrick Lester, "Building Performance Systems for Social Service Programs," IBM Center for the Business of Government, 2016. <http://www.businessofgovernment.org/sites/default/files/Building%20Performance%20Systems%20for%20Social%20Service%20Programs.pdf>.

164. Ibid.

165. California Evidence-based Clearinghouse, "The State of the Evidence for Intervention and Prevention Programs for Child Welfare-Involved Populations," May 2019. <https://www.cebc4cw.org/files/CEBCStateOfEvidenceResource.pdf>.

166. Children's Bureau, "Building Capacity to Improve Program Evaluation in Child Welfare," accessed October 31, 2019. <https://www.acf.hhs.gov/cb/capacity/program-evaluation>.

167. OPRE, "Supporting Evidence Building in Child Welfare, 2016-2021: Project Overview," accessed October 31, 2019. <https://www.acf.hhs.gov/opre/research/project/supporting-evidence-building-in-child-welfare>.

Given limited federal resources, states may need to play a more active role. States are currently required to develop evaluation plans for some evidence-based services funded by the law. The Children’s Bureau has released guidance confirming that matching funds will be available for this work. States should aggressively use this authority to fund new research, partnering with in-state researchers (many of whom worked previously on child welfare waiver evaluations) and collaborating with other states to pool resources and conduct cross-site evaluations.¹⁶⁸ States may also wish to explore Medicaid waivers as another evaluation option.¹⁶⁹

The Family First Prevention Services Act is an important first step toward scaling evidence-based interventions in child welfare. If states implement it fully and successfully, it could help transform existing systems and make the goals of permanence, safety, and well-being a reality for the children and families they serve.

BROADER LESSONS FOR EVIDENCE-BASED POLICY

Most of the recommendations in this report apply specifically to Family First, but there are also broader lessons that are applicable to evidence-based policy in general. These include:

The Need for Dedicated Federal Research Funding: Each of the three primary categories of prevention services covered by Family First has a history of substantial federal investment in research. As a result, the existing evidence base is much stronger for these issues than for other child welfare-related services. These investments in research matter. Family First is similar to other traditional tiered evidence initiatives, but a major missing element is dedicated federal funding and support for new research.

Federal and State Support for Scale: The mental health and substance abuse fields amply demonstrate that federal investments in research are not enough to ensure that evidence-based interventions will be used. A major barrier is increased cost. Scaling evidence-based interventions will probably not occur without evidence mandates and other incentives that proactively bring them to scale.

Implementation Quality: Bringing an evidence-based intervention to scale is not enough by itself to ensure that population-level improvements in targeted outcomes will occur. Quality implementation matters. In some cases, states and federal agencies have provided targeted technical assistance for implementation, but model developers also play a critical (and often overlooked) role in ensuring implementation quality.

168. Amy McClinton, “Applying the Research and Evaluation Provisions of the Family First Prevention Services Act,” Child Trends, October 2019. <https://www.childtrends.org/publications/applying-the-research-and-evaluation-provisions-of-the-family-first-prevention-services-act>.

169. Elizabeth Hinton, “Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending Waivers,” Kaiser Family Foundation, February 2019. <https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-demonstration-waivers-the-current-landscape-of-approved-and-pending-waivers/>.

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