

On February 9, 2018, the Family First Prevention Services Act (FFPSA) was signed into law, as part of Division E in the Bipartisan Budget Act of 2018 (H.R. 1892). This multifaceted act prioritizes keeping children and youth safely with their families and out of foster care, while also ensuring children and youth are placed in the least restrictive, most family-like setting when out-of-home care is necessary to meet their needs. FFPSA also allows states to access federal funds under Title IV-E of the Social Security Act to provide evidence-based programs for 1) mental health and substance abuse prevention and treatment services and 2) in-home parent skill-based services. The services may be provided for up to 12 months for two different populations: 1) children and adolescents who are at imminent risk of entering foster care, along with their parents and kin caregivers, and 2) foster youth who are pregnant or parenting a child of their own along with their parents and kin caregivers.

How is the CEBC involved in FFPSA?

The CEBC is not directly involved in FFPSA. However, the FFPSA used the [CEBC Scientific Rating Scale](#) as the basis for the Evidence Standards that practices will need to meet to be funded using FFPSA dollars. In some places, the CEBC language has been used verbatim, while in other areas, fundamental changes have been made to the criteria. A direct comparison of the CEBC and FFPSA criteria are provided in the table on the next page, with the differences shown in **bold** text.

Does this mean a practice needs to be listed on the CEBC to be funded under FFPSA?

NO. The FFPSA criteria are different from the CEBC Scientific Rating scale in several key areas. The federal government will be releasing more clarification of the FFPSA criteria later this year, but in the meantime, it is clear that being rated by or included on the CEBC will **NOT** be a requirement for FFPSA funding. While it is likely that programs rated a 1, 2, or 3 by the CEBC in the relevant topic areas would meet the FFPSA criteria, until the fully operationalized FFPSA criteria have been released, this is not a certainty.

How do the differences between the criteria affect what programs will meet FFPSA criteria?

It appears that the FFPSA criteria will be more inclusive, as published, peer-reviewed studies are not a requirement under FFPSA. In addition, the FFPSA criteria allow for rigorous quasi-experimental studies at the highest levels, in place of the randomized controlled trials required by the CEBC. However, until the fully operationalized FFPSA criteria have been released later this year, it is not possible to determine the exact impact on program inclusion.

What resources does the CEBC have to support service delivery under the FFPSA?

Although the FFPSA rating standards are still being finalized, you can learn more about available evidence-based practices in the many CEBC topic areas that are relevant to the areas identified for funding under the FFPSA, including:

- [Anxiety Treatment \(Child & Adolescent\)](#)
- [Attachment Interventions \(Child & Adolescent\)](#)
- [Bipolar Disorder Treatment \(Child & Adolescent\)](#)
- [Depression Treatment \(Adult\)](#)
- [Depression Treatment \(Child & Adolescent\)](#)
- [Disruptive Behavior Treatment \(Child & Adolescent\)](#)
- [Home Visiting Programs for Child Well-Being](#)
- [Home Visiting Programs for Prevention of Child Abuse & Neglect](#)
- [Infant and Toddler Mental Health Programs \(0-3\)](#)
- [Parent Training Programs](#)
- [Resource Parent Programs](#)
- [Sexual Behavior Problems Treatment \(Adolescents\)](#)
- [Sexual Behavior Problems Treatment \(Children\)](#)
- [Substance Abuse Treatment \(Adolescent\)](#)
- [Substance Abuse Treatment \(Adult\)](#)
- [Trauma Treatment \(Adult\)](#)
- [Trauma Treatment \(Child & Adolescent\)](#)

Study Designs Descriptions

Randomized Controlled Trial

Participants are randomly assigned to receive either an intervention or control treatment. This allows the effect of the intervention to be studied in groups of people who are the same at the outset and treated the same way, except for the intervention being studied. Any differences seen in the groups at the end can be attributed to the difference in treatment alone, and not to bias or chance.

Quasi-Experimental Study

Participants are **not** randomly assigned, which may result in the groups being different at the outset and introducing bias and chance, limiting the ability to attribute any differences at the end to the treatment.

CEBC Criteria*	Criteria Comparison	FFPSA Criteria*
REQUIREMENTS FOR ALL PRACTICES		
The practice has a book, manual, and/or other available writings that specify the components of the practice protocol and describe how to administer it.	Same/very similar	The practice has a book, manual, or other available writings that specify the components of the practice protocol and describe how to administer the practice.
There is no legal or empirical basis suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.	Same/very similar	There is no empirical basis suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.
If multiple outcome studies have been published , the overall weight of evidence supports the benefit of the practice.	Same/very similar	If multiple outcome studies have been conducted, the overall weight of evidence supports the benefits of the practice.
Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects.	Same/very similar	Outcome measures are reliable and valid, and are administered consistently and accurately across all those receiving the practice.
There is no case data suggesting a risk of harm that: a) was probably caused by the treatment and b) the harm was severe or frequent.	Same/very similar	There is no case data suggesting a risk of harm that was probably caused by the treatment and that was severe or frequent.
The study has been reported in published, peer-reviewed literature.	Different – CEBC requires published and peer-reviewed vs. FFPSA independent systematic review (which is not defined)	The study was rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed.
PROMISING RESEARCH EVIDENCE (CEBC Scientific Rating of 3)		
<ul style="list-style-type: none"> • Practice meets the “All Practices” criteria above • At least one study utilizing some form of control (e.g., untreated group, placebo group, matched wait list study) has established the practice's benefit over the control, or found it to be comparable to a practice rated a 1, 2, or 3 on this rating scale or superior to an appropriate comparison practice. 	<p>Different - CEBC allows for comparable outcomes when comparison group is a practice rated a 1, 2, or 3 on the CEBC</p> <p>Unclear - FFPSA states superiority to an appropriate comparison practice is required, but also that the control group can be an untreated or waitlist group</p>	<p>PROMISING PRACTICE</p> <ul style="list-style-type: none"> • Practice meets the “All Practices” criteria above • The practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least one study utilizing some form of control (such as an untreated group, a placebo group, or a wait list study).
SUPPORTED BY RESEARCH EVIDENCE (CEBC Scientific Rating of 2)		
<ul style="list-style-type: none"> • Practice meets the “All Practices” criteria above 		<p>SUPPORTED PRACTICE</p> <ul style="list-style-type: none"> • Practice meets the “All Practices” criteria above

<ul style="list-style-type: none"> • At least one rigorous randomized controlled trial (RCT) in usual care or practice setting has found the practice to be superior to an appropriate comparison practice. • In that same RCT, the practice has shown to have a sustained effect of at least six months beyond the end of treatment, when compared to a control group. 	<p>Different - FFPSA allows for rigorous quasi-experimental study (which is not defined) in place of an RCT</p>	<ul style="list-style-type: none"> • The practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least one rigorous random-controlled trial (or, if not available, a study using a rigorous quasi-experimental research design) carried out in a usual care or practice setting; • The RCT/quasi-experimental study established that the practice has a sustained effect (when compared to a control group) for at least 6 months beyond the end of the treatment.
<p>WELL-SUPPORTED BY RESEARCH EVIDENCE (CEBC Scientific Rating of 1)</p> <ul style="list-style-type: none"> • Practice meets the “All Practices” criteria above • At least two rigorous randomized controlled trials (RCTs) in different usual care or practice settings have found the practice to be superior to an appropriate comparison practice. • In at least one of these RCTs, the practice has shown to have a sustained effect at least one year beyond the end of treatment, when compared to a control group. 	<p>Different – FFPSA allows for rigorous quasi-experimental study (which is not defined) in place of an RCT</p>	<p>WELL-SUPPORTED PRACTICE</p> <ul style="list-style-type: none"> • Practice meets the “All Practices” criteria above • The practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least two rigorous random-controlled trials (or, if not available, studies using a rigorous quasi-experimental research design) carried out in a usual care or practice setting • At least one of the RCT / quasi-experimental studies established that the practice has a sustained effect (when compared to a control group) for at least 1 year beyond the end of the treatment.

* Substantial differences are shown in **bold** text

The CEBC is operated by Rady Children’s Hospital-San Diego (RCHSD): Chadwick Center for Children & Families. The CEBC is made possible with funding from the California Department of Social Services (CDSS): Office of Child Abuse Prevention. Any opinions, findings, conclusions and/or recommendations expressed are those of RCHSD and do not necessarily reflect the views of the CDSS.