Financing Evidence-Based Prevention Programs START, Intercept, and Family Centered Treatment

August 2026

Meet Your Presenters

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Program Director
Child and Family Futures

START™
Sobriety Treatment and Recovery Teams

Sarah Hurley, Ph.D.
Managing Director of Data Science

Youth VILLAGES
The force for families

Tim Wood, LCMHC
Chief Executive Officer

FAMILY CENTERED TREATMENT®

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Meet Your Facilitators

Elizabeth Black

PUBLIC KNOWLEDGE

Lisa Rich

SSG
A Sols Company
SIVIC SOLUTIONS GROUP

What You Will Leave With

01	**Understand each EBP**	Understand each program and its role in child welfare prevention.
02	**Finance each EBP**	Understand how the program can be financed and sustained.
03	**Return on Investment**	Understand cost savings, cost avoidance, or reductions in foster care utilization associated with each program.
04	**Impact**	Understand the impact of each program on children and families.

Session Background

Evidence-Based Prevention Programs (EBPs) improve family outcomes, reduce entries into foster care, and create long-term cost savings for child welfare systems.

START™
Sobriety Treatment and Recovery Teams

The START Model:
A Smart Investment in Child Welfare








What is START?

- Child welfare-based intervention for families with a young child 0-5, including infants with prenatal substance exposure.
- Helps parents achieve recovery and keeps children in home when safe and possible.
- Intense and coordinated service delivery between child welfare and substance use disorder (SUD)/mental health (MH) treatment providers.
- Family-centered approach.
- Catalyst for transforming the system of care within and between child welfare, SUD treatment providers, courts, and other family-serving systems.

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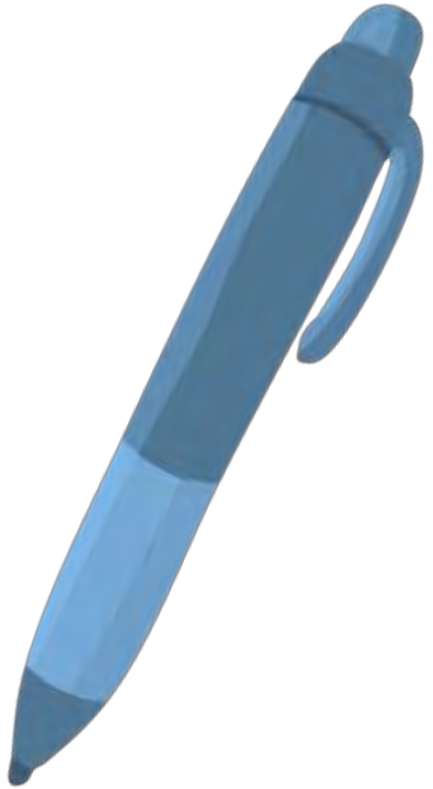
Goals of START

- [ ] Ensure child safety and well-being
- [ ] Prevent/decrease out-of-home placements
- [ ] Support parents in achieving and maintaining recovery
- [ ] Increase family stability and parental capacity
- [ ] Reduce repeat maltreatment
- [ ] Improve system capacity for addressing co-occurring SUD/MH and child maltreatment



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START Components

Child welfare worker/family mentor (FM) dyad share capped caseload

FM with “lived” child welfare and recovery experience helps parents navigate systems

Shared decision-making with partners and the family at critical points in the case

Intensive case management and weekly home visits by START worker and FM

Rigorous program evaluation and use of data for program improvement

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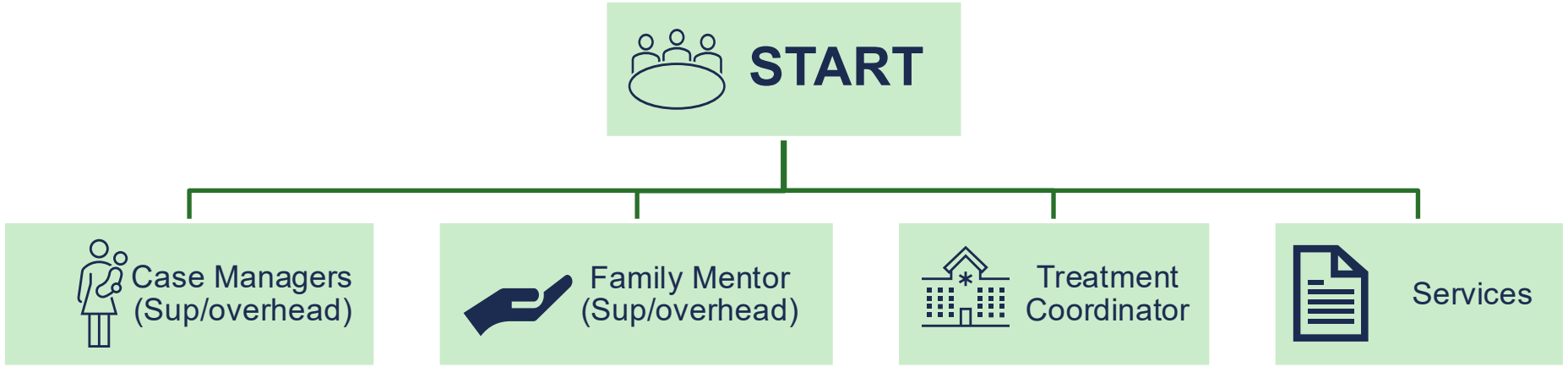
Required Service Elements



CQI/Program Evaluation

Child and Family Futures (training, coaching, certification, monitoring)

Required Service Elements (e.g., Flexible Funds, Drug Testing)

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Which program components are potentially claimable or reimbursable, and what documentation or administrative requirements are needed to support claiming?

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Case Manager

Administration or Service?

The Case Manager role can be either Administration, Service, or both.

Service will, in most cases, result in higher FFP (beginning in FY 2027), but your state will need to have enough Well-Supported services in place to allow for claiming (since START is Supported).

Costs will need to be split between Family First Candidates for Foster Care and those who are not Candidates (e.g., no active Prevention Plan with START listed, children who are in foster care).

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Family Mentor

Administration or Service?

The Family Mentor role can be either Administration or Service.

Service will in most cases result in higher FFP (beginning in FY 2027), but your state will need to have enough Well-Supported services in place to allow for claiming (since START is Supported)

Costs will need to be split between Family First Candidates for Foster Care and those who are not Candidates (e.g., no active Prevention Plan with START listed, children who are in foster care).

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What outcomes are you seeing with the START program?

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START OUTCOMES

What Research Tells Us

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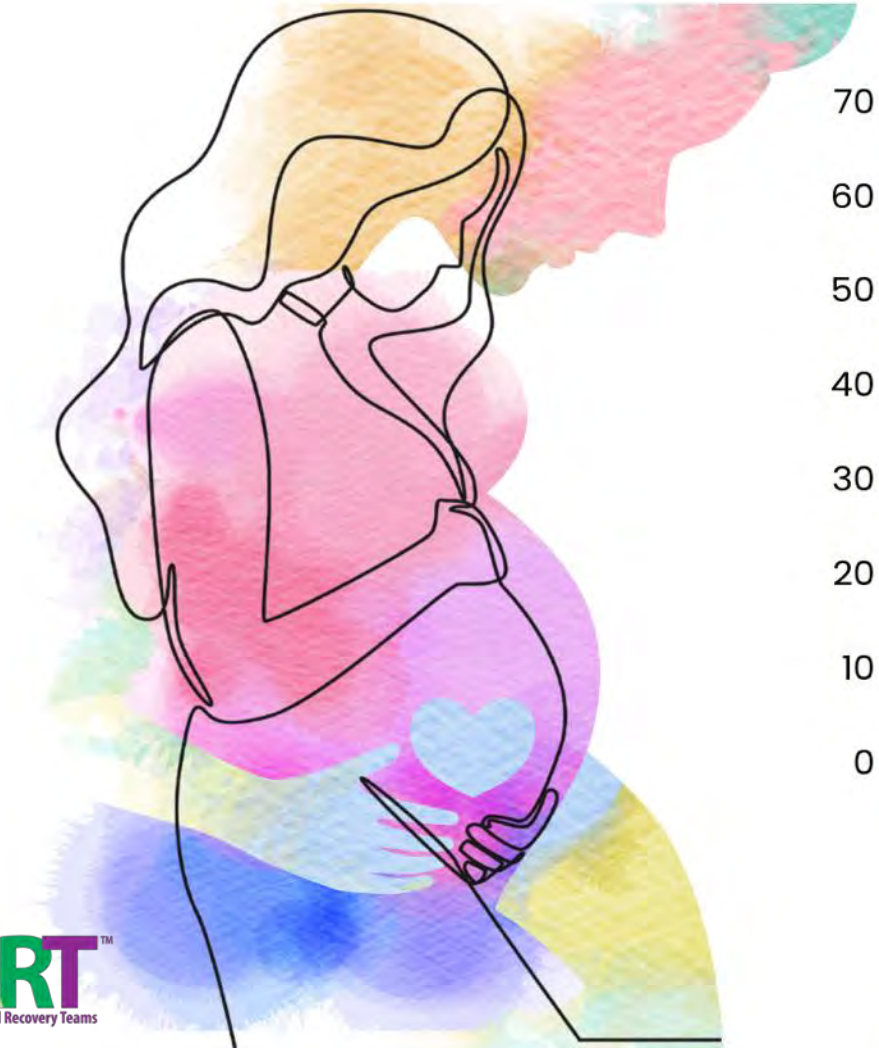
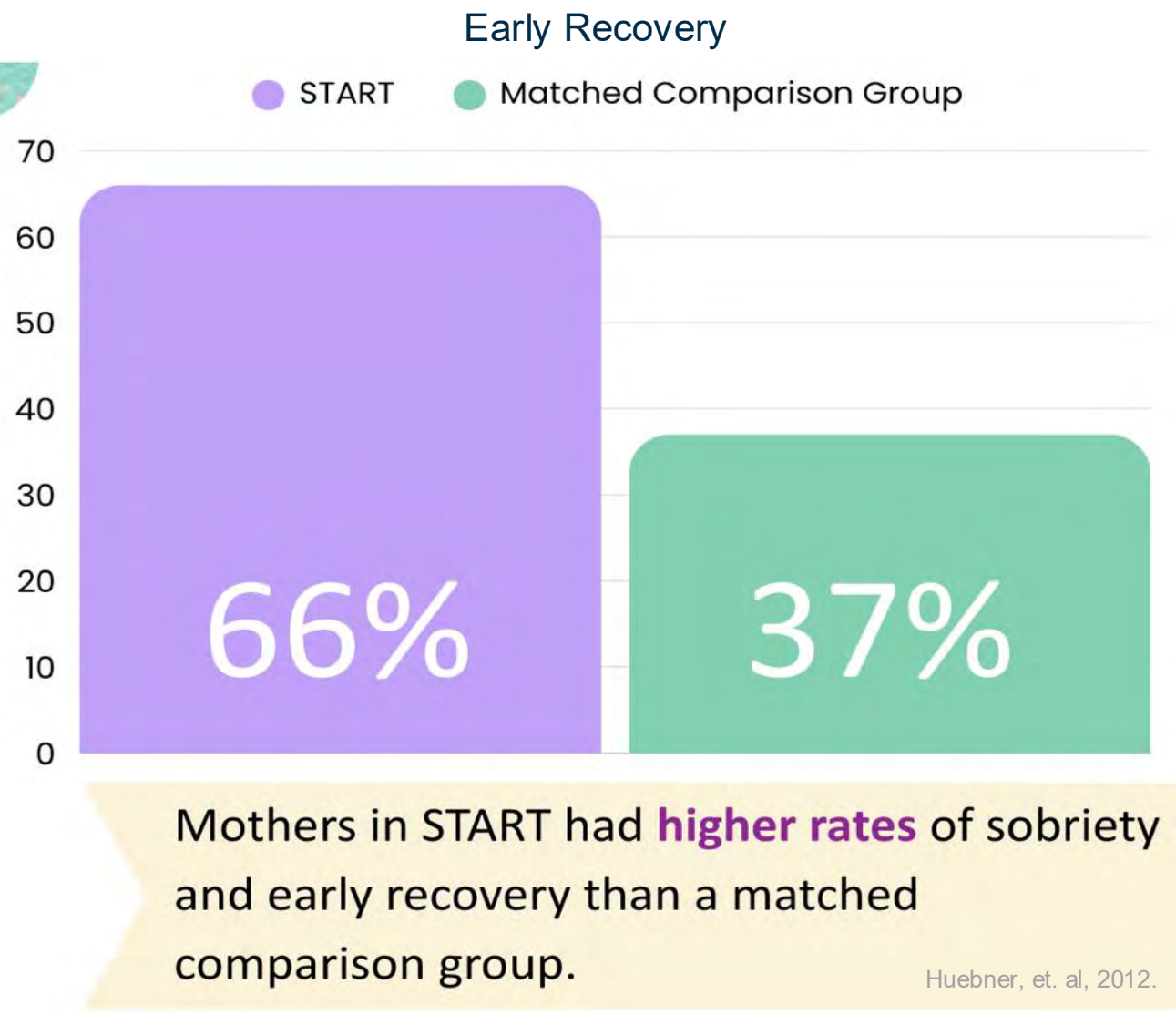
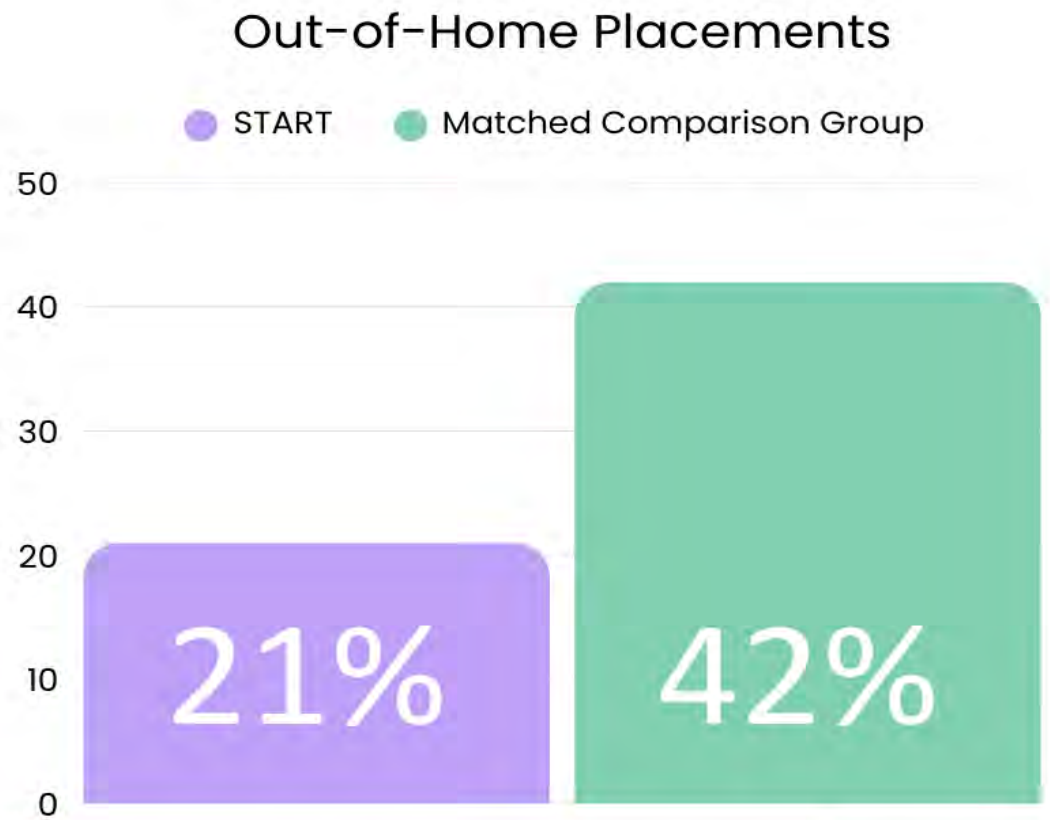
Published Outcomes

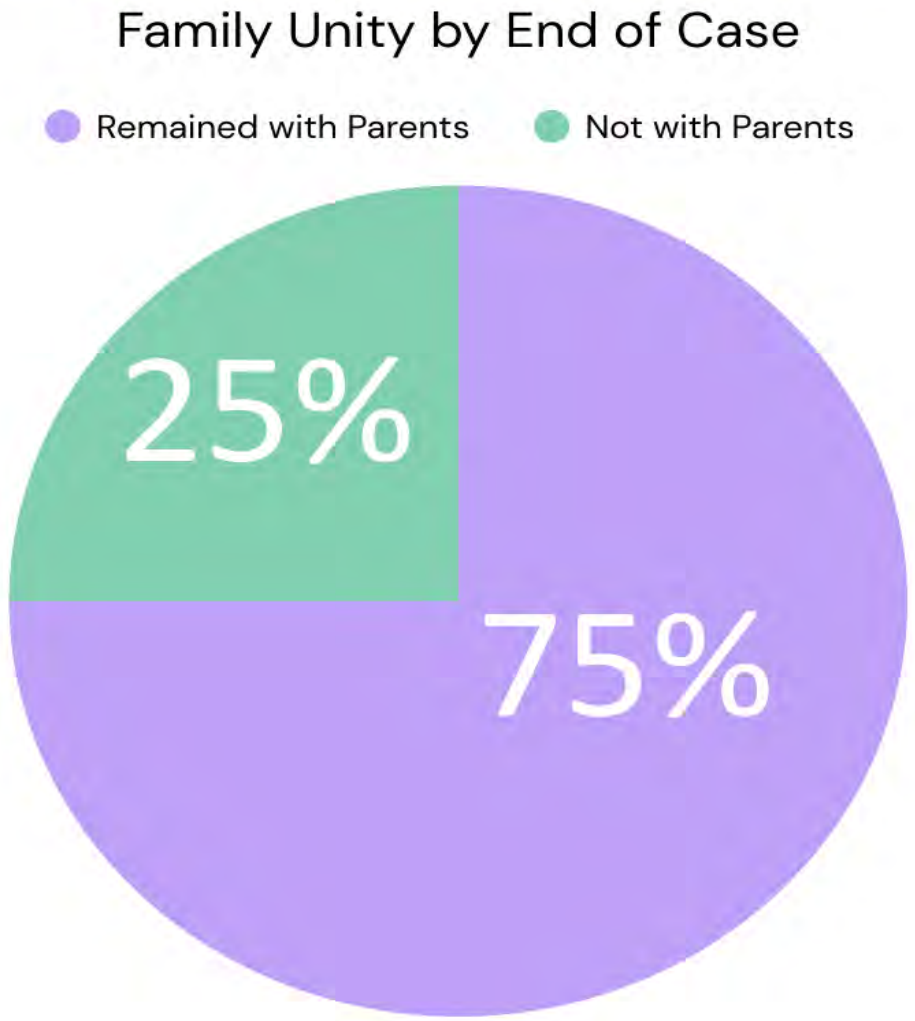




Published Outcomes



Children in START entered out-of-home placement at **half the rate** of children from a matched comparison group



At case closure, more than **75% of children in START remained with or were reunified** with their parent(s).

Huebner, et. al, 2012.

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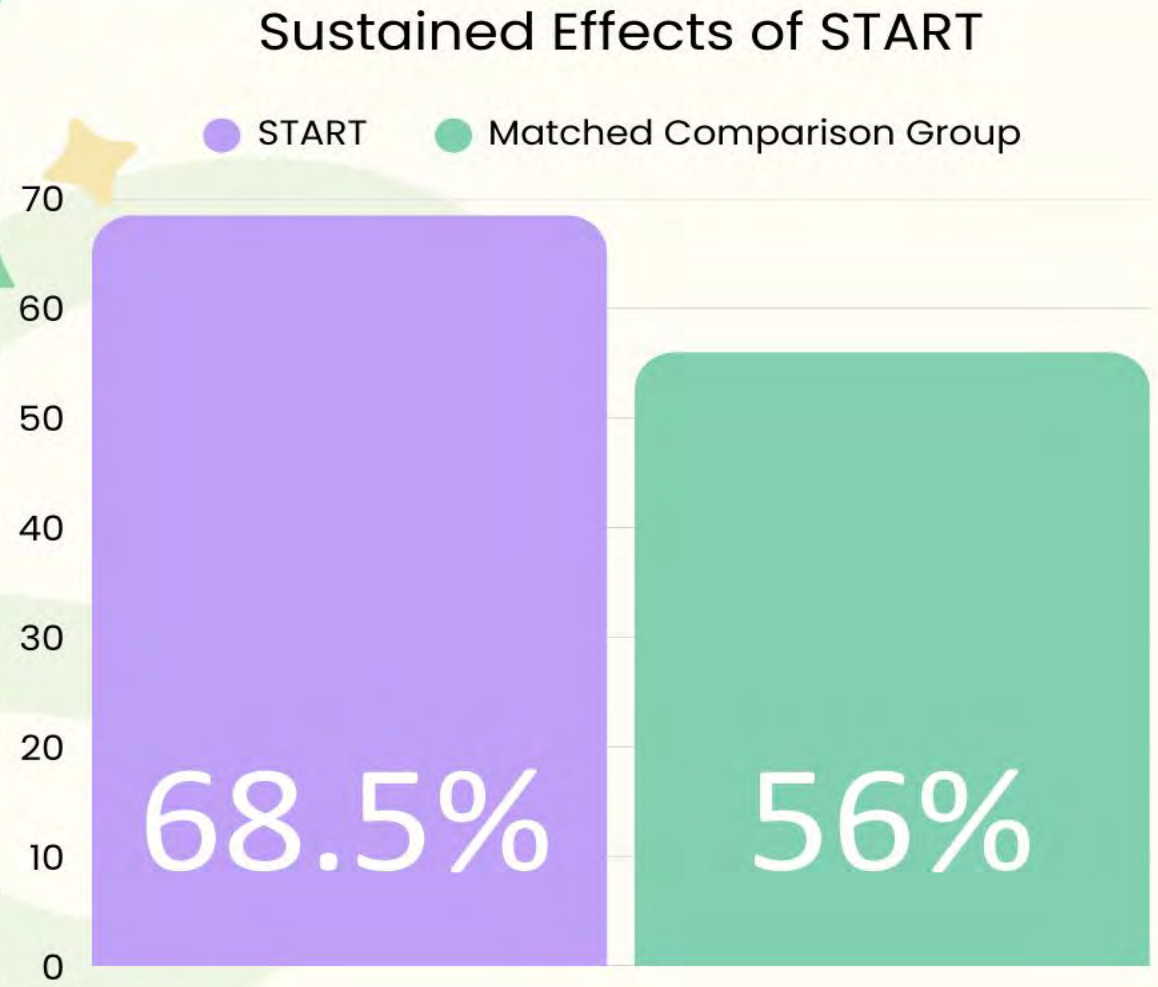
Published Outcomes

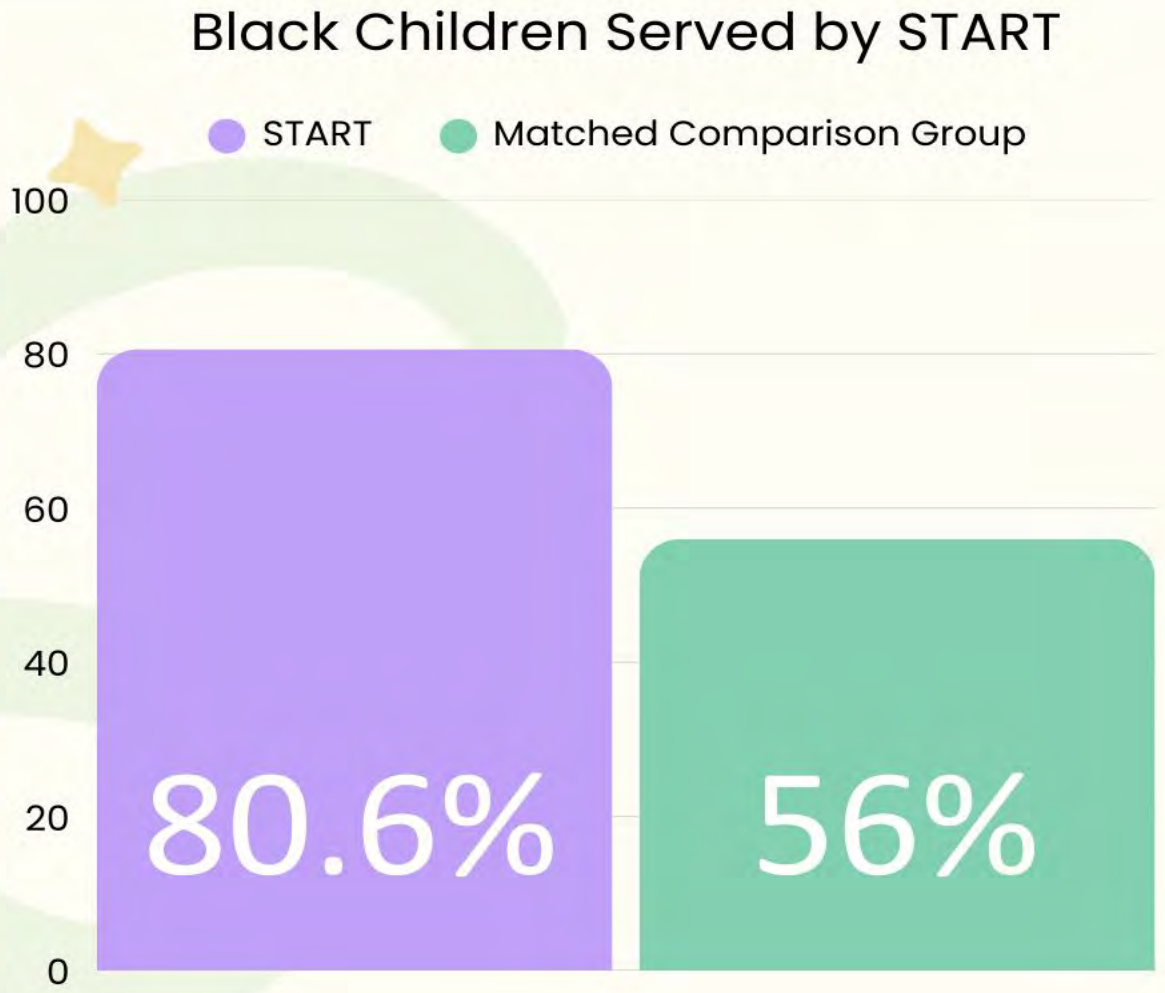
At **12 months post-intervention**, more children in START remained free from both out-of-home placement and recurrence of child abuse/neglect as compared to children served in traditional child welfare services.



 Huebner, et. al, 2021a.

Published Outcomes

At **12 months post-intervention**, more Black children in START **remained free of** out-of-home placement and child abuse or neglect than Black children served in traditional child welfare services.



 Huebner, et. al, 2021b.

What is the Return on Investment for the START program?

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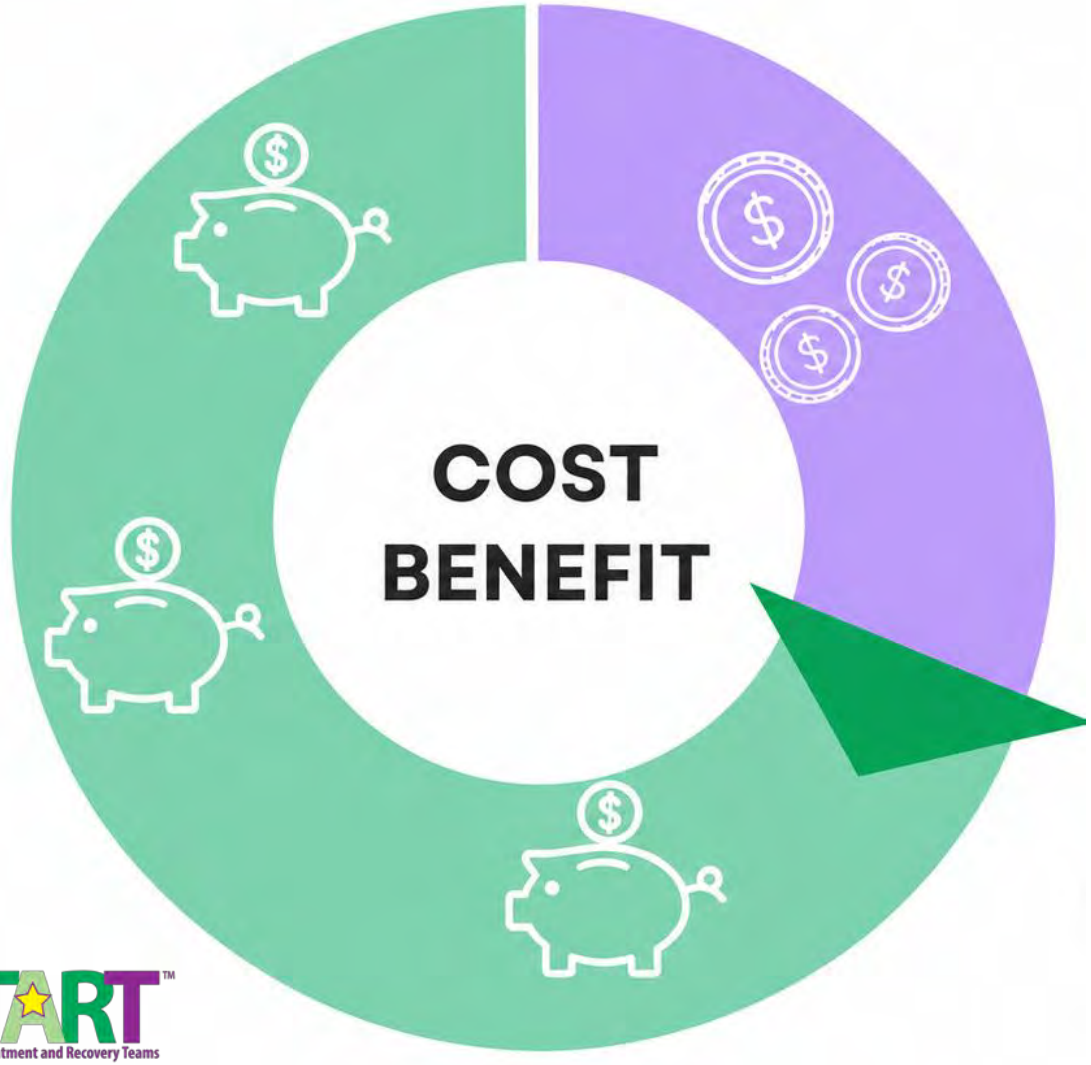
Published Outcomes



For every $1.00 spent on START

Jurisdictions potentially saved $2.22 on costs associated with out-of-home placement.

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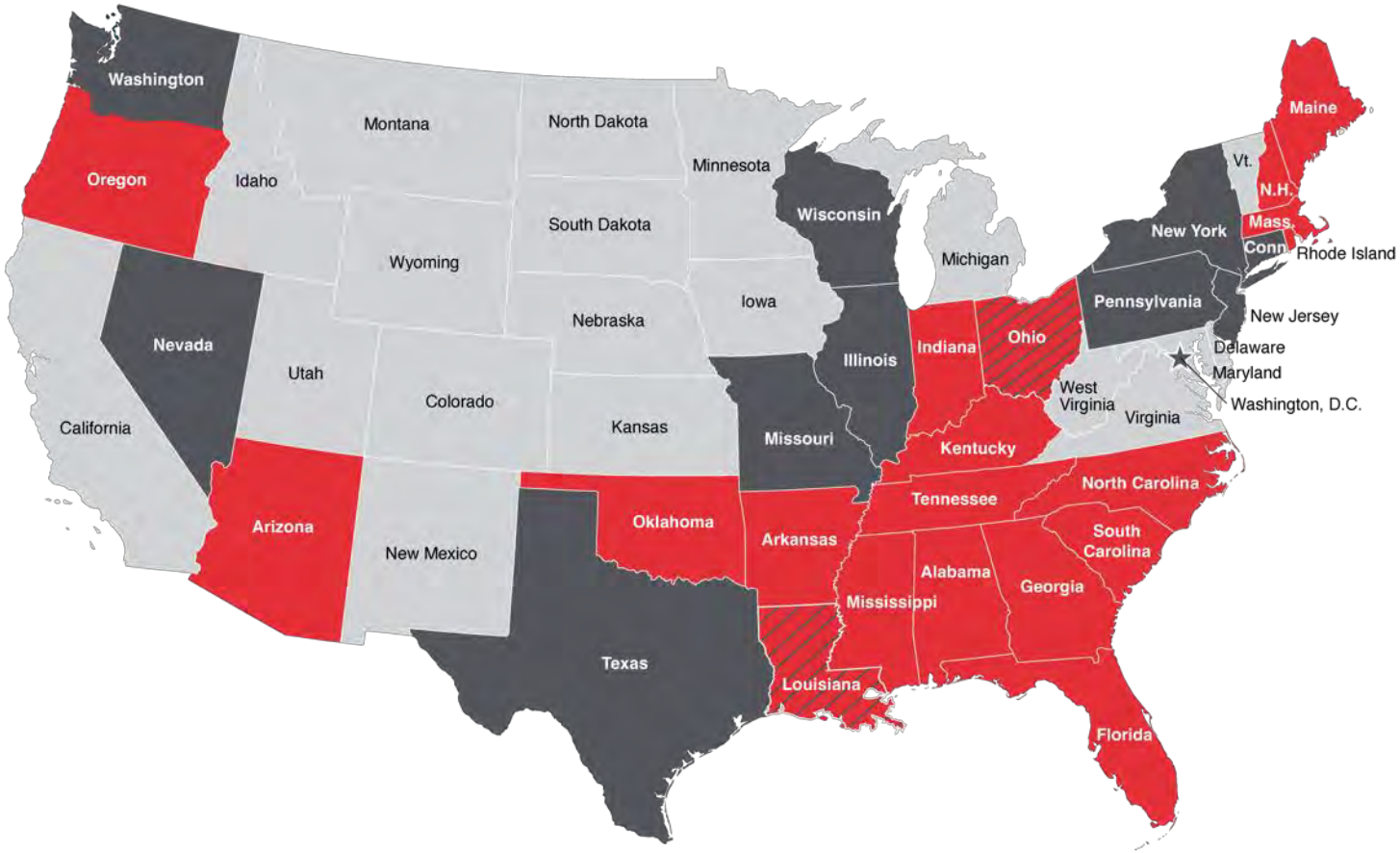
The force for families

Youth Villages National Footprint

Youth Villages direct service delivery

Implementation of Youth Villages' services through partners

Louisiana and Ohio serve children and families through both partnerships and direct services.



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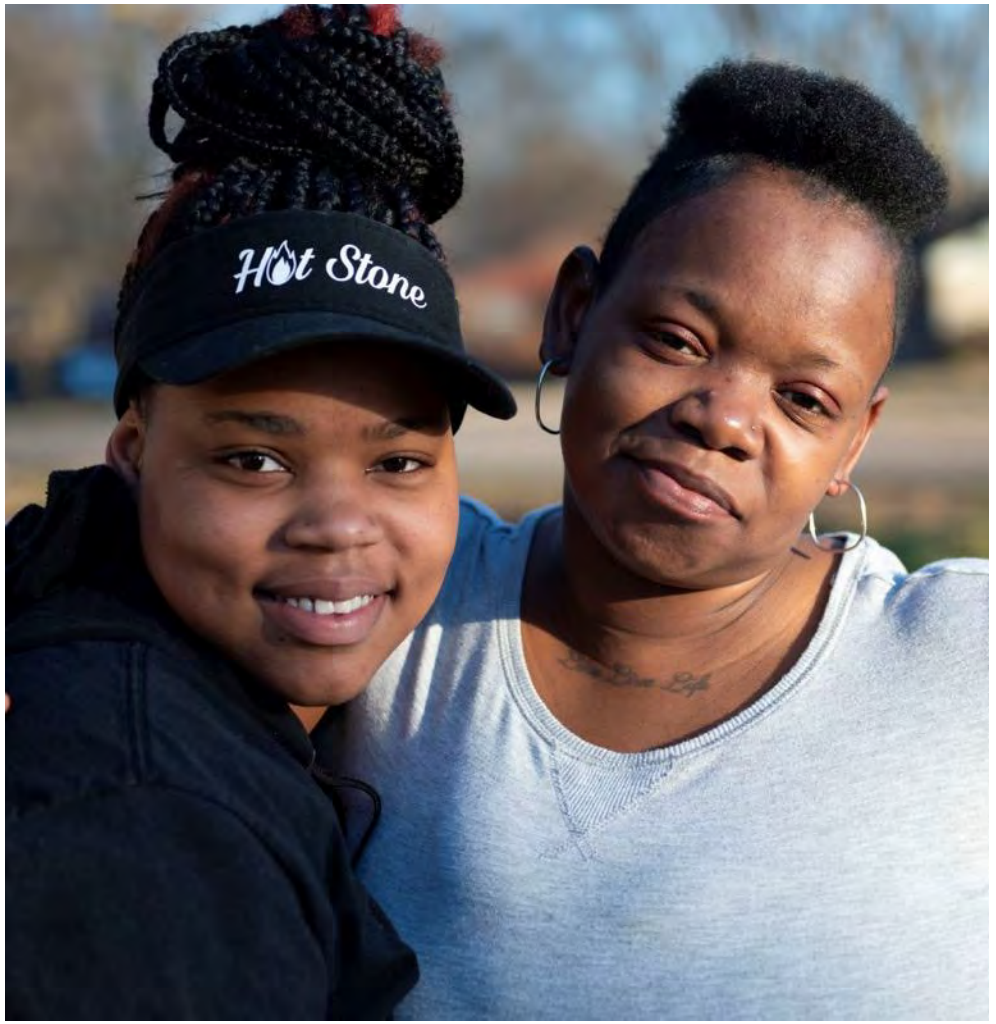
Key Model Elements

- **Codified program model** with practice elements and adherence measures; programs reviewed annually for fidelity
- Utilizes the **Youth Villages GuideTree** case conceptualization and service planning process (science- and evidence-driven interventions)
- **Service planning every two weeks** with intensive training and supervision
- **Three rigorous evaluations** have been completed showing positive outcomes



Key Model Elements

- Ecological model, **serving infants to age 18** as identified client
- Teams include **4-5 specialists** with caseloads of **4-6 families** per specialist.
- Service is intensive—average **two to three sessions per week**, per family
- Program length **average 4-6 months;** reunification will have a longer length of stay
- Crisis support available **24/7**
- **Outcome data collection** at program completion, 6- and 12-months post

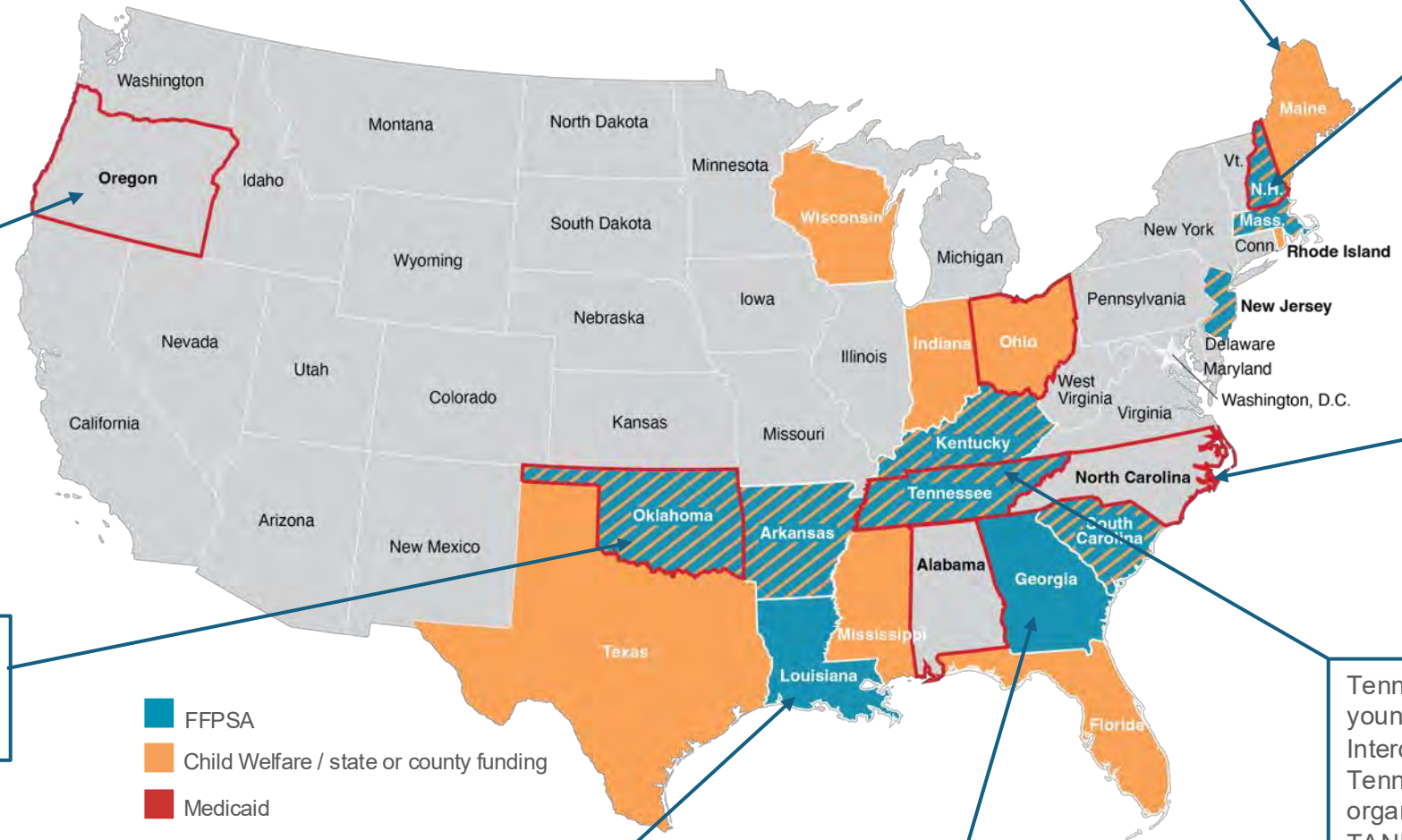
Which program components are potentially claimable or reimbursable, and what documentation or administrative requirements are needed to support claiming?

Intercept Funding

Maine launched Intercept as a pilot using a Systems of Care grant and leveraged Family First Transition Act (FFTA) funding to sustain. Today the state funds Intercept through child welfare funding while awaiting federal approval of their FFPSA plan amendment to include Intercept.

In New Hampshire, juvenile justice cases are served by Intercept because child welfare and juvenile justice are under a single state agency; Non-Medicaid eligible prevention cases are funded by IV-E through FFPSA; state funding and Medicaid are leveraged for reunification and juvenile justice cases.

Oregon utilizes Medicaid funding through managed care to provide Intercept as a mental health service for children and families, preventing unnecessary out-of-home placements.



North Carolina utilizes Medicaid funding to provide Intercept as a mental health service for children and families through EPSDT, preventing unnecessary out-of-home placements.

Medicaid funding comes through Oklahoma's child welfare carve out using an in lieu of service definition.

Tennessee has the largest number of young people served annually by Intercept and uses DCS / FFPSA and TennCare via managed care organizations under CCFT as well as TANF grant funding for Intercept.

Georgia utilizes Intercept as a prevention service for child welfare populations and as a mental health intervention with high acuity/complex needs youth to prevent out-of-home placements and/or step down from residential treatment.

Louisiana was the first jurisdiction to contract a private provider to implement Intercept.

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What outcomes are you seeing with the Intercept program?

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Rigorous Evaluations

- Placement Study No. 1: Intercept reduced the odds of out-of-home placement by 53% following the first maltreatment investigation.
- Placement Study No. 2: Examining a more recent sample of youth in a shorter evaluation window, Intercept reduced the odds of out-of-home placement by 37% following a maltreatment investigation.
- Permanency Study: Compared to a matched comparison group, the odds of achieving permanency were 24% higher with Intercept.

What is the Return on Investment for the Intercept program?

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Family Centered Treatment Foundation™

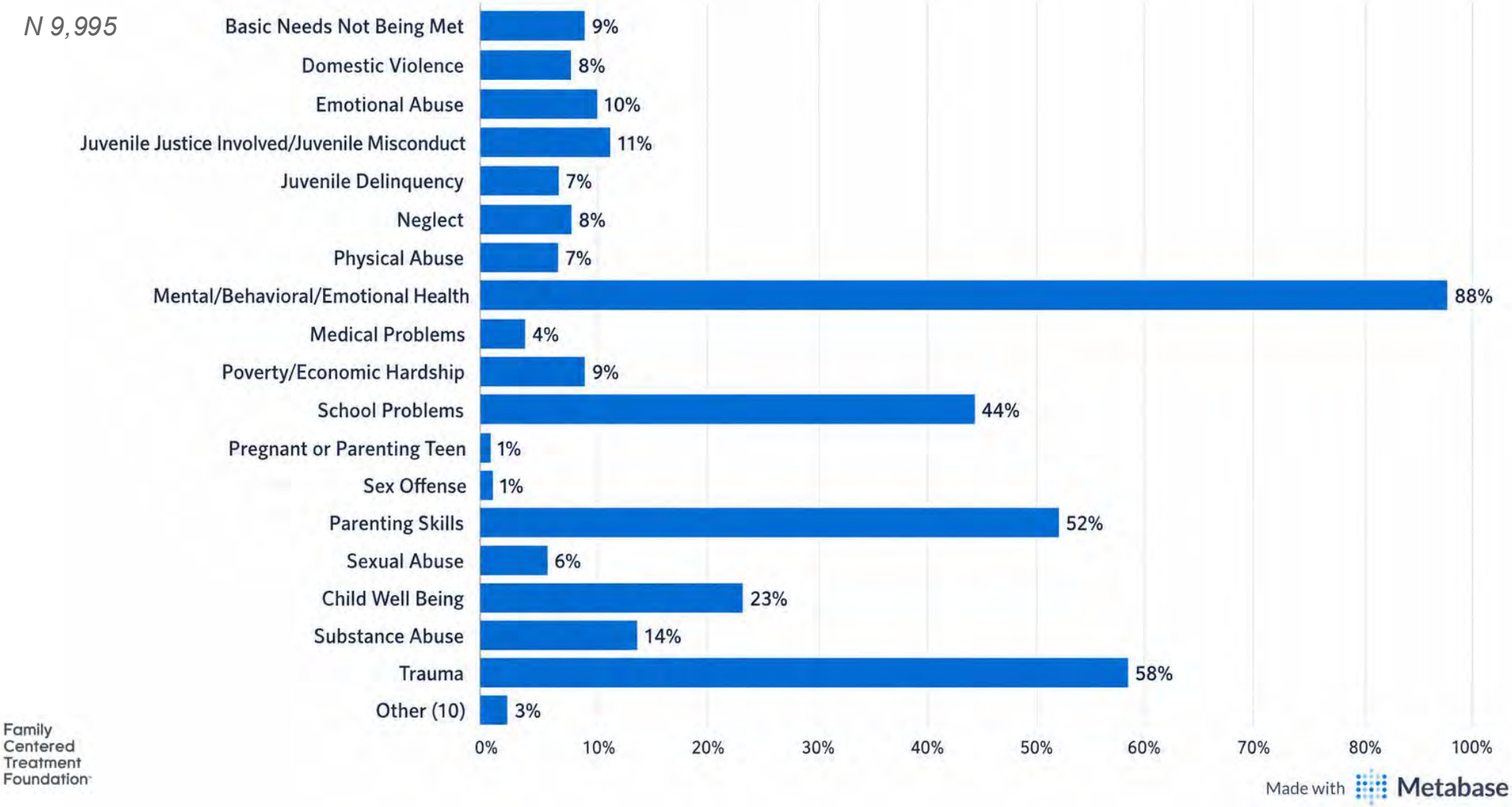
Since 1992, the FCT Foundation has been proud to assist organizations in enhancing their service delivery to serve >45,000 families!

FCT is licensed and trained through the FCT Foundation with the overriding belief that human service organizations should have the ability to provide affordable, high-quality EBP's with fidelity.

What is Family Centered Treatment?

- FCT is an **evidence-based, intensive trauma treatment model** of home-based family therapy
- **Practitioner/Family** Developed
- **Simple, practical, and common-sense** solutions delivered via **experiential treatment**
- Designed to increase **family health** and **well-being**, promote **attachment** and **resiliency,** and develop functional solutions for maladaptive patterns (family behavior)
- Builds upon the family's true **strengths** and addresses **systemic trauma** by addressing **underlying causes**, not just the symptoms
- Effective as both a **stabilization/prevention** and **reunification/restoration** service

Issues Addressed During FCT Services



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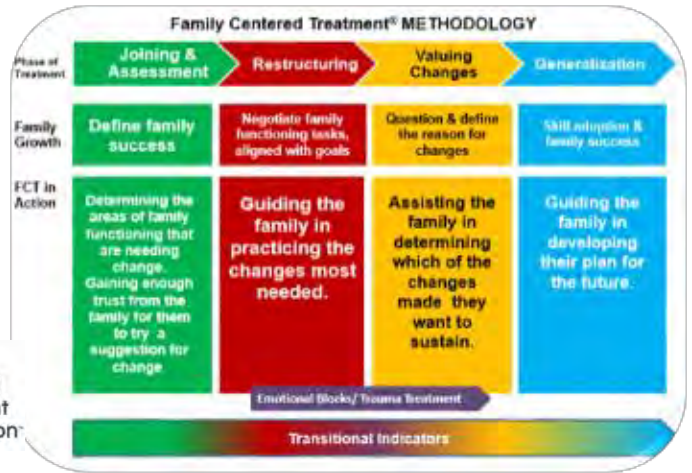
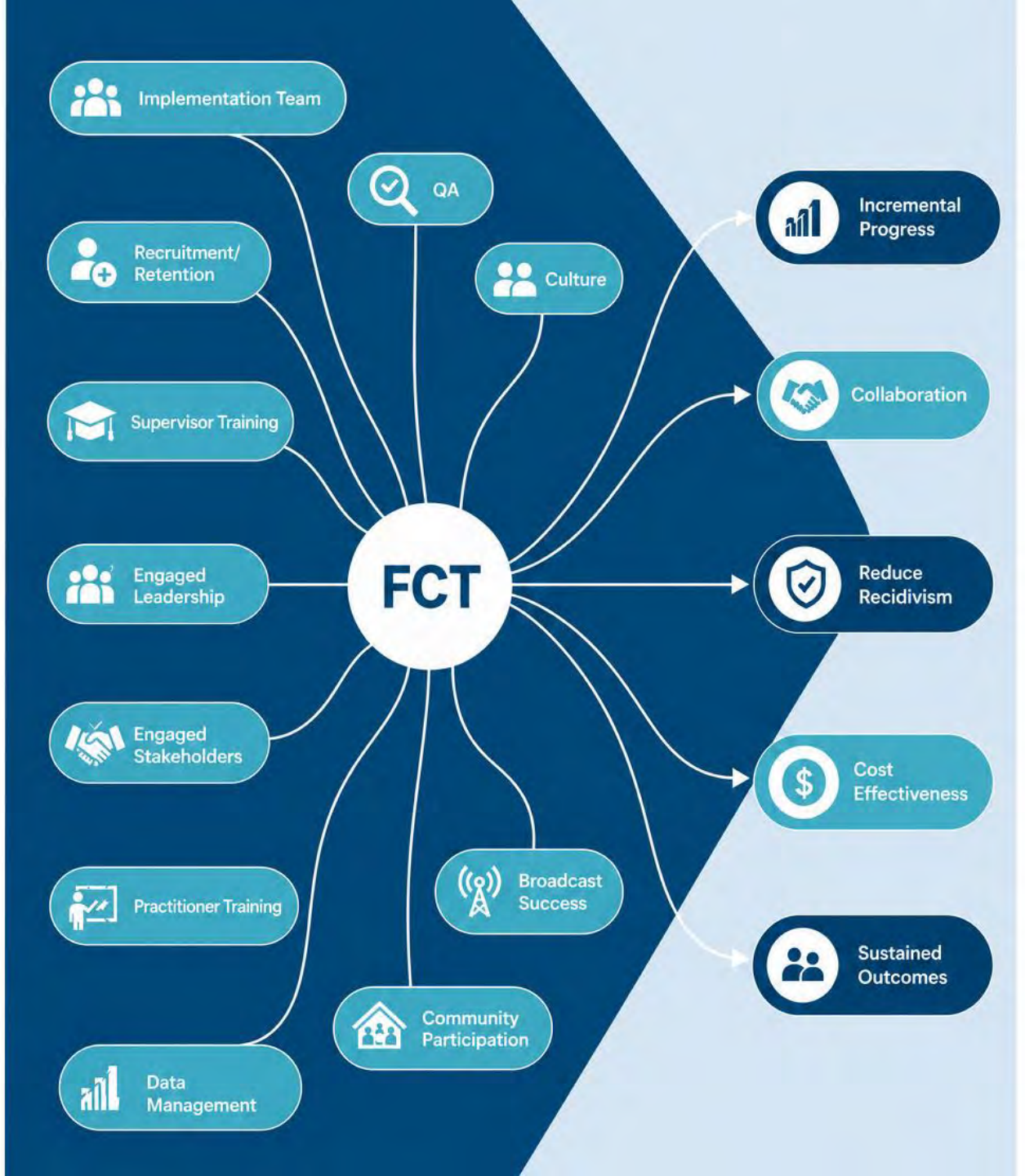
Evidence-Based Practice: Inputs & Outputs

Co-Occurring Processes





Family Centered Treatment Foundation

Training

- Wheels of Change® Certification Training Curriculum
  - Standardized intensive training process in place since 2004
  - 3-phase Certification Training Process
    - Online learning of theory and processes
    - Field-based observation and experience
    - Field testing of 16 core component skill demonstrations

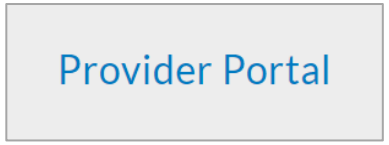
Certification

- 5 Levels of FCT Certification

Level 1
Level 2
Supervisor
Level 3
Level 4

- Recertification procedures commensurate with highest level of certification held

Resources



- Provider Portal
- Monthly Foundation Updates
- Implementation Updates
- Intervention Toolbox
- FCT Roadmap
- FCT Family Workbook
- Leadership Cohorts
- Podcasts
- Let's Talk Series
- Skills Labs
- Grand Rounds

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Quality Assurance & Oversight

Family Centered Treatment Foundation™

www.familycenteredtreatment.org

Audits

- Readiness Assessment
- Meetings/Matrix
- Licensing and Implementation Reporting
- Implementation Driver Assessment/FIT

Review Tools

- QA Fidelity Tool
- Session Note Tool
- Supervision Note Tool
- Web based Practice Management Tool

Surveys

- Family Satisfaction Surveys
- Stakeholder Surveys
- FCT Leadership & Practitioner Surveys

Teams

- Implementation Team
- FCT Practitioner
- FCT Foundation QA Team
- Implementation Director Team

Training

- Wheels of Change Time Lines
- Data training
- Certification Tracking
- Recertification Tracking

Clinical Support

- Direct Observation of FCT sessions with feedback
- Case Staffings/Clinical Guidance
- Grand Rounds for Complex Cases

Data Collection & Utilization

- Demographics, Fidelity, Outcome data
- Routine Monitoring and Quality Reviews
- FCT Dashboard

Leadership

- Situational Leadership Consultations
- Supervisor Training/Consults
- Engagement with All Levels of Leadership

Last updated: December 2023

What outcomes are you seeing with Family Centered Treatment?

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Key to Financial Accountability and Business Modeling: Know Your Data

135,567 Total FCT Sessions conducted for cases closed

11,869 Family members engaged by attending 6+ sessions for cases closed

4191 Families served by FCT programs

7396 Hours devoted to Implementation and Development

4626 Technical Assistance hours provided to community partners

2200+ Hours devoted to Training and Certification

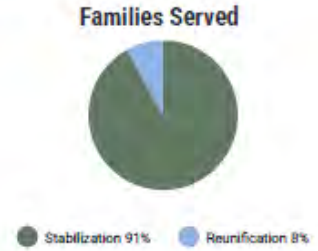
2000 Hours spent with FCT Teams

1900+ Hours for in-person site visits with FCT provider agencies

1780 Supervisor Consultation hours

FCT Fidelity: Ensuring Consistency, Quality, and Impact

- **99%** Families who completed all 4 phases of FCT **achieved successful conclusion of services.**
- **97%** Families who completed all 4 phases reported **progress towards their treatment goals.**
- **90%** Families engaged in 6 or more sessions.



Insights from Families Served

% of families who endorse/agree

- **97%** "We are satisfied with the amount of services our family received from our FCT agency."
- **95%** "The services we received from our FCT agency helped us to better handle our family problems on a day to day basis."
- **91%** "We created safety in our family during FCT services."
- **92%** "FCT has improved our quality of life."
- **95%** "How likely is it that your family would recommend FCT to a family needing/wanting services?"

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Which program components are potentially claimable or reimbursable, and what documentation or administrative requirements are needed to support claiming?

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Funding Claiming Opportunities

Current Implementation:

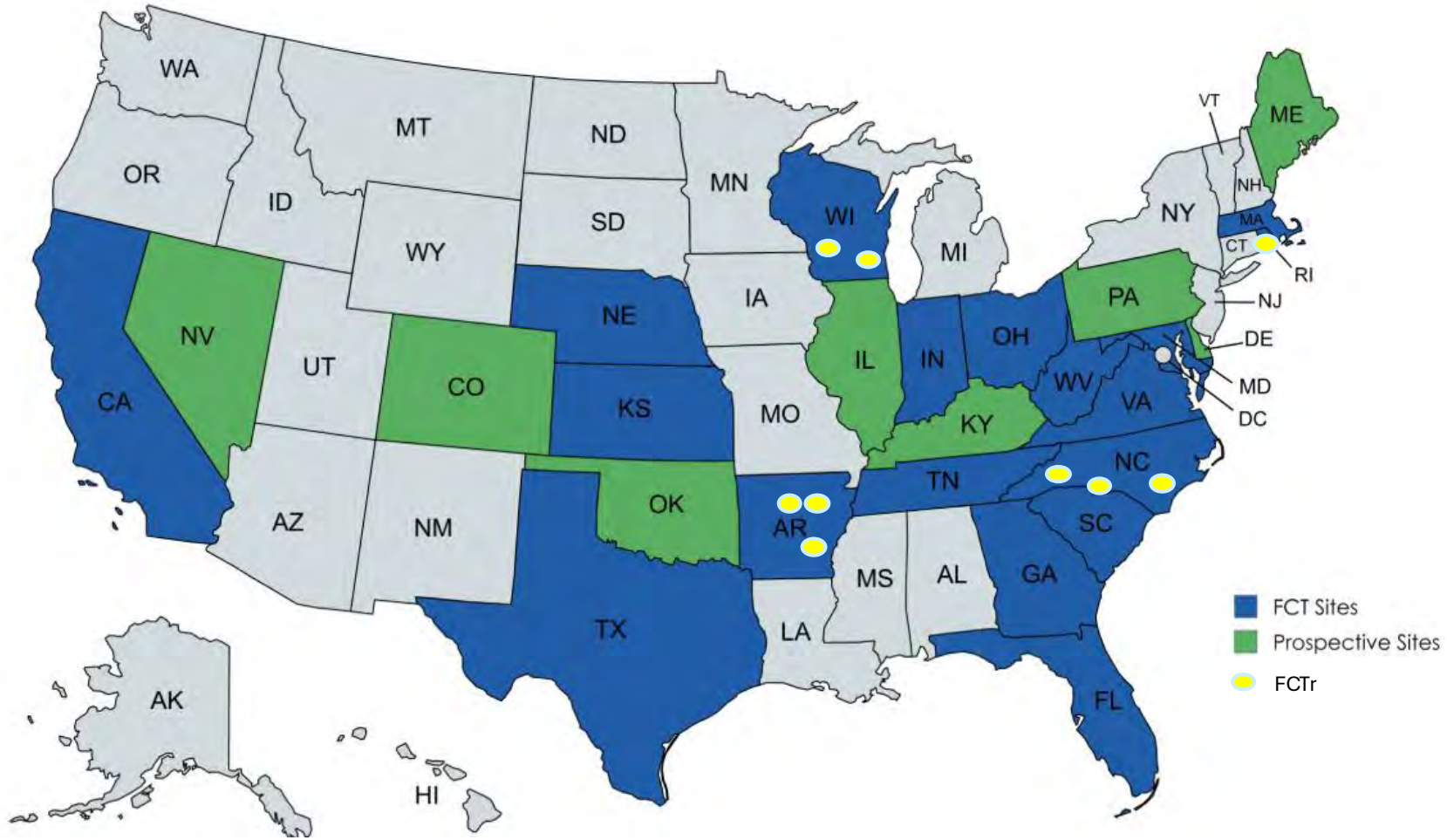
- 53+ Unique Licensed Organizations
- >125 ‘Sites’
- Scaled Statewide implementation
- Urban, Rural, Mixed, Frontier
- Pilot sites: FCT-R, PRTF reduction, School-based, Women's Shelter

Program Funding Includes:

- Medicaid (MCO [commercial and state])
- Title IV-E, Prevention Services
- State and local grant/contract awards
- Hybrid/Bundled/Braided
- Federal grant funding (SAMHSA)
- Shared Risk/Incentivized

Implementation Funding:

- Self-pay
- Grant funding (various)
- MCO and State-sponsored training



What is the Return on Investment for Family Centered Treatment?

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National Comparative Costs for FCT, Group Home Placements and Foster Care

2024 Average Cost per Length of Stay per Youth

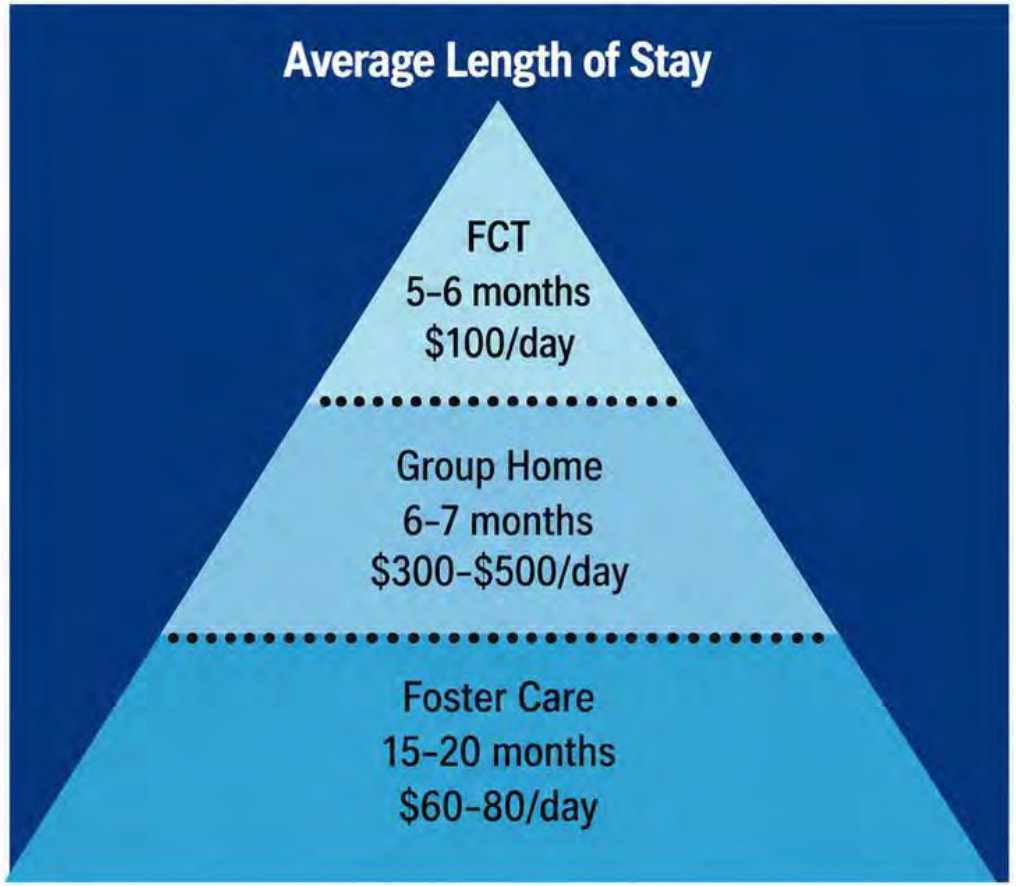
$15,200–$18,300
Family Centered Treatment*

$61,000–$106,000
Group Home

$27,000–$49,000
Foster Care

*FCT serves on average 3 members per household

Utilization of FCT saves:
$11,800–$87,700
per stay per youth



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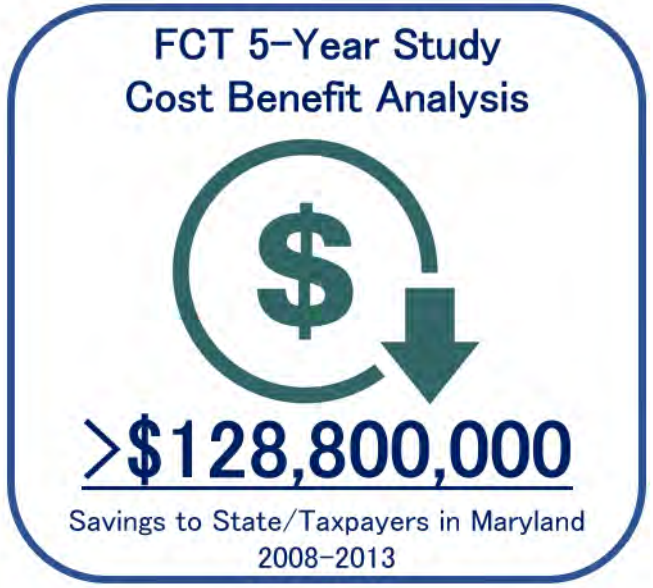
The FCT Model has been empirically studied for cost-effectiveness by two independent peer-reviewed publications, with the results published in 2012 and 2015.

- $27,916 saved per youth compared with Group Homes and $25,433 saved per youth compared with Therapeutic Group Homes.
- Lower placement costs over time: FCT was reported as $30,170 less per youth initially, $41,730 less per youth during the first 12 months, and $20,339 less per youth during months 12–24 compared with group-home youth.
- Foster care/permanency signal: Research summaries cite fewer days to reunification, less time in child welfare to permanency, and lower likelihood of repeat out-of-home placement after FCT compared with group home care.



University of Maryland School of Social Work, 2015
"Moreover, given the findings in [the] cost analysis, FCT is substantially more economical than group home use."

OJJDP Journal of Juvenile Justice, 2012
"Indeed, the cost benefits of FCT to the state of Maryland reflect reported direct cost reductions in states using diversion programs for adjudicated youth throughout the United States."

ELSEVIER

Children and Youth Services Review

Volume 136, May 2022, 106395

Effectiveness of Family Centered Treatment on reunification and days in care: Propensity score matched sample from Indiana child welfare data

Barbara J. Pierce [a], Finneran K. Muzzey [b], Kori R. Bloomquist [c], Teresa M. Imburgia [a]

Highlights

- Propensity-score matching created equivalent statistical proxy control group.
- Family Centered Treatment reduced days in out-of-home care by two months.
- Family Centered Treatment had more consistent treatment timing.

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Children receiving FCT who were removed from their homes had **significantly fewer number of days to reunification** than children not receiving FCT (341 vs. 417, $p < .05$) and the children receiving **FCT spent significantly less time, over two months, in child welfare services reaching permanency more quickly** than children who did not receive FCT.

Key conclusions drawn include: (1) propensity score matching provided a rigorous and appropriate analytic tool for post-hoc creation of an equivalent "control" group leading to the second conclusion (2) that our analysis of FCT demonstrated it as a robust intervention that **decreased days in out-of-home care by over two months for the children receiving FCT versus those who did not receive the intervention.**

Implications for future use of PSM and intervention research given the Family First Prevention Services Act of 2018 are included.

OPEN MINDS

WEEKLY NEWS WIRE | June 18, 2026

94% Of Arkansas Participants In Family Centered Treatment Avoided Higher Levels Of Care

Among families discharged from Arkansas' Family Centered Treatment (FCT) initiative during 2025, 94% did not require referral to a higher level of care for behavioral health or family relationship challenges, according to an evaluation reported by the Arkansas Department of Human Services (DHS). FCT is an intensive, trauma-informed, in-home therapy program designed for families experiencing significant behavioral health and relationship difficulties.

The evaluation included outcomes for more than 500 Arkansas families who received FCT services between January 1 and December 31, 2025. According to the evaluation, approximately 97% of participants reported that the program improved their family life . . .

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What Fiscal Leaders Should Know About ROI and Long-Term Impact

- FCT is a system investment, not just a service purchase.
- Start-up funding builds provider capacity, workforce readiness, training/certification, fidelity monitoring, referral pathways, and data systems.
- The ROI is primarily cost avoidance. The fiscal value comes from safely reducing reliance on higher-cost settings such as residential treatment, foster care, inpatient care, and deeper system involvement.
- Sustainability depends on financing design. Arkansas pursued Medicaid/PASSE reimbursement and identified FFPSA as an additional long-term funding pathway, moving the model beyond short-term grant dependency.
- Long-term system impact includes infrastructure. Arkansas' implementation created a blueprint for statewide provider expansion, cross-system engagement, Medicaid coverage, workforce development, and fidelity-based quality oversight.
- Other states have done similar things, and still others are lining up behind this.

What financing or implementation challenges have states encountered, and what strategies have been successful in addressing them?

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Thank You

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