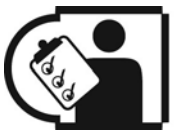

Evidence-Based Practice

A GUIDE TO EVIDENCE-BASED PRACTICES

for **CHILD WELFARE**

SAGINAW COUNTY
COMMUNITY MENTAL
HEALTH AUTHORITY

This report was produced with the support of the Saginaw County Community Mental Health Authority

October 2008

Compiled by Barbara Glassheim

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FORWARD

This report, which is one of a series produced for the Saginaw County Community Mental Health Authority, contains information to guide practice within the field of child welfare as well as inform policy, particularly in the development of a System of Care model for children, adolescents, and their families. It was compiled from a review of the relevant literature base in child welfare as well as mental health, substance use disorder treatment, education, primary care, the justice system, developmental disability field, and public health.

There is a vast body of literature in the field of child welfare that merits due consideration in a report such as this. However, this document merely skims the surface in an effort to acquaint the reader with key concepts and programs. Much is omitted or discussed in brief due to time and resource constraints. Some relevant material can be found in other reports in this series (e.g., culture, disparities in populations represented in child welfare, and juvenile justice programs, etc.). The selected references and resources found in the appendices offer more information and links (in blue underlined text) to various websites that can be consulted. There are also links between sections within the report.

Some of the material contained in this report can be found in other Saginaw County Community Mental Health Authority evidence based practices series. However, much of the material is new or updated from those reports due to changes made to programs and services since those other documents were produced. Like the other reports, this one is a snapshot in time; as evidence accumulates and the field develops, revisions and updates will be called for.

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October, 2008

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INTRODUCTION AND OVERVIEW

The field of child welfare has increasingly been held accountable for services and interventions provided to children and families since the early to mid 1980's. A heightened demand for accountability for outcomes has created an impetus for many child welfare agencies to use evidence-based practices as a way to assure both best practice and positive outcomes for children and families.

State and federal legislation attempting to improve the child welfare system also focus on outcomes. The Department of Health and Human Services established national goals for children in the child welfare system: safety, permanency, and well-being. The emphasis on child safety and permanency are two outcomes often used in evaluations of agency and/or system performance.

Generally accepted measures of effectiveness for child welfare have been proposed:

- Reduction in foster care placements
- Children reunified with their families
- Children placed with relatives
- Child deaths from abuse/neglect

Core outcome domains:

- **Safety** for both the child and the community
- **Permanence** in the context of continuity of care
- **Improvements in functioning and well-being** including health, mental health, and education

Effective child welfare systems integrate prevention, protection, in-home and out-of-home services, a full range of permanency options (i.e., reunification, adoption, guardianship, placement with kin and other planned permanent living arrangements), and post-permanency supports and services integrated into a system of care that serves children and families at whatever point they need assistance using evidence-based practices.

Child Safety and Family Support	A safe and permanent home with family members is the best place for a child to grow up. All children have the right to be free from physical, sexual, emotional, and other forms of harm by their parents or caretakers. Parents have a responsibility to meet children's needs for adequate food, shelter, clothing, and a safe environment. When a child is at risk of harm, the child's parents, extended family or kin, substitute caregivers, and community members known to and trusted by the child all have a role to play in the development and implementation of a safety plan.
Child and Family Well-Being	Child well-being means that a child's basic needs are met and the child has an opportunity to grow and develop in an environment which provides consistent nurture, support and stimulation. Family well-being means that a family has the capacity to care for its children and fulfill their basic developmental, educational, social, cultural, health, and housing needs. Supporting family efforts to care for their children is an important goal of child welfare agencies.
Community Supports for Families	Communities need to support families in providing a safe and nurturing child-rearing environment. Basic supports such as jobs, housing, and community economic development are needed so that the child welfare system can stem

	the causes of child maltreatment, rather than simply responding after children have suffered abuse or neglect. Easily accessible, community-based preventive and family supportive services are critical underpinnings of a responsive child welfare system.
Family-Centered Services	Families that are actively involved in making key decisions about their children and in designing services that meet their needs are more likely to have an increased capacity to safely care for their children. Help is family-driven, rather than allowing the availability of a particular funding stream to drive the provision of services that do not address the needs of a specific child and family. Even when a child's parents cannot be his or her primary caregivers, family members and extended family are a vital part of the caring circle for children.
Cultural Competence	A culturally competent system is one that develops behaviors, attitudes, and policies to promote effective cross-cultural work. Providing workers and the agency as a whole with a flexible context for gaining and expanding cultural knowledge, understanding the dynamics arising from cultural differences, and promoting successful adaptation of services to meet unique cultural needs in partnership with community members, is the most effective way for agencies to improve their cultural competence.
System Accountability and Timeliness	A well-organized service delivery system, accountable to specific performance standards and time frames for service provision, is essential to protect children effectively and to strengthen families. Effective services are timely from a child's perspective, that is, services are provided quickly enough to respond a child's developmental and emotional needs.
Coordination of System Resources	A cohesive system of family-centered, community-centered, culturally competent, timely and accountable services and supports for children and their families. At the individual family level, formal efforts to coordinate services and supports are necessary among different providers serving the same family. At the systems level, formal agreements can increase the cohesiveness of related services provided by different agencies.

(Casey Outcomes and Decision-Making Project)

Evidence-based practices are interventions that have been determined to be efficacious by the strongest possible empirical evidence. In the field of child welfare, evidenced-based practices entail: (1) an individualized assessment; (2) the best available external evidence related to the client's concerns and an estimate of the extent to which it applies to a specific client; and (3) a consideration of clients' values and expectations.

The most potent tools for evaluating the effectiveness of interventions are meta-analyses and systematic reviews. Systematic reviews are the synthesis of research studied in which the researchers outline their methodology and sources of biases. Meta-analyses use statistical analysis to determine the effectiveness of an intervention used in multiple randomized trials. Randomized controlled trials (RCTs) control for known and unknown factors that may account for the outcome of an intervention. Evidence-based practice relies on available randomized controlled trials and systematic reviews or meta-analyses which serve as a basis for discussing choices with clients. The involvement of clients in making decisions regarding services they will receive and programs they will participate in is a critical to evidence-based practice.

In the absence of meta-analyses and randomized controlled trials, child welfare workers need to know what evidence is available and the strengths and limitations of the methodologies that are employed. While studies that use secondary data-analysis and sophisticated statistical analyses are not as strong for providing evidence regarding effectiveness, such methodologies answer important questions that may not be testable through randomized controlled trials. Moreover,

qualitative studies provide a wealth of information about interventions as well as clients' perspectives which are critical to understanding thoughts, emotions, and experiences associated with their situations.

Child protective services caseworkers must effectively engage families that often present with and face significant challenges including substance abuse, mental health problems, economic stress, unemployment, separation and/or divorce, inadequate housing, crime, and incarceration in order to effectively perform their responsibilities of protecting children at risk for maltreatment. Thus, the field of child welfare draws evidence form a number of fields due to the multi-faceted situations that are dealt with. Literature reviews in the fields of substance abuse treatment, mental health, education, public health, the justice system, developmental disability field, and primary care were conducted to develop this practice guide for the delivery of child welfare services and supports. Some of the material contained in this report has been covered in other evidence-based practice reports, but much new information specific to child welfare can be found in the various sections.

The first section of this document contains information on prevention within child welfare. It is followed by sections on family-centered practice and family preservation services, hallmarks of contemporary child welfare systems. Included is information on various service delivery models such as alternate response and ways to achieve permanency within the timeframes mandated by the Adoption and Safe Families Act. This followed by a section of the report devoted to a review of programs and services found within the literature base of child welfare (e.g., CASATART, Nurse-Family Partnership, Positive Parenting Program, Parent-Child Interaction Therapy, SafeCare, Participation Enhancement Intervention, HOMEBUILDERS, and Multidimensional Treatment Foster Care) as well as other applicable fields. Methods that have been found to be effective in delivering services and supports are reviewed in the last section. Two appendices are attached which contain references and resources that can be consulted for more information.

PREVENTION

Prevention services are targeted to preventing child abuse and neglect[2] prior its occurrence and, hence, any involvement with the child welfare system. Prevention in the child welfare arena means averting the reoccurrence of abuse or neglect or removal once a child and family are involved with the child welfare system. It can also mean preventing a child from returning to care or being removed from their caregiver.

There is often a significant separation of programs and services focused on preventing child abuse and neglect from the rest of the child welfare system which deals with children and families reported to the child welfare system. Moreover, while a number of prevention activities are typically provided in communities, they are not coordinated or linked. Many fall under various federal programs, or utilize local, state, and/or foundation funds. These factors present challenges in ensuring access to appropriate services and supports.

A continuum of programs and services for prevention of child abuse and neglect are needed to keep children safe in their own home and communities including:

- Programs and services targeted to the general population that focus on preventing child abuse/neglect from taking place:
    - Outreach and public education services that highlight risk factors, where to get support, and reporting of potential abuse/neglect.
    - Family support services that are made available for all children and families.
- Programs and services targeted to children and families who are or might become involved with the child welfare system including prevention services for children and youth as well as parents and/or family members beyond those aimed at the prevention of child abuse and neglect:
    - Substance abuse prevention/intervention services and support
    - Mental health prevention/intervention services and supports
    - Domestic violence prevention/intervention

Prevention programs can include substance abuse treatment programs for women with children, respite care programs for families with children who have disabilities, and parent education programs and support groups for families affected by domestic violence and family resource centers offering information and referral services to families living in impoverished neighborhoods. Many prevention programs focus on strengthening child and family protective factors (e.g., knowledge and skills children need to help protect themselves from sexual abuse,

[2] The abuse and neglect of children can have profoundly negative consequences for their social, psychological, and physical health. Physical abuse (e.g., shaking a crying baby) and neglect of infants is linked to a range of physical and emotional maladies (e.g., seizures, irritability, developmental delays, and learning disabilities). Physical and psychological abuse of preschoolers and school-aged children is associated with depression, low self-esteem, antisocial behavior, juvenile delinquency, and adult criminal behavior. Sexual abuse is associated with depression, substance abuse, eating disorders, suicidal behavior, and promiscuity. Neglect is associated with non-organic failure to thrive, which is characterized by below-average weight, height, and intellectual development; neglect is also linked to attachment disorders, aggression, and difficulty dealing with others.

promotion of positive interactions between children and parents, and knowledge and skills needed by parents need to raise healthy, contented children.

Parent or caregiver factors	• Personality characteristics and psychological well-being • History of maltreatment • Substance abuse • Attitudes and knowledge • Age
Family factors	• Marital conflict • Domestic violence • Single parenthood • Unemployment • Financial stress • Social isolation
Child factors	• Age • Physical, mental, emotional, and social development • Physical, cognitive, and emotional disabilities (e.g., aggression, attention deficits, difficult temperament, behavior problems) • Infants born prematurely or with low birth-weight
Environmental factors	• Poverty • Unemployment • Social isolation • Community characteristics (e.g., living in a violent/dangerous neighborhood • Promotion of violence in cultural norms and the media

Protective factors include supportive, emotionally satisfying relationships with a network of relatives or friends.

A continuum consists of three levels of child abuse and neglect prevention services: primary prevention, secondary prevention, and tertiary prevention.

Primary or Universal	Primary prevention consists of activities that are targeted to the community at large in order to impact families prior to any allegations of abuse and neglect.
Secondary or Selected	Secondary prevention includes activities targeted to vulnerable families that have one or more risk factors (e.g., substance abuse, teen parents, parents of special needs children, single parents, and low income families).
Tertiary or Indicated	Tertiary prevention consists of activities targeted to families that have confirmed or unconfirmed child abuse and neglect reports. These families have an established the need for intervention, either with or without court supervision, and qualify for services under child welfare programs. Such families have an open case.

- **Primary prevention services and supports:**
  - Public awareness campaigns for prevention of child abuse and neglect, such as shaken baby syndrome, child sex exploitation, when to report abuse/neglect
  - Public education and outreach activities
  - Information and referral regarding community and social services available for families
  - Parent education classes that are open to anyone in the community
  - Family support programs (e.g., family resource centers)
- **Secondary prevention services and supports:**
  - Parenting Classes (parent education/skills classes targeted for high-risk parents)
  - Domestic violence services
  - Concrete services (clothing, food, utility payment, housing assistance, job training, and transportation)
  - Counseling (for adults and for children)
  - Population-specific services:
    - Parents (all, new, teens, etc.)
    - Parents/children with disabilities
    - Racial and ethnic minorities
    - Members of underserved or underrepresented groups
    - Fathers
  - Respite care/crisis care for parents of a child with a disability or for families at risk of abuse and/or neglect, such as:
    - Crisis Nurseries
    - Homemaker
    - Parent aide
  - Voluntary home visiting programs for :
    - New parents
    - Pregnant teens
  - Parenting programs for new mothers
  - Parent mutual support/self-help
  - Mentoring programs for high risk youth.
  - Family resource centers/family support services for at risk families
  - Home based early intervention services for at risk populations, including:
    - Support for parents with children with special needs
    - Services/supports for children with special needs
  - Evidence-based programs such as Nurse Family Partnership Program, Healthy Families
- **Tertiary prevention services and supports:**
  - Treatment/intervention services for children that have been abused and/or neglected
  - Intensive family intervention services where abuse/ neglect has taken place
  - Family reunification services to prevent reoccurrence of abuse/neglect
  - Parenting Classes – for parents where abuse/neglect has taken place
  - Supports for Foster Parents and Resource Providers caring for children who have been abused and/or neglected

HEALTHY START

Healthy Start is an effective intervention designed to reduce infant mortality and improve early childhood outcomes in communities plagued by high rates of infant mortality. The program is designed to reduce racial and ethnic disparities in access to and utilization of health services; improve local health care systems; and increase consumer/community voice and participation in health care decisions.

The program is comprised of nine core components:

- Outreach
- Case management
- Health education
- Perinatal depression screening
- Interconceptional care
- A consortium of neighborhood residents, parents, medical providers, social service agencies, faith representatives, and business leaders
- A local Health System Action Plan
- Collaboration and coordination with Title V

Healthy Start has been shown to lead to reductions in infant mortality and low birth weight, improvements in prenatal care, and decreasing barriers to health care for pregnant women and newborns.

FAMILY-CENTERED PRACTICE

Family-centered practice includes a range of strategies, including advocacy for improved conditions for families, support and stabilization during crises, reunification of those who are separated, the creation of new families, and connecting families to resources that will sustain them in the future. The support and preservation of families using strengths-based approaches are endemic to an appreciation of families as central to children's well-being. Family-centered practice approaches (e.g., family group decision-making) are based on two core values:

- The best place for children to grow up is in families.
- Providing services that engage, involve, strengthen, and support families is the most effective approach to ensuring children's safety, permanency, and well-being.

Family-centered practice is a way of working formally and informally with families across service systems to enhance their capacity to care for and protect their children. It focuses on the needs and welfare of children within the context of their families and communities. Family-centered practice recognizes the strengths of family relationships and builds on these strengths to achieve optimal outcomes. Family is defined broadly to include birth, blended, kinship, and foster and adoptive families.

In family-centered practice, families are active participants in the development of policy, program design, and evaluation, and are active decision-makers in the selection of services for themselves and their children. Family and child assessment is strengths-based and solution-focused. Services are community-based and build upon informal supports and resources. Families are recognized as experts in determining what is best for themselves and their children. Agencies and professionals enter into partnerships with families and youth, who are given equal voice in all aspects of policy, program, and service design; decision-making; implementation; and evaluation.

Key components of family-centered practice include:

- Working with the family unit to ensure the safety and well-being of all family members
- Strengthening the capacity of families to function effectively
- Engaging, empowering, and partnering with families throughout decision-making and goal-setting processes
- Providing individualized, culturally responsive, flexible, and relevant services for each family
- Linking families with collaborative, comprehensive, culturally relevant, community-based networks of supports and services

Family-centered practice approaches include:

- FAMILY GROUP DECISION-MAKING includes a number of approaches in which family members are brought together to make decisions about how to care for their children and develop a plan for services.
  - A FAMILY GROUP CONFERENCE (FGC) is a formal meeting during which members of a child's immediate family, extended kin, and members of the child's community develop a comprehensive plan to for the care and safety of the child safe in an inclusive and culturally sensitive manner.

- FAMILY-CENTERED, NEIGHBORHOOD-BASED FOSTER CARE approaches, based on principles of strengths-focused, neighborhood-based, culturally sensitive care for children and their families. Such approaches include NEIGHBOR TO NEIGHBOR, NEIGHBOR TO FAMILY, AND FAMILY TO FAMILY programs. These approaches focus primarily on innovations in the provision of foster care services, building on the support of community collaborations, and networks for families.

Parental incarceration and the disruption of family relationships can produce negative outcomes for children, including poverty, poor academic performance, aggression, depression, delinquency, and substance abuse. Incarcerated mothers and fathers are unable to work on parenting skills that may be necessary for reunification, and separation interferes with the ability of parent and child to form or maintain a strong attachment. Family-centered services for incarcerated parents, their children, and families focus on parenting programs, family strengthening activities, nurturing of family relationships, community supports for families during incarceration and following release, and gender-specific interventions.

ALTERNATIVE RESPONSE

Child welfare agencies have traditionally responded to allegations of child abuse and neglect by investigating the report, determining whether maltreatment[3] has occurred or if the child is at risk, and putting an appropriate intervention in place. A growing number of states and local child protective services agencies are moving to a more family-centered approach called alternative response, differential response, or multiple response. The focus of these models is on assessing the strengths and needs of the family and child while ensuring the child's safety, usually without requiring a determination regarding maltreatment. Families may receive services through diversion to community agencies. In other words, families reported for suspected child abuse or neglect may receive either a traditional investigation or an assessment alternative, depending on the severity of the allegation and other considerations.

Family mediation, also known as alternative dispute resolution, collaborative negotiation, conflict resolution, or conflict intervention, is also increasingly being used in making child protection, child placement, and permanency decisions for children. In this collaborative model, court and community-based mediators work with families to resolve child abuse and neglect cases, expedite permanency planning, and develop post-permanency plans for ongoing birth family involvement in the lives of their children. The process emphasizes the needs of the child, family empowerment, and cooperation between families and professionals in contrast to the traditional adversarial, rights-based decision-making process,

DIFFERENTIAL RESPONSE SERVICES

Differential response, also known as dual track, multiple track, or alternative response, is an approach that allows child protective services to respond differently to accepted reports of child

[3] **Maltreatment** is commonly classified into four categories: **Physical abuse** includes punching, beating, kicking, biting or shaking a child. **Sexual abuse** refers to any sexual contact with a child, the simulation of such conduct with a child, or exposing a child to sexually explicit material or conduct. **Child neglect** is a failure to provide for a child's basic needs for health care, food, clothing, adult supervision, education, and nurturing. **Psychological maltreatment** refers to behavior, such as ridiculing, terrorizing, corrupting, or denying affection to a child.

abuse and neglect, based on factors such as the type and severity of the alleged maltreatment, number and sources of previous reports, and willingness of the family to participate in services. It is generally used for low and moderate-risk cases that receive a non-investigation assessment response without a formal determination or substantiation of child abuse and neglect. It has been suggested that families that receive a non-investigation assessment response are more likely to be receptive and engaged in the receipt of services when approached in a non-adversarial, non-accusatory way. Incident-based investigations, often perceived adversarial, are reserved for accepted reports that are high-risk and serious.

- **Two or more discrete tracks of intervention**
- **Multiple responses for reports of maltreatment that are screened in and accepted for response**
- **Track assignment determined by presence of imminent danger, level of risk, number of previous reports, source of the report, and/or presenting case characteristics such as type of alleged maltreatment and age of the alleged victim**
- **A possible decrease or elevation in original track assignments based on additional information gathered during the investigation or assessment phase. An increase or decrease in threats of harm or risk level can trigger a change in track assignment**
- **Establishment of multiple tracks codified in statute, policy and/or protocols**
- **Voluntary services for families who receive a non-investigatory response; families can accept or refuse the offered services without consequence**
- **No substantiation of alleged maltreatment for families served in a non-investigation track and services offered without a formal determination of child maltreatment (i.e., substantiation). This means that perpetrators and victims are not identified for the alleged reports of maltreatment that receive a non-investigation response**
- **Differential use of central registry depending on track, meaning the name of the alleged perpetrator is not entered into the central registry for those individuals who are served through a non-investigation track**

MODEL DEPENDENCY COURTS

Studies indicate that children who are abused and neglected are at significantly higher risk for academic failure, chronic delinquency, adult criminal behavior, antisocial personality disorder, and engaging in violent crimes. In addition, as a child's length of time in out-of-home care increases, the probability of negative outcomes also increases. Research suggests that more efficient and effective dependency courts can reduce the length of time children spend in the system.

Model Dependency Courts have been developed to improve the processing of child abuse and neglect cases and focus on continually assessing child abuse and neglect case processing, impediments to timely court practices and delivery of services to children in care and their families and timely permanency, developing and instituting plans for court improvement, working collaboratively to effect systems' change, how well the court is meeting federal and statutory requirements; how well social service agencies are meeting clients' needs; and how well the child protection system as a whole is meeting the needs of the children and families it serves.

Model Courts are designed to provide early and intensive intervention by remedial services and the court to minimize the number of days children spend in out-of-home placements. Components include empowerment of all parties through participatory pre-hearing conferences designed to solve problems; tightly scheduled pre-hearing conferences followed immediately by a judicial hearing; a reduction in hearing continuances; and compliance with federal regulations

to make a determination within twelve months as to whether an abused or neglected child should be returned to his parents or directed toward adoption.

Each court uses unique, individualized methods of collaborating with related child welfare agencies and community groups to benefit abused and neglected children who are in foster care, or at risk of being placed in foster care. For example, reorganized one-family/one-judge court calendars have been developed to ensure that judicial decision-makers assigned to specific dependency cases remain on those cases until the children involved achieve permanence either by being safely reunited with their rehabilitated families or placed in permanent adoptive homes. Family group conferencing and mediation programs have been incorporated into many Model Court jurisdictions. Many have expanded preliminary protective hearings to ensure that related issues are substantively investigated at the early stages of child abuse and neglect litigation. Scheduling hearings at specific times, implementing strict continuance policies, and developing state-of-the-art data information systems are goals of several Model Courts, while others are focusing on increasing adoptions. All Model Courts are seeking to shorten timelines for children under court supervision, and many are striving to decrease the number of cases under court supervision by examining records and clearing case backlogs. Child health and safety remain paramount concerns as these innovative alternative dispute resolution methods are integrated into court and community responses to child abuse and neglect.

The Permanency Planning for Children Department of the National Council of Juvenile and Family Court Judges (NCJFCJ) provides intensive training and technical assistance to improve courts' handling of child abuse and neglect cases and to ensure timelier decision-making in permanency planning through the Model Dependency Courts Initiative. Information can be obtained from http://www.ncjfcj.org/content/view/82/146/.

FATHERHOOD TRAINING CURRICULUM

The research base on the link between fathers and maltreatment suggests that fathers are directly involved in almost thirty seven percent (36.8%) of maltreatment cases, act alone in almost nineteen percent (18.8%), and with others in eighteen percent. Unrelated male figures and stepfathers in households tend to be more abusive than biological, married fathers. The presence of fathers in the home is tied to lower rates of maltreatment. The quality of the relationship between the mother and father has an important indirect effect on the odds of maltreatment. Thus, a father in the home can be a strong protective factor for children, but may also play a role in child maltreatment. Research shows that poverty, underemployment, or unemployment can increase a father's stress level which can increase the potential for child physical abuse.

Fathers have traditionally not been as involved in child welfare case planning as mothers. A number of studies indicate that caseworkers may overlook fathers in connection with their investigations and interventions regarding child maltreatment. It is recommended that fathers, irrespective of whether or not they are the perpetrators of child maltreatment or whether they live with their children, be effectively involved in case planning and service provision.

The Fatherhood Training Curriculum is designed to engage and involve fathers in their children's lives. While the curriculum is aimed primarily at working with the non-custodial fathers not living with their children, it is also applicable to other fathers. The basic curriculum includes:

- Why fathers are important
- How to assess whether your agency is father-friendly
- Barriers to involving fathers
- Motivating staff to begin involving fathers in their children's lives

- Learning how to communicate with fathers
- Acknowledging the mother as gatekeeper and her role in involving the father
- National fatherhood expert's tips on engaging fathers
- Case examples with principles of practice
- Family portrait of an involved father

Current child welfare practices regarding fathers are reviewed and Information on fathers as untapped resource that must by addressed by the child welfare system. Agency assessment and policies that father-friendly approaches are suggested. Information on communicating with fathers, principles of practice and case examples are reviewed. A tool for practitioners and a tool for administrators to evaluated progress in engaging and involving fathers in their children's lives is included.

The training package consists of:

- Fifty Basic Fatherhood Training Curriculum manuals
- Training script for 4 hours of fatherhood training, including handouts and overheads
- Video with tips on engaging fathers and interviews with fathers, mother, and children (40 minutes)
- Guide for setting up training
- Agency self-assessment survey
- Assessment tool for father involvement
- Activities for dads and their children
- A message for moms, including the benefits of a father's involvement in the child's life
- Tips for engaging fathers
- Protective factors for father involvement … and more!

The Advanced Fatherhood Training Curriculum focuses on skills for engaging fathers who are resistant or reluctant to become involved with their children. This training package contains:

A thirty three-page manual that includes:

- Differences in fathers' and mothers' communication and parenting styles
- Strategies for overcoming obstacles to father involvement
- Helpful hints when engaging fathers
- Case examples identifying specific skills to use to engage fathers
- Section for administrators on agency policies, competency levels, and research findings that promote father-friendly practice

A thirty three-minute video on best practice that includes:

- Administrators' perspectives on creating a father-friendly agency
- Success stories from practitioners on engaging and involving fathers in their children's lives
- Insights from fathers on how they became engaged and involved with their children
- Essays from school-age children on what their father means to them

Information on the fatherhood training curricula is available from the National Family Preservation Network http://www.nfpn.org/fatherhood/fatherhood/.

FAMILY PRESERVATION SERVICES

Family preservation services (FPS) are short-term, family-based services designed to assist families in crisis by improving parenting and family functioning while keeping children safe. These services were developed largely in response to the over-reliance on out-of-home care that characterized services during the 1970's. Since that time family preservation has been used to describe a variety of programs that are intended to provide services to children and families who are experiencing serious problems that may eventually lead to the placement of children in foster care or otherwise result in the dissolution of the family unit. Family preservation services grew out of the recognition that children need a safe and stable family and separating children from their families is traumatic for them, often resulting enduring adverse effects. These services are based on the conviction that many children can be safely protected and treated within their own homes when parents are provided with services and supports and empowered to change their lives.

In 1993, Congress passed legislation establishing title IV, part B-2 of the Social Security Act, creating funding for family preservation and family support programs. The legislation does not endorse any single program model for family preservation services; states are allowed to determine their own program models.

Family preservation services are family-focused, community-based services designed to help families at risk or in crisis address major challenges, cope with significant stresses or problems that interfere with their ability to nurture their children, stabilize families, and enhance family functioning. The goal of family preservation services is to maintain children with their families, or to reunify them, whenever it can be safely accomplished. Family preservation services may be provided to different types of families including birth or biological families (both immediate and extended), kinship families, foster families, and adoptive families,

Family preservation services include:

- Services designed to help children where appropriate, return to families from which they have been removed; or be placed for adoption, with a legal guardian or in some other planned, permanent living arrangement;
- Pre-placement prevention services programs, (e.g., intensive family preservation programs) designed to help children at risk of foster care placement remain with their families
- Service programs designed to provide follow-up care to families to whom a child has been returned after a foster care placement
- Respite care of children to provide temporary relief for parents and other caregivers (including foster parents)
- Services designed to improve parenting skills (by reinforcing parents' confidence in their strengths, helping them identify where improvement is needed, and obtain assistance in improving those skills) in areas such as child development, family budgeting, coping with stress, health, and nutrition

A review of the literature reveals that family preservation services are most often provided to families that have come to the attention of the child welfare, mental health, or juvenile justice systems because of child abuse or neglect, child behavioral health challenges, delinquency, or serious parent-child conflict. These services are applicable to families that are at risk of disruption/out-of-home placement across systems.

Intensive family preservation services, like family preservation services, are family-focused, community-based crisis intervention services designed to maintain children safely in their homes and prevent the unnecessary separation of families. IFPS are characterized by small caseloads for workers, short duration of services, twenty four-hour availability of staff, and the provision of services primarily in the family's home or in another environment familiar to the family. They are often offered to families as an alternative to their children's out-of-home placement. HOMEBUILDERS and Families First[4] are examples of intensive family preservation programs.

Since the term family preservation services was coined in the 1980s, there has been significant confusion about the essential elements of these services and which types of programs fall into this category. Although family preservation programs share many common characteristics, they vary considerably with respect to auspices (i.e., public or private agencies), theoretical orientation, target population, identified problem, and primary location of service. Programs also vary considerably in terms of intensity, duration, caseloads, and teaming with other professionals or paraprofessionals.

ACHIEVING AND MAINTAINING PERMANENCY

A number of approaches have been developed to aid in ensuring a legally permanent, nurturing family for children in out-of-home care through family reunification, adoption from foster care, guardianship, and permanent placements with relatives.Permanency practices within the special needs adoption and intensive family preservation/reunification movements have resulted in successful reunification, adoption and guardianship outcomes for older youth in care.

CONCURRENT PLANNING

Concurrent planning is an approach that seeks to eliminate delays in attaining permanent family placements for children in the foster care system. Concurrent planning involves considering all reasonable options for permanency at the earliest possible point following a child's entry into foster care and concurrently pursuing those that will best serve the child's needs. Typically the primary plan is reunification with the child's family of origin. In concurrent planning, an alternative permanency goal is pursued simultaneously. Evaluations of concurrent planning efforts suggest they lead to earlier permanence for children than the sequential case planning that was common practice following the passage of the Adoption Assistance and Child Welfare Act of 1980. That practice, which required a preferred permanent plan to be ruled out before an alternative was developed, is believed to contribute to long lengths of stay in out-of-home care.

The literature on concurrent planning offers little in the way of evidence-based programs and practices. Most available studies consist of tracking permanency outcomes or gleaning qualitative information from focus groups, surveys, or interviews with caseworkers, families, foster/adoptive parents, or other stakeholders. Despite the limitations, recent evaluations do appear to offer support for the approach, especially with younger children[5].

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[4] Families First of Michigan offers in-home intensive, short-term crisis intervention and family education services in their home for four to six weeks as an alternative for children who are at imminent risk of out-of-home placement because of substantiated child abuse, child neglect, or delinquency. Services are available to eligible families twenty four hours a day, seven days a week.

[5] Although concurrent planning is used for children of all ages, the practice was originally developed for younger children considered at risk for delayed permanency. Some research has found that younger children are more likely than older children to benefit from concurrent planning.

As noted above, the primary benefit of concurrent planning appears to be earlier attainment of a permanent family outside of the foster care system. Anecdotal evidence also suggests that openness and direct communication between birth parents and caregivers in concurrent planning may lead to more voluntary relinquishments and open adoptions. Evaluations have identified critical factors in successful concurrent planning efforts:

- Individualized assessment and intensive, time-limited work with birth families targeting the problems that necessitated foster care placement.
- Full, documented disclosure with birth parents regarding problems, changes, possible consequences, and time frames.
- Early aggressive search for birth family resources for achieving permanency.
- Early identification and consideration of all permanency options.
- Frequent and constructive use of parent-child visitation as part of reunification efforts.
- Early use of foster/adoptive or kinship placements.
- Involvement of foster/adoptive and kinship caregivers in teaching and skill-building with birth parents.

The literature has also identified factors that may predict timely permanency including caseworker consistency, fewer placements, ineligibility for Title IV-E assistance (i.e., extreme poverty), identified substance abuse issues in the family, and more days of parental visitation per week. Other factors found to relate to timely permanency include clear identification of the concurrent plan in the written service plan and parental signatures on the plan. Some research suggests that the terminology used by agencies regarding foster/adoptive parents appears to be related to differences in how families are viewed as part of the concurrent planning process. Those that refer to foster/adoptive parents as resource families have been found to involve them more fully in the planning process and make earlier foster/adoptive placements for children than did those who refer to such families as legal risk"

Attempts to use and develop tools to predict reunion failure have been mixed. The most commonly used poor prognosis indicators are a parent who has previously killed or seriously harmed another child, repeatedly and with premeditation harmed a child[6], has only visible support from a drug culture and makes no significant effort to change over time, significant, protracted and untreated mental health issues, and their rights to another child have been involuntarily terminated. However, some research has found no relationship between poor prognosis indicators and the likelihood of family reunification. Therefore, it is recommended that poor prognosis indicators be used as only one part of a comprehensive family assessment, along with other assessment tools (e.g., strengths, risk, and safety indicators).

Challenges of multiple systems working toward the goal of permanency have been identified including poor communication and, lack of collaboration, role clarity across systems, early and accurate assessment of child and birth parent needs, and involvement of service providers for mental health, substance abuse, and domestic violence issues.

The importance of judicial involvement in concurrent planning has been highlighted in the literature. In one model, for example the use of concurrent planning is combined with other permanency planning activities for achieving timely permanence including risk assessment, representation by a single attorney from initial filing to permanency, and early placement in foster/adoptive and kinship homes. Changes in court procedures and roles of court personnel,

[6] It should be noted that, with the 1997 passage of the Adoption and Safe Families Act and corresponding legislation in states, attempts to reunite families are not typically required when a parent has killed or seriously or repeatedly harmed a child.

as well as efforts to improve communication between the child welfare agency and the courts are also made. Outcomes indicate that children experience stability of placement and shorter lengths of stay relative to area foster care populations.

The integral role of the court in concurrent planning has been demonstrated by the success of the Expedited Permanency Planning model in Colorado. Colorado enacted legislation mandating the courts to work with the child welfare agency to achieve more timely permanence for children aged six or younger when they enter foster care. As a result, courts accelerate the judicial process in child dependency cases.

Concurrent planning is stressful and requires more information to determine various permanency options early in a case. The literature, as well as anecdotal reports, indicates that caseworkers often experience difficulty grappling with the tension inherent in attempting to reunite a child with their family while also working on an alternative permanent plan. Caseworkers need to understand the dynamics underlying child maltreatment and be skilled in conducting differential assessments. They also must be competent in working with parents and other professionals to plan and deliver targeted services and assess progress toward goals.

Increasingly, foster parents are seen as key players in the team working to achieve permanency for children in foster care. Foster parents may work with birth parents and support reunification efforts. They also may consider adopting the children in their care if the children cannot return home. As the children's primary caretakers, foster parents can have significant roles in carrying out the tasks in the permanency plan.

The literature indicates that recruitment, preparation, and support of foster/adoptive families is one of the most challenging aspects of concurrent planning. While not all concurrent planning models use foster/adoptive families, those that do need to ensure that families are well-prepared and supported. The approach demands much of these families; they must be willing to make a permanent commitment to a child placed in their home, while at the same time work cooperatively with the agency and family of origin to effect reunification. Their work often includes teaching and modeling skills for birth parents and other family members as well as mentoring new foster/adoptive families.

The limited evaluations of concurrent planning conducted thus far appear to offer support for the approach in strengthening permanency outcomes for children. The evidence base in concurrent planning suggests the following guiding principles:

- Concurrent planning needs to be supported philosophically and with adequate resources both within the child welfare agency and among service providers and related professionals; lack of acceptance on the part of any group can jeopardize the effectiveness of the approach; agency partners serving families should be part of the planning, training, and implementation process.
- Cooperation and preparation of the judicial system is especially critical. More timely planning and casework services cannot be effective without the development and enforcement of judicial procedures that ensure smooth progress of cases through court. Early involvement of attorneys and judges in planning and support for concurrent planning efforts is critical.
- Early and aggressive efforts should be made to identify all reasonable permanency options for children entering foster care; concurrent planning focuses permanency efforts on the best interests of the child.
- Families should be engaged in collaborative planning and decision-making in the permanent plan for their child.

- Interactions with families should be based on respect, honesty, and openness to engage them and clarify ethical considerations for caseworkers and legal issues for the courts.

The National Resource Center for Foster Care and Permanency Planning (NRCFCPP) has worked with some programs that seem to be moving toward faster, safer and lasting reunifications. However, research evidence of the effectiveness of these programs is sparse. Several practices are believed to be important components of reunification:

- Placement decision-making
- Parent-child visiting
- Intensive services
- Resource parent/birth parent collaboration
- Aftercare services

These are not the only practices that should be incorporated into a reunification program, nor do they provide a guarantee of success when used individually or in combination. Rather, they represent some of the important building blocks on which a comprehensive system of reunification can be based.

Some of the hallmarks of programs that make placement decisions resulting in reunifications are:

1. **Involvement of the family through processes such as family group conferencing**, which can lead to decreased time in care. Families who participate in decision-making – not just in terms of where the child will live while in out-of-home care, but to also to discuss issues such as long-term safety and well-being and extended family supports for reunification – are empowered to engage with the agency in finding solutions that work with family strengths.
2. **When placing with kin is not possible, children should be placed in their own neighborhoods, communities, and schools**. Neighborhood-based family foster care helps to keep children connected with their friends, schools, churches, and culture, but more importantly allows for frequent parent-child visiting. Targeted recruitment efforts provide the agency with a sufficient pool of competent resource families who reflect the ethnic and racial diversity of children in need of out-of-home care in the communities from which the children come. (One goal of the Annie E. Casey Foundation's Family to Family Initiative is neighborhood-based family foster care.)
3. **Competent legal representation of birth parents**, which enables families to take a more effective role in court proceedings. In a pilot program in Washington State parents were provided with attorney representation. Results indicated a number of improved outcomes, including increased numbers of reunifications.

PARENT-CHILD VISITING

Visiting between parents and their children in foster care is generally considered to be the most important factor contributing toward timely reunification. Parent-child visiting can be a component of residential care as well as family foster care. Visiting maintains the connection between parents and their children during placement and allows the readiness of parent and child for reunification to be assessed. Effective visiting does not limit contacts between parents and children to short visits in an agency office. Components of parent-child visiting that have been found to effectively lead to reunification are:

- Structuring visits in ways that enhance opportunities for parents to practice and enhance their care-giving skills
- Scheduling visits at the home of foster families, at times that include increasingly more challenging situations such as meal times and bedtimes, and for longer periods of time
- Including parents in activities that allow them to be part of their children's lives, such as school activities, doctor appointments and recreational opportunities
- Encouraging foster parents to interact with birth parents

INTENSIVE FAMILY-BASED SERVICES

Intensive in-home services for reunification focus on making sure that families are able to meet the basic needs of their children. Parents are given hands-on learning experiences in areas in which they are experiencing problems such as meal planning, food shopping, and meal preparation or housekeeping tasks.

Intensive family-based services are often cited as a critical component of effective reunification programs. Studies have found that children whose families received such services were much more likely to be reunified within ninety days and remain at home one year later. The Family Reunification Program of the Michigan Family Independence Agency employs intensive services.

The National Family Preservation Network recommends that intensive family reunification services should include the following components:

- Staff are available on call, twenty four hours a day, seven days a week
- Caseloads are limited to two to four families
- Families see a reunification worker within three days of referral
- Most reunification services are delivered in the family's home
- Intensive services are provided five to twenty hours per week
- Services are available during evenings and on weekends
- Services are limited to sixty to ninety days

It has been noted that part of the challenge of providing intensive in-home services is the difficulty in funding them. Title IV-E monies can only be used for eligible children and for routine care so they are generally not available for intensive in-home services. It is recommended that Title IV-B funds, TANF monies, the Social Services Block Grant, and targeted case management under Medicaid be used to fund such services. Some states have obtained IV-E waivers for intensive services in family preservation and reunification programs.

PARENT/BIRTH PARENT COLLABORATION

Several programs have been developed to encourage resource families to act as mentors to birth parents to facilitate parent-child visiting, teach and mentor birth parents in parenting skills, and participate in placement conferences are contributors to the reunification effort. Permanency Plus in New Hampshire, which combines the services of a home-based counseling agency, NH Easter Seals, and the Department of Children, Youth and Families. These organizations collaborate to provide a combination of home and community-based treatment for families whose children are temporarily removed from the home in first time placements because of child abuse/neglect. Resource parents are recruited and trained with the understanding that they will be actively involved with the placement and reunification plan and should reunification not occur, agree to provide a permanent home for children placed with them.

Shared family care (SFC) is an extension of resource family mentoring. In this model, the child enters care along with his or her birth parent. An example can be found in Contra Costa County, California where the birth parent(s) move into the resource family's home for about six months. In addition, birth parents are served by a family support team that helps identify goals, develop a plan for achieving them, and provides intensive case management services and links to community resources. Families also receive six months of aftercare services based upon individual needs.

AFTERCARE SERVICES

Reunification is the preferred permanency outcome, but; like other forms of permanence, is a process that needs to be sustained with post-permanency services. Birth parents need many of the same kind of services and supports that are often given to adoptive parents, guardians, and other permanent caregivers. In addition, they may need other services that specifically address the issues that brought the child into care in the first place. The intensity of needs may vary as the family experiences challenges or crises subsequent to the child's return to the home. The provision of such services can be quite challenging in reunification for a number of reasons, including the following:

- Some birth parents are ambivalent about parenting and being reunited with their children.
- Birth parents may receive conflicting messages from the child welfare and legal systems about their skills and ability to adequately parent their children. Reactions to real or perceived negative attitudes may be played out in ways that look like noncompliance.
- Birth parents may want to their involvement with the child welfare system after complying with case plans that may have required significant life changes in order to regain custody of their children, Nevertheless, post-reunification services tailored to the individual needs of the child and family and supports are considered essential including:
    - Clinical services such as individual, couples, or family therapy, substance abuse treatment, domestic violence intervention, or crisis intervention;
    - Material or financial services such as income support, job training, health care coverage, or housing assistance; and
    - Support networks such as day care, respite care, peer support groups, linkages with the health and education systems and other community-based services.

PREPARATION FOR ADULTHOOD

Aging out of the foster care system without a permanent family have been shown to be associated with adverse outcomes including homelessness, incarceration, criminal involvement, violence, homelessness, early pregnancy, mental illness, substance use disorders, and other adverse health outcomes. In addition, they are more likely to drop out of high school, and not attain postsecondary education, and are less likely to be employed or have jobs that do not pay a living wage.

While permanency planning was initially intended as a process to limit entry into and time spent in out-of-home placement, current literature regarding achieving permanency means having an enduring family relationship that is safe and meant to last a lifetime; offers the legal rights and social status of full family membership; provides for physical, emotional, social, cognitive and

spiritual well-being; and assures lifelong connections to extended family, siblings, other significant adults, family history and traditions, race and ethnic heritage, culture, religion and language.

Factors found to increase positive outcomes in providing foundations for self-sufficiency include:

- Foster care that does not involve multiple placement changes and runaway incidents can significantly improve mental health and education outcomes
- Youth who have concrete resources when they exit care (e.g., funds, dishes and utensils, and a driver's license) and more comprehensive independent living preparation experience better employment and finance outcomes.
- Youth who have an early positive engagement with employment appear to function better as adults.
- Youth who stay in foster care beyond age eighteen fare better across a number of domains.

The literature recommends the provision of an array of post-permanency services and supports to families (irrespective of exiting foster care through reunification, adoption, or guardianship) to ensure that children safely remain in their permanent homes. Research shows that adolescents who exit foster care are most likely to reenter, particularly those aged thirteen to seventeen. Such necessary services and supports include access to physical health and mental health care, independent living skills training (e.g., basic study skills, work skills, money management, social development, self-care and practical daily living skills), education supports, employment supports, and access to safe, stable and affordable housing[7].

The following options for achieving permanency have been identified:

- Safe, stable, and secure permanency with a youth's family of origin
- Family preservation, reunification, adoption and legal guardianship which offer a secure legal status and the full legal rights and benefits of family membership.
- Exploration of adoption or legal guardianship with both relatives and non-relatives when permanency with a youth's family of origin can not be achieved
- A plan of alternative planned permanent living arrangement (APPLA) made more secure by assuring the permanent commitment of a person (rather than just a place to live) that can be reinforced with rituals, ceremonies, a legal name change, inclusion in a family's legal will and/or other symbols of belonging or claiming when a legal permanency outcome can not be achieved"
- Permanent kinship placement, informal adoption and customary adoption (such as those found in some African American and Native American communities) may best honor a youth's emotional attachments as well as preserve continuity of connections to family, culture, ethnicity, religion and language.

Innovative permanency and preparation for adulthood initiatives have demonstrated that collaborative team planning and decision-making should include:

- Partnering with youth as the central player in their own integrated planning process, engaging them in identifying essential team members that include:

[7] The Education and Training Voucher Program (ETV Program) provides financial assistance to help defray the costs of postsecondary education both to youth who age out of foster care and youth who leave care at or after age to adoption. The Chafee Independent Living Program is designed to serve all youth who have aged out of foster care between the ages of eighteen and twenty one. It is also intended to provide life skills training and services to youth in foster care who are likely to age out of foster care.

- Parent(s), family members and other adults significant in a youth's life, both past and present (including birth, foster, respite and adoptive parents; siblings; grandparents and other relatives; godparents; family friends; teachers; coaches; mentors; neighbors; former social workers or child care staff, etc.)
- Adults in the process of being recruited and prepared as potential permanent parent(s), if any
- Child welfare staff and other professionals in a position of decision-making power (social workers, attorneys, residential staff, therapists, etc.)
- Professionals or individuals from the local community able to assist in or provide expanded opportunities or resources

- The development of a youth-centered, family-focused integrated plan that addresses:
  - Safety: how physical safety and psychological safety will be achieved and sustained over time, and how and when a safety plan will be developed and implemented;
  - Permanence: how the most secure and lasting commitment by a permanent parent will be achieved and sustained over time; how enduring connections to birth parents, siblings, extended family members, other significant adults, race, ethnicity, culture, religion and language will be achieved and sustained over time;
  - Well-being: how optimal outcomes related to health, mental health, education, vocation, employment/career, housing, identity, life skills and community engagement will be achieved and sustained over time.
- Facilitation of an ongoing collaborative team planning process to insure a safe and secure family permanency outcome and monitor progress toward comprehensive preparation for adulthood; and enhance the network of formal and informal post-permanency supports and services necessary beyond exit from the system; and strengthen relationships among team members functioning as the safety net of adults committed to supporting a youth into adulthood.

EVIDENCE-BASED AND EVIDENCE-INFORMED PROGRAMS

This section lists selected parent education curricula, in-home services and supports, school-based programs, and family-oriented services and that have been included on various registries of evidence-based and evidence-informed programs. The programs and interventions discussed below does not constitute an all-inclusive review of all interventions, programs, and services or an endorsement of any particular one. More information about these programs and the criteria used to evaluate them can be found on various web sites (which are listed where available) resources section of this paper. Additional programs and services can be found in other Saginaw County Community Mental Health Authority evidence-based practice reports.

PARENTING PROGRAMS

SAFECARE

SafeCare is an evidenced-based parenting program for at-risk and parents who maltreat their children that addresses the social and family ecology in which child maltreatment occurs. It is an in-home parenting model program that provides direct skill training to parents in child behavior management and planned activities training, home safety training, and child health care skills to prevent child maltreatment. It is targeted to parents of children from birth to age twelve who have a history or at risk for child neglect or abuse. It is conducted in adoptive, birth family, and foster family homes, once a week for approximately one and a half hours per session for eighteen to twenty weeks. The program addresses difficulty managing behavior, inability to complete developmentally appropriate daily living tasks, and child health and safety concerns. Outcome studies indicate participation results in significant improvements in child health care, home safety, and parent–child interactions.

Planned Activities assessment and training	• Teach parent time management • Explain rules to child • Reinforcement/rewards • Incidental teaching • Activity preparation • Outcome discussions with child • Explain expectations to child
Home Safety assessment and training	• Assess accessible home hazards with the *Home Accident Prevention Inventory-Revised* to assess accessible home hazards • Provide parents with door and cabinet latches • Use graduated plan to have parents remove identified hazards and to child proof doors and cabinets • Perform healthy home assessment and training
Infant and child health care assessment and training	• Use health checklists to assess parent skills • Teach any skill deficits (i.e., how to take a temperature) • Teach use of health checklists and how to determine when to self-treat illness and when to seek medical care

	• Include problem solving training as needed
Parent and staff training	• Modeling • Role rehearsal • Performance criteria in simulation and actual interactions. • Monitoring of staff for model fidelity • Booster training if performance falls below criteria

A training manual that describes how to implement SafeCare is available from http://www.marcus.org/treatment/safecare.html.

PARENT-CHILD INTERACTION THERAPY (PCIT)

PCIT is a parent management training program for families of children between the ages of two and six who are experiencing emotional, behavioral or developmental difficulties and family problems. The program uses play therapy and in vivo teaching to give feedback regarding mother-child interactions. It is a short-term, manualized intervention that is comprised of two phases, Child-Directed Interaction (CDI), and Parent-Directed Interaction (PDI). The focus of the CDI phase is on enhancing parent-child attachment. This is the foundation for PDI, which focuses on using a structured and consistent approach to discipline. CDI is based on attachment theory. Parents are taught skills to promote positive, nurturing interaction in order to provide a secure attachment for the child. PDI is based on social learning theory and addresses ineffective/maladaptive parent-child interactions that can create and maintain behavioral problems.

The program consists of ten to sixteen one-hour sessions conducted on a weekly basis consisting of:

- A pretreatment initial assessment of child and family functioning
- Joint development of therapy goals by the clinician and parents
- Feedback, teaching, and coaching of parents in the CDI skills
- Teaching and coaching parents in the PDI skills
- Direct consultation and coaching for the child's teacher
- Teaching generalization skills
- Post treatment assessment
- Booster sessions over a twelve month period to maintain positive skills

Each phase of treatment entails a didactic session for parents during which interactional skills and their rationales are taught via modeling and role-plays. Then, parents and their children attend weekly coaching sessions together. They are given homework to practice skills between sessions on a daily basis for five to ten minutes per day. During CDI, parents are taught to use PRIDE (praise, reflection, imitation, description, enthusiasm) skills while avoiding questions, commands, and criticism when playing with their children. During PDI, parents are taught to impart clear, developmentally appropriate, direct commands and confer consistent consequences for both compliance and noncompliance. Praise is used for compliance and time-outs are used for noncompliance.

Research indicates PCIT is effective in reducing children's behavior problems at home and school, and results in improved parental interactional styles. Parents report gains in confidence in their parenting abilities and reductions in personal distress. The beneficial effects of PCIT have been shown to generalize to other family members (i.e., siblings who have not undergone treatment). Studies that have included culturally diverse families have also found these positive

outcomes. PCIT has been shown to be most effective if it is used continuously in the home and other significant environments.

A comprehensive treatment manual, test outline of the program, and implementation recommendations are available. However, there are several training models and these are of varying levels of intensity. Information on PCIT can be found on the web at http://www.pcit.org/.

FAMILIES THAT CARE: GUIDING GOOD CHOICES (FTC:GGC)

This SAMHSA model parent training program, formerly known as Preparing For The Drug **Free** Years (PDFY), is a multimedia drug prevention program that gives parents of children in the fourth through eighth grades (aged eight to thirteen) that is designed to give parents skills needed to guide their children through early adolescence and help reduce their children's risk for using alcohol and other drugs by enhancing family management and communication skills.

FTC:GGC is comprised of a five-session curriculum that addresses preventing substance abuse in the family, setting clear family expectations regarding drugs and alcohol, avoiding trouble, managing family conflict, and strengthening family bonds. The sessions are interactive and skill based, with opportunities for parents to practice new skills and receive feedback. It uses video-based vignettes that demonstrate parenting skills. Families receive a Family Guide containing family activities, discussion topics, skill-building exercises, and information on positive parenting. The program reviews refusal skills designed to enhance children's ability to avoid partaking in alcohol, tobacco, and other drugs, as well as non-drug risk behaviors. Parents practice these skills with their children. In general, the program targets risk factors (such as family management problems, family conflict, etc.) and protective factors (such as family communication skills) that relate to later substance use and abuse.

The program's five two-hour workshop sessions are typically conducted at convenient community locations over the course of five consecutive weeks, although the curriculum can also be presented in ten one-hour sessions. Session topics include:

- Preventing substance abuse in your family
- Setting clear family expectations regarding drugs and alcohol
- Avoiding trouble
- Managing family conflict
- Strengthening family bonds

The sessions are interactive and skill-based, with opportunities for parents to practice new skills and receive feedback from workshop leaders and other parents. Video-based vignettes are used to demonstrate parenting skills through the portrayal of a variety of family situations. Families also receive a Family Guide containing family activities, discussion topics, skill-building exercises, and information on positive parenting. The program has been offered to parents in schools, worksites, faith communities, community centers, homes, hospitals, and prisons. Parents who attend all five sessions are awarded a certificate of completion at the end of the program.

FTC:GGC is conducted by two co-leaders who share responsibilities for instruction, modeling skills, and answering questions. It is recommended that this two-person team consist of a parent and someone with group facilitation experience. It is most beneficial if workshop leaders are representative of the community. Implementation of FTC:GGC includes broad, community-based recruitment efforts; workshop leaders are trained to enlist the help of local financial, site, and celebrity sponsors, including schools, churches, PTAs, restaurants, retail stores, and sports or media personalities.

Outcome studies indicate that participation in this program leads to reductions in substance, delinquent behaviors, and increased involvement in family activities and decisions and better ability to manage anger and conflict.

Implementation costs are estimated to range from $5000.00 to $10,000 including on-site training and materials. A workshop guide, video, family guide, and visual aids are available from http://www.channing-bete.com/prevention-programs/guiding-good-choices/.

THE INCREDIBLE YEARS

The Incredible Years is a parent training program that uses a comprehensive curriculum for children aged two to eight, their parents, and teachers. It is a prevention and intervention model that is designed to enhance emotional and social competence as well as ameliorate behavioral and emotional problems. The program is comprised of three components, a parent training program, child training program, and teacher training program:

❶ Parent training:

- The Basic Parent-Training module consists of twelve to fourteen two-hour sessions held once a week that focuses on parenting skills designed to foster children's social competence and reduce behavioral problems. It teaches parents how to play with children, help children learn, give effective praise and incentives, use limit-setting, and deal with misbehavior.
- The Advance module is an eight to ten-session program that focuses on parental communication skill building (e.g., effective communication, anger management, problem-solving between adults), and ways to give and receive support.
- The School module is comprised of three to four two-hour sessions that focus on parenting techniques designed to foster children's academic skills. These include reading skills enhancement, establishing homework routines, and establishing collaborative relationships with teachers.

❷ Child training:

The child-training component uses the Dina Dinosaur Curriculum, an intervention program for small groups of children who exhibit conduct problems (e.g., aggressive, defiant, oppositional, and compulsive behaviors). It focuses on communicating feelings, empathy for others, friendship development, anger management, interpersonal problem-solving, and obedience to school rules and regulations. It is conducted in groups of five to six children in weekly two-hour sessions for eighteen to twenty weeks. The Dina Dinosaur character is used to teach emotional literacy, empathy and perspective taking, friendship development, anger management, impersonal problem-solving (e.g., waiting, taking turns), and following school rules (e.g., being quiet, raising one's hand to speak, listening to the teacher).

❸ Teacher training:

The teacher-training component is comprised of a six-day, forty-two hour workshop that focuses on classroom management skills development. These include effective use of attention given to children, praise and encouragement, incentives for difficult behavior problems, proactive teaching techniques, and ways to manage inappropriate classroom behavior and enhance positive relationships with students. The program encourages teachers to be sensitive to children's individual developmental differences (e.g., variations in attention spans and activity levels, heightened interest in novel situations), and teaches them how to respond to these differences in a positive, accepting, and

consistent manner. Teachers are also taught how to prevent peer rejection by teaching children who display aggression appropriate problem-solving strategies and helping their peers respond appropriately to aggression. Teachers, parents, and group facilitators jointly develop transition plans that detail classroom strategies found to be effective for each child, goals achieved and those remaining, and the child's characteristics, interests, as well as motivators for children who display conduct problems.

Studies have shown that The Incredible Years produces beneficial outcomes including decreases in the frequency of problem behaviors (including noncompliance/failure to respond and aggression toward peers), negative behaviors, and increases in behaviors that are more prosocial such as social problem-solving (e.g., positive response to hypothetical conflict situations). In addition, parents use less corporal punishment (spanking).

Trained facilitators devote five hours per week to a two-hour parent group and provide workshops and weekly meetings for teacher training. The costs for program are as follows: $1300.00 for the Basic component, $775.00 for the Advance component, $995.00 for the School component, $1250.00 for the teacher training, and $975.00 for the child training program. Training and technical assistance costs are charged on daily rate. The certification fee for facilitators is $350.00. Information about the program is available on the web at http://www.incrdiblyears.com/.

PARENT-CHILD INTERACTION THERAPY (PCIT)

PCIT is a parent management training program for families of children between the ages of two and six who are experiencing emotional, behavioral or developmental difficulties and family problems. The program uses play therapy and in vivo teaching to give feedback regarding mother-child interactions. It is a short-term, manualized intervention that is comprised of two phases, Child-Directed Interaction (CDI), and Parent-Directed Interaction (PDI). The focus of the CDI phase is on enhancing parent-child attachment. This is the foundation for PDI, which focuses on using a structured and consistent approach to discipline. CDI is based on attachment theory. Parents are taught skills to promote positive, nurturing interaction in order to provide a secure attachment for the child. PDI is based on social learning theory and addresses ineffective/maladaptive parent-child interactions that can create and maintain behavioral problems.

The program consists of ten to sixteen one-hour sessions conducted on a weekly basis consisting of:

- A pretreatment initial assessment of child and family functioning
- Joint development of therapy goals by the clinician and parents
- Feedback, teaching, and coaching of parents in the CDI skills
- Teaching and coaching parents in the PDI skills
- Direct consultation and coaching for the child's teacher
- Teaching generalization skills
- Post treatment assessment
- Booster sessions over a twelve month period to maintain positive skills

Each phase of treatment entails a didactic session for parents during which interactional skills and their rationales are taught via modeling and role-plays. Then, parents and their children attend weekly coaching sessions together. They are given homework to practice skills between sessions on a daily basis for five to ten minutes per day. During CDI, parents are taught to use PRIDE (praise, reflection, imitation, description, enthusiasm) skills while avoiding questions, commands, and criticism when playing with their children. During PDI, parents are taught to impart clear, developmentally appropriate, direct commands and confer consistent

consequences for both compliance and noncompliance. Praise is used for compliance and time-outs are used for noncompliance.

Research indicates PCIT is effective in reducing children's behavior problems at home and school, and results in improved parental interactional styles. Parents report gains in confidence in their parenting abilities and reductions in personal distress. The beneficial effects of PCIT have been shown to generalize to other family members (i.e., siblings who have not undergone treatment). Studies that have included culturally diverse families have also found these positive outcomes. PCIT has been shown to be most effective if it is used continuously in the home and other significant environments.

A comprehensive treatment manual, test outline of the program, and implementation recommendations are available. However, there are several training models and these are of varying levels of intensity. Information on PCIT can be found on the web at http://www.pcit.org/.

PARTICIPATION ENHANCEMENT INTERVENTION (PEI)

PEI is an office-based, brief adjunctive intervention that incorporates selected motivational enhancement techniques designed to increase parents' motivation for treatment and their ability to identify and overcome potential barriers to participating in treatment. Clinicians help parents create self-motivational statements about their plans for changing their parenting behaviors, attending the treatment sessions, and adhering to the treatment regimen (e.g., "What steps can you take to help change your child's behavior?") for five to fifteen minutes during the first, fifth and seventh sessions for a total of fifteen to forty five minutes, Clinicians also inquire about a range of potential barriers to participating in treatment, such as problems with transportation, a lack of support from others, or the perception that treatment is too demanding or irrelevant during these discussions, A Change Plan Worksheet (CPW) is used to help parents develop specific plans to overcome each identified barrier that might arise or become exacerbated. . The CPW begins with three questions and ends with one additional question designed to elicit self-motivational statements about changing the child's behavior and participating in treatment (see CPW for actual items). It includes six other questions that require the parent to identify and attempt to resolve potential barriers to treatment participation that may arise over the course of treatment. Parents rate how much each potential barrier is likely to interfere with treatment (0-4), and responds accordingly. A manual and forms are available at no cost from http://www.wjh.harvard.edu/~nock/nocklab/index.html.

NURSE-FAMILY PARTNERSHIP PROGRAM (NFP)

Originally called the Elmira Prenatal/Early Infancy Project, this SAMHSA model program targets families who are young, single-parent, and socioeconomically challenged. The program was established by the National Center for Children and Families and Communities (NCCFC) and provides home visits by public health nurses to enhance maternal, prenatal and early childhood health, mental health, family and peer supports, parental roles, and well-being of first-time mothers who have limited incomes. Issues such as pregnancy planning, education, and employment are addressed. The program uses the Nurse-Family Partnership Home Visit Guidelines which detail the structure of each visit and tools to use in working with mothers. The mother's health, quality of care giving for the child and their own development are addressed with resources that match the developmental needs of the child and family.

Outcome studies indicate that nurse home visits both during and subsequent to pregnancy lead to improved birth outcomes through reductions of pre-term and low birth weight babies, decreased quickly recurring and unintended pregnancies, incidents of child abuse, and behavioral problems. In addition, participants become more involved with their children, and

report reductions in incidents of arrests, convictions, alcohol consumption, and lifetime sexual partners. Children display reductions in conduct disorders, involvement in crime, and delinquent behaviors. The costs of the program have been found to be more than offset by the higher taxes the women pay through increased participation in the workforce, and by projected savings on community-based interventions. The original program saved four dollars for every dollar invested due to reduced need for welfare benefits, fewer arrests, and lower health care (especially emergency room) costs. A fifteen-year follow-up of the original Elmira New York participants found significant reductions in child abuse and neglect, maternal behavioral problems due to use of alcohol and drugs, fewer arrests among the mothers, as well as fewer arrests, convictions, sexual partners, cigarettes smoked, and days of alcohol consumption alcohol among their fifteen year old children.

It should be noted that efforts to replicate the nurse home visitation program have met with limited success when paraprofessionals are used. Fidelity to the original model is therefore integral to its success. The NCCFC provides consultation and training to assist communities in establishing the program. Each local program then participates in a national program quality and performance evaluation to identify factors that contribute most significantly to the program's success or failure in a variety of settings. Information is available on the web at http://www.nccfc.org/.

NURTURING PARENTING PROGRAMS

Nurturing Parenting Programs are designed to *b*uild nurturing parenting skills as an alternative to abusive and neglectful parenting and child-rearing practices, in order to prevent recidivism in families receiving social services, reduce the rates of teenage pregnancies, juvenile delinquency, and alcohol abuse, and stop the intergenerational cycle of child abuse. Programs are targeted to parents with children birth to five years old, five to eleven years old, and twelve to eighteen years old. Programs for school-age children aged five to eleven and teens aged twelve to eighteen are also offered. Programs are conducted in birth family homes, community agencies, mental health programs, department of social services agencies, parent education programs, prisons, residential care facilities, and schools, in groups of eight to twelve adults and separate groups for children for twelve to forty eight weeks. The frequency and duration of sessions vary in accordance with the type of program. In general, group-based sessions run from two and a half to three hours once per week. Home-based sessions run one and a half hours once a week. The number of group-based sessions ranges from twelve (for parents and adolescents) to twenty three (for parents and children, birth to five years). Home-based sessions for birth to five years are held do not exceed forty five in total.

There are a number of Nurturing Parenting Programs:

- Prenatal Families
- Parents and Children, Birth to Five Years
- Parents and Children, Five to Eleven Years
- Parents and Adolescents
- Teenage Parents and Their Families
- Foster and Adoptive Parents and Their Children
- Parents With Special Learning Needs and Their Children
- Families in Substance Abuse Treatment and Recovery
- Hmong Parents and Their Adolescents
- African American Families
- Crianza con Cariño Programa Para Padres y Niños (Hispanic Parents and Children, Birth to 5 Years)

- Crianza con Cariño Programa Para Padres e Hijos (Hispanic Parents and Children, Four to twelve Years)
- The ABC's Parenting Program for Parents and Children

Home-based programs: The Nurturing Parenting Program home visitor meets one-on-one with the parents for the first hour of a one and a half-hour session. Each home session follows the following format:

- **Icebreaker and Home Practice Check-In (ten minutes):** During this time the home visitor introduces the concept for the session and parents review their success in completing their home practice exercise.
- **Parenting Skills and Self-Nurturing Activities (45 minutes).** The parents and the home visitor engage in role playing, discuss new ideas, view videos, and engage in self-expression through art activities using paints, markers, and clay. Home sessions alternate focus between nurturing parenting skills and nurturing self skills.
- **Home Practice Exercise (5 minutes):** At the end of the parent portion of the visits a home practice exercise is assigned for parents to complete for the next session.
- **Family Nurturing Time (25 minutes):** Parents and children learn new skills and ways to have fun.
- **Infant Activities (birth to 15 months).** These include telling stories using fingers ("Mr. Pointer Finger says 'Good morning' "), systematic use of infant massage as a daily parent-child interaction, and interactive play.
- **Toddler Activities (15 months to 3 years).** Activities include finger plays, hand-eye motor coordination skills, large muscle movement, sensory discovery, language development, and child massage.
- **Preschooler Activities (3 to 5 years):** Activities include Hello Time, a chance for everyone to talk, sing, and have fun; Big Motor Time, activities to promote movement and large muscle exercise; Circle Time, a time for family members to talk about a topic using puppets and games to facilitate learning; and Art Time, a time for family members to work together and individually on creative projects.
- **Family Hug (5 minutes):** At the end of each home visit, the home visitor, parents, and children engage in a group hug.

Group-based programs: parent format:

- **Icebreaker and Home Practice Check-In (20 minutes):** The group facilitator introduces the concept for the session and parents share their thoughts and feelings giving them the opportunity to share their successes in trying out new concepts and skills.
- **Parenting Skills Activities (40 minutes):** Parenting skills, nurturing routines, and behavior encouragement techniques are presented through videos, discussion, art activities, and role-playing.
- **Family Nurturing Time (30 minutes):** Parents, children, and group facilitators engage in activities, including games, songs, and infant massage, and enjoy snacks and beverages. Facilitators model and teach new skills and supervise parents practicing them.
- **Self-Nurturing Activities (50 minutes):** Parents increase their self-awareness and self-growth and learn ways to nurture themselves through group discussion, videos, role-playing, and art activities.
- **Home Practice Exercise (5 minutes):** Parents are given a brief exercise related to the session concept to practice at home before the next session.

- **Group Hug (5 minutes):** Sessions conclude with a group hug is to increase group cohesion, offer praise, and experience positive touch.

Group-based programs: child format: Children participate in Family Nurturing Time with their parents and engage in age-appropriate activities for the remainder of the session which include:

- **Infant Activities (2 hours):** Facilitators engage infants in age-appropriate activities, including infant stimulation, reading stories, holding, smiling, and talking to the infants during the times parents are in groups.
- **Toddler Activities (2 hours):** Children participate in songs, games, and large muscle motor activities.
- **Preschooler Activities (2 hours):** Children aged three to five participate in scheduled activities that include Hello Time, Big Motor Time, Circle Time, Art Time, and closing Group Hug.

Parenting skill instruction program topics include:

- Discipline: philosophy of discipline, alternatives to spanking, rewards and punishment, family rules, timeout, loss of privilege, restitution, being grounded.
- Nurturing: needs and self-esteem; developing empathy; ways to nurture others; praise; nurturing routines at mealtime, bath time, bedtime, dressing time; communicating with your child through touch.
- Communication: redirecting, ignoring, communicating age-appropriate expectations, recognizing and understanding feelings, "I" statements.
- Spoiling children.
- Toilet training.
- Baby-proofing a home.
- Establishing morals, values, and rules.
- Relationship between anger, alcohol, and abuse.

Two professionals or paraprofessionals facilitate the parent group and at least two staff facilitate the children's program. Professionals in parent education, social work, psychology, education, public health, and the helping fields (i.e., medicine, mental health, parent aide programs, and home visitor programs) and paraprofessionals in helping fields facilitate the parent, adolescent, and children's programs.

The program uses the following teaching aids to engage parents and children on both cognitive and affective levels:

- Training manuals (activities manuals) for parents, children, and adolescents. These manuals are program specific and constitute the curriculum for each of the thirteen Nurturing Parenting Programs.
- Parenting handbooks for parents and adolescents. These handbooks are written at a fifth-grade reading level.
- Implementation manual that describes the how-to's of implementing the programs, facilitating groups, gathering pretest and posttest data, recruiting families, and working with children.
- Instructional videos in which actors demonstrate examples of abusive parenting with inappropriate behaviors such as hitting and yelling. Parents discuss the interactions dramatized in the video and alternatives to the abusive behavior.
- Games for parents and children that help build their nurturing skills and provide an opportunity for them to interact and have fun together. The games reinforce the concepts that are being presented.
- Instructional aids that include card games, pictures, and questionnaires

Outcome studies indicate significant increases in parenting attitudes of both parents and children; increased positive personality characteristics in both parents and children, improvements in family interaction patterns, and child rearing practices.

Instructor training workshops last from two to four days, depending on the group and costs also vary, depending on whether the workshops are sponsored by an agency (e.g., house of worship YMCA/YWCA, or Boys & Girls Club) implementing the program or by an community and participants register individually. In the latter case, registration fees generally average $125.00 per workshop. Information on these SAMHSA model programs can be obtained from http://www.nurturingparenting.com/.

STAYING CONNECTED WITH YOUR TEEN (SCT)

Staying Connected With Your Teen, formerly known as Parents Who Care (PWC), is a skill-building educational program for families with children aged twelve to sixteen that targets family and peer risk factors (e.g., parent and sibling substance use, positive parental attitudes towards drug use, ineffective and inconsistent parenting, family conflict, inadequate family communication and involvement and bonding, and affiliations with peers who engage in delinquent behaviors and use substances). The program focuses on strengthening family bonds and establishing clear standards for behavior in order to help parents appropriately manage their adolescent's behavior while encouraging growth toward independence.

The program is led by a facilitator on a once weekly basis for five to six ninety-minute sessions in schools, healthcare organizations, civic organizations, social service organizations, and faith-based institutions. Parents are provided with their own parent module for use at home. A book has been developed that consists of seven chapters and corresponding video segments. The video depicts common parenting challenges of four ethnically diverse families. The program is structured around three major topics: (1) setting the stage, which covers the importance of risk and protective factors; (2) the effects of communication; and (3) family management.

Outcomes for parent participants indicate improvements in family discipline and supervision, parental commitment to school, family attitudes regarding antisocial behavior, and family bonding. Information on this SAMHSA model program can be found on the web at A workshop guide, video, family guide, PowerPoint presentation, and CD; telephone advisor if necessary are available for training. Information can be obtained from http://www.channing-bete.com/prevention-programs/staying-connected-w-your-teen/.

STEP (SYSTEMATIC TRAINING FOR EFFECTIVE PARENTING)

STEP is a multi-component seven week parenting education curriculum conducted in parent education study groups that is designed to help parents learn effective ways to relate to their children, how to encourage cooperative behavior in their children, and how not to reinforce unacceptable behaviors. STEP also helps parents change dysfunctional and destructive relationships with their children by offering concrete alternatives to abusive and ineffective methods of discipline and control.

STEP is offered in three separate programs covering early childhood, children ages seven through twelve, and teenagers. Each program contains a leader's resource guide, promotional tools, videos and parent handbooks. It can be conducted in adoptive homes, birth family homes, community agencies, foster homes, hospitals, outpatient clinics, residential care facilities, and schools in small discussion groups to promote better interaction. Sessions are held once a week for sixty to ninety minutes. Parents read a chapter each week from a short parent handbook. Activities each week include observations of their child's behavior and implementation of skills

learned each week in the parenting group. Parents are asked to provide brief oral reports each week sharing their results. They also share their concerns and gain awareness that their problems are not unique and that their own reactions and attitudes may have unintentionally influenced their children's unacceptable behaviors

STEP Course Objectives.

- Parents gain an understanding of developmental sequences and their child's accomplishments.
- Parents learn how children's belief systems are formed.
- Parents learn to identify the four goals of misbehavior and how to foster positive results
    - Attention
    - Power
    - Revenge
    - Inadequacy
- Parents discover ways to build children's self-esteem through the process of encouragement
- Parents develop an effective discipline system based on both firmness and kindness
- Parents learn to deal with emotional problems and promote positive emotional growth

Training and program manuals are available from http://www.steppublishers.com/.

1-2-3 MAGIC

1-2-3 Magic is designed to help parents and other caregivers (e.g., grandparents, teachers, babysitters) learn effective methods of controlling negative behavior, encouraging good behavior, and strengthening the parent/caregiver-child-relationship. It is conducted in adoptive homes, birth family homes, community agencies, foster homes, hospitals, outpatient clinics, residential care facilities, and schools in groups of six to twenty five parents of children aged two to twelve for one and a half hours per session for four to eight weeks.

The program divides the parenting responsibilities into three tasks: controlling negative behavior, encouraging good behavior, and strengthening the child-parent relationship. The program seeks to encourage gentle, but firm, discipline without arguing, yelling, or spanking. Homework assignments are given that involve managing "Stop" behaviors (e.g., whining, arguing, tantrums, sibling rivalry, etc.) and encouraging "Start" behaviors (e.g., cleaning rooms, going to bed, doing homework, etc.) and relationship building strategies.

For example, when a child engages in undesirable behavior a parent/caregiver does not like, the parent/caretaker says, “That’s one.” If the child continues, the parent/caretaker says, “That’s two.” If the child keeps going, the parent says, “That’s three. Take five” which means the child has to go to his/her room for a time-out that lasts about one minute for each year of the child’s age. During the time-out, friends, phones, televisions, computers and electronic games are off-limits. Severe behavior, (e.g., hitting or cursing) results in a parental/caretaker response of “That’s three,” and time is added depending on the severity of the behavior. During the counting and after the time-out, the parent/caregiver can give a two or three word explanation but does not say anything else and avoids lecturing, arguing, or yelling (i.e., parental/caregiver “no talking” and “no emotion” rules).

1-2-3 Magic has been found to effectively address arguing, whining, sibling rivalry, disrespect, bedtime issues, homework and other compliance issues. More information and a training manual can be obtained and a training manual are available from http://www.parentmagic.com/.

TRIPLE P-POSITIVE PARENTING PROGRAM

The Triple P-Positive Parenting Program is an evidence-based, multi-level, parenting and family support strategy that is designed to prevent severe behavioral, emotional and developmental problems in children by enhancing parental knowledge, skills, and confidence. The program is conducted in adoptive homes, birth family homes, community agencies, foster homes, hospitals, outpatient clinics, residential care facilities, and schools in groups of ten to twelve parents of children and adolescents from birth to age sixteen. The duration varies depending on the type of intervention required.

The program targets five different developmental periods from infancy to adolescence and the intervention can vary from being very broad (targeting an entire population) to narrow (targeting only high-risk children) within each developmental period. Triple P incorporates five levels of intervention of increasing strength for parents of children from birth to age sixteen.

- **Level 1:** A universal parent information strategy that provides parents with access to information about parenting through a coordinated media and promotional campaign using print and electronic media. This level of intervention aims to increase community awareness of parenting resources, to encourage parents to participate in programs, and to create a sense of optimism by depicting solutions to common behavioral and developmental concerns.
- **Level 2:** A brief, one or two-session primary health care intervention providing anticipatory developmental guidance to parents of children with mild behavior difficulties, with the aid of user-friendly parenting tip sheets and videotapes that demonstrate specific parenting strategies.
- **Level 3:** A four-session primary care intervention, targets children with mild to moderate behavior difficulties and includes active skills training for parents.
- **Level 4:** An intensive eight to ten-session individual, group or self-help parenting program for parents of children with more severe behavior difficulties.
- **Level 5:** An enhanced behavioral family intervention program for families where parenting difficulties are complicated by other sources of family distress (e.g. relationship conflict, parental depression or high levels of stress).

A training manual and addition information can be obtained from http://www.triplep-america.com/.

SCHOOL-BASED PROGRAMS

CASASTART

CASASTART (Striving Together to Achieve Rewarding Tomorrows, formerly known as Children at Risk), is a community-based, school-centered substance abuse and violence prevention program developed by the National Center on Addiction and Substance Abuse at Columbia University (CASA). CASASTART targets at risk youth between eight and thirteen years of age. This SAMHSA model program is designed to reduce drug and alcohol use, involvement in drug

trafficking, associations with delinquent peers, reduce violent offenses, and improve academic performance, Participants may remain in the program up to two years.

CASASTART is staffed by case managers and requires the cooperation of area police departments and local social service and juvenile crime agencies. Key stakeholders in schools, law enforcement agencies, social services and health agencies develop tailored approaches to the delivery of the core service components consistent with local culture and practice.

CASASTART's is comprised of the following components:

- Community-enhanced policing
- Intensive case management
- Juvenile justice intervention
- Family services
- After-school and summer activities
- Education services
- Mentoring
- Incentives to encourage youth development activities.

Studies indicate the program leads to beneficial outcomes including reductions in the use of gateway drugs (i.e., cigarettes, alcohol, inhalants, and marijuana), psychedelics, crack, other cocaine, heroin, or nonmedical prescription drugs, drug trafficking, violence, associations with delinquent peers, and increases in school promotion (i.e., progression to the next grade).

CASASTART costs between $2,500.00 and $4,000.00 to implement per child/family per year. A typical annual program budget ranges between $100,000.00 and $150,000.00. CASA staff provide training and technical assistance for new CASASTART sites at a cost of approximately $3,000.00 per day. CASA works with sites for a minimum of twelve days during the first year, which includes six days of training in core program elements and six days of on-site assistance; fewer days can be negotiated. In addition, new sites are incorporated into the national CASASTART network, are invited to participate on bimonthly conference calls and annual conferences, and regularly receive literature and CASA reports and information. More information and a CASASTART Field Guide for implementing the programs are available from http://casastart.org/.

IN-HOME SERVICES

HOMEBUILDERS PROGRAM

HOMEBUILDERS is an intensive, short-term family preservation program for families with newborns to teenagers first established in Tacoma, Washington, as an outgrowth of efforts to prevent of out-of-home placements. The program utilizes professionals, parent advocates, and aides who maintain small caseloads and have frequent group supervision. It is designed to prevent the need for foster care, residential, and other out-of-home placements, and strengthen the family. Its goals include improving family functioning, social support, parenting skills, school and job attendance and performance, household living conditions, daily household routines, and self-esteem. It focuses on helping consumers become self-sufficient, enhancing their motivation for change, and reducing family violence.

HOMEBUILDERS is comprised of four to six weeks of intensive in-home services for children and families. A practitioner provides counseling and other services, spending an average of eight to ten hours per week in direct contact with the family. The practitioner is on call twenty-fours hours per day, seven days a week for crisis intervention. Skill building, behavioral interventions, motivational interviewing, relapse prevention, rational emotive therapy, and other

cognitive-behavioral strategies are the primary interventions used to teach effective parenting skills.

The program has been evaluated both formally and informally since it began in 1974. Studies have indicated positive results including out-of-home placement prevention and improvements in child and family functioning. While the model has been used throughout the country for family preservation, it has not always been replicated with fidelity to the original model resulting in less than optimal outcomes. Information regarding HOMEBUILDERS is available from the Institute for Family Development at http://www.institutefamily.org/.

HEALTHY FAMILIES AMERICA (HFA)

Healthy Families America (HFA) is a national program begun in 1992 by Prevent Child Abuse America (formerly the National Committee to Prevent Child Abuse) in partnership with the Ronald McDonald House, and is modeled after Hawaii's Healthy Start program. It is a home visiting program that is designed to promote positive parenting skills development, healthy pregnancy practices, use of social system resources, child health and development, and prevent negative birth outcomes (e.g., low birth weight), child abuse/neglect, substance abuse, and criminal activities. Expectant and new mothers are linked to community resources (e.g., primary care, housing assistance, substance abuse treatment programs) by trained staff who provide home visits and referrals. Children's Charter is the designee for Healthy Families America work in Michigan. It is located on the web at http://www.childcrt.org/.

HFA is designed for families with children aged zero to five who are deemed at-risk. The program is of comprised assessments and home visits beginning prenatally or shortly after birth. A family support worker (FSW) initiates visits on an at least once weekly basis at the outset; visit frequency decreases over a course of three to five years. The FSW offers information, education, and referrals to community resources as well as assistance with the development of support systems and problem-solving skills training to promote positive parent-child interaction.

Studies indicate that benefits for participants accrue in the areas of parent-child interaction and parenting skill capacities. Most families who have received services have been found to be better able to care for their children, access and effectively use health care services, avoid reports of child abuse or neglect, and resolve many personal and familial problems associated with families that are economically challenged and single-parent. However, many of these findings have emerged from the quasi-experimental designs, rather than from randomized trials. Information can be found on the web site at http://www.healthyfamiliesamerica.org.

MELD

MELD is a family strengthening, parent education program developed in 1973 that uses peer support groups to develop parenting skills. It is designed to strengthen families by: (1) reducing family isolation that can lead to child maltreatment, (2) increasing parents' knowledge of child development, (3) increasing parents' problem-solving skills, decision-making capabilities, and ability to manage family life, and (4) fostering parental personal growth.

MELD targets parents of preschool aged children and has been adapted to meet the needs of first-time adult parents, parents of children with special needs, young, single mothers, and single fathers, Hispanic/Latino and Southeast Asian parents, and parents who have hearing impairments. The curriculum is accessible to parents who do not have high levels of literacy, and it addresses concerns of parents with financial challenges.

MELD parent education groups usually meet twice per month (or as often as once a week). The groups are facilitated by community volunteers who use a standardized curriculum and are

provided ongoing support and supervision from a local certified MELD professional. The curriculum addresses the following topics:

- Health
- Child development
- Child guidance
- Family management
- Use of community resources
- Home and community safety
- Balancing work and family
- Other issues related to the parenting needs of the specific group

MELD is a SAMHSA model program with demonstrable benefits that include: (1) parents gaining more appropriate expectations of children's abilities and increased knowledge of child development; (2) increased empathic awareness of children's needs and appropriate responses; (3) decreased belief in the value of corporal punishment; (4) reduced social isolation and parental depression; (4) increased awareness that parents' purpose is to respond to the needs of their children (and that children do not exist to please and love their parents).

SUBSTANCE ABUSE

Substance abuse by parents/caretakers is strongly associated with higher rates of abuse and neglect. Model programs in child welfare involve substance abuse treatment professionals in home visits and treatment planning for parents with substance use disorders who have been referred for child protective services investigations. In addition, relapse prevention for substance abuse/use is also recommended in the child welfare literature.

FAMILY DEPENDENCY TREATMENT COURTS (FDTC)

Substance abuse has been estimated to be a factor in seventy-five percent of all foster care placements. Children whose parents abuse substances are almost three times more likely to be abused and more than four times likely to be neglected than children of parents who do not abuse substances. Family dependency treatment courts have been developed as a means of assisting parents who have substance use disorders and are at risk of losing their children due to child abuse and/or neglect. Their purpose is to protect the safety and welfare of children while offering parents the skills they need to become sober, responsible caregivers. In order to accomplish this, an interdisciplinary team (with ample cross-system training) works collaboratively to assess families' situations and formulate comprehensive plans that address the needs of both the parents and their children. Teams meet regularly (typically on a weekly basis) to share information regarding the parents' and children's progress, attendance at hearings, and participation in treatment.

The first family dependency treatment court opened in 1994 in Reno, Nevada and a number of such courts are now operating across the country. These courts are the result of collaboration between the judicial, child protection, and mental health fields. Inspired by adult drug courts, FDTCs are a collaborative approach to therapeutic jurisprudence, with teams that include judges, substance abuse treatment providers, child welfare specialists, attorneys (including the prosecution as well as those representing protection agencies, parents, and children), mental health practitioners, and others.

FDTCs have the following characteristics:

- Most FDTCs accept individuals who have civil cases, while some accept those who have both civil and criminal cases.
- FDTCs can function under the jurisdiction of family, juvenile or general jurisdiction courts.
- In some FDTCs all pending cases involving any member of the family are placed under the oversight of an FDTC judge, while others use multiple judges from the dependency court, the FTDC, and other criminal and civil courts in which family members have matters pending.
- Some FDTCs are fully integrated within a dependency court while others complement the dependency court case process and intervene at a specific point in the process to review parental compliance with court orders.
- Some programs have a particular focus (e.g., mothers of infants exposed to drugs), while others have a broader focus and consider any dependency case in which parental substance use contributes to the abuse or neglect of children.
- Frequent judicial review of cases is conducted.
- A graduated system of sanctions and incentives are used to maintain parental accountability. (Sanctions function as a consequence for parents who test positive for drugs, miss a treatment session, miss a hearing date, or are otherwise nonadherent. Such sanctions might include verbal admonitions from the judge, therapeutic essay writing, community service, fines, and increased frequency of drug testing. Some judges use jail as a sanction for serious nonadherence issues. For example, a judge may order an offender to jail for two days, a week, or longer. However, when considering a jail sentence for a parent, the first consideration is how such a sanction might affect the safety and welfare of the children and every effort is made to avoid adverse effects. [It is recommended that jail time not conflict with a parent's time with their child, even if the child is in foster care.] Incentives reward parents who achieve program objectives or succeed in a program. Sanctions and incentives have been found to have a therapeutic impact on parents and assist them in accepting responsibility for their behaviors.)
- Team meetings (or staffings) are held on a regular (usually weekly) basis.
- Aftercare planning begins when a family first enters the program. Parents often need access to self-help groups, counseling sessions, and other resources such as alumni events, support groups, and social functions. Aftercare plans also include services for children who may have experienced maltreatment.

The primary role of the judge in abuse and neglect cases is to ensure the child's safety, permanency, and well-being. The judge, who serves as a role model and authority figure, functions as the team leader and oversees the family members' progress in treatment. An FDTC coordinator maintains the ongoing operation of program activities including overall monitoring services, ongoing scheduling of cases, maintenance of files, identifying and allocating resources, budgeting, and performance evaluation. A substance abuse treatment professional determines the appropriate substance abuse treatment for the parents, educates the team on relevant issues regarding treatment options, issues (e.g., relapse), and substances of abuse specific to the jurisdiction. Treatment providers attend and participate in staffings and court sessions to offer information about the progress of participants. Child protective services, probation and parole officers, and case managers are responsible for linking parents with community supervision, treatment, and law enforcement services. A child welfare representative is responsible for protecting children's health and safety, advocating on behalf of the children's best interests, and ensuring that they and their parents receive necessary services. A parent attorney ensures that parents' interests are considered while protecting the safety and welfare

of their children. This attorney informs parents about court procedures, makes parents aware of the benefits of the program, encourages their participation, and handles any related criminal charges against the parents. The prosecuting attorney identifies cases eligible for participation in the FDTC, is responsible for bringing cases forward, files motions and petitions necessary to initiate the parents' involvement in the FDTC, attends and participates in team meetings and court hearings to ensure ASFA (Adoption and Safe Families Act) timelines are met and the safety and best interests of the child are maintained. Family members are included to ensure that parents have opportunities to advocate for services to meet the needs of their children. Children have a voice through their social worker, parents, or representatives, or may speak directly to the court regarding their own safety, well-being, and permanency.

Family dependency treatment courts incorporate the needs of both children and parents; the entire family is viewed as the client. While decisions are always made in the best interest of the child, a parallel focus on the interests of the parent is maintained. Family reunification is contingent upon parents' demonstrated ability to provide for their children's health, safety, and well-being within the timelines mandated by ASFA.[8] The goals of these courts are to ensure the safe return of children to their families, or find permanent placements for those who cannot return home.

OUT-OF-HOME CARE

When children are removed from their families and placed in out-of-home care, they may be placed in a number of different types of settings. Current laws and policies require that children be placed in the least restrictive setting that can meet their needs and that relatives or kin be given priority in placement decisions. In addition to relatives' homes, other family settings include family foster care and treatment foster care.

When needed, children can be placed in residential or group care. In some communities, children entering out-of-home care are placed into emergency foster care settings which may be either a family or a group setting. Another alternative is Shared Family Care, discussed earlier, in which birth parents and their children move into a supervised, supportive home of a host family together. The host family is trained to mentor and support the parents as they develop skills and supports necessary to care for their children independently. SFC can be used to prevent out-of-home placement, provide a safe environment for the reunification of a family that has been separated, or to help parents consider other permanency options, including relinquishment of parental rights.

APPLA (Another Planned Permanent Living Arrangement) and LTFC (Long-Term Foster Care) describe the permanency status of children or youth in out-of-home care who are considered unlikely to be reunified with their families or achieve permanency through adoption or guardianship. These children may live in any one of the types of settings mentioned above.

[8] Because relapse is common for individuals with a substance use disorder, the long-term timeframes required for recovery may not mesh with the shorter timelines mandated by ASFA or those set by child welfare agencies to make child placement decisions. These mandated shortened timeframes mean that parents with substance use disorders have significantly less time to enroll and participate in treatment and establish their capacity to provide a safe home for their children. Thus, a child's needs for a permanent, safe home may conflict with their parents' needs for extended treatment.

FOSTER CARE

Foster care can be classified as either respite (i.e., short-term for emergencies, assessment or preparation for long-term placement; medium term respite; and long-term respite) or specialized foster care. Foster care can be either temporary or permanent.

KINSHIP CARE

Title IV-E of the Social Security Act requires states to give preference to relatives (who meet child protection standards) over non-related caregivers when placing a child. Kinship care is provided by relatives, members of their tribes or clans, godparents, stepparents, or any adult who has a kinship bond with a child. Kinship caregivers are unlicensed caregivers approved by courts because they are relatives by blood, marriage, or adoption, or have a significant, long-standing relationship with the child's family. Kinship care programs provide community-based support services to relative caregivers so that children can remain with their extended families and avoid placement in the foster care system.

Kinship care should be the first option considered when a child needs to be removed from his/her home for emergency placement. Experts believe there are substantial benefits to placing children separated from their parents with relatives rather than with unrelated foster parents. Relatives can provide family support and frequent contact with birth parents and siblings. Kinship connections help reduce children's and families' trauma and stress, child abuse and neglect, as well as maintain connections with family and community, increase the possibility of reunification, and achieve permanency and stability.

FAMILY-TO-FAMILY PROGRAM

The Family-to-Family program has been implemented in several counties across Michigan, including Saginaw. It is a partnership between local Departments of Human Services and communities designed to decrease disruption in the lives of at-risk children and ensure that birth parents, foster parents, and community representatives are involved in the decision-making process concerning children's placement and service needs. The program is intended to ensure that children who must be removed from their families are placed with one permanent and stable family in their own community until reunification with birth families or a release for adoption occurs. Foster families, also known as resource families, work with biological families in this approach.

Family-to-Family aims to reduce the number of children served in institutional and congregate care, lengths of stay in out-of-home placements, children served away from their own families, children who re-enter care, and placement moves experienced by children in care, as well as increase the number of siblings placed together and planned family reunifications.

Family-to-Family is comprised of four strategies:

- Recruitment, training, and support for resource families (i.e., foster parents and relative care givers)
- The creation of community partnerships among organizations in neighborhoods with high rates of referral to create supports for families involved in the child welfare system
- Team decision-making involving foster parents, caseworkers, birth families, and community members in all placement decisions to create a support network
- Evaluation data on child and family outcomes to assess progress and delineate areas for change

A 1998 national evaluation of Family-to-Family indicated that foster children in this program moved less frequently and were more likely to live with relatives. In some communities they were also found to be reunited with their parents more often. Information on the program can be found on the web at http://www.aecf.org/initiatives/familytofamily/.

THERAPEUTIC FOSTER CARE (TFC)

Therapeutic foster care is an alternative to incarceration, hospitalization, group, and residential treatment for children and adolescents who have a history of delinquency, emotional disturbance, and who display ongoing antisocial behavior. It provides a highly structured environment that rewards (reinforces) positive social behaviors and penalizes aggressive and disruptive behaviors. It also separates participants from peers who engage in delinquent acts. Close supervision at home and in school is provided. Therapeutic foster care is considered the least restrictive form of out-of-home therapeutic placement for children who have severe emotional disorders.

In this model trained foster parents function as the primary interventionists and provide care in their homes. While therapeutic foster care programs vary, they have the following features in common:

- Foster parents receive extensive pre-service training, in-service training, supervision, and support.
- Biological parents or legal guardians are taught how to provide effective supervision, discipline, support, encouragement, use daily behavioral management point systems, conflict management, communication and problem-solving skills. (Regular home visits allow for the practice of these skills.)
- Therapeutic foster parents are given a higher stipend than that given to traditional foster parents.
- Frequent contacts between participants and their biological parents/legal guardians, including home visits, are maintained.
- Progress in school is monitored.
- Coordination with probation/parole officers is provided.
- Frequent contact between case managers/care coordinators and foster families is maintained.
- Psychiatric consultation and medication management are available.
- Peer associations are closely monitored and access to negative peer associations is restricted.
- An individualized daily program comprised of scheduled activities and behavioral expectations is designed by a case manager in conjunction with the foster parents.
- Appropriate and positive behaviors are reinforced. A point system is assigned that specifies the number of points that can be earned for acceptable performance. Points are removed for misbehaviors and rule violations.
- Close supervision is provided at all times.

  There may be three levels of supervision:

  1. Level one, which usually lasts for three weeks, entails continuous supervision; the youth is within visual contact at all times (except when asleep), and is driven to and from school.

2. Level two, which usually lasts four months, entails limited free time in the community that can be earned through substantial program rule compliance.
3. Level three, which usually lasts from one and a half to three months, entails more frequent home visits and less structured peer activities.

- Clear, specific and consistent rules and limits are set.
- There is consistent follow through with consequences.
- The development of academic skills and positive work habits are encouraged.
- Family conflict and communication skills are taught.

Research indicates that adolescents aged twelve to eighteen years who display chronic delinquency benefit significantly from therapeutic foster care. Studies show about a seventy percent reduction in the commission of violent crimes when compared to standard group residential treatment. It has been estimated that $14.00 are saved by the juvenile justice system for every dollar invested in the program model. Costs range from $20,351 to $81,664 per participant.

MULTIDIMENSIONAL TREATMENT FOSTER CARE (MTFC)

MTFC an evidence-based, therapeutic foster care, SAMHSA model program developed by the Oregon Social Learning Center (OSLC) as an alternative to institutional, residential or group home placement for teens who have histories of chronic and serious criminal behaviors and are at risk for incarceration. It is a six to nine month program that is far less costly and disruptive than institutional care. Youth are referred to MTFC by the juvenile justice, foster care, and mental health systems.

MTFC provides:

- Close supervision
- Equitable and consistent limits
- Predictable consequences for violations of rules
- A supportive relationship with at least one mentoring adult
- Reduced exposure to peers with similar problems

The intervention is multifaceted and occurs in multiple settings. The intervention components include:

- Behavioral parent training and support for MTFC foster parents
- Family therapy for biological parents (or other aftercare resources)
- Skills training for youth
- Supportive therapy for youth
- School-based behavioral interventions and academic support
- Psychiatric consultation and medication management as needed

Core components:

Children/Adolescents:

- Daily structure and support
- An individualized point system
- Weekly individual treatment
- Consistent didactic nonphysical discipline
- Psychiatric consultation and medication management as needed

Families:

- Weekly family therapy with a focus on skill development
- Behavioral management techniques instruction
- Frequent home visits from staff
- Access to crisis services and supports on a twenty-four hour, seven day per week basis

Foster parents:

- Daily telephone contacts
- Support and training
- Access to crisis services and supports twenty-four hour, seven day per week basis

Foster parents are recruited, trained and supervised by clinical staff of the Oregon Social Learning Center (OSLC). They must complete twenty hours of pre-service training during which they are taught principles of social learning theory and how to implement a daily behavior management program at home. Adolescents earn daily points for adaptive and prosocial behaviors across home, school, and community settings; points are lost for negative or undesirable behaviors. The points can used to purchase privileges. The levels of responsibility and privilege increase as they progress through the program. The adolescents participate in weekly individual therapy sessions that focus on developing effective problem-solving, social, and emotion regulation skills. Their parents or guardians attend weekly family therapy sessions designed to teach effective parenting and family management techniques. The adolescents attend public schools; their attendance and performance are monitored daily. OSLC staff members provide support to foster and biological parents/guardians on a twenty-four hour, seven-day-a-week basis.

Studies have demonstrated that compared to alternate residential models, participants spend sixty percent fewer days incarcerated, experience significantly fewer subsequent arrests, elope from the program three times less often, use significantly less hard drugs, and are placed far more rapidly into community settings from more restrictive settings. An inverse correlation between the number of days in treatment and the number of days of subsequent incarceration has been noted.

The program has been modified to include MTFC-P for preschool-aged children (aged three to five), MTFC-L for latency-aged children (aged six to eleven), and MTFC-A for adolescents (aged twelve to eighteen). OSLC provides training, consultation and clinical supervision which cost $40,000 for the first year. The program costs $120/day. Information on all three models can be obtained from OSLC at www.oslc.org.

RESIDENTIAL TREATMENT

TEACHING-FAMILY MODEL (TFM)

The Teaching-Family Model is an evidence-based residential treatment program for children and adolescents within the juvenile justice and child welfare systems. In this model, a married couple, the teaching parents, live with children/adolescents in a group home and teach them essential interpersonal and living skills. Services and supports are provided by trained staff in homes located in the community where participants can attend local schools. Each home typically serves five to ten consumers. An array of therapeutic interventions are used which include individual psychotherapy, group therapy, and behavior modification. The teaching family

model emphasizes structured behavioral interventions to teach new skills and reinforce improved behavior.

The Teaching Family Model is comprised of the following components:

- A positive, proactive interaction style that fosters learning appropriate problem-solving skills. This style entails starting all interactions with a positive empathic statement, using specific behavioral descriptions, explanations of how the behavior helps or hinders the individual, examination of alternatives, engagement of the individual in the interaction, administration of praise and consequences for all appropriate behaviors
- Teaching problem-solving and self-control skills and the appropriate experience of emotion in various situations
- Engaging parents and children in supportive relationships with agency staff to create trust
- Providing advocacy for children and their families
- Using behavior management or motivation systems to encourage and support children's acquisition of appropriate skills

Research indicates that this model is less effective for adolescents with emotional disturbances. Although therapeutic group home programs produce positive gains in adolescents while they are in the home, these changes are rarely maintained after discharge. Therapeutic foster care (see discussion below) is a more effective alternative that is well supported by research.

The Teaching-Family Association provides consultation and has developed standards for the certification of member agencies that are reviewed on annual basis to ensure fidelity to the model. The Teaching-Family Certification Manual can be found on the web at http://www.teaching-family.org/. Michigan's Teaching Family Organization is located on the web at http://www.teachingfamilyhomes.org/.

DOMESTIC VIOLENCE

Child welfare cases frequently involve domestic violence. Interventions to stop adult-to-adult domestic violence have historically been viewed as separate from the goal of protecting children who have been maltreated; responding to incidences of child abuse and neglect was the task of the child welfare system, while the job of protecting battered women belonged to community agencies, law enforcement, and the courts. However, current research and clinical experience indicate that child maltreatment and domestic violence are often intertwined – and so compel child welfare, community agencies and juvenile and family court judges to incorporate new coordinated responses to family violence.

Studies demonstrate that domestic violence places children at high risk for physical abuse; men who frequently abuse their wives also frequently abuse their children. Domestic violence has also been linked to severe and fatal cases of child abuse. Lack of interventions for parents leads to increased foster care placements of affected children, continued reentries into the child protective system as hidden domestic violence escalates and child injuries and deaths. In addition, some children sustain injuries when trying to stop an assault against their mothers. Domestic violence also co-occurs with other problems (e.g., parental substance abuse and mental illness) that lead to child abuse and neglect. In addition, a number of children, while not assaulted directly or neglected by their parents, experience emotional harmed as a result of witnessing repeated assaults and threats against their mothers. Evidence strongly suggests that such repeated exposure to violence creates elevated symptoms of depression, anxiety, or aggression for some children.

Risk reduction is viewed as contemporaneously creating safety for children and their mothers. In addition, it is recommended that responses be coordinated so that battered mothers can obtain needed help without losing custody of their children and domestic violence perpetrators can receive intervention to help stop or reduce their violence and coercive behavior. The following principles guide intervention efforts:

Research has shown that domestic violence and child maltreatment often coexist in families; adults and children are often victimized in the same family. Child welfare agencies alone cannot keep children safe. Coordination among the child protection and welfare system, community-based domestic violence programs, and the juvenile or other trial courts which have jurisdiction over child maltreatment cases, as well as law enforcement, child welfare, faith institutions, schools, health care systems, extended families, and community-based agencies has been found to be effective. In addition, violent perpetrators need to be held responsible for their behavior and legal interventions and services provided to stop the violence.

Core values that guide community-wide collaborative responses to domestic violence have been proposed to create safety, enhance well-being, and provide stability for children and families:

- Children should remain in the care of their non-offending parent (or parents) whenever possible to ensure stability and permanency
- A community service system with multiple points of entry should be created to provide safety and stability for families with the provision of services in appropriate settings as soon as problems are identified; services providers need to be trained to respond meaningfully and respectfully and services need to minimize the need for victims to respond to multiple and changing service providers to meet family needs and avoid out-of-home placements.
- Interventions and responses that are appropriate to the diverse range of families experiencing domestic violence and child maltreatment should be implemented
- Communities should have a mechanism to close gaps in services, coordinate multiple interventions, and develop interagency agreements and protocols for providing basic services to families; coordination efforts should include active involvement of domestic violence advocates, child protection workers, and community residents
- Communities should make a commitment to building internal capacity to respond effectively to families experiencing domestic violence and child maltreatment
- Agencies and courts should develop memos delineating the mandates of each system, confidentiality requirements, and agreements for sharing information
- Information gathering and evaluation systems should be used to determine intended and unintended outcomes of collaborative efforts
- Child protection agencies develop the capacity to respond effectively to domestic violence:
    - Child protection services and community-based child welfare agencies should collaborate with domestic violence organizations and juvenile courts to promote family safety by: developing new services and publicly articulating the need for additional resources; assessing the availability of resources in the community and developing new responses; and monitoring the effectiveness of community programs.
    - Child protection services should improve their capacity to promote safety for all family members using screening procedures for domestic

violence during child protection intakes and assessments provided by a team of child welfare and domestic violence professionals.

- Service plans and referrals should focus on the safety, stability, and well-being of all victims of family violence and hold domestic violence perpetrators accountable and be based safety assessment, safety planning, services, support, and monitoring.
- Child protection services should avoid strategies that blame a non-abusive parent for the violence committed by others and should avoid using, or use with great care, potentially dangerous or inappropriate interventions such as couples counseling, mediation, or family group conferencing in cases of domestic violence.
- Separate service plans for adult victims and perpetrators (irrespective of their legal status vis-à-vis the children) should be developed that assess potential harm to a child resulting from being maltreated or from witnessing adult domestic violence and plans to address this harm should be developed.
- Domestic violence specialists should be available inside the child protection agency to consult with workers and supervisors, develop safety plans for high risk cases, and establish effective linkages with the domestic violence service community, batterer intervention programs, police and the courts.
- Child protection services should avoid placing a child in foster care or kinship care with persons who have a documented history of domestic violence. Court records on protection orders should be checked as well as criminal convictions.
- Differential responses for children and families experiencing domestic violence should be employed; all children suffer when they witness assaults against their mothers. Families with less serious cases of child maltreatment and domestic violence be able to access help without the initiation of a child protection investigation or the substantiation of a finding of maltreatment since domestic violence encompasses a wide range of behaviors families require a range of interventions, some of which are voluntary and some mandated.

FAMILY SUPPORTS

PARENTS ANONYMOUS

Parents Anonymous provides mutual support and resources to families who are overwhelmed by everyday stressors. It is rated as a promising approach for prevention, education and as an intervention for child maltreatment. It consists of weekly parent meetings lead by a professionally trained facilitator and co-led by a parent group leader. Participants determine the agenda for each meeting which includes topics related to basic parenting skills, such as communication and discipline. Group members offer twenty-four hour support for parents experiencing a crisis or stress. A complementary children's program includes activities to assist with the acquisition of skills such as conflict resolution, appropriate peer interactions, identification and communication of thoughts and feelings.

Outcome studies have found Parents Anonymous to be a cost effective means of reducing the frequency of child abuse, enhancing parents' feelings of competency and their ability to manage stress effectively. Research indicates that benefits accrue proportionality in relation to the length

of participation with longer term involvement leading to increased self-esteem, decreased social isolation, and increased knowledge regarding child development and behavior.

Parents Anonymous, Inc. offers training, publications and technical assistance free of charge. Information on the program can be found at http://www.parentsanonymous.org/.

RESPITE SERVICES

Raising a child who has a serious emotional disturbance or developmental disability can be very stressful. Adult family members need occasional relief from stressors, or a change of pace, in order to maintain their own physical and mental health. Such relief should be available to all members of the family, including caregivers as well as siblings, and be provided in a manner that is in accordance with their specific needs.

Respite is defined as temporary relief provided to primary caregivers in order to reduce stress, support family stability, prevent abuse and neglect, and minimize the need for out-of-home placements. Families receiving respite can include intact families, foster and adoptive families, kinship families, and other caregivers. Respite is an important component in the prevention of child abuse and neglect. The Community-Based Family Resource and Support (CBFRS) program, established by Title II of the Child Abuse Prevention and Treatment Act (CAPTA) Amendments of 1996, includes respite as a mandated service. Therapeutic respite offers parents time for themselves so they can be the best parents possible, and provides relief from stress during crises as a means of preventing child abuse.

Respite services can be utilized within the home or outside of the home. In-home respite can include a sitter or companion for a child, siblings, or homemaker, or be comprised of an informal network of assistance. Out-of-home respite models include services offered in respite providers' homes, foster homes, group daycare centers, residential treatment centers, crisis and emergency facilities, and parent cooperatives where parents volunteer to care for each other's children on a planned or emergency basis.

Respite settings include:

- Agencies
- Families' homes
- Day care centers
- Recreational facilities
- Hospitals
- Family resource/support centers
- Providers' homes
- Residential facilities
- Camps
- Schools
- Faith-based organizations
- Therapeutic child development programs

Planned respite services are scheduled, whereas crisis respite services are provided on an emergency basis. Crisis respite provides a safe haven for children and families experiencing challenges such as financial, housing, and social stressors, substance abuse, mental illness, inadequate parenting skills, and domestic violence. Crisis nurseries are an example of out-of-home crisis respite care. Crisis nurseries are designed to prevent abuse and neglect by providing temporary child care for young children who are at-risk, while offering an array of support services to the families and caregivers of these children.

Planned and crisis respite care can help prevent child abuse by reducing the stress of working parents, increasing the ability of parents to cope with the pressures of child care, enhancing parent-child communication, decreasing family isolation, improving access to health care and other services, and offering families relief from the demands of daily child care. It can also help reduce disrupted foster care placements. Studies of families of children who are at risk for abuse and/or neglect have found significant decreases in reports of child maltreatment as well

as levels of stress in families using crisis respite services. The provision of respite care for families of children with emotional disturbances has been shown to result in reductions of out-of-home placements.

MENTORING

The provision of mentoring and social opportunities for children who have experienced maltreatment and parent mentor programs with stable, non-abusive families who function as role models of effective parenting practices and provide support to families in crisis have been shown to be of benefit to families. Shared family care is an example of a parent mentoring program.

BIG BROTHERS/BIG SISTERS OF AMERICA (BBBSA)

Big Brothers/Big Sisters of America, founded in 1904, is a community-based mentoring program that is targeted to children and adolescents who are between the ages of six and eighteen living in single parent homes. Services are provided by adult volunteers (Big Brothers and Big Sisters) to children/adolescents (Little Brothers and Little sisters) in one-on-one relationships. Volunteers are screened by case managers who then match them with children and monitor the relationship from the onset until termination (which is due to a voluntary decision or lack of meeting eligibility criteria). The program is designed to enhance prosocial behaviors, academic achievement, and family and peer relationships.

BBBSA's published standards and requirements include the following components:

- Screening of all volunteers that includes a written application, background investigation, extensive interview, and a home assessment to screen out individuals who lack the capacity to form a caring bond with a child, may cause harm to a child, or are unlikely to honor their time commitments.
- An orientation to the program is required for all volunteers.
- An assessment of each child/adolescent that entails a written application, interviews with the child and the parent, a home assessment designed to help the case manager become acquainted with the child in order to make the best possible match, and secure parental permission.
- Matches are made based on the needs of the children/adolescents, abilities of volunteers, preferences of parents, and capacity of program staff.
- Supervision is provided starting with an initial contact with parents, children/adolescents, and volunteers within two weeks of the match. Monthly telephone contact is maintained with volunteers, parents and/or children/adolescents during the first year. Quarterly contact is maintained with all parties thereafter for the duration of the match.

Outcome studies indicate that participants are less likely to initiate substance use, strike another person, and demonstrate positive academic behavior, attitudes, and performance. They are more likely to have more positive relationships with their parents/guardians and peers. The average cost of creating and supporting a match relationship is $1,000 per year. Information can be obtained from the BBSA web site http://www.bbbsa.org.

QUANTUM OPPORTUNITIES PROGRAM (QOP)

The Quantum Opportunities Program (QOP) is an intensive, multi-component intervention for high school aged teens from fourteen to eighteen who are from disadvantaged circumstances

and whose families receive public assistance. The four-year program, which originated in 1989, aims to increase graduation rates, and decrease teen pregnancy rates and violent behavior.

Participants are involved during all four years of high school for two hundred fifty hours per year in three areas: (1) educational support, (2) community service activities, and (3) developmental activities.

Component	Provider	Duration	Description
Education-related activities (tutoring, computer-assisted instruction, homework assistance)	Adult counselors	250 hours/year after school	Different settings: community agencies, public schools, homes, group activities
Development activities (acquiring life and family skills; planning for college and jobs)	Adult counselors	250 hours/year after school	Different settings: community agencies, public schools, homes, group activities
Service activities (community service projects, helping with public events, holding regular jobs)	Adult counselors	250 hours/year after school	Different settings: community agencies, public schools, homes, group activities
Hourly stipends and bonuses for completing each segment of the program			

The program operates year-round and combines features of case management, mentoring, computer-assisted academic assistance and instruction, work experience, community service, and financial incentives. A counselor is assigned to a small group of students and commits to stay with the group for all four years of high school and beyond.

The original demonstration program enrolled twenty five students in five different sites around the country: San Antonio, Philadelphia, Milwaukee, Oklahoma City, and Saginaw, Michigan. QOP has also been replicated on a larger scale in seven more cities, with a total of six hundred multiethnic participants (Hispanic/Latino, Asian, and Caucasian). Outcomes studies clearly demonstrate that participants are less likely to drop out of high school and more likely to graduate, attend post-secondary school, receive an honor or award, and are less likely to become teen parents or be arrested. The cost for four years is $10,600.00 per participant, or $2,650.00 per year.

TRAUMA-INFORMED INTERVENTION

COGNITIVE BEHAVIORAL THERAPY FOR CHILD SEXUAL ABUSE (CBT-CSA)

Cognitive Behavioral Therapy for Child Sexual Abuse (CBT-CSA), a SAMHSA model program, is designed for children and adolescents aged three through eighteen who have experienced sexual abuse and exhibit posttraumatic stress, depression, and other abuse-related difficulties (e.g., age-inappropriate sexual behaviors, problematic fears, social isolation). It has been used successfully with African American, Hispanic/Latino, and Caucasian children from all socioeconomic backgrounds. The program is used by therapists in community settings, including child protection and mental health programs in urban, suburban, and rural settings. Children are generally referred for treatment following an investigation conducted by child protection or law enforcement personnel in which allegations of sexual abuse are found to be credible. Whenever possible, a caregiver or parent who was not involved in the abuse is encouraged to participate along with the child.

CBT-CSA is designed to assist children in talking about their experiences and in coping with their feelings and concerns. It also focuses on helping parents cope with abuse-specific distress, respond effectively to their children's emotional and behavioral problems, and improve parent-child communication and interactions. Cognitive behavioral techniques are used to help parents learn to cope with their own distress as well as respond effectively to their children's behavioral difficulties.

CBT-CSA consists of parallel sessions with children and their parent(s) who were not involved with the abuse, as well as joint parent-child sessions during the later stages of therapy. It can be implemented in twelve individual or group therapy sessions. Treatment components for both the children and parents include:

- Education regarding child sexual abuse and healthy sexuality
- Coping skills training, including relaxation, emotional expression, and cognitive coping
- Gradual exposure and processing of traumatic memories and cues
- Personal body safety skills training

Parents receive behavioral management training to foster children's positive behaviors and minimize behavioral difficulties. Joint parent-child sessions focus on assisting parents and children with practice and utilization of the skills learned, while promoting more effective parent-child communication about the abuse and related issues.

Outcomes studies indicate that children who participate in CBT-CSA with their parents who were not involved with the abuse display reductions in symptoms of posttraumatic stress disorder and depression, and externalizing behaviors. Parents demonstrate reductions in emotional distress and intrusive thoughts related to their children's sexual abuse.

TRAUMA FOCUSED COGNITIVE BEHAVIOR THERAPY (TF-CBT)

Trauma-Focused Cognitive Behavioral (TF-CBT) is an empirically supported intervention designed to help children and adolescents, aged three to eighteen, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; or exposure to disasters, terrorist attacks, or war trauma. The program can be provided in individual, family, and group sessions.

It targets symptoms of posttraumatic stress disorder, which often co-occur with depression and behavior problems. The intervention also addresses issues commonly experienced by children who have been traumatized (e.g., poor self-esteem, difficulty trusting others, mood instability, and self-injurious behavior).

TCF-CBT is a SAMHSA model program that consists of twelve to sixteen sixty to ninety-minute sessions (held for thirty to forty-five minutes each with parents and children) for children and their parents, three of which are held jointly, typically provided on a weekly basis. It incorporates learning principles, cognitive-behavioral therapy, and stress inoculation training to reduce children's negative emotional and behavioral responses, and modify their beliefs and attributions related to abusive experiences. It also aims to provide support and skills to help parents who were not involved in the abuse cope effectively with their own emotional distress and provide appropriate support to their children who have suffered abuse.

Components of the TF-CBT protocol:

- **Psychoeducation** regarding child abuse, typical reactions of victims, normalization of reactions, safety skills, and healthy sexuality
- **Stress management techniques** such as focused breathing, progressive muscle relaxation, emotional expression skills, thought stopping, thought replacement, and other cognitive therapy interventions
- **Constructing the Trauma Narrative** which entails gradual exposure techniques including verbal, written and/or symbolic recounting (using dolls, puppets, etc.) of abusive event(s)
- **Cognitive processing** (or cognitive reframing) which consists of exploration and correction of inaccurate attributions about the cause of, responsibility for, and results of the abusive experience(s)
- **Parental participation** in parallel or conjoint treatment including psychoeducation, gradual exposure, anxiety management and correction of cognitive distortions
- **Parental instruction** in child behavior management strategies
- **Family work** to enhance communication and create opportunities for therapeutic discussion about the abuse

The parent treatment component is an integral part of this treatment model. It parallels the interventions used with the child so that parents are aware of the content covered with the child and are prepared to reinforce or discuss this material with the child between treatment sessions and after treatment has ended. Parents are assisted to explore their own thoughts and feelings regarding their child's experience, resolve their own personal trauma related distress, learn effective parenting skills, and provide support to their children. Children acquire skills in stress management, cognitive processing, communication, problem-solving, and safety. Sessions address feeling identification, introduction of cognitive triangle, stress inoculation therapy, gradual exposure (creating a narrative of the traumatic events the child experienced), and cognitive processing. Adaptive skills for dealing with stress are developed along with reduced anxiety, thinking or talking about the event.

Beneficial outcomes including significantly fewer behavior problems, reductions in posttraumatic stress disorder and depressive symptoms, negative attributions (such as self-blame) about the traumatic event, defiant and oppositional behaviors, anxiety, and improved social competences that have been demonstrated to be maintained well over a year after the termination of treatment. The program has also been found to enhance accurate and helpful cognitions and children's personal safety skills, as well as resolve parental distress regarding their child's

experience. Finally it has been shown to prepare children to anticipate and cope with reminders of traumatic loss. The cost is estimated to be $1,001.00 to $5,000.00.

ASSESSMENT TOOLS

NCFAS-G ASSESSMENT SCALE FOR LOW TO MODERATE RISK FAMILIES

The North Carolina Family Assessment Scale for General Services (NCFAS-G) is designed specifically for child and family serving agencies employing an integrated services model. Many families may be at low to moderate risk for child maltreatment, and thus do not warrant a child protection response. However, these families can benefit from services targeted to reducing future risk for child maltreatment or enhancing their levels of family functioning, resource management, safety, self-sufficiency or health. Providing services and to such families is increasingly recognized as cost effective and many localities are developing mechanisms to identify and engage them. Alternative practice models are being implemented that integrate services in which families voluntarily participate some of which are termed multiple response, differential response, dual track, or other similar labels intended to imply the voluntary nature of families' involvement with a child welfare agency, as well as the extensiveness of services available. Such integrated service programs entail partnerships with families to offer assistance before family stressors or circumstances overwhelm them and children become at high risk for harm. Services are strengths-based, and predicated on assessments of family functioning rather than upon child maltreatment investigations in such integrated service systems.

The NCFAS-G is designed to assist these types of programs. It helps staff assess families in eight domains of family functioning: Environment, Parental Capabilities, Family Interactions, Family Safety, Child Well-Being, Social and Community Life, Self-Sufficiency, and Family Health. The scale provides assessment ratings of problems and strengths at intake and at case closure. Its psychometric properties have a high degree of reliability and concurrent validity. A training package is available.

CHILD ABUSE PREVENTION (CAP) INVENTORY

The CAP Inventory is a preliminary screening tool for the detection of physical child abuse in populations at high risk for physical child abuse by protective services workers during investigations of reported child abuse cases. The CAP contains ten scales and three validity scales. The CAP Inventory was designed primarily as a screening tool for the detection of physical child abuse by protective services workers in their investigations of reported child abuse cases. It is a one hundred sixty item, valid and reliable objective self-report screening instrument that can assist protective services workers in making case decisions. It contains ten scales. The primary clinical scale (Abuse) is divided into six factor scales: Distress, Rigidity, Unhappiness, Problems With Child and Self, Problems With Family, and Problems With Others. In addition, the CAP Inventory contains three validity scales: Lie, Random Response, and Inconsistency. It is a paper and pencil instrument that can be administered by trained nonprofessionals. Materials can be purchased from Psychological Assessment Resources located at http://www3.parinc.com/products/product.aspx?Productid=CAP.

STRUCTURED DECISION MAKING (SDM)

Assessment tools are not intended to make case decisions for direct service workers; professional judgment must still be exercised. However, various tools can be employed to help structure decisions by bringing objective information to bear on critical questions:

- Are factors present that indicate the child may be in immediate danger if left in the home during the investigation?
- What is the likelihood that abuse or neglect will recur in this family in the near future?
- What specific family issues need to be addressed in order to reduce risk?
- What relative priority for agency service resources should this family receive?
- Can the child be returned home?

- The Children's Research Center's (CRC) Structured Decision-Making Model uses different criteria at each decision point to address the issues at each stage of a case:

  1. Responding to allegations of abuse/neglect:

     The initial call alleging abuse or neglect typically requires determine whether it is an allegation of abuse or neglect and, if so, how rapidly does an investigation need to be initiated. These determination have major implications for child safety and for agency workload

  2. Assessing the threat of imminent harm:

     The safety assessment helps focus attention on a set of ten to twelve clearly defined, specific conditions that potentially represent a threat to child safety.

  3. Assessing future risk

  4. Assessment of family needs and strengths

     The strengths/needs assessment is used to systematically identify family issues and provides a foundation for a service plan.

  5. Structured decision-making for children in out-of-home care

     - Presumptive guidelines for children in care are established by the model based on:
     - Risk of future maltreatment;
     - The safety of the home environment; and
     - Demonstrated parental interest and involvement in the lives of their children.

- The reunification model consists of four assessment components:

  1. A structured risk reassessment;
  2. A structured evaluation of parental compliance with visitation schedules;
  3. A reunification safety assessment; and,
  4. A structured guidelines for changing the permanency planning goal.

- Workload measurement which translates caseload into time requirements and ultimately, staffing needs.

- Management information reports which provide data for planning, monitoring and evaluation

  Information is provided to management to routinely monitor and evaluate programs, assess the impact of policy, identify service needs, and determine which programs and intervention strategies provide the best results for various types of cases.

SUMMARY OF STRUCTURED DECISION MAKING SYSTEM COMPONENTS

COMPONENT	WHEN USED	PURPOSE/DECISIONS	METHOD OF DEVELOPMENT
1. Response Priority	At time of referral	Accept referral or not, how quickly to respond	Policy/consensus
2. Safety Assessment	At onset of investigation; prior to any removal and when considering return	Identify immediate threat of harm and potential protecting interventions/removal	Policy/consensus/research
3. Risk Assessment	By completion of investigation	Assess long-term likelihood of re-abuse or re-neglect, open or close decision, level of service	Research - risk study
4. Family Strengths and Needs Assessment	By completion of investigation (typically for opened cases)	Assess family strengths/needs, help determine level of service, drive case plan	Policy/consensus
5. Child Strengths and Needs Assessment	By completion of investigation (typically for those entering out-of-home care)	Assess child's strengths/needs, drive child's service plan	Policy/consensus
6. Classification and Service Standards	At completion of risk/needs	Differentiate levels of service for opened cases	Policy
7. Risk/Needs Reassessment	Every 3-6 months	Measure progress, adjust service level, amend case plan, case closure	Research/policy
8. Reunification Assessment	When considering return from foster care	Reassess risk, safety, compliance with case plan and visitation	Research/policy
9. Workload Management	Ongoing	Assess number of staff needed, workload allocation, case assignments	Research - workload study
10. Management Information	Ongoing	Monitor quality assurance, planning, evaluation, budgeting	Aggregate data: assessment results; service referrals; workload; outcomes

Michigan's child welfare system and the CRC designed a Structured Decision Making system comprised of risk and needs assessments, case planning tools, reassessments and differentiated service standards that were piloted in thirteen counties in 1992. Outcomes indicated that counties using the model were significantly more likely to close low and moderate risk cases following substantiation than counties not using the model which closed more high risk cases. In addition, re-referral rates on cases closed without services were significantly lower. Families in counties using the model were also found to have considerably higher levels of participation in services and supports (e.g., parenting skills training, substance abuse treatment, family counseling, and mental health services), particularly those deemed high risk. Finally, families at high risk had less new referrals, subsequent child injuries, lower rates of subsequent placement in foster care, were only half as likely as families in non participating counties to have a subsequent substantiation. The SDM reunification assessment was subsequently added and outcomes of its use studied. Findings showed that more children achieved permanency within fifteen months and less re-entered foster care than in the counties not using the model.

SERVICE COORDINATION

CASE MANAGEMENT

Although research and experience indicate that case management is both beneficial and prevalent in children's mental health service delivery, a set of consistent standards for case management models is lacking. However, all models include the following functions:

- **Assessment** to determine needs or problems
- **Planning** to identify specific goals and the services and supports needed to attain them
- **Linking** to connect consumers to appropriate services and supports
- **Monitoring** to ensure services and supports are being delivered and are appropriate to need as well as ongoing evaluation of progress
- **Advocacy** to ensure consumers obtain services and entitlements

INTENSIVE CASE MANAGEMENT (ICM)

Intensive case management services are targeted to children and adolescents who have serious emotional disturbances and their families in order to reduce the need for more intensive levels of care (i.e., hospitalization) by providing assistance in accessing needed services and supports, monitoring service delivery, and helping with problem resolution. Caseloads are small, with a one to twelve case manager to consumer ratio. Services are available on a twenty-four hour basis, seven days a week and provided for as long as necessary. The wraparound process can be used to achieve comprehensive care coordination with the case manager assuming a lead role in assuring care coordination.

Core Functions:

- Assessment
- Service Planning
- Service Plan Implementation
- Service Coordination
- Monitoring and Evaluation
- Advocacy
- Providing Clinical Services
- Role Modeling
- Case Identification or Outreach

Services provided:

- Individualized Service Plans
- Home Visits
- Assistance with obtaining and maintaining basic living needs and skills, such as housing, food, medical care, recreation, education and employment
- Twenty-four-hour availability
- Linkages with community resources and natural supports
- Assistance arranging transportation to and from appointments

Research indicates that ICM results in significant behavioral improvements and decreases in unmet medical, recreational and educational needs, and decreased use of inpatient hospital and

residential services. The use of flexible service dollars to provide services and supports that are not part of standard service packages has been found to be beneficial.

WRAPAROUND

Wraparound is a family-centered process for the identification, selection and provision of a unique set of services and supports to children and families based upon their strengths and needs, and woven seamlessly into an individualized plan of care; it is not a program, model, or service. The wraparound process involves teams working together to operationalize Systems of Care at the child and family level. It is based upon the premise that all children should have the chance to have their mental health needs met within their home and community. Wraparound processes are organized around all key life domains (home, school, and community living). Some services may be delivered through formal agency procedures, while others may be delivered through informal arrangements in the community.

VALUES OF WRAPAROUND

- Voice and choice for the child and family
  - Access – parents and children have valid options in the decision-making process
  - Voice – parents and children are heard and listened to during all planning stages
  - Ownership – parents and children agree with and are committed to plans made
- Integration of services and systems
- Compassion for children and families
- Flexible approaches to funding, service provision and working with families
- A focus on safety, success, and permanency in home, school, community
- Care that is:
  - Unconditional
  - Individualized
  - Strengths-based
  - Family-centered
  - Culturally competent
  - Community-based (with services close to home in natural settings)
- A relationship with the child and family characterized by:
  - A lack of blame
  - A lack of shame
  - Dignity
  - Respect
  - Empathy
  - Listening
  - Support
  - Meaningful options
  - Self-determination

Wraparound represents the antithesis of the traditional provider-consumer relationship wherein the professional is the authority, and the parents are the problem and, when their children experience difficulties, they become the property of the provider agency and may be removed from home and community so they and their parents can be fixed. Wraparound, on the other hand, places families in decision-making positions as core members of the team. Services and supports are individualized and tailored to meet the needs identified by children and their families rather than placing them into sets of services that are on the current menu of particular agencies. Care is based on needs, not on programs that are available. For instance, if a child

requires half-day school attendance to maintain behavioral control, then the child attends school for half days irrespective of traditional attendance requirements.

The wraparound process provides services and supports in places children and their families identify as their community. An inherent element of the process is the belief that children will not acquire the skills needed to succeed in their natural environments unless they remain within the community in the least restrictive setting feasible; opportunities for teachable moments are more likely to occur in natural environments.

Steps of the wraparound process:

Step 1: Engagement of the Child and Family
Step 2: Immediate Crisis Stabilization and Safety Planning
Step 3: Strengths, Needs, and Culture Discovery
Step 4: Child and Family Team Formation and Nurturing
Step 5: Creating the Child and Family Team Plan

Preparing for the Meeting
Facilitating the Meeting
The Wraparound Plan

Step 6: Ongoing Crisis and Safety Planning
Step 7: Tracking and Adapting (the Wraparound Plan)
Step 8: Transition (Out of Formal Services)

Wraparound is conducive to managed care models, particularly in the capacity to provide flexible funding rather than having to rely on billing under categorical fee-for-service mechanisms that may not match the needs or desires of children and families. It is compatible with the goal of managed care to ensure that the right services are delivered in the right amount at the right time. Wraparound offers the opportunity to maximize flexibility in the allocation of resources effectively and efficiently. Funds that are saved due to diversions from more expensive residential or hospital care can be reinvested in the system of care to increase service capacity.

Wraparound teams monitor progress in all targeted life domains and focus on ensuring services are of high quality. The outcomes of wraparound that are tracked can include changes in school attendance, incidence of juvenile justice charges and adjudications, restrictiveness of living situation, and behavioral functioning measured by the Child Behavior Checklist (CBCL), Child and Adolescents Functional Assessment Scale (CAFAS), and others. System outcomes can include tracking of costs. However, it should be noted that while traditional mental health services often measure outcomes using standardized assessment instruments listed above, scores on such instruments may not always reflect what families want or identify as their needs.

In Michigan statewide Wraparound Quality Assurance (QA) Tools have been developed. The state of Michigan introduced four mandatory Quality Assurance tools for counties that have a DHS/FIA contract for Wraparound. These tools are designed to identify needed county outcomes as well as state outcomes. Wraparound standards were set forth in the *Information Advisory for Multi-Purpose Collaborative Bodies* which has been distributed to child mental health service providers.

CORE ELEMENTS OF WRAPAROUND

- **Community-based** services and supports**.** Wraparound is based on the premise that children belong in their natural environments.
- **Individualized and strength-focused** planning for services and supports in all life domains. These should fit the child (as opposed to fitting the child into some pre-existing program), focus on positives and build on strengths rather than problems, diagnoses or deficits.
- **Culturally competent services/supports** that demonstrate respect for unique family cultures in demonstrable recognition that every family has its own culture.
- **Family-driven** Families are full and active partners at every level of the process and responsible for decisions and allocation of resources (with input from the professionals on the team), rather than passive consumers of care. Family choices are adhered to and prioritized in accordance with needs because families have the best knowledge regarding how services and supports should enter into their lives. The process is structured to give families voice, choice and ownership. Success is defined from the perspectives of the *family* and provider.
- **Team-based** involving the child, family, natural supports, agencies, and community services. Team members are selected on the basis of their connection or attachment to the family rather than their roles. Teams include professionals (e.g., social workers, teachers) and natural supports (e.g., friends, coworkers, family) who are equal partners in the planning process. Teams change over time with respect to roles and membership. The ideal composition of a team includes less than fifty percent professional membership.[9]
- **Flexibly funded** with access to monies that can be used to meet the basic needs (e.g., medical, financial, requirements for safety and comfort) of children and their families. Access to non-categorical funding is essential. Often, several child-serving agencies create pooled funding streams to support children who have multiple agency involvement. The dollars follow the child and family, instead of being tied to specific programs and services. Flexible funds can be used for service and support activities that are outside traditional funding streams and are non-reimbursable by state and federal funding streams.[10]
- **Balanced between conventional and natural supports** Natural supports are a source of

[9] The involvement of a parent advocate early in the process is helpful due to perceptions of shared experiences which enhance the development of supportive relationships. Parent advocates offer nonjudgmental emotional support during crises, assist with problem-solving and navigating service delivery systems. Family resource developers (who are paid staff members whose children have received or are receiving services) can also be of assistance in identifying natural supports within the community and advocate for garnering resources.

[10] Ideally, funds are pooled from a variety of agencies (e.g., mental health, child welfare, juvenile justice, and education) and can be readily accessed and used flexibly to alleviate continuous unmet needs of families that result in a significant depletion of the capacity to meet emotional, social and behavioral challenges. Funds are not restricted to specific services and supports. For example, funds that might be typically used to support residential care are reallocated to provide home and community-based services and supports. Flexible funds may be used for sport equipment, bus passes, car repairs, personal care items, camp fees, alternative activities for children, nutritional counseling, behavioral reward programs (e.g., earning points that can redeemed for items), clothing, childcare, school supplies, etc. that result in positive consequences far beyond the solution of an immediate problem. The provision of funds up front eliminates extensive inter and intra-agency negotiations and stipulations and enhances families' control over the use of the funds. It has been found that when families are placed in charge of a budget, they demand provider accountability which in turn can result in improved quality. Research indicates that, contrary to concerns regarding budgetary constraints, flexible funding expenditures are comparable to, or less than, funds expended for traditional services and supports. Annual savings have been consistently found in numerous reviews of flexible funding arrangements.

culturally relevant caring and support for families. Ideally, conventional clinical services are gradually replaced with natural ones (e.g., extended family members, friends, neighbors, members of the faith-based community, volunteers, local service organizations, teachers, and coaches). Many families who enter into a wraparound process have experienced rejection by extended family members or isolation due to their difficulties. Thus, natural supports are absent from their lives and wraparound teams need to work to rebuild such supports. Self-sustaining, culturally relevant, nurturing natural supports endure long after professional relationships end.

- **Unconditionally committed** A "no reject, no eject" policy and a mindset of doing whatever it takes to meet the needs of the child and family is maintained. When difficulties arise, services and supports are changed, but never eliminated. An attitude of *doing whatever it takes* to meet the needs of children and their families and overcoming barriers and obstacles is adopted.
- **Collaborative** Interagency/community/neighborhood collaboration is used to develop individualized support and service plans. The approach is "how can we as a group get this accomplished and funded?"
- **Accountability for outcomes** that are based on family, child and team priorities. Outcomes are identified, documented, and progress is measured. Goals often include achieving success, safety, and permanence in the home, school and community.

Beneficial outcomes from the wraparound process have been shown to be enhanced by competent respite providers, mentors, one-on-one aides, quality summer programming and in-home behavioral support providers. It has been found that inexperienced one-on-one aides, untrained mentors, and less than competent therapists can seriously harm the wraparound process. Staffing issues are not uncommon due to shortages in many communities. This has been addressed in some localities by forming interagency recruitment-retention committees comprised of staff from agencies that share responsibilities.

Outcomes studies indicate that wraparound produces a number of beneficial outcomes including less restrictive living situations, decreased costs for care, and improvements in school, community and social functioning for participants. Studies show that children who have serious emotional disturbances demonstrate improvements in behavior, social and familial relationships, academic performance, and are less likely to require out-of–home placement. The wraparound process has been found to be more acceptable and empowering to families. Research also indicates that children's perceptions of their wraparound teams as unconditionally committed directly correlates to reductions in the severity of acting-out behaviors, depression, self-injurious behaviors, and increases in overall satisfaction with services.

Fidelity to the wraparound process as well as oversight have been found to vary by location. There are published criteria with common key components and implementation manuals to measure fidelity (see resource section in Appendix B).

The duration of service is usually one to three years. A five-year study in Kentucky indicated that the average cost during the first year is $1224.00 per child and $2455.00 during the fifth year.

APPENDIX A: SELECTED REFERENCES

Ahart, A., Bruer, Rutsch, C., Schmidt, R., Zaro, S. (1992). *Intensive Foster Care Reunification Programs.* United States Department of Health and Human Services. Washington DC.

American Academy of Child and Adolescent Psychiatry. (2002). *Policy Statement on Mental Health and Substance Use Screening and Assessment of Children in Foster Care.* [On line]. Available: www.aacap.org/publications/policy/collab01.htm.

American Academy of Child and Adolescent Psychiatry (Undated). *Policy Statement on Foster Care Mental Health Values Subcommittee-Policy Statement,* [On line]. Available: www.aacap.org/publications/policy/collab02.htm.

American Humane Association. (1998). *Assessing Outcomes in Child Welfare Services: Principles, Concepts, and a Framework of Core Outcome Indicators.* The Casey Outcomes and Decision-Making Project. American Humane Association, Children's Division. Englewood, CO. [On-line]. Available: http://www.americanhumane.org/site/DocServer/casey_outcomes.pdf?docID=163.

American Humane Association. (2005). *Differential Response in Child Welfare.* American Humane Association. Englewood, CO. [On-line]. Available: http://www.americanhumane.org/site/DocServer/PC_20.2_20.3.pdf?docID=7001.

Anderson G., Whalen, P. (2004). *Permanency Planning Mediation Pilot Program: Evaluation Final Report*. Michigan State University, School of Social Work. East Lansing, MI.

Annie E. Casey Foundation. (2001). *Family to Family: Tools for Rebuilding Foster Care. Lessons Learned.* [On-line]. Available: http://www.aecf.org/initiatives/familytofamily/tools/lessons.pdf.

Baird, C., Ereth, J., Wagner, D. (1999). Research-Based Risk Assessment: Adding Equity to CPS Decision Making. Children's Research Center. Madison, WI.

Bavolek, S. (November 2000). The Nurturing Parenting Programs. Juvenile Justice Bulletin. U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. Washington, DC.[On-line]. Available: http://www.ncjrs.gov/pdffiles1/ojjdp/172848.pdf.

Bazemore, G., Umbreit, M. (1998). *Guide for Implementing the Balanced and Restorative Justice Model*. US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. Washington, DC.

Belenko, S. (2001). *Research on Drug Courts: A Critical Review. 2001 Update*. National Center on Addiction and Substance Abuse. New York, NY. [On-line]. Available: http://www.casacolumbia.org/absolutenm/articlefiles/researchondrug.pdf.

Belenko, S., Dumanovsky, T. (1993). *Special Drug Courts: Program Brief*. Bureau of Justice Assistance. Washington, DC.

Bennett, L. (1995). Substance Abuse and the Domestic Assault of Women. *Social Work 40:* 760-772.

Berry, M., Martens, P., Propp, J. (2005). The Use of Intensive Family Preservation Services with Post-Adoptive Families. National Family Preservation Network. Buhl, ID. [On-line]. Available: http://www.nfpn.org/images/stories/files/ifps-adoptreport.pdf.

Brooks, T., Petit, M. (1997). *Early Intervention: Crafting a Community Response to Child Abuse and Violence.* Child Welfare League of America. Washington, DC.

Burke, B.C., & Pine, B. (Spring/Summer1999). Family reunification: Necessary components and skillful practices. *Permanency Planning Today*, 10-12. Available: http://www.hunter.cuny.edu/socwork/nrcfcpp/newsletters.html.

Burns, B., Goldman, S. (Eds.) (1999). Promising Practices in Wraparound for Children with Serious Emotional Disturbance and Their Families. In *Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Vol. 4.* Center for Effective Collaboration and Practice, American Institutes for Research. Washington, DC.

California Center for Judicial Education and Research. (Summer 1994). *Drug Courts: A Judicial Manual*. California Center for Judicial Education and Research. Berkeley, CA.

Carroll K. (1996). Relapse Prevention as a Psychosocial Treatment: A Review of Controlled Clinical Trials. *Experimental & Clinical Psychopharmacology 4:* 46-54.

Casey Family Programs. (2008). *Improving Outcomes for Older Youth in Foster Care*. Casey Family Programs. Seattle WA. [On-line]. Available: http://www.casey.org/NR/rdonlyres/983E5E8D-DE21-49A5-BC42-3C137D757FDE/658/WhitePaper_ImprovingOutcomesOlderYouth_FR.pdf.

Center for Substance Abuse Treatment. (1999). *Brief Interventions and Brief Therapies for Substance Abuse. Treatment Improvement Protocol (TIP) Series 34.* Substance Abuse and Mental Health Services Administration. Rockville, MD.

Center for Substance Abuse Treatment. (1993). *Improving Treatment For Drug-Exposed Infants. Treatment Improvement Protocol (TIP) Series 5.* Substance Abuse and Mental Health Services Administration. Rockville, MD.

Center for Substance Abuse Treatment. (1994). *Practical Approaches in the Treatment of Women who Abuse Alcohol and Other Drugs.* Substance Abuse and Mental Health Services Administration. Rockville, MD.

Center for Substance Abuse Treatment. (1993). *Pregnant, Substance-Using Women. Treatment Improvement Protocol (TIP) Series 2.* Substance Abuse and Mental Health Services Administration. Rockville, MD.

Center for Substance Abuse Treatment. (1993). *Relapse Prevention and the Substance-Abusing Criminal Offender. Technical Assistance Publication (TAP) Series 8.* Substance Abuse and Mental Health Services Administration. Rockville, MD.

Center for Substance Abuse Treatment. (1997). *Substance Abuse Treatment and Domestic Violence. Treatment Improvement Protocol (TIP) Series 25.* Substance Abuse and Mental Health Services Administration. Rockville, MD.

Center for Substance Abuse Treatment. (2000). *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues. Treatment Improvement Protocol (TIP) Series 36.* Substance Abuse and Mental Health Services Administration. Rockville, MD.

Center for Substance Abuse Treatment. (2005). *Substance Abuse Treatment for Persons With Co-Occurring Disorders. Treatment Improvement Protocol (TIP) Series 42.* Substance Abuse and Mental Health Services Administration. Rockville, MD.

Center for Substance Abuse Treatment. (1999). *Substance Abuse Treatment for Women Offenders: Guide to Promising Practices. Technical Assistance Publication (TAP) Series 23.* Substance Abuse and Mental Health Services Administration. Rockville, MD.

Center for Substance Abuse Treatment. (1998). *Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing. Treatment Improvement Protocol (TIP) Series 23.* Substance Abuse and Mental Health Services Administration. Rockville, MD.

Chamberlain, P. (2003). A Glimpse at Establishing the Evidence: Multidimensional Treatment Foster Care. *Data Matters 6:* 8-9.

Chamberlain, P. (December 1998). *Treatment Foster Care*. Juvenile Justice Bulletin. U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, Washington, DC.

Chamberlain, P, Mihalic, S. (1988). *Blueprints for Violence Prevention: Multidimensional Treatment Foster Care.* University of Colorado at Boulder, Center for the Study and Prevention of Violence. Boulder, CO.

Chapin Hall Center for Children. (1995). A Review of Family Preservation and Family Reunification Programs. Chapin Hall Center for Children, University of Chicago. Chicago IL.

Children's Research Center. (1993). *A New Approach to Child Protection: The CRC Model.* National Council on Crime and Delinquency. Madison, WI.

Children's Research Center. (2008). *The Structured Decision Making Model: An Evidence-based Approach to Human Services.* National Council on Crime and Delinquency. Madison, WI. [On-line]. Available: http://www.nccd-crc.org/crc/pdf/2008_sdm_book.pdf.

Children's Research Center, National Council on Crime and Delinquency. (1999). *The Improvement of Child Protective Services with Structured Decision Making: The CRC Model.* Children's Research Center, National Council on Crime and Delinquency. Madison, WI. [On-line]. Available: http://www.nccd-crc.org/crc/pubs/crc_sdm_book.pdf.

Child Welfare League of America. (1993). *Cultural Competence Self-Assessment Instrument.* Child Welfare League of America. Washington, DC.

Child Welfare League of America. (March 2002,). Family reunification. *Research Roundup*. [On-line]. Available: http://www.cwla.org/programs/r2p/rrnews.htm.

Chipungu, S., Everett, J., Verdieck, M. Jones, J. (1998). *Children Placed in Foster Care with Relatives: A Multi–State Study*. U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. Washington, D.C.

Christian, S. (2001). Returning Home from Foster Care: What Policymakers Need to Know. *Nation Conference of State Legislatures' State Legislative Report, 26.* [On-line]. Available: http://www.ncsl.org/programs/cyf/slr2612.htm.

Cicchetti, D., Rogosch, F. A., Toth, S. L. (2000). The Efficacy of Toddler-Parent Psychotherapy for Fostering Cognitive Development in Offspring of Depressed Mothers. *Journal of Abnormal Child Psychology 28:* 135-148.

Clark, C. (2002). Addressing Histories of Trauma and Victimization through Treatment. The GAINS Center. Delmar, NY.

Cross, T., Bazron, B., Dennis, K., Isaacs, M. (1989). *Towards a Culturally Competent System of Care, Vol. 1.* Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health. Washington, DC.

Crosson-Tower, C. (2003). *The Role of Educators in Preventing and Responding to Child Abuse and Neglect*. United States Department of Health and Human Services, Administration for Children and Families, Administration on Children, Office on Child Abuse and Neglect, Youth and Families, Children's Bureau. [On-line]. Available:

http://www.childwelfare.gov/pubs/usermanuals/educator/educator.pdf.

Curtis, P., Alexander, G., Lunghofer, L. (2001). A Literature Review Comparing the Outcomes of Residential Group Care and Therapeutic Foster Care. *Child and Adolescent Social Work Journal 18:* 377-392.

De La Rosa, M., Lambert, E., Gropper, B. (Eds.). (1990). *Drugs and Violence: Causes, Correlates, and Consequences*. *NIDA Research Monograph Series, Number 103*. National Institute on Drug Abuse. Rockville, MD.

Doughtery, S. (2004). *Promising Practices in Reunification*. National Resource Center for Foster Care & Permanency Planning, Hunter College School of Social Work. New York, NY.

Doughtery, S., Yu, E., Edgar, M., et al. (Undated). *Planned and Crisis Respite for Families with Children: Results of a Collaborative Study*. [On-Line]. Available: http://archrespite.org/.

Drug Court Clearinghouse and Technical Assistance Project at the American University. (1998). *Juvenile and Family Drug Courts: An Overview.* U.S. Department of Justice. Washington, DC.

Earp, B. ((2004). *Family Dependency Treatment Courts: Addressing Child Abuse and Neglect Cases Using the Drug Court Model.* U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance. Washington, DC.

Edleson, J.(2006). *Emerging Responses to Children Exposed to Domestic Violence*. National Online Resource Center on Violence Against Women. Harrisburg, PA.

Evans, M., Boothroyd, R., Armstrong, M. et al. (2003). An Experimental Study of the Effectiveness of Intensive In-Home Crisis Services for Children and Their Families: Program Outcomes. *Journal of Emotional and Behavioral Disorders 11:* 93-104.

Evans, M., Huz, S., McNulty, T., Banks, S. (1996a). Child, Family and System Outcomes of Intensive Case Management in New York State. *Psychiatric Quarterly 6:* 283-87.

Eyberg, S., Funderburk, B., Hembree-Kigin, T., et al. (2001). Parent–Child Interaction Therapy: One and Two Year Maintenance of Treatment Effects in the Family. *Child and Family Behavior Therapy 23:* 1–20.

Family Support Network. (2002). Child Abuse and Neglect. [On-line]. Available: http://www.familysupport.org/Abuse.cfm.

Feldman, J., Kazdin, A. (1995). Parent Management Training for Oppositional and Conduct Problem Children. *The Clinical Psychologist 48:* 3-5.

Fisher, P., Chamberlain, P. (2001). Multidimensional Treatment Foster Care. *Journal of Emotional and Behavioral Disorders 8:* 155-169.

Flango, C., Flango, V., Rubin H. (1999). *How are Courts Coordinating Family Cases?* National Center for State Courts. Williamsburg, VA.

Frey, L., Greenblatt, S., Brown, J. (2005). *An Integrated Approach to Youth Permanency and Preparation for Adulthood.* The Casey Center for Effective Child Welfare Practice. New Haven, CT. [On-line]. Available: http://www.aecf.org/upload/publicationfiles/casey_permanency_0505.pdf.

Gardner, Deseree. (2008). *Youth Aging Out of Foster* Care: Identifying Strategies and Best Practices. *National Association of Counties Issue Brief*. National Association of Counties. Washington DC. [On-line]. Available: http://www.naco.org/Content/ContentGroups/Issue_Briefs/IB-YouthAgingoutofFoster-2008.pdf.

Garland, A., Hough, R., Landsverk, J., et al. (2000). Racial and Ethnic Variations in Mental Health Care Utilization Among Children in Foster Care Children's Services. *Social Policy, Research, and Practice 3:* 133-146.

Gira, E., Kessler, M., Poertner, J. (2001). Evidence-Based Practice in Child Welfare: Challenges and Opportunities. Children and Family Research Center, School of Social Work, University of Illinois at Urbana-Champaign. Urbana, IL.

Glassheim, B. (2006). *A Guide to Evidence-Based Practices for Individuals with Substance Use Disorders.* Saginaw County Community Mental Health Authority. Saginaw, MI. [On-line]. Available: http://sccmha.org/quality.html.

Glassheim, B. (2007). *A Guide to Evidence-Based Mental Health Practices for Children, Adolescents and their Families.* Saginaw County Community Mental Health Authority. Saginaw, MI. [On-line]. Available: http://sccmha.org/quality.html.

Goldman, J., Salus, M. (2003). *A Coordinated Response to Child Abuse and Neglect: The Foundation of Effective Practice.* U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Office on Child Abuse and Neglect, Youth and Families, Children's Bureau. [On-line]. Available: http://www.childwelfare.gov/pubs/usermanuals/foundation/foundation.pdf.

Heneghan, A., Horwitz, S., Leventhal, J. (1996). Evaluating Intensive Family Preservation Programs: A Methodological Review. *Pediatrics 97:* 535-542.

Henggeler, S., Mihalic, S., Rone, L., et al. (1998). *Blueprints For Violence Prevention: Multisystemic Therapy*. Center for the Study and Prevention of Violence, University of Colorado. Boulder, CO.

Henggeler, S., Pickrel, S., Brondino, M., Crouch, J. (1996). Multisystemic Therapy: An Effective Violence Prevention Approach for Serious Juvenile Offenders. American Journal of Psychiatry 153: 427-428.

Herschell, A., Calzada, E., Eyberg, S., McNeil, C. (2002). Parent-Child Interaction Therapy: New Directions in Research. *Cognitive and Behavioral Practice 9:* 9-16.

Hodges, S., Nesman, T., Hernandez, M. (1999). Promising Practices: Building Collaboration in Systems of Care. *Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Volume VI.* Center for Effective Collaboration and Practices, American Institutes for Research. Washington, DC.

Howard, D., Caskey, R. (Summer 2002). Structuring Designs In Foster Care: Michigan's Family Reunification Assessment. *Permanency Planning Today 12-14*.[On-line]. Available: http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/newsletter/ppt-summer-2002.pdf.

Hyde, P., Falls, K., Morris, J., Schoenwald, S. (2003). *Turning Knowledge Into Practice: A Manual for Behavioral Health Administrators and Practitioners About Understanding and Implementing Evidence-Based Practices.* [On-Line]. Available: http://www.tacinc.org/.

Kakavelakis I., Macdonald G. (2004). Cognitive-Behavioral Training Interventions for Assisting Foster Carers in the Management of Difficult Behavior (Protocol for a Cochrane Review). In *The Cochrane Library: Issue 2*. John Wiley and Sons, Ltd. Chichester, UK.

Kaufmann, R., Dodge, J. (l997). *Prevention and Early Interventions for Young Children at Risk for Mental Health and Substance Abuse Problem and Their Families: A Background Paper.* National Technical Assistance Center for Children's Mental Health, Georgetown University. Washington, DC.

Kazdin, A., Weisz, J. (Eds.). (2003). *Evidence-Based Psychotherapies for Children and Adolescents.* The Guilford Press, New York.

Kendziora, K., Bruns, E., Osher, D., et al (2001). *Systems of Care: Promising Practices in Children's Mental Health, 2001 Series, Volume 1.* Center for Effective Collaboration and Practice, American Institute for Research. Washington, DC.

Kerr, S. (2000). The Application of the Americans with Disabilities Act to the Termination of the Parental Rights of Individuals with Mental Disabilities. *Journal of Contemporary Law and Policy 16:* 387.

Knitzer, J. (1982). *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services.* The Children's Defense Fund. Washington, DC.

Knitzer, J. (2000). *Promoting Resilience: Helping Young Children Affected by Substance Abuse, Domestic Violence, and Depression in the Context of Welfare Reform.* National Center for Children in Poverty. New York, NY.

Kotler, J., (1998). From Adolescence to Adulthood: Transition Services to Help Youth Build a Better Future. *Network:* 2-14.

Koyanagi, C. (2002). *Avoiding Cruel Choices: A Guide for Policymakers and Family Organizations on Medicaid's Role in Preventing Custody Relinquishment.* pp. 1–15. Judge David L. Bazelon Center for Mental Health Law, Washington, DC.

Kropenske, V., Howard, J. (1994). *Protecting Children in Substance-Abusing Families: The User Manual Series.* U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect. Washington, DC.

Kumpfer, K., Alvarado, R. (1998). *Effective Family Strengthening Interventions.* Bulletin. U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. Washington, DC.

Leashore, B. (1999, Spring/Summer). Family support and reunification: A community resource model. *Permanency Planning Today*, 12-14. [On-line]. Available: http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/newsletter/ppt-spring-summer-1999.pdf

Lehman, A., Goldman, H., Dixon, L., Churchill, R. (2004). *Evidence-Based Mental health Treatments and Services: Examples to Inform Public Policy.* Millbank Memorial Fund, New York, NY.

Lennon, M., Blome, J., English, K. (2001*). Depression and Low Income Women: Challenges for TANF and Welfare-to-Work Policies and Programs*. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Rockville, MD.

Levin, S., Greene, J. (Eds.). (2000). *Linking Substance Abuse Treatment and Domestic Violence Services: A Guide for Administrators. Concise Desk Reference Guide*. Center for Substance Abuse Treatment. Rockville, MD.

Lieberman, A. (1992). Infant Parent Psychotherapy With Toddlers*. Development and Psychopathology 4:* 559-574.

Little, J., Schuerman , J. (1995). *A Synthesis of Research on Family Preservation and Family Reunification Programs*. Washington, DC: U. S. Department of Health and Human Services. Available: http://aspe.os.dhhs.gov/hsp/cyp/fplitrev.htm

Lundberg Stratton, E. (2003). *Expediting Dependency Appeals – Trends in 2003: Developing Strategies for Courts to Help Move Children Quickly Through the Appeals Process Knowledge and Information Services*. National Center for State Courts. Williamsburg, VA

Marsenich, L. (2002). *Evidence-Based Practices in Mental Health Services for Foster Youth.* California Institute for Mental Health. Sacramento, CA.

Masten, A., Best, K., and Garmezy, N. (1990). Resilience and Development: Contributions from the Study of Children Who Overcome Adversity. *Development and Psychopathology 2:* 425-444.

McCroskey, J. Meezan, W. (1998). Family-Centered Services: Approaches and Effectiveness. *The Future of Children 8:* 54-71.

McNeely, S. (Summer 2001). Family group decision making as a time limited reunification service. *Permanency Planning Today*, 10-11. [On-line]. Available: http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/newsletter/ppt-summer-2001.pdf.

Mentaberry, M. (1999). Model Courts Serve Abused and Neglected Children*. Office of Juvenile Justice and Delinquency Prevention Fact Sheet # 90.* U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. Washington, DC. [On-line]. Available: http://www.ncjrs.gov/pdffiles1/fs-9990.pdf.

Molgaard, V., Spoth, R., Redmond, E. (2000). Competency Training: The Strengthening Families Program: For Parents and Youth 10-14. *Juvenile Justice Bulletin August 2000.* U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, Rockville, MD.

Mullen, P., Martin, J., Anderson, J., et al. (1996). The Long-Term Impact of the Physical, Emotional, and Sexual Abuse of Children: A Community Study. *Child Abuse and Neglect 20*: 7-21.

Mullick, M., Miller, L., Jacobsen, T. (2001). Insight Into Mental Illness and Child Maltreatment Risk Among Mothers With Major Psychiatric Disorders. *Psychiatric Services 52:* 488-492.

Multipurpose Collaborative Bodies and Collaborative Initiatives (1996). *Putting it Together with Michigan Families: 9.*

National Center for Children in Poverty. (2001a). *Improving the Odds for the Healthy Development of Young Children in Foster Care.* [On line]. Available: www.nccp.org.

National Center for Children in Poverty. (2001b). *Building Services and Systems to Support the Healthy Emotional Development of Young Children: An Action Guide for Policymakers.* [On line]. Available: www.nccp.org.

National Center for Injury Prevention and Control. (2004) *Using Evidence-Based Parenting Programs to Advance CDC Efforts in Child Maltreatment Prevention Research Activities.* Centers for Disease Control and Prevention. Atlanta, GA.

National Child Resources Center for Family-Centered Practice. (Summer 2002). *Father Involvement.* National Child Resources Center for Family-Centered Practice. Washington, DC. [On-line]. Available: http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/newsletter/BPNPSummer02.pdf.

National Council of Juvenile and Family Court Judges. (2008). *Bringing the Green Book to Life: A Resource Guide for Communities.* National Council of Juvenile and Family Court Judges. Reno, NV. [On-line]. Available: http://www.thegreenbook.info/documents/BJA.pdf.

National Council of Juvenile and Family Court Judges. (1999). Executive Summary of Effective Intervention in Domestic Violence and Child Maltreatment Cases: Guidelines for Policy and Practice. National Council of Juvenile and Family Court Judges. Reno, NV.

National Family Preservation Network. (2006). *An Effective Child Welfare System and Evidence-Based Practice for the Child Welfare System.* National Family Preservation Network. Buhl, ID.

National Family Preservation Network. (2003). *Intensive Family Reunification Services Protocol.* National Family Preservation Network Buhl, ID: [On-line]. Available: http://www.nfpn.org/images/stories/files/ifrs_protocol.pdf

New York Office for the Prevention of Domestic Violence. (Undated). Information and Resources: *The False Connection Between Adult Domestic Violence and Alcohol.*

Nicholson, J., Biebel, K., Hinden, B., et al. (2001). *Critical Issues for Parents with Mental Illness and Their Families.* Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Rockville, MD.

Nock, M. (2005*). Participation Enhancement Intervention: A Brief Manual for a Brief Intervention.* Unpublished Manuscript. Harvard University, Cambridge, MA. [On-line]. Available: http://www.wjh.harvard.edu/~nock/nocklab/Participation%20Enhancement%20Intervention_Brief%20Manual.pdf.

Office of Applied Studies. (2005). Substance Use and Need for Treatment among Youths Who Have Been in Foster Care. *The National Survey on Drug Use and Health Report.* Substance Abuse and Mental Health Services Administration. Rockville, MD.

Office of Minority Health. (2001). *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*. Office of Minority Health. Washington, DC. [On-line]. Available: http://www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf.

Olds, D., Eckenrode, J., Henderson, C., et al. (1997). Long-term Effects of Home Visitation on Maternal Life Course, Child Abuse and Neglect, and Children's Arrests: Fifteen-Year Follow-up of a Randomized Trial. *Journal of the American Medical Association. 278*: 637-643.

Olds, D., Henderson, C., Tatelbaum, R., Chamberlin, R. (1988). Improving the Life-Course Development of Socially Disadvantaged Mothers: A Randomized Trial of Nurse Home Visitation. *American Journal of Public Health 78:* 1436-1445.

Parra, G. *Welfare Reform and Substance Abuse: Innovative State Strategies*. (2002). NHPF Issue Brief. National Health Policy Forum. Washington, DC. [On-line]. Available:

http://www.nhpf.org/pdfs/8%2D771%2B%28web%29%2Epdf.

Peterson, L., Gable, S., Saldana, L. (1996). Treatment of Maternal Addiction to Prevent Child Abuse and Neglect. *Addictive Behaviors 21:* 789-801.

Pires, S. (2002). *Building Systems of Care: A Primer.* Georgetown University Child Development Center, CASSP Technical Assistance Center. Washington, DC.

Roberts, C., Mazzucchelli, T., Studman, L., Sanders, M. (2006). A Randomized Control Trial of Behavioral Family Intervention for Young Children with Developmental and Behavioral Problems. *Journal of Clinical Child and Adolescent Psychology 35:* 180-193. [On-line]. Available: http://www.pfsc.uq.edu.au/papers/2006BehavioralFamilyIntervention.pdf.

Robbins, M., Szapocznik, J. (2000). Brief Strategic Family Therapy. *Juvenile Justice Bulletin.* Office of Juvenile Justice and Delinquency Prevention. Washington, DC. [On-line]. Available: http://www.ncjrs.org/html/ojjdp/jjbul2000_04_3/contents.html.

Rosenberg J., Wilcox W. (2006). *The Importance of Fathers in the Health Development of Children.* United States Department of Health and Human Services, Administration for Children

and Families, Administration on Children, Office on Child Abuse and Neglect, Youth and Families, Children's Bureau. [On-line]. Available: http://www.childwelfare.gov/pubs/usermanuals/fatherhood/fatherhood.pdf.

Rycus, J., Hughes, R. (2003).*Issues in Risk Assessment in Child Protective Services: Policy White Paper.* North American Resource Center for Child Welfare, Center for Child Welfare Policy. Columbus, OH.

Sanders, M., Markie-Dadds, C. Turner, K. (2003). Theoretical, Scientific and Clinical Foundations of the Triple P - Positive Parenting Program: A Population Approach to the Promotion of Parenting Competence. Parenting Research and Practice Monograph No. 1. The Parenting and Family Support Centre, The University of Queensland. [On-line]. Available: http://www.triplep-america.com/.

Seybold, E., (2002). *WrapAround Milwaukee*. A Report. Milwaukee Community Health Division, Child and Adolescent Services Branch. Milwaukee, WI.

Szapocnik, J., Williams, R. (2000) Brief Strategic Family Therapy: Twenty-five Years of Interplay Among Theory Research and Practice in Adolescent Behavior Problems and Drug Abuse, *Clinical Child and Family Psychology Review 3:* 111-134.

Taggart, S., Litton, L. (2008).*Reflections from the Field: Considerations for Domestic Violence Specialists.* National Council of Juvenile and Family Court Judges. Reno , NV.

The Casey Outcomes and Decision-Making Project (1998) *Assessing Outcomes in Child Welfare Services: Principles, Concepts, and a Framework of Core Indicators.* The Casey Outcomes and Decision-Making Project at American Humane Association, Children's Division. East Englewood, CO. [On-line]. Available: http://www.americanhumane.org/site/DocServer/casey_outcomes.pdf?docID=163.

Thomas, D., Leicht, C. Hughes, C., et al. (2003). *Emerging Practices in the Prevention of Child Abuse and Neglect.* United States Department of Health and Human Services. Washington, DC.

United States Department of Health and Human Services. (2000). *Healthy People 2010: Understanding and Improving Health.* U.S. Government Printing Office. Washington, DC. [On-line]. Available: http://www.health.gov/healthypeople/Document/pdf/uih/2010uandih.pdf.

United States Department of Health and Human Services (2000). *National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care*. U.S. Department of Health and Human Services, Office of Public Health and Science, Office of Minority Health. Washington, DC.

United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General.*: Department of Health and Human Services, U.S. Public Health Service. Rockville, MD. [On-Line]. Available: http://www.surgeongeneral.gov/library/mentalhealth/home.html.

United States Public Health Service Office of the Surgeon General. (2001). *Mental Health: Culture, Race, and Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General.* Department of Health and Human Services, U.S. Pubic Health Service. Rockville, MD. [On-Line]. Available: http://www.surgeongeneral.gov/library/mentalhealth/home.html.

United States Department of Health and Human Services. (2000). *Rethinking Child Welfare Practice Under the Adoption and Safe Families Act of 1997: A Resource Guide.* United States Government Printing Office. Washington, DC. [On-line]. Available: www.cwresource.org and www.calib.com/nccanch.

United States Department of Health and Human Services, Administration for Children and Families, Substance Abuse and Mental Health Services Administration. (2000). *Welfare Reform: Employment Strategies for Overcoming Substance Abuse/Mental Health Barriers. National Conference Report.* U.S. Government Printing Office. Washington, DC.

United States Department of Health and Human Services, Administration for Children and Families, Substance Abuse and Mental Health Services Administration, Office of the Assistant Secretary for Planning and Evaluation (ASPE). (1999). *Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection.* U.S. Government Printing Office. Washington, DC.

United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS). (2003). *Science-Based Prevention Programs and Principles.* Rockville, MD.

United States Department of Justice, Bureau of Justice Assistance. (2004). *Family Dependency Treatment Courts: Addressing Child Abuse and Neglect Cases using the Drug Court Model.* U.S. Department of Justice, Office of Justice Programs. Washington, DC.

Vandell, D., Wolfe, B. (2000). *Child Care Quality: Does It Matter and Does It Need to be Improved*? U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Washington, DC.

VanDenBerg, J., Grealish, M. (1996). Individualized Services and Supports through the Wraparound Process: Philosophy and Procedures. *Journal of Child and Family Studies 5:* 7-21.

Wagner, D., Johnson, K., Caskey, R. (2002) *Evaluation of Michigan's Foster Care Structured Decision Making Case Management System*. Children's Research Center. Madison, WI.

Wilson, C., Alexandra, L. (2005). *Guide for Child Welfare Administrators on Evidence Based Practice.* National Association of Public Child Welfare Administrators. Washington DC. [On-line]. Available: http://www.chadwickcenter.org/Documents/Guide-for-Evidence-Based-Practice.pdf.

Wolf, M., Kirigin, K., Fixsen, D., et al. (1995). The Teaching-Family Model: A Case Study in Data-Based Program Development and Refinement (and Dragon Wrestling). *Journal of Organizational Behavior Management 15:* 11-68.

Wulczyn, F. (2004). Family Reunification. *The Future of Children, 14*. [Online]. Available: http://www.futureofchildren.org/index.htm.

APPENDIX B: SELECTED RESOURCES

Evidence-Based Practices

Blueprints for Violence Prevention: www.colorado.edu/cspv/blueprints/
Program matrix: www.colorado.edu/cspv/blueprints/matrix/matrix.pdf).
California Evidence-Based Clearinghouse for Child Welfare: http://www.cachildwelfareclearinghouse.org/
Campbell Collaborative: www.campbellcollaboration.org
Cochrane Collaborative: www.cochrane.org and www.cochrane.org/cochrane/revabstr/BEHAVAbstractIndex.htm).
National Child Welfare Resource Center for Youth Development: www.nrcys.ou.edu/nrcyd/resources/clearing.shtml and www.nrcys.ou.edu/nrcyd/publications.shtml).
National Clearinghouse on Child Abuse and Neglect: http://nccanch.acf.hhs.gov/ And http://nccanch.acf.hhs.gov/profess/promising/index.cfm
The Office of Juvenile Justice and Delinquency Prevention's Model Programs Guide (MPG) (OJJDP Model Programs Guide): www.dsgonline.com/mpg2.5/mpg_index.htm
Promising Practice Network (PPN): www.promisingpractices.net/
SAMHSA Model Programs: www.modelprograms.samhsa.gov
Strengthening America's Families: www.strengtheningfamilies.org
Program matrix: www.strengtheningfamilies.org/html/programs_1999/programs_list_1999.html.
Child Physical & Sexual Abuse: Guidelines for Treatment: http://www.musc.edu/cvc/guide1.htm
Office for Victims of Crime: http://www.ojp.usdoj.gov/ovc
Campbell Collaborative: http://www.campbellcollaboration.org
American Humane: http://www.americanhumane.org/site/PageServer?pagename=pc_home
Child Welfare Information Gateway: http://www.childwelfare.gov/

FAMILY PRESERVATION

Child Welfare League of America: http://www.cwla.org/
National Resource Center for Family-Centered Practice & Permanency Planning: http://www.hunter.cuny.edu/socwork/nrcfcpp/
Chapin Hall Center for Children: http://www.chapinhall.org/

ALTERNATIVE RESPONSES

National Child Welfare Resource Center for Family-Centered Practice: http://www.hunter.cuny.edu/socwork/nrcfcpp/
Center for the Study of Social Policy: http://www.cssp.org/
California Social Work Education Center: http://calswec.berkeley.edu/
National Conference of State Legislatures: http://www.ncsl.org/
National Abandoned Infants Assistance Resource Center: http://aia.berkeley.edu/

FAMILY MEDIATION

National Resource Center for Foster Care and Permanency Planning: http://www.hunter.cuny.edu/socwork/nrcfcpp/

National Center for State Courts: http://www.ncsconline.org/

FATHERS

U.S. Department of Health and Human Services: http://fatherhood.hhsgov/index.shtml
National Fatherhood Initiative: www.fatherhood.org
National Center for Fathering: www.fathers.com
Bootcamp for New Dads: http://www.newdads.com
Center on Fathers, Families, and Public Policy: http://cff pp.org
Family and Corrections Network: http://www.fcnetwork.org
The e Fathers Network: http://www.fathersnetwork.org
Center for Successful Fathering: http://www.fathering.org
National Center on Shaken Baby Syndrome: http://www.dontshake.com
National Latino Fatherhood and Family Institute: http://www.bienvenidos.org/nlffi
Slowlane.com: http://www.slowlane.com

SUBSTANCE ABUSE

Center for Substance Abuse Treatment: http://csat.samhsa.gov/
Bureau of Justice Assistance: http://www.ojp.usdoj.gov/BJA/
National Abandoned Infants Assistance Resource Center: http://aia.berkeley.edu/
Emory University School of Medicine: http://www.med.emory.edu/
Washington Department of Social and Health Services: http://www1.dshs.wa.gov/

DOMESTIC VIOLENCE, ABUSE, AND NEGLECT

National Clearinghouse on Child Abuse and Neglect: http://www.childwelfare.gov/
National Domestic Violence Hotline: (800) 799-SAFE and (800) 787-3224 (TDD)
Rape, Abuse, and Incest National Network (RAINN): (800) 656-4673
Childhelp USA/National Child Abuse Hotline: (800) 4A-CHILD
American College of Obstetricians and Gynecologists (ACOG): http://www.acog.org/
American Medical Association (AMA): http://www.ama-assn.org/
March of Dimes Birth Defects Foundation: http://www.marchofdimes.com/
March of Dimes Resource Center: resourcecenter@modimes.org
National Center for Missing or Exploited Children (NCMEC):
http://www.missingkids.com/
National Coalition Against Domestic Violence: http://www.ncadv.org/
National Sheriffs' Association: http://www.sheriffs.org/home.shtml
National Victim Center (NVC)/INFOLINK: www.nvc.org
FaithTrust Institute (formerly the Center for the Prevention of Sexual and Domestic Violence):
http://www.faithtrustinstitute.org/
This is a national organization working with and within religious communities on issues of sexual
Colorado Coalition Against Domestic Violence: http://www.ccadv.org/
Family Violence and Sexual Assault Institute: fvsai@e-tex.com
National Center on Elder Abuse (NCEA): http://www.elderabusecenter.org/
National Clearinghouse on Marital and Date Rape:
http://members.aol.com/ncmdr/index.html
National Criminal Justice Reference Service (NCJRS): askncjrs@ncjrs.org
Health Resource Center on Domestic Violence: http://www.fvpf.org/health/
Battered Women's Justice Project (BWJP): http://www.bwjp.org/

INFORMATION AND ADVOCACY

Federation of Families for Children's Mental Health: http://www.ffcmh.org
Child Welfare League of America (CWLA): http://www.cwla.org/
Center for the Improvement of Child Caring: http://www.ciccparenting.org/

PREVENTION

National Alliance of Children's Trust and Prevention Funds: www.ctfalliance.org
Prevent Child Abuse America: http://www.preventchildabuse.org

CHILD SAFETY

Children's Safety Network (CSN): www.edc.org/HHD/csn
The Children's Safety Network: http://www.childrenssafetynetwork.org/
Centers for Disease Control and Prevention (CDC): www.cdc.gov/ncipc/dvp or http://www.cdc.gov/

SERVICES FOR CHILDREN AND FAMILIES OF PRISONERS

National Human Services Assembly: http://www.nydic.org/nassembly/
Welfare Peer Technical Assistance Network: http://peerta.acf.hhs.gov/
Research and Training Center on Family Support and Children's Mental Health: http://www.rtc.pdx.edu/
Family Support America: http://www.familysupportamerica.org/

PARENT/BIRTH PARENT COLLABORATION

National Abandoned Infants Assistance Resource Center at the University of California, Berkeley: http://aia.berkeley.edu/
Annie E. Casey Foundation: http://www.aecf.org/

FAMILY REUNIFICATION

Casey Family Programs: http://www.casey.org/Home

PERMANENCY PLANNING

National Center for Family-Centered Practice and Permanency Planning: http://www.hunter.cuny.edu/socwork/nrcfcpp/

RESPITE

ARCH National Respite Network: http://www.archrespite.org/index.htm

CHILD WELFARE ORGANIZATIONS

American Humane Association Children's Division: http://www.americanhumane.org
AVANCE Family Support and Education Program: www.avance.org
Child Welfare League of America: http://www.cwla.org
National Black Child Development Institute: www.nbcdi.org
National Indian Child Welfare Association: http://www.nicwa.org

Wraparound

National Wraparound Initiative: http://www.rtc.pdx.edu/nwi/

Center for Effective Collaboration and Practice – Wraparound Planning: http://cecp.air.org/wraparound/default.htm
Community Partners, Inc. (Mary Grealish): http://www.wraparoundsolutions.com/steps.asp
Wraparound Evaluation and Research Team (WERT): http://depts.washington.edu/wrapeval/
National Mental Health Association: www.nmha.org
Center for Mental Health Services, Knowledge Exchange Network (KEN): www.mentalhealth.org/child
National Center for Mental Health and Juvenile Justice: http://www.ncmhjj.com/
Bazelon Center for Mental Health Law: www.bazelon.org
Substance Abuse and Mental Health Administration Center for Mental Health Services: Website: www.samhsa.gov/centers/cmhs/cmhs.html
Office of Juvenile Justice and Delinquency Prevention (OJJDP): www.ojp.usdoj.gov
Federation of Families for Children's Mental Health: Website: www.ffcmh.org
Washington Business Group on Health: www.wgbh.com
National Technical Assistance Center for Children's Mental Health: www.georgetown.edu
Research and Training Center for Children's Mental Health: www.fmhi.usf.edu
Portland State University: www.rtc.pdx.edu