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OVERVIEW AND PURPOSE

The Quality Improvement Center on Family-Centered Reunification (QIC-R), led by The Institute for Innovation & Implementation at the University of Maryland School of Social Work in collaboration with the Children’s Bureau (CB), will work with five to seven sites to install, implement, and evaluate selected practices and interventions to support the timely, stable, and lasting reunification of families by preserving, nurturing, and strengthening parent-child relationships and supportive community connections and resources, including through meaningful engagement of birth parents, foster families, youth, alumni of foster care, and other stakeholders. The QIC-R is a partnership with Children and Family Futures, Tribal Law and Policy Institute, Youth MOVE National, and The Center for the Study of Social Policy with an expert pool that includes birth parents, youth and alumni of foster care, and foster parents, all of whom will be engaged throughout all activities of the QIC-R. The service population for the QIC-R will be children in foster care with a goal of reunification and the parent(s) with whom they are going to be reunified. The QIC-R represents an opportunity to reshape child welfare through a focus on community- and family-level strengths and challenges to improve well-being for both children and parents and achieve lasting reunification and permanency.

The purpose of this scoping review is to provide applicants with relevant background information on the reunification interventions and best practices that could guide the design of the applicant’s intervention. This report offers an overview of the state of the research evidence about interventions designed to promote reunification and presents a catalogue of reunification programs that outlines each intervention’s: Programmatic approach, service population, level of research evidence, implementation considerations, and outcomes studied.

While this document offers guidance, applicants can select a best practice or evidence-informed practice not included in this guide. Additionally, applicants may adapt a practice model highlighted in this document to better meet the specific needs of their identified population. The selected model(s) must be a fully developed practice model¹, not a concept at the time of the application. Additionally, applicants are encouraged to implement more than one intervention to address both the local child welfare department’s systemic needs to support improved practice as well as interventions directly serving children, youth, and their families. Though the applicant’s selected intervention may or may not be listed in this literature review, all interventions are required to include a strong evaluation component with the goal of scaling up to evidence-based or evidence-informed practices.

¹For an example of what we mean by a practice model, see https://www.chapinhall.org/project/transforming-child-welfare-practice-in-maryland-through-the-integrated-child-welfare-practice-model/
After several years of decline, the number of children served in the foster care system has been steadily increasing across the country. On September 30, 2018\(^2\), 437,000 children experienced a foster care episode, an increase of more than 10% from 396,000 children on September 30, 2012 (HHS, 2019a).

In 1998, the Children’s Bureau wrote about The Adoption and Safe Families Act (ASFA) of 1997 as follows: “…our national goals for children in the child welfare system are safety, permanency, and well-being…this new law gives us an unprecedented opportunity…to make the system more responsive to the multiple, and often complex, needs of children and families” (Children’s Bureau [CB], 1998, p.2). Although written more than 20 years ago, this statement remains just as relevant today.

Children belong in families—their own, when it is safe. In FY 2018, just over half (56%) of the children in foster care had a primary case plan goal of reunification and nearly half (49%) of the children experiencing an exit from foster care had reunification as the primary reason for their discharge (HHS 2019b). There are numerous factors that impact whether children are reunified with their families and if that reunification is successful (e.g., children remain safely at home and do not need to re-enter foster care). Practices that support reunification include regular and quality visits with parents and siblings while the child is in state custody (CW Information Gateway, 2017; McWey & Cui, 2017); comprehensive family assessments (CW Information Gateway, 2017; Jedwab et al., 2018; Smithgall et al., 2012); meaningful inclusion of the family and youth in planning and decision-making (CW Information Gateway, 2017; Jedwab et al., 2018); competent legal representation for parents (Courtney et al., 2011); support for parents (Jedwab et al., 2018; Lietz et al., 2011); and, parent support partners and mentors (Capacity Building Center for States, 2016; Casey Family Programs, 2011; CW Information Gateway, 2016; Enano et al., 2017; Leake et al., 2012).

Children with previous experience with foster care are at greater risk for further re-entry after reunification, and factors such as child behavior challenges, siblings in foster care at the same time, and instances of court-ordered return home against agency recommendation all increased the likelihood of re-entry after reunification (Goering & Shaw, 2017; Jedwab & Shaw, 2017; Shaw, 2006; Shaw, 2020; Shipe et al., 2017). Caseworker visits after reunification and trial home visits prior to reunification appear to decrease risk of re-entry in children who had not had previous foster care episodes (Jedwab & Shaw, 2017; Shaw, 2015; Shaw, 2020). Akin et al. (2017) found that removals due to child behavior and family poverty were associated with increased risk of re-entry after reunification for families with parental substance use disorder as a factor. D’Andrade (2019, p.549) observed that heavily loaded case plans with numerous (and sometimes conflicting) requirements for parents to achieve reunification may be caused by workers attempting to address all presenting problems through “cookie-cutter case plans” that enable agencies, courts, and reviewers to more easily “assess whether reasonable efforts have been made.”

\(^2\)FY2018 (October 1, 2017–September 30, 2018) is the most recent year for national data due to lags in reporting.
The placement of a child in out-of-home foster care suggests that there are safety issues in the home that need to be addressed prior to the child being able to return home. The reunification process is likely to require time for the child welfare system and family to work together. Children in care for short periods of time have been consistently found to be at increased risk for reentry (Jedwab & Shaw, 2017; Mc Grath-Lone et al., 2017; Semanchin Jones & LaLiberte, 2017; Shaw, 2006; Shaw & Webster, 2011; Wulczyn et al., 2020). This does not mean that rapid reunification processes are ill-advised, but does suggest that the inclusion of some form of post-permanency services might facilitate the stability of the family after exit (Shaw, 2006).

Although there are consistent and well-disseminated findings regarding what works to support successful reunifications, actual practice does not always reflect best practice. Federal Child and Family Services Review (CFSR) Round 3 Results show that states are still struggling more than two decades after the passage of ASFA to achieve conformity with activities related to permanency. In fact, according to the CB (2019, p.18), “No state achieved substantial conformity with Permanency Outcome 2” of the CFSR: The continuity of family relationships and connections is preserved for children. In the CFSR Round 3 reviews, the CB found one-quarter of children reviewed did not have visitation with their mother with sufficient frequency to maintain or promote the relationship (Item 8A). For 31% of children reviewed, concerted efforts were not made during the period under review to maintain the child’s important connections; 30% of children reviewed who were a member of or eligible for membership in a federally recognized Tribe did not have concerted efforts made to place them in foster care in accordance with Indian Child Welfare Act (ICWA) placement preferences (CB, 2019).

Many public child welfare (CW) agencies are reactive in nature, responding to crises, being risk adverse, and favoring safety over well-being and permanency (Mignon, 2017). Orlando et al. (2019) found that typical parenting programs focus on preventing placement or on parenting when a child returns home, but not on the parenting that occurs while a child is experiencing a foster care episode. All of this results in challenges in engaging families in a meaningful way (from the first point of contact); inconsistencies in utilizing comprehensive, trauma-responsive assessments to identify strengths and needs of the child and family in collaboration with the child and family; struggles in recruiting and retaining quality resource families from the neighborhoods and communities children and families live in who want to engage in shared parenting; difficulties in addressing multi-generational trauma and inequities; and a lack of understanding of how to identify, install, implement, and sustain in-home and community-based services that can be customized to meet the needs of the child and family (Bossard et al., 2014; Corwin, 2012; CW Information Gateway. 2016; Duerr Berrick, 2006).

In an April 29, 2020 Information Memorandum (ACYF-CB-IM-20-06), the CB identified a number of best practices that facilitate the use of foster care as a support to families. These include creating a culture of viewing and utilizing foster care as a support for entire families; ensuring exhaustive family search efforts at the onset of CW involvement so children can be placed with relatives or kin; recruiting and training resource families committed to serving as a support to families with children in foster care; supporting relationships between foster and birth parents; developing written family time and shared
parenting agreements; utilizing resource families as post-reunification supports; prioritizing retention of resource families; and celebrating successes to support ongoing engagement. All of these strategies can contribute to addressing trauma related to removal and temporary placement in foster care; facilitating participation in activities of interest for all children (i.e., reasonable and prudent parenting); keeping meaningful connections; and ultimately improving stability, permanency, and well-being.

As is the case with the society at large, CW struggles with addressing historical and structural racism and racial inequities. Black, Latinx, and Native American families are disproportionately involved with the CW system (CW Information Gateway, 2016; Shaw et al., 2008). Black families are over-represented in Child Protection Services by 1.6 times, and in foster care by 1.8 times compared to their proportion in the general population (CW Information Gateway, 2016); American Indian/Alaska Native [AI/AN] are overrepresented in state foster care at a rate that is 2.6 times greater than their proportion in the general population (NICWA, 2019). Disproportionality in foster care placements has increased from 2010 through 2017 for children who are AI/AN (NICWA, 2019).

Gross-Manos et al. (2019) found that CW workers consistently perceived higher social disorder and lower collective efficacy of neighborhoods than residents did, which has implications for how CW systems collaborate with communities and recruit and retain foster families from the same neighborhoods as the families being served. CW systems (e.g., courts, legal representatives, and other stakeholders) must utilize intertwined strategies to improve outcomes and reduce disparities (see CSSP, 2012; Duarte & Summers, 2012; Lorthridge et al., 2012). CW systems have been found to do an inadequate job of matching services to the needs of Black families and paying insufficient attention to the trauma experienced by Black families, especially grief and loss. CW systems often fail to understand how their approach, which relies on extended family without providing adequate support, can undermine Black families (CSSP, 2021). Some potential building blocks for sustained change in the philosophy and culture of the CW system include leadership’s commitment to decreasing racial disproportionality and disparities, efforts to improve partnership with courts, and efforts to engage families and community partners (CSSP, 2012).
Research Findings

To assess the current state of best practices and the research about reunification programs, the first step was an extensive search of the notable evidence-base practice databases, including the California Evidence-Based Clearinghouse, Family First Prevention Services Clearinghouse, Pew Results First Clearinghouse Database, Child Welfare Information Gateway, and Washington State Institute for Public Policy databases. Search terms included: Permanency, permanency enhancement, reunification, visitation, and parent substance use.

After identifying specific models, a search of the literature was conducted in four electronic databases: Scopus, Family Studies Abstracts, PsycINFO, and SocIndex. Results were limited to articles published in the last 10 years and were not restricted to only peer reviewed literature. A targeted list of keywords focused on finding invention-based research on family reunification, while trying to eliminate articles that simply describe the concept. The search strategy contained the following keywords: “family reunification” AND (intervention OR model OR practice OR program) AND (“child welfare” OR “foster care” OR visitation OR “shared parenting” OR trauma). After removing duplicate records, 270 unique articles were screened. A final search process using Google and Google Scholar was conducted for any practice model identified in the evidence-based practice databases that were not found through the scholarly database search. An additional screen was performed to filter through articles that focused explicitly on a practice model and excluded any programs that were specific to implementation at a provider organization only; that focused on treating specific behavioral health needs of children; that were designed only for post-reunification support; that focused solely on foster/ resource parents and stability in kin or foster placements; and that required a specific number of siblings experiencing removal.

A team of five researchers then reviewed and coded 63 research articles and evaluation reports about 33 different interventions designed to promote reunification. Full methodological details are available in Appendix A. After a brief synthesis of overarching themes and findings that cut across the interventions, more detailed information about each intervention is provided in a catalogue of reviewed programs that includes (a) a summary table highlighting key information across all interventions and (b) intervention overview summaries that provide more specific and detailed information about each intervention.
Programmatic Categories to Reunification

After reviewing all the identified models designed to support reunification, reviewers organized these interventions into seven different programmatic approaches. Each of the programmatic categories are described below, along with the number of interventions that fall within that programmatic category.

- **Comprehensive/Wraparound** interventions provide a holistic way of serving children and families, typically addressing multiple needs at once. (n = 11 interventions)

- **Court/Legal-Based** interventions focus on the court system, working to create a less adversarial environment and often helping lawyers specialize on child welfare work. (n = 6)

- **Parent Coaching/Peer Mentoring** interventions use coaching or mentoring for parents, with the coaches/mentors typically being trained individuals with lived experience who were formerly involved with the child welfare system. (n = 5)

- **Parent Skill-Building** interventions work to strengthen parents’ abilities to care for their children, often with a manualized curriculum that includes training on topics ranging from child development to specific parent skills. (n = 5)

- **Enhanced Visitation** interventions occur during scheduled visits between children who have already been removed from the home and their parents. These interventions are aimed at improving visitation experiences and, typically, setting the parents up for success. (n = 3)

- **Training and Supporting Foster Families** programs work to prepare foster families to, in turn, help birth families succeed. (n = 2)

- **Parent Support** interventions use the model of parent support groups, with families and a trained facilitator helping each other as they move through difficult experiences. (n = 1)

The programmatic categories identified correspond to many of the factors identified in the broader literature review about factors that influence reunification and its success. The programmatic category with the largest number of programs was comprehensive/wraparound services. Families receiving reunification services often have complex, multi-faceted needs. Interventions with a comprehensive/wraparound approach attempt to acknowledge this complexity, addressing as many facets as possible.
Best Practice Focus Areas

After the categorization described above, all the models highlighted in this document have been coded according to the seven focus areas listed below. These focus areas were initially developed by the Children’s Bureau to describe the required aims of this project and the work of local implementation sites related to reunification. All QIC-R local implementation site applicants must address four of the seven focus areas in their application and describe how their selected approaches will be implemented to address these focus areas which include:

1. CW systems’ philosophies and cultures related to working with birth families and parents with children in foster care. (n = 33 interventions)
2. Comprehensive assessment of family needs with meaningful input by parents, relatives, significant family supports, and children and youth. (n = 12)
3. Provision of timely and tailored in-home and out-of-home biological family/family of origin services through collaborative practice with other service providers that intentionally support reunification and ensure the service array. (n = 8)
4. Preparation of foster families that promotes and demonstrates parental support and engagement, shared parenting, and development of meaningful connections. (n = 6)
5. Development of reunification-centered resources and services in the neighborhoods and communities of origin and where reunified families will live. (n = 2)
6. Maintenance of children’s important connections by providing foster care services in their neighborhoods, keeping them in their communities and schools of origin, and facilitating participation in activities of interest that children in foster care can enjoy. (n = 10)
7. Comprehensively addressing both child and parental well-being, including trauma related to removal and temporary placement in foster care. (n = 15)

Every intervention reviewed included a focus on the child welfare systems’ philosophy and culture related to working with birth families and parents of children in foster care. Each of these interventions attempted to meaningfully change the way of doing business for children and families involved in the child welfare system.

The next most common area addressed was “comprehensively addressing child and parental well-being, including trauma.” Indeed, comprehensive approaches were so popular that it became one of the programmatic approaches described above.

Few interventions focused on “development of reunification-centered resources and services in the neighborhoods of families served.”
State of the Research Evidence

Twelve of the 32 interventions included in this review (38%) had achieved positive ratings on one or more of the three clearinghouses that rate child welfare interventions (i.e., the California Evidence-Based Clearinghouse for Child Welfare [CEBC], Title IV-E Prevention Services Clearinghouse, or Blueprints for Healthy Youth Development [BHYD]). Almost all the interventions included in this review demonstrated positive outcomes in one or more of the seven focus areas.

Methodological approaches varied across studies. Over half of the studies used experimental or quasi-experimental research designs that are typically considered more methodologically rigorous and therefore generate more robust research evidence.

- 14% used an experimental design that randomly assigned cases into treatment and control groups (Maryland Scientific Methods Scale [MSMS] Level 5).
- 41% used quasi-experimental designs that included measures before and after treatment for an intervention and comparison group (MSMS Level 3–4).
- 31% used cross-sectional designs that compared intervention and comparison groups at a single point in time (after treatment) or compared a treated group before-and-after treatment (MSMS Level 1–2).
- 15% were qualitative studies or did not provide evaluation data (MSMS not rated).

Implementation Supports Available

In addition to reviewing research evidence and use of best practices, the review team gathered data about how ready interventions were for replication by assessing the implementation supports available. Across interventions, there was a wide range of implementation support materials available. For some interventions, the only information about the intervention is what was available in journal articles. Other interventions have websites, implementation manuals, established trainings, and fidelity measures.

Interventions that used comprehensive/wraparound and coaching/peer mentoring programmatic approaches were least likely to have extensive implementation materials available. This may be because, while some of the other categories are more likely to have manualized interventions with set curriculum, in these categories, the interventions may be more likely to be homegrown and closely targeted to the populations they serve.
As agencies explore which interventions to implement, an important consideration is the degree to which the intervention is designed to address the specific needs or achieve the specific goals identified by the agency. In many ways, the interventions reviewed matched the needs identified in the literature review. For example, the literature suggests that stable reunification may be particularly challenging in family situations where the child has been removed due to family poverty; interventions include comprehensive/wraparound category work to address these larger contextual issues, often through the provision of case management and referrals to other providers. The literature also shows that legal representation can be a key factor for reunification; the court/legal-based strategies address this need by providing resources and supports for lawyers to serve families more effectively.

There is, however, an important need that has been identified in numerous CW systems around the country that is not explicitly addressed by any of the reviewed interventions. Black and Brown families are disproportionality involved with the CW systems, which can present a substantial challenge for agencies striving for equitable outcomes. As described in the pages that follow, almost none of the interventions reviewed identified Black and Brown families as their specific population of interest. One noteworthy exception was an evaluation of SafeCare, which specifically focused on Native American parents (Chaffin et al., 2012). It is important for agencies to be attentive to issues of cultural appropriateness and responsiveness of the interventions for their intended service populations. As the evidence about reunification programs continues to develop, another priority outcome to consider could include the degree to which interventions reduce disproportionalities when they are present.

Overall, this scoping review demonstrates that a wide range of interventions are available for agencies and organizations focused on family reunification. They differ across multiple domains, including focus area, service population, and even available implementation support materials. The National Implementation Research Network (NIRN) developed a tool used to explore the need, fit, evidence, supports, capacity, and usability of potential programs and practices called The Hexagon. Before selecting a program or practice, use The Hexagon tool to make sure the intervention is feasible and that it meets the needs of the population and subpopulations.

When considering the need of the populations and fit of the intervention, consider the questions below. It is important to note that one intervention will not likely create long-term systemic changes. As you explore the need of your populations and the fit of particular programs and practices, consider the dynamics that lead to the population’s needs and how other systems, stakeholders, and the communities have
a role in addressing and preventing those needs from occurring. Systemic and long-term change may require many practice changes and initiatives to accomplish the goals. The questions below are for you to consider to determine if the intervention is the best fit to address the need and in aligning with your agency’s goals.

1. What do you know from families? What have been their reunification experiences?
2. What is the greatest need you have identified in your reunification services? Does the intervention fall into a programmatic approach that will best meet the population’s needs? Does it build on the work of your agency?
3. What population does your organization serve? Has the intervention been used with that population? Could it be modified to meet the needs of your population?
4. What else is needed outside of the program or practice to meet the need?
5. What is the role of the community and other systems in preventing the need?
6. Are there significant family supports that will be needed from agencies and organizations that are not formally part of the intervention after reunification?

When assessing the evidence of a particular program’s or practice’s influence, examine the strength of evidence.

1. What is the research evidence for a specific population? Do the circumstances under which it was studied match your organization’s situation and if not, do adaptations need to be developed?
2. How are the creators and other users of the intervention defining success? How are they measuring success? Do their definitions of success align with what the research and client populations identify as the need? Are the success measures used by partner agencies (e.g., treatment, early care, home visiting) different from those measured by the intervention? Can shared outcomes be agreed upon with those agencies?
When examining the supports and capacity, consider what resources and expertise is needed to implement the interventions as intended.

1. What are the costs of implementing the intervention and can your organization and your partners sustain those costs long-term?
   a. Will the intervention be eligible for funding through FFPSA or eligible for funding from other sources?
   b. Do partner agencies have resources to support scaling up the intervention (i.e., Medicaid expansion)?

2. Does the workforce have the capacity to engage in the necessary data collection, fidelity, coaching, and training that mastering the intervention requires?

3. Are there anticipated barriers and red tape caused by bureaucratic practices or policies that could hinder the effective implementation of the intervention?

4. How much implementation support is available for a specific population? Is it enough to effectively support and guide your staff?

Programs and practices should also be assessed for usability. The following questions are adapted from NIRN’s Usable Intervention Criteria and can be used to assess whether an intervention can be taught and replicated. If interventions do not meet these criteria, they will be harder to implement and evaluate.

1. Does the intervention have clear, written descriptions of the program's steps or practices that include values and principles?
2. Does the intervention have clear information on who is eligible to enroll in the program and who is not?
3. Are the core components of the program clearly defined and are there explanations of why each is important?
4. Are there examples of each core component so that implementing staff know what they need to do, say, and practice to provide the intervention?
5. Does the intervention have fidelity tools that capture performance of the core components and can the tool be used in a typical service setting?
6. Is the intervention self-contained with adequate resources? Will negotiations with other, eternal agencies be needed to access their resources and staff as active partners?
The summary table on the following pages lists each intervention reviewed (n = 3232), organized by programmatic category (described above). The focus area addressed, service population, and results found in the reviewed articles are summarized here for all the identified interventions.

Service Population
Some interventions may have been initially developed for a more general population but have been tailored to a more specific population. This summary table lists the tailored population that is most relevant for this review. The service population descriptions are written to match as closely as possible to the way the interventions describe themselves.

Outcomes
The review of the literature led to the identification of overarching outcome domains related to reunification including: Child safety; rate of, time to, and stability of reunification; rate of permanency with family members; family well-being; child well-being; community-supported environments; and qualitative feedback from families and staff (see Appendix A for more details). Each outcome domain summarizes all findings across the articles reviewed for each intervention. If, for example, one article had a positive finding in rate of reunification and another had mixed findings in time to reunification, the column will include both a positive (+) and mixed (M) result in that column/outcome domain. Appendix A provides a full description of the outcomes that were coded.

Intervention Overviews
After the table of all interventions, more detailed information for each intervention is then provided to help agencies determine if the intervention might be appropriate for their use. The one-page intervention overviews include a description of the intervention, programmatic approach, service population, and information about Clearinghouse ratings, when applicable. Implementation considerations offer general statements about the resources that are available for agencies considering implementation. More detailed outcomes from the research/evaluation studies are also provided along with the study’s rating on the Maryland Scale of Scientific Methods scale and methodological limitations identified by the authors.
## Summary of Family-Centered Reunification Interventions

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Focus Area(s)</th>
<th>Service Population</th>
<th>Reunification (Rate/Time)</th>
<th>Stability of Reunification</th>
<th>Child Safety</th>
<th>Permanency with Family</th>
<th>Family/Parent Well-Being</th>
<th>Qualitative Feedback</th>
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<td><strong>Parent Support Approaches</strong></td>
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<tr>
<td>Parents Anonymous</td>
<td>1,7</td>
<td>Families at risk of becoming (or already are) involved in the child welfare system whose children have behavioral health challenges or other family issues</td>
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<tr>
<td><strong>Court/Legal Based Approaches</strong></td>
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<tr>
<td>Family Drug Court</td>
<td>1,2</td>
<td>Families with open child welfare cases and documented substance abuse</td>
<td>+ - M</td>
<td>+</td>
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<tr>
<td>SeFamily Drug Court Adaptation: Celebrating Families!</td>
<td>1,2,7</td>
<td>Families with children ages 0–17 in which one or both parents have a substance use disorder</td>
<td></td>
<td>+</td>
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<tr>
<td>Family Drug Court Adaptation: Engaging Moms Program</td>
<td>1,2,7</td>
<td>Mothers with open child welfare cases and documented substance abuse</td>
<td></td>
<td>+</td>
<td></td>
<td>+</td>
<td></td>
<td></td>
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<tr>
<td>Interdisciplinary Law Offices in NY</td>
<td>1,7</td>
<td>Families with child protection cases in NYC</td>
<td></td>
<td>+</td>
<td></td>
<td>NS</td>
<td>+</td>
<td>+</td>
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<td>Parental Representation Program (WA)</td>
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<td>Families with a child removed from the home</td>
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<td>+</td>
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<td>Safe Babies Court Team</td>
<td>1,4,5,6,7</td>
<td>Children with an out-of-home placement before age 3</td>
<td>+</td>
<td>M</td>
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<td><strong>Comprehensive/Wraparound Approaches</strong></td>
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</tr>
<tr>
<td>California Treatment Outcome Project (CalTOP)</td>
<td>1,2</td>
<td>Mothers receiving substance abuse treatment with at least one child in out-of-home care</td>
<td>+</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Child Protective Services Reintegration Project</td>
<td>1,2,3</td>
<td>Children and adolescents with mental health challenges and who are in therapeutic or residential treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Family First</td>
<td>1,6</td>
<td>Families at least one child in out-of-home care</td>
<td>+</td>
<td></td>
<td></td>
<td>+</td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Homebuilders</td>
<td>1,2,3,7</td>
<td>Families with children in imminent danger of placement or with children in placement who cannot return home without intensive services</td>
<td>+</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NS</td>
</tr>
<tr>
<td>Intensive Permanence Services</td>
<td>1,6</td>
<td>Youth in foster care with histories of trauma, grief, and loss</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Jackson County, OR Family-focused, housing-based, drug treatment program with wraparound services</td>
<td>1,3,4,5,6,7</td>
<td>Children aged 8 and under in, or at risk for, an out-of-home placement due to the substance use disorder of a parent or caretaker</td>
<td>+</td>
<td></td>
<td></td>
<td>+</td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Live-In Family Enhancement (LIFE)</td>
<td>1,4,6,7</td>
<td>Families in the child welfare system in Canada where at least one child has been removed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Intervention</td>
<td>Focus Area(s)</td>
<td>Service Population</td>
<td>Reunification (Rate/Time)</td>
<td>Stability of Reunification</td>
<td>Child Safety</td>
<td>Permanency with Family</td>
<td>Family/Parent Well-Being</td>
<td>Qualitative Feedback</td>
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</tr>
<tr>
<td>Neighbor to Neighbor/ Neighbor to Family Sibling Foster Care Model</td>
<td>1,2,4, 6,7</td>
<td>Siblings between the ages of 0–21 who are in the custody of the child welfare system</td>
<td>+</td>
<td>NS</td>
<td>+</td>
<td>+</td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Project Connect</td>
<td>1,2,3, 6,7</td>
<td>High-risk families affected by problems of parental substance abuse and involved in the child welfare system</td>
<td>+</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Sobriety Treatment and Recovery Teams (START)</td>
<td>1,2,3, 6,7</td>
<td>Families with at least one child under 6 years of age who are in the child welfare system and have a parent whose substance use is a primary child risk factor</td>
<td>+</td>
<td>+</td>
<td>+ NS</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Transitioning Youth to Families</td>
<td>1,2,6</td>
<td>Youth at least 10 years of age currently placed in child welfare group care settings</td>
<td>+ NS</td>
<td></td>
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<td>M</td>
</tr>
</tbody>
</table>

**Coaching/Peer Mentoring Approaches**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Focus Area(s)</th>
<th>Service Population</th>
<th>Reunification (Rate/Time)</th>
<th>Stability of Reunification</th>
<th>Child Safety</th>
<th>Permanency with Family</th>
<th>Family/Parent Well-Being</th>
<th>Qualitative Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Success Initiative in NYC</td>
<td>1</td>
<td>Families with child welfare involvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Illinois AODA Waiver Demonstration</td>
<td>1,2,7</td>
<td>Families with child welfare system involvement who are drug-involved</td>
<td>+</td>
<td>+</td>
<td></td>
<td>+</td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Iowa Parent Partner Approach</td>
<td>1</td>
<td>Parents with a child removed from the home and parents who can only reside with their children under special conditions set by the courts</td>
<td>+ NS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Parent Partner</td>
<td>1</td>
<td>Families with a child removed from the home</td>
<td>+</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Parents in Partnership</td>
<td>1,7</td>
<td>Families with a child removed from the home</td>
<td>+</td>
<td></td>
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<td></td>
<td>+</td>
</tr>
</tbody>
</table>

**Parent Skill-Building Approaches**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Focus Area(s)</th>
<th>Service Population</th>
<th>Reunification (Rate/Time)</th>
<th>Stability of Reunification</th>
<th>Child Safety</th>
<th>Permanency with Family</th>
<th>Family/Parent Well-Being</th>
<th>Qualitative Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent Management Training, the Oregon Model (PMTO)/Generation PMTO</td>
<td>1,3</td>
<td>Children ages 3–16 in foster care with emotional/ behavioral problems with parents having a case plan goal of reunification</td>
<td>+</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Pathways Home</td>
<td>1,3,7</td>
<td>Families with a child age 5–12 removed from the home and mother with a substance abuse disorder</td>
<td>+</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Safe@Home</td>
<td>1,2,3</td>
<td>Children assessed to be unsafe who are at imminent risk of foster care placement, or children in foster care seeking reunification, and their parents/ caregivers</td>
<td>+</td>
<td>NS</td>
<td>NS</td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>SafeCare</td>
<td>1</td>
<td>Parents of children 5 years old or younger who are at-risk for or have been reported for child neglect or physical abuse</td>
<td>+</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Strengthening Families Program</td>
<td>1</td>
<td>Available for general population families; used with families with a child removed from the home and parental substance abuse</td>
<td>+ -</td>
<td>-</td>
<td></td>
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<td>-</td>
</tr>
</tbody>
</table>

**Enhanced Visitation Approaches**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Focus Area(s)</th>
<th>Service Population</th>
<th>Reunification (Rate/Time)</th>
<th>Stability of Reunification</th>
<th>Child Safety</th>
<th>Permanency with Family</th>
<th>Family/Parent Well-Being</th>
<th>Qualitative Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Visit Coaching</td>
<td>1</td>
<td>Parents with at least one child in out-of-home care who are participating in visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Intervention</td>
<td>Focus Area(s)</td>
<td>Service Population</td>
<td>Reunification (Rate/Time)</td>
<td>Stability of Reunification</td>
<td>Child Safety</td>
<td>Permanency with Family</td>
<td>Family/Parent Well-Being</td>
<td>Qualitative Feedback</td>
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</tr>
<tr>
<td>Strive</td>
<td>1</td>
<td>Parents with at least one child in out-of-home care who are participating in visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Video Assisted Visitation</td>
<td>1,6</td>
<td>Social workers facilitating visits with children in out-of-home care and their families</td>
<td></td>
<td></td>
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<td></td>
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<td>+</td>
</tr>
</tbody>
</table>

**Training and Supporting Foster Families**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Focus Area(s)</th>
<th>Service Population</th>
<th>Reunification (Rate/Time)</th>
<th>Stability of Reunification</th>
<th>Child Safety</th>
<th>Permanency with Family</th>
<th>Family/Parent Well-Being</th>
<th>Qualitative Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Parenting Initiative</td>
<td>1,4</td>
<td>Foster parents, caseworkers, and supervisors</td>
<td>+</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Trauma Integrative Treatment Foster Care (TI-TFC)</td>
<td>1,4,7</td>
<td>Foster parents, or potential foster parents, of children and youth age 0–21 years who have experienced complex trauma or neglect and may also have developmental disabilities and/or medically fragile conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+</td>
</tr>
</tbody>
</table>
Parents Anonymous uses a support group model to prevent child abuse and neglect through weekly, community-based groups for parents, children, and youth, co-led by trained parent group leaders and facilitators. The program aims to increase protective factors and reduce risk factors through four core therapeutic processes: Mutual support, parent leadership, shared leadership, and personal growth and change. The organization currently incorporates trauma-informed care and an anti-racist, anti-sexist, and anti-classist approach to helping others. Today, the organization consists of an international network of hundreds of accredited affiliates. The National Parent Helpline® is available for parents to call and receive emotional support and appropriate referrals.

<table>
<thead>
<tr>
<th>Programmatic Approach</th>
<th>Parent support groups</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Population</strong></td>
<td>Families that are at risk of becoming (or already are) involved in the child welfare system, have behavioral health challenges, or face other family issues</td>
</tr>
<tr>
<td><strong>Research Clearinghouse Rating</strong></td>
<td>CEBC, Promising Research Evidence</td>
</tr>
<tr>
<td><strong>Implementation Considerations</strong></td>
<td>The website provides information about program philosophy, national certification for parent leaders and staff, program materials, and technical assistance.</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>Positive findings in child safety(^2,3) Positive findings(^2) and non-significant findings(^4) in the area of preserving parent/child relationships/meaningful connections of children and families Positive findings(^2,3) and non-significant findings(^3) in family/parent well-being</td>
</tr>
</tbody>
</table>

**Evaluation Research Reviewed**
Limitations of current research include:
* Results are based on self-report of past behavior.\(^4\)
* Participants are self-selected, with a lack of experimental design to control for personal history.\(^2,3\)
* Program does not have consistent requirements for treatment duration or dosage.\(^1\)


**Resources**
Parents Anonymous: [https://parentsanonymous.org](https://parentsanonymous.org)
### Overview

Family drug courts, also known by other terms such as family treatment courts or dependency drug courts, use a multidisciplinary, collaborative approach to serve families with substance use disorders and who are involved with the child welfare system. There is some variation in the structure and practices over the hundreds of sites across the U.S. However, most family drug courts share certain basic features including a non-adversarial and collaborative relationship among partners, early and comprehensive assessment of service needs for the family, frequent court hearings and drug testing, intensive judicial supervision, intensive supports to ensure enrollment and engagement in quality substance abuse treatment and other necessary services, recovery support services including the use of Peer Recovery Specialists, and a system of therapeutic responses to behavior (e.g., court administered rewards and sanctions). Individuals are successfully discharged from family drug court programs upon accomplishing significant goals identified in the collaboratively developed case plan. Goals include successful participation in a substance use disorder treatment program, completion of a substance use disorder treatment program, having a specified period of continuous abstinence, showing evidence of a safe and stable living situation, spending a substantial period of time adequately performing the parent role, and having a life plan initiated and in place (e.g., employment, education, vocational training).

<table>
<thead>
<tr>
<th>Programmatic Approach</th>
<th>Court/Legal Based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Population</td>
<td>Families affected by substance use and involved with child welfare</td>
</tr>
<tr>
<td>Research Clearinghouse Rating</td>
<td>N/A</td>
</tr>
<tr>
<td>Implementation Considerations</td>
<td>A variety of resources exist that discuss inclusion and exclusion criteria for the intended service population, core components, and intervention activities.</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Positive findings(^1,2,4,5), negative findings(^2) and mixed findings(^4) in rate of reunification/time to reunification, Positive findings in stability of reunification(^2)</td>
</tr>
</tbody>
</table>

### Evaluation Research Reviewed

Limitations of current research include:
- *Non-randomized research design\(^1,2,4,5\).*
- *Lack of ability to control for all variables influencing outcomes\(^1,2,4\).*
- *Results are based on self-report with no control group.\(^3\)*
- *Data not collected at program completion, only at enrollment and at 6 months post enrollment.\(^3\)*
- *The study used a large number of statistical tests, and therefore, some of the findings may have been significant by chance, especially for effects with small sample sizes.\(^5\)*


Resources


National Strategic Plan for Family Drug Courts, from Children and Family Futures (CFF) through a training and technical assistance cooperative agreement with the Office of Juvenile Justice and Delinquency Prevention (OJJDP): http://www.cffutures.org/files/FDC_StrategicPlan_V1R1.pdf

National Drug Court Resource Center: https://ndcrc.org/family-treatment-courts/

**Overview**  
This intervention is an expansion of the Family Drug Court (FDC) model that includes the addition of the Celebrating Families! program. Family drug courts, also known by other terms such as family treatment courts or dependency drug courts, use a multidisciplinary, collaborative approach to serve families with substance use disorders and who are involved with the child welfare system. There is variation in structure, components, and practices over the hundreds of sites across the United States. However, most family drug courts share certain basic features, including a non-adversarial relationship among the parties, comprehensive assessment of service needs, frequent court hearings and drug testing, intensive judicial supervision, enrollment in substance abuse treatment and other necessary services, and court administered rewards and sanctions. To graduate from dependency drug courts, participants must have successfully completed substance abuse treatment, have a specified period of continuous abstinence, show evidence of a safe and stable living situation, spend a substantial period of time adequately performing the parent role, and have a life plan initiated and in place (e.g., employment, education, vocational training). The Celebrating Families! Program is an evidenced-based, skills-building program designed for families who have been impacted by addiction. Built using a cognitive behavioral therapy model, the program is a 16-week curriculum administered in a group format. The program uses an intergenerational approach, engaging parents with substance use disorders, their children through age 17, and the children’s caregivers, with a focus on preventing children’s future addiction.

<table>
<thead>
<tr>
<th>Programmatic Approach</th>
<th>Court/Legal Based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Population</td>
<td>Families with children ages 0–17 in which one or both parents have a substance use disorder</td>
</tr>
<tr>
<td>Research Clearinghouse Rating</td>
<td>N/A</td>
</tr>
<tr>
<td>Implementation Considerations</td>
<td>A variety of Family Drug Court resources exist that discuss inclusion and exclusion criteria for the intended service population, core components, and intervention activities. The Celebrating Families website provides information about program philosophy, training, program curriculum, and technical assistance.</td>
</tr>
</tbody>
</table>
| Outcomes               | Positive findings in rate of reunification/time to reunification\(^1\)  
Positive findings in child safety\(^1\) |

**Evaluation Research Reviewed**  
Limitations of current research include:  
*Impact of the enhanced parenting programs to the Family Drug Court program (Strengthening Families and Celebrating Families) is unknown and cannot be fully evaluated.\(^1\)*  
*The study used a non-randomized research design.\(^1\)*  
*There was a lack of ability to control for all variables influencing outcomes.\(^1\)*  
*Only child indicators were used for matching, not parent indicators.\(^1\)*


**Resources**  
Celebrating Families: [www.celebratingfamilies.net](http://www.celebratingfamilies.net)  
National Center on Substance Abuse and Child Welfare: [https://ncsacw.samhsa.gov/topics/family-treatment-courts.aspx](https://ncsacw.samhsa.gov/topics/family-treatment-courts.aspx)  
National Strategic Plan for Family Drug Courts, from Children and Family Futures (CFF) through a training and technical assistance cooperative agreement with the Office of Juvenile Justice and Delinquency Prevention (OJJDP): [http://www.cffutures.org/files/FDC_StrategicPlan_V1R1.pdf](http://www.cffutures.org/files/FDC_StrategicPlan_V1R1.pdf)  
National Drug Court Resource Center: [https://ndcrc.org/family-treatment-courts/](https://ndcrc.org/family-treatment-courts/)  
Family Drug Court Adaptation: Engaging Moms Program

Overview
This intervention is an expansion of the Family Drug Court (FDC) model that includes the addition of an adapted version of the Engaging Moms Program (EMP). Family drug courts, also known by other terms such as family treatment courts or dependency drug courts, use a multidisciplinary, collaborative approach to serve families with substance use disorders and who are involved with the child welfare system. There is variation in structure, components, and practices over the hundreds of sites across the U.S. However, most family drug courts share certain basic features, including a non-adversarial relationship among the parties, comprehensive assessment of service needs, frequent court hearings and drug testing, intensive judicial supervision, enrollment in substance abuse treatment and other necessary services, and court administered rewards and sanctions. In order to graduate from dependency drug courts, participants must have successfully completed substance abuse treatment, have a specified period of continuous abstinence, show evidence of a safe and stable living situation, spend a substantial period of time adequately performing the parent role, and have a life plan initiated and in place (e.g., employment, education, vocational training).

The EMP is based on the theory and method of Multidimensional Family Therapy. Mothers engage in a series of sessions with an EMP counselor, who works with them on six core areas of change: (1) Mother’s motivation and commitment to succeed in drug court and to change her life; (2) the emotional attachment between the mother and her children; (3) relationships between the mother and her family of origin; (4) parenting skills; (5) mother’s romantic relationships; and (6) emotional regulation, problem solving, and communication skills. The intervention is organized in 3 stages: Stage 1: Alliance and Motivation, Stage 2: Behavioral Change, and Stage 3: Launch to an Independent Life. EMP is now known as Multidimensional Family Recovery (MDFR).

Programmatic Approach
Court/Legal Based

Service Population
Mothers with open child welfare cases and documented substance abuse

Research Clearinghouse Rating
N/A

Implementation Considerations
A variety of resources exist that discuss inclusion and exclusion criteria for the intended service population, core components, and intervention activities.

Outcomes
Positive findings in rate of reunification/time to reunification
Positive findings in family/parental well-being

Evaluation Research Reviewed
Limitations of current research include:
* There was no comparison to mothers in a non-drug court setting.¹,²
* The study used a non-randomized research design.²
* There was no measure of intervention integrity or quality of clinical work, and many of the same caseworkers delivered services to both groups.²
* Data were limited to court records, which limited the ability to study other influencing factors.²


Resources
Multidimensional Family Recovery/EMP: http://www.mdft.org/MDFT-Program/MDFR
National Strategic Plan for Family Drug Courts, from Children and Family Futures (CFF) through a training and technical assistance cooperative agreement with the Office of Juvenile Justice and Delinquency Prevention (OJJDP): http://www.cffutures.org/files/FDC_StrategicPlan_V1R1.pdf
National Drug Court Resource Center: https://ndcrc.org/family-treatment-courts/
Overview
Interdisciplinary law offices (ILOs) employ an interdisciplinary and holistic case practice approach when representing parents, in contrast with the panel attorney model it replaced. In addition to staff attorneys who appear in court and only represent parents in child welfare cases, these three offices employ social workers, parent advocates, lawyers who specialize in aspects of child welfare law, supervisors, and other in-house personnel. With this interdisciplinary case practice model, most parents are represented by a lawyer along with a social worker and/or parent advocate. Parent advocates are individuals who have themselves faced proceedings in the Family Court as parents charged with maltreating their children. Some providers have additional experts on staff, as well: Attorneys to represent clients in criminal, housing, and immigration court; experts who focus on troubleshooting public assistance, educational issues, and other government systems; paralegals; and investigators. The organizational structure of the offices differs substantially from panel attorneys:
1. Unlike panel attorneys, lawyers in the ILOs specialize in child welfare cases and represent only parents in those matters.
2. Each provider is a nonprofit organization contracted for up to a certain number of cases through the New York City Mayor’s Office of Criminal Justice and supplemented with each organization’s private fundraising efforts. Nonprofit law offices are paid a set fee per case specified in each organization’s contract, regardless of the number of hours worked.
3. The attorneys in these offices are employees of the organization and paid a salary with benefits.
4. The offices offer administrative support and central office locations.
5. The lawyers in these offices have supervising attorneys and colleagues, allowing the staff to collaborate on complex cases and to appear in court for one another when a principal lawyer is unavailable.
6. As the phrase “interdisciplinary law office” suggests, these offices all have non-attorney professional employees on their paid staff who work with the attorneys.

Programmatic Approach | Court/Legal Based
---|---
Service Population | Families with child protection cases in NYC
Research Clearinghouse Rating | N/A
Implementation Considerations | The article outlines core components, but no additional implementation documentation was found.
Outcomes | Positive findings in the area rate of reunification/time to reunification\(^1,2\)
| Non-significant findings in child safety\(^2\)
| Positive findings in rate of permanency with family members\(^2\)
| Positive findings in qualitative feedback from families/staff\(^1\)

Evaluation Research Reviewed
Limitations of current research include:
* The study used a small sample size, with a non-representative sample of parents.\(^1\)
* There were possibly unobserved confounders that, if measured, could nullify results. The Rosenbaum Bounds analysis suggests that findings are vulnerable to such an unmeasured confounder.\(^2\)


Resources
No additional resources found.
# Overview

The Parental Representation Program in Washington is an innovative, state-funded, enhanced parent representation program that targets indigent parents, custodians, and legal guardians involved in child dependency and termination of parental rights proceedings. The goals of the program include: (1) Reducing the number of continuances requested by attorneys, including those based on their unavailability; (2) setting maximum caseload requirements per full-time attorney; (3) enhancing defense attorneys’ practice standards, including reasonable time for case preparation and the delivery of adequate client advice; (4) supporting the use of investigative and expert services in dependency cases; and (5) ensuring implementation of indigency screenings of parents, guardians, and legal custodians. To achieve these goals, the program includes the following core components: (1) Selection criteria for attorneys; (2) attorney training on topics including client communication, standards of representation, use of independent experts and social workers, remedial services and trial skills; (3) adherence to program standards through the following oversight mechanisms: Developing a client complaint procedure and creating an expectation of reviews prior to contract renewal; (4) in addition to the use of expert and investigative resources (including expert testimony), program attorneys have access to social work staff; and (5) periodic surveys of county judicial officers regarding quality and practice standards.

<table>
<thead>
<tr>
<th>Programmatic Approach</th>
<th>Court/Legal Based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Population</td>
<td>Families with a child removed from the home</td>
</tr>
<tr>
<td>Research Clearinghouse Rating</td>
<td>N/A</td>
</tr>
<tr>
<td>Implementation Considerations</td>
<td>The article and website include information on the intended service population, staffing standards, description of core components, and timeline activities.</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Positive findings in the area rate of reunification/time to reunification¹</td>
</tr>
</tbody>
</table>

## Evaluation Research Reviewed

Limitations of current research include:

1. The study compares a particular form of enhanced parental representation to “representation as usual” in a single state with a state-administered human services system.¹
2. The study design does not allow for an analysis to identify which aspects of the program contribute to the impacts observed.¹
3. Some conclusions about the impact of the program are based on the observed association between the presence or absence of the program in a county and the rate of children’s exits from care, but association does not necessarily imply causation.¹


## Resources

Washington State Office of Public Defense, Parents Representation Program:
[https://opd.wa.gov/program/parents-representation](https://opd.wa.gov/program/parents-representation)
# Safe Babies Court Team

## Overview
The Safe Babies Court Team™ (SBCT) is a community engagement and systems change initiative focused on improving how the courts, child welfare agencies, and related child-serving organizations work together to improve and expedite services for young children who are under court supervision. The SBCT is designed to protect babies from further harm, address the damage already done, and expose the structural issues in the child welfare system that prevent families from succeeding. Each SBCT is convened by a judge with jurisdiction over foster care cases and by child welfare agency leaders. Other judges, child welfare staff, attorneys, service providers, and community leaders are also included. Once convened, an agency contracts with ZERO TO THREE to hire and supervise a dedicated community coordinator who staffs the SBCT, oversees program implementation, and works collaboratively with the local leaders who make final decisions about what works in their community. Once the SBCT is established, they work with individual families, learning important lessons that are applied to subsequent cases and to updating the policies, regulations, and laws governing child welfare practice, creating the basis for wider practice and systems change. To facilitate the work of the SBCT, ZERO TO THREE also provides the scientific context, a forum for system reform discussions, and increased national attention on infants and toddlers in foster care.

## Programmatic Approach
<table>
<thead>
<tr>
<th></th>
<th>Court/Legal Based</th>
</tr>
</thead>
</table>

## Service Population
Children with an out-of-home placement before age 3

## Research Clearinghouse Rating
CEBC Promising Research Evidence

## Implementation Considerations
The website provides information about program philosophy, inclusion and exclusion criteria for the intended service population, description of core components, practice vignettes, logic model, and other program and measurement materials.

## Outcomes
Positive findings in rate of reunification/time to reunification\(^1\)
Mixed findings in rate of permanency with family members\(^1\)

## Evaluation Research Reviewed
Limitations of current research include:
\(^1\)The study used a non-randomized research design.\(^1\)
\(^1\)Results are based only on a child’s first removal episode and does not consider subsequent maltreatment or re-entry.\(^1\)
\(^1\)There were operational and practice-related differences among the four included ZERO TO THREE sites.\(^1\)


## Resources
- Safe Babies Court Team: [https://www.zerotothree.org/resources/services/the-safe-babies-court-team-approach](https://www.zerotothree.org/resources/services/the-safe-babies-court-team-approach)
- The National Infant-Toddler Court Program, funded by the U.S. Department of Health and Human Resources, Health Resources and Services Administration: [https://www.zerotothree.org/resources/series/national-infant-toddler-court-program](https://www.zerotothree.org/resources/series/national-infant-toddler-court-program)
COMPREHENSIVE/WRAPAROUND INTERVENTIONS
California Treatment Outcome Project (CalTOP) was a multisite and multicounty prospective treatment outcome study that was part of the Treatment Outcome Pilot Projects II funded by the Substance Abuse and Mental Health Services Administration’s Center for Substance Abuse Treatment. This study explores predictors of child reunification for mothers who participated in the program and had child welfare involvement. Participating mothers received services across a range of categories: intake and assessment, individual and group counseling, education/training, laboratory tests, medical, pharmacotherapy, vocational/educational—rehabilitation, social support, and other(s).

### Programmatic Approach
Comprehensive/Wraparound

### Service Population
Mothers receiving substance abuse treatment with at least one child in out-of-home care

### Research Clearinghouse Rating
N/A

### Implementation Considerations
The article outlines core components, but no additional implementation documentation was found.

### Outcomes
- Positive findings in rate of reunification and time to reunification
- Positive findings in parental well-being

### Evaluation Research Reviewed
Limitations of current research include:
- "Some data is self-reported by the program administrator, making it possible that the availability of services and degree of participation in these services were not accurately reported."¹
- "The study provides evidence of an association between program-level characteristics and reunification outcomes but does not explain the mechanisms of the observed association."¹


### Resources
No additional resources found.
**Overview**
The Child Protective Services (CPS) Reintegration Project provides home- and community-based services to help children/adolescents with mental health challenges transition back to the community from out-of-home placements. The CPS Reintegration Project utilizes a wraparound process, building on families’ inherent strengths to care for youth with complex needs. Each youth/family is assigned to a Care Coordinator, whose role is to empower the youth and family to set their own goals, decide how to meet them, and access/advocate for necessary support. There are six distinct phases to the project: Referral, Screening, Pre-Reintegration Planning, Reintegration, Ongoing Support, and Case Closure.

<table>
<thead>
<tr>
<th>Programmatic Approach</th>
<th>Comprehensive/Wraparound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Population</td>
<td>Children/Adolescents ages 5–17 who reside in therapeutic or residential placement facilitated by child welfare</td>
</tr>
<tr>
<td>Research Clearinghouse Rating</td>
<td>CEBC, NR—Not Able to Be Rated</td>
</tr>
<tr>
<td>Implementation Considerations</td>
<td>Information is available on the project websites about core program components, inclusion criteria, and staff training requirements.</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Positive findings in qualitative feedback from families/staff</td>
</tr>
</tbody>
</table>

**Evaluation Research Reviewed**
Limitations of current research include:
*Study is descriptive evaluation with no randomization or comparison group and has a small sample size.*


**Resources**
Casey Family Programs, CPS Reintegration Project Overview: [https://www.casey.org/promoting-permanency/](https://www.casey.org/promoting-permanency/)

### Overview
Family First was designed to find and maintain foster and kinship families who can support children and families in their own neighborhoods. The program fostered community partnerships to better link families with services. Family First provided Team Decision Making (TDM) meetings and created self-evaluation tools utilizing family outcome data that allowed DCFS staff, community members, service providers, and local organizations to identify areas of progress and change. The program significantly reduced standard caseworker caseloads and used a single-worker case management approach, with one case worker managing a family’s case from intake to case closure.

<table>
<thead>
<tr>
<th>Programmatic Approach</th>
<th>Comprehensive/Wraparound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Population</td>
<td>Families with at least one child in out-of-home care</td>
</tr>
<tr>
<td>Research Clearinghouse Rating</td>
<td>N/A</td>
</tr>
<tr>
<td>Implementation Considerations</td>
<td>The articles outline core components, but no additional implementation documentation was found.</td>
</tr>
</tbody>
</table>
| Outcomes              | Positive findings in rate of reunification/time to reunification¹,²  
                        | Positive findings in stability of reunification²  
                        | Positive findings in child safety²  
                        | Positive findings in family/parent well-being² |

### Evaluation Research Reviewed
Limitations of current research include:
* Interviews and surveys were conducted in one large urban city in Southern California; parent participants represented those experiencing a first-time removal of their children; and parent participants were all women. The findings may not be generalizable to other demographic groups.¹,²
* The study had a small sample size.¹,²
* The Los Angeles County Department of Children and Family Services had implemented several community-based partnership models over the years and this program benefited from those efforts.¹
* Data was only collected using closed case files and computerized database.²
* The measurement of service did not include treatment quality or intensity, and family needs were determined by self-reports of the caseworkers and family members.²


### Resources
### Overview

Homebuilders® is a home- and community-based intensive family preservation services treatment program designed to avoid unnecessary placement of children and youth into foster care, group care, psychiatric hospitals, or juvenile justice facilities. The program model engages families by delivering services in their natural environment, at times when they are most receptive to learning, and by enlisting them as partners in assessment, goal setting, and treatment planning. Reunification cases often require case activities related to reintegrating the child into the home and community. Examples include helping the parent find childcare, enrolling the child in school, refurbishing the child’s bedroom, and helping the child connect with clubs, sports or other community groups. Child neglect referrals often require case activities related to improving the physical condition of the home, improving supervision of children, decreasing parental depression and/or alcohol and substance abuse, and helping families access needed community supports. Key components are Engagement, Assessment and Goal Setting, Behavior Change, Skills Development, Concrete Services, Community Coordination and Interactions, Immediate Response to Referral, Services Provided in the Natural Environment, Caseload Size, and Flexibility and Responsiveness.

<table>
<thead>
<tr>
<th>Programmatic Approach</th>
<th>Comprehensive/Wraparound Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Population</td>
<td>Families with children in imminent danger of placement or with children in placement who cannot return home without intensive services</td>
</tr>
<tr>
<td>Research Clearinghouse Rating</td>
<td>CEBC, Supported by Research Evidence Title IV-E, Well-Supported</td>
</tr>
<tr>
<td>Implementation Considerations</td>
<td>Materials about program philosophy, implementation materials, training guides, and fidelity measures are all available on the program website.</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Positive findings in rate of reunification/time to reunification(^3) Non-significant findings in stability of reunification(^3)</td>
</tr>
</tbody>
</table>

### Evaluation Research Reviewed

Limitations of current research include:

1. The study was limited by including only data available through Utah’s Unified Social Services Delivery System, meaning it was available for analysis if the case was open to the Division of Children and Family Services.\(^2\)
2. The study was limited to a unidimensional analysis of service history, meaning it did not capture foster care dynamics.\(^2\)
3. The study could benefit from using varying periods of service and larger sample sizes, and longer-term follow-up in order to develop a clearer understanding of who benefits and fails to benefit from brief services.\(^3\)
4. Families and children were not randomly assigned to the in-home services group or the comparison group.\(^4\)
5. Informal field interviews with county social workers who were able to refer families to in-home services brought to light workers and supervisors who had biases for or against in-home services, or for or against particular families.\(^4\)

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### Overview

Intensive Permanence Services (IPS) is a trauma-informed intervention model that utilizes family search and engagement strategies, as well as strategies that help prepare youth for permanency by addressing trauma, grief, and loss. IPS is delivered by staff who have completed extensive training in providing intensive services to youth and their supportive connections. IPS is delivered in four phases that take approximately 24 months, on average, to complete: Phase I—the Trusting Phase (0 to 10 months), Phase II—the Healing Phase (6 to 18 months), Phase III—the Connecting Phase (12 to 18 months), and Phase IV—the Supporting Phase (18 to 24+ months). IPS uses the 3-5-7 Model, a copyrighted strengths-based approach that empowers young people and families to engage in the work of grieving their losses and re-building relationships towards the goals of well-being, safety, and permanency.

<table>
<thead>
<tr>
<th>Programmatic Approach</th>
<th>Comprehensive/Wraparound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Population</td>
<td>Youth in foster care with histories of trauma, grief, and loss</td>
</tr>
<tr>
<td>Research Clearinghouse Rating</td>
<td>N/A</td>
</tr>
<tr>
<td>Implementation Considerations</td>
<td>While there is not a manual, a description of the program is available on the HeartShare website.</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Positive findings in qualitative feedback from families/staff(^1)</td>
</tr>
</tbody>
</table>

### Evaluation Research Reviewed

Limitations of current research include:
- Study had a small sample size and only included the perspectives of staff.\(^1\)
- Implementation of IPS may require considerations that are unique to specific settings, such as larger agencies, public child welfare settings, or agencies located in other regions of the country.\(^1\)


### Resources

Overview
1. Trained and certified treatment providers (peer assisters), who have personal child welfare experience and are in recovery from a substance use disorder go with child welfare case workers on investigations involving substance use allegations.
2. The family, along with the child welfare caseworker and the peer assister, develops a services plan that usually involves immediate entry into emergency housing where the families are supervised 24/7 by on-site case managers and other treatment provider staff. This plan is shared with the judge, who usually accepts it.
3. The program requires families to participate in intensive day treatment 20 hours per week as well as utilizing support services such as: Case management and bonding and attachment services.
4. Families are provided with emergency housing where there is 24/7 supervision. Families move to transitional, then permanent, housing as threats are removed.
5. Other support services include transportation, relationship education, couples and family therapy, and medical education and care.
6. Children are provided with therapeutic childcare and developmental services to address assessed deficiencies.
7. Treatment for the substance use disorder is trauma-informed and provided along with family-strengthening services, including bonding and attachment therapy, family and couples therapy, relationship education, yoga, and music with children.
8. After active treatment is completed, many families move into permanent affordable housing, with drug- and alcohol-free leases offered by the treatment provider.
9. Foster parents are recruited who are willing to mentor families through the “Partners in Parenting” program.

<table>
<thead>
<tr>
<th>Programmatic Approach</th>
<th>Comprehensive/Wraparound Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Population</td>
<td>Children aged 8 and under in, or at risk for, an out-of-home placement due to the substance use disorder of a parent or caretaker</td>
</tr>
<tr>
<td>Research Clearinghouse Rating</td>
<td>N/A</td>
</tr>
<tr>
<td>Implementation Considerations</td>
<td>Key program components are outlined in the article and in information from the original grant, but no additional implementation documentation was found.</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Positive findings in rate of reunification/time to reunification¹</td>
</tr>
</tbody>
</table>

Evaluation Research Reviewed
Limitations of current research include:
*The characteristics of the comparison group may influence the generalizability of results.¹
*Using a non-equivalent comparison group design means that a selection bias could have impacted the results. Factors that affected comparability of the groups in this study favored the comparison group (only examining children in the comparison group who had been reunified and who were subjected to lower levels of DHHS supervision than the treatment group), but the treatment group that enjoyed more supportive services had better outcomes.¹
*The positive outcome of a small number of subsequent maltreatment removals presented a statistical limitation; the authors very few statistically significant predictors of failure in analyses conducted for the final grant report that were not presented in this article.¹
*National reports have highlighted limitations particularly of data in AFCARS.¹


Resources
### Overview
The L.I.F.E. (Living in Family Enhancement) program offers a unique alternative to the apprehension and removal of children from their family. The program provides the opportunity to keep the family together while the children are in care through the placement of the entire family in a supported and supervised setting. All families reside with a trained foster parent who will act as a role model and will support, guide, and mentor the parents in order to restore the strength, health and well-being of all family members and to strengthen the care provided to the children within the circle of their family. Referrals to this program are made through the family services worker.

<table>
<thead>
<tr>
<th>Programmatic Approach</th>
<th>Comprehensive/Wraparound Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Population</td>
<td>Families in the child welfare system in Canada</td>
</tr>
<tr>
<td>Research Clearinghouse Rating</td>
<td>N/A</td>
</tr>
<tr>
<td>Implementation Considerations</td>
<td>The article outlines core components, but no additional implementation documentation was found.</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Positive findings in qualitative feedback from families/staff¹</td>
</tr>
</tbody>
</table>

#### Evaluation Research Reviewed
Limitations of current research include:
*All of the data is qualitative, with no evaluation component.¹*


| Resources | No additional resources found. |
Neighbor to Neighbor/Neighbor to Family Sibling Foster Care Model

**Overview**
This child-centered, family-focused foster care model is designed to keep sibling groups, including large sibling groups, together in stable foster care placements while working intensively on reunification or permanency plans that keep the siblings together. The program uses a community-based, team-oriented approach, including foster caregivers and birth parents as part of the treatment team. Trained and supported foster caregivers are key to the model's success. Foster families, birth families, and children receive comprehensive and intensive services including individualized case management, advocacy, and clinical services on a weekly basis.

<table>
<thead>
<tr>
<th>Programmatic Approach</th>
<th>Comprehensive/Wraparound Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Population</strong></td>
<td>Siblings between the ages of 0–21 who are in the custody of the child welfare system</td>
</tr>
<tr>
<td><strong>Research Clearinghouse Rating</strong></td>
<td>CEBC, Promising Research Evidence</td>
</tr>
<tr>
<td><strong>Implementation Considerations</strong></td>
<td>The organization website identifies the mission and core values. The organization offers training, implementation, and fidelity materials.</td>
</tr>
</tbody>
</table>
| **Outcomes** | Positive findings in rate of reunification/time to reunification\(^1\)  
Non-significant findings in child safety\(^1\)  
Positive findings in rate of permanency with family members\(^1\)  
Positive findings in parent/child relationship/meaningful connections of children and families\(^1\) |

**Evaluation Research Reviewed**
Limitations of current research include:
* Some counties had fewer available foster care slots than the number of children who needed to be served.\(^1\)
* Placement out of county and average length of care is higher in the counties in the study than the national average.\(^1\)
* The study had small sample sizes.\(^1\)
* Control group direct costs were grossly underestimated.\(^1\)


**Resources**
Neighbor to Family: [https://www.neighbortofamily.org/](https://www.neighbortofamily.org/)
**Overview**
Using an in-home services program model, Project Connect works collaboratively with the child welfare system, substance abuse treatment providers, the courts, and other community agencies to support parental recovery, enhance safety and permanency, and strengthen family relationships. Services include home-based counseling, nursing services, court advocacy, transportation assistance, and service linkage to services such as substance abuse treatment, safe and affordable housing, and adequate health care for parents and their children.

<table>
<thead>
<tr>
<th>Programmatic Approach</th>
<th>Comprehensive/Wraparound Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Population</td>
<td>High-risk families affected by problems of parental substance abuse and involved in the child welfare system</td>
</tr>
<tr>
<td>Research Clearinghouse Rating</td>
<td>CEBC, Promising Research Evidence</td>
</tr>
<tr>
<td>Implementation Considerations</td>
<td>The project description outlines core program components. There is not a manual for the intervention; however, training and fidelity materials are available. Staff qualifications are clearly outlined.</td>
</tr>
</tbody>
</table>
| Outcomes                     | Positive findings in rate of reunification/time to reunification\(^1,2\)  
Positive findings in stability of reunification\(^2\)  
Positive findings in child safety\(^1\)  
Positive findings in family/parent well-being\(^1,2\) |

**Evaluation Research Reviewed**
Limitations of current research include:
* It is possible that other factors not considered in study may have contributed to parents’ involvement in services.\(^1\)
* The study did not collect self-report measures.\(^1\)
* Sample size limited the analysis of safety outcomes.\(^1\)


**Resources**
Children’s Friend, Project Connect: [https://www.cfsri.org/programs-and-services/project-connect/](https://www.cfsri.org/programs-and-services/project-connect/)


| **Overview** | START is designed to keep children safely with their parents whenever possible and to promote parental recovery and capacity to care for their children. START pairs child welfare workers trained in family engagement with family mentors (i.e., peer support employees in long-term recovery) using a system-of-care and shared decision-making approach with families, treatment providers, and the courts. The child welfare worker and family mentor conduct home visits on a weekly basis at a minimum. Essential elements of the model include quick entry into START and rapid access to intensive substance use disorder (SUD) treatment services to safely maintain child placement in the home, when possible. Each START child welfare worker-mentor dyad has a capped caseload, allowing the team to work intensively with families, engage them in individualized wraparound services, and identify natural supports with goals of child safety, permanency, and parental recovery and capacity. Strategies in both child welfare and SUD Treatment are designed to be trauma-responsive. |
| **Programmatic Approach** | Comprehensive/Wraparound Services |
| **Service Population** | Families with at least one child under 6 years of age who are in the child welfare system and have a parent whose substance use is a primary child safety risk factor |
| **Research Clearinghouse Rating** | CEBC, Promising Research Evidence |
| **Implementation Considerations** | Title IV-E, Promising |
| **Outcomes** | The project website offers an implementation manual and implementation support, as well as training information and fidelity materials. |
| **Evaluation Research Reviewed** | |
| **Limitations of current research include:** | |
| *It is not possible to know if the positive findings are the result of the START teams or other factors.* | |
| *The study does not include client perspectives or a linking of team successes with child and family outcomes.* | |
| *Intervention and control groups were not randomized, and their baseline equivalency was only partially established.* | |
| *Outcome study relied exclusively on administrative data, and intervention and control groups could not be compared on some important primary outcomes.* | |
| *Other demographic or service indicators might produce different cluster groups.* | |
| *Multiple comparisons completed without adjusting the statistical significance level, suggesting some differences may have occurred by chance.* | |
| *The research design does not support causal conclusions.* | |
| *The comparison group had small sample sizes.* | |
| **Overview** | START is designed to keep children safely with their parents whenever possible and to promote parental recovery and capacity to care for their children. START pairs child welfare workers trained in family engagement with family mentors (i.e., peer support employees in long-term recovery) using a system-of-care and shared decision-making approach with families, treatment providers, and the courts. The child welfare worker and family mentor conduct home visits on a weekly basis at a minimum. Essential elements of the model include quick entry into START and rapid access to intensive substance use disorder (SUD) treatment services to safely maintain child placement in the home, when possible. Each START child welfare worker-mentor dyad has a capped caseload, allowing the team to work intensively with families, engage them in individualized wraparound services, and identify natural supports with goals of child safety, permanency, and parental recovery and capacity. Strategies in both child welfare and SUD Treatment are designed to be trauma-responsive. |
| **Programmatic Approach** | Comprehensive/Wraparound Services |
| **Service Population** | Families with at least one child under 6 years of age who are in the child welfare system and have a parent whose substance use is a primary child safety risk factor |
| **Research Clearinghouse Rating** | CEBC, Promising Research Evidence |
| **Implementation Considerations** | Title IV-E, Promising |
| **Outcomes** | The project website offers an implementation manual and implementation support, as well as training information and fidelity materials. |
| **Evaluation Research Reviewed** | |
| **Limitations of current research include:** | |
| *It is not possible to know if the positive findings are the result of the START teams or other factors.* | |
| *The study does not include client perspectives or a linking of team successes with child and family outcomes.* | |
| *Intervention and control groups were not randomized, and their baseline equivalency was only partially established.* | |
| *Outcome study relied exclusively on administrative data, and intervention and control groups could not be compared on some important primary outcomes.* | |
| *Other demographic or service indicators might produce different cluster groups.* | |
| *Multiple comparisons completed without adjusting the statistical significance level, suggesting some differences may have occurred by chance.* | |
| *The research design does not support causal conclusions.* | |
| *The comparison group had small sample sizes.* | |

---

**Resources**

Children and Family Futures, START: [https://www.cffutures.org/start/](https://www.cffutures.org/start/)
Overview
The Transitioning Youth to Families (TYTF) intervention involved several components, including identifying youth needs and strengths, engaging other public systems (e.g., juvenile justice, education, mental health) in anticipating transition services, and working with identified family and supportive adults. An Administrative Review Team meeting (ART) was conducted for each youth in group care. These occurred between January and May 2009. This meeting was intended to be multi-disciplinary, with attendees including internal child welfare staff and external systems represented by a diverse group of professionals. The focus of the meeting was to consider what it would take for the youth in group care to move to a family setting by identifying barriers and brainstorming ways to overcome these barriers. Meeting participants subjectively determined next steps after discussing the strengths and challenges of the youth and potential family placement resources. If the team determined that the youth was not yet ready for a family placement, the professionals discussed the most pressing barriers to family care and how to address them. For youth ready to transition from group care, a Family Involvement Meeting was scheduled following the Administrative Review Team meeting. The goal of a Family Involvement Meeting was to reach a consensus about a plan that best served the youth and engaged the family in decision-making and resource identification.

Programmatic Approach
Comprehensive/Wraparound Services

Service Population
Youth at least 10 years of age currently placed in child welfare group care settings

Research Clearinghouse Rating
N/A

Implementation Considerations
The article outlines core components, but no additional implementation documentation was found.

Outcomes
Positive and non-significant findings in rate of reunification/time to reunification
Mixed findings in qualitative feedback from families/staff

Evaluation Research Reviewed
Limitations of current research include:
* Group care programs may provide a unique array of services not easily replicated in familial care.
* The intervention may not have addressed all the barriers to making this process a success.
* Stability in placement may serve as a competing value to permanency.
* It is possible that some youth did exit group care and return to family setting but were stepped back up into group care within 12 months.


Resources
No additional resources found.
COACHING/PEER MENTORING
### Overview
The Family Success Initiative uses peer mentors, called family coaches, to assist parents with the reunification process through individual meetings and support groups. The goals are ensuring the parent’s and child’s readiness for reunification, successful integration of the child into the family, and providing post-reunification services to maintain stability. The family coach is a parent who has had a personal history of child welfare involvement and has successfully reunited with their child. The family coach is trained in the Solution-Based Casework model, Motivational Interviewing, engaging fathers, strategies for promoting permanency, overview of public benefits, and culture and diversity: Overcoming prejudice, discrimination, and harassment. Training is provided by the agency.

<table>
<thead>
<tr>
<th>Programmatic Approach</th>
<th>Coaching/Peer Mentoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Population</td>
<td>Families with child welfare involvement</td>
</tr>
<tr>
<td>Research Clearinghouse Rating</td>
<td>N/A</td>
</tr>
<tr>
<td>Implementation Considerations</td>
<td>The article describes the role of the family coach, but no additional implementation documentation was found.</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Positive findings in qualitative feedback from families/staff¹</td>
</tr>
</tbody>
</table>

**Evaluation Research Reviewed**
Limitations of current research include:
- Sampling strategies do not ensure representation of the full population served; thus, the findings should be interpreted with caution.¹
- The study did not analyze responses based on parents’ pre- or post-reunification stage.¹
- The two coaches in this study may have been particularly skilled or engaging.¹
- This study did not examine the reunification outcomes in relation to the supports received.¹


**Resources**
No additional resources found.
Overview
The Illinois AODA Waiver Demonstration Project uses a model of intensive case management, featuring the use of recovery coaches. The use of recovery coaches is intended to increase access to substance abuse services, improve substance abuse treatment outcomes, shorten length of time in substitute care placement, and affect child welfare outcomes, including increasing rates of family reunification. To achieve these stated goals, recovery coaches engage in a variety of activities, including comprehensive clinical assessments, advocacy, service planning, outreach, and case management. The recovery coach's primary focus is getting parents into treatment and helping parents stay connected with treatment. Additionally, recovery coaches continue to provide services and support until the case is closed—well after reunification is achieved.

Programmatic Approach | Coaching/Peer Mentoring
--- | ---
Service Population | Families with child welfare system involvement who are drug-involved
Research Clearinghouse Rating | N/A
Implementation Considerations | The article describes the role of the recovery coach, but no additional implementation documentation was found.
Outcomes | Positive findings in rate of reunification/time to reunification\(^1,3,4\)
| Positive findings in stability of reunification\(^1\)
| Positive findings in family/parent well-being\(^2,4\)

Evaluation Research Reviewed
Limitations of current research include:
* The outcome measure in the current study (reunification stability) does not capture the reason reunifications are disrupted.\(^1\)
* There was no measure of treatment fidelity.\(^1\)
* All measures (with the exception of treatment completion) were derived from self-report assessments.\(^2\)
* Information about the existence of families' problems and progress was reported solely from perspectives of service providers.\(^3\)
* The program was evaluated on whether it worked or not, rather than evaluating what components made it work.\(^4\)
* The data did not make it possible to differentiate which specific types of services were used by families.\(^4\)
* There were differing rates in providing non-consent in the experimental and control groups.\(^4\)


Resources
University of Michigan Child & Adolescent Data Lab, The Illinois Alcohol and Other Drug Abuse Waiver Demonstration: [https://ssw-datalab.org/project/illinois-waiver-demonstration](https://ssw-datalab.org/project/illinois-waiver-demonstration)
Iowa Parent Partner Approach

**Overview**
The Iowa Parent Partner Program is a model of parent partner programming that works to reduce re-abuse rates and increase reunification rates by partnering parents whose children have been removed from the home with parents who have gone through a similar experience and were successful in managing and working with the child welfare system. The intervention identifies these “successful” parents and trains them in pertinent curricula, how to engage parents, how to provide parental advocacy and support, and how to collaborate with agency personnel and other partners. Once trained, they provide one-on-one mentoring by providing advice, support, and encouragement to families whose children are currently involved with DHS in efforts to enhance their capacity to provide for and guide their children’s healthy development. Parent Partners meet with families face-to-face as well as contact by phone. Parent Partners offer to be present as a support at Family Team Decision Making Meetings, staffings, and court appearances. All activities and contacts the Parent Partner has with the family are documented on a monthly activity form.

<table>
<thead>
<tr>
<th>Programmatic Approach</th>
<th>Coaching/Peer Mentoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Population</td>
<td>Parents with a child removed from the home and parents who can only reside with their children under special conditions set by the courts</td>
</tr>
<tr>
<td>Research Clearinghouse Rating</td>
<td>CEBC, Promising Research Evidence</td>
</tr>
<tr>
<td></td>
<td>Title IV-E, Promising</td>
</tr>
<tr>
<td>Implementation Considerations</td>
<td>The website offers a handbook, guidance, fidelity materials and support, as well as outlining qualifications for Parent Partners.</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Positive and non-significant findings in the area of rate of reunification/time to reunification¹</td>
</tr>
<tr>
<td></td>
<td>Positive findings in the area of stability of reunification¹</td>
</tr>
</tbody>
</table>

**Evaluation Research Reviewed**
Limitations of current research include:

*Random assignment of Parent Partner participants was not feasible, leading to a quasi-experimental design. As a result, differences found between treatment and control groups might be related to the choice to participate and engage in the Parent Partner program and/or that the differences found are related to unobserved factors that influence outcomes.¹*

*Different parts of the state were in various stages of implementation, leading to areas with years of implementation and areas where the implementation had more recently begun.¹*

*While the fidelity measures used by the agency did indicate high levels of fidelity, these measures were preliminary.¹*


<table>
<thead>
<tr>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iowa Department of Human Services, Parent Partner (for Contractors):</td>
</tr>
<tr>
<td><a href="https://dhs.iowa.gov/parent-partners/Contractors">https://dhs.iowa.gov/parent-partners/Contractors</a></td>
</tr>
</tbody>
</table>
Parent Partner

Overview
Through Parent Partner programs, parents with experience in child welfare provide mentoring and support to other parents who are entering the system. Since peer-to-peer support is based on the shared experience of the family and the mentor, parent partners must have had experience with the child welfare system and understand the complex needs of families entering child welfare. Eligible candidates should have resolved their own issues related to child welfare involvement and currently have healthy and stable family situations. In addition, parent partners must possess personal qualities that promote partnerships and professional conduct.

<table>
<thead>
<tr>
<th>Programmatic Approach</th>
<th>Coaching/Peer Mentoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Population</td>
<td>Families with a child removed from the home</td>
</tr>
<tr>
<td>Research Clearinghouse Rating</td>
<td>N/A</td>
</tr>
<tr>
<td>Implementation Considerations</td>
<td>The Navigator on the Children’s Bureau website offers implementation and training materials.</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Positive outcomes in rate of reunification/time to reunification.¹</td>
</tr>
</tbody>
</table>

Evaluation Research Reviewed
Limitations of current research include:
* The study did not use a randomized control trial, instead using a historical cohort as a comparison group.
* The treatment group may represent parents most motivated or best positioned to engage in services.¹
* No analysis of re-entry to care.¹


Resources
Child Welfare Capacity Building Collaborative, Parent Partner Program Navigator:
https://capacity.childwelfare.gov/states/focus-areas/foster-care-permanency/parent-partner-navigator/
Parents in Partnership

Overview
Parents in Partnership (PIP) is a pilot intervention run by the child welfare system regional office. The program involves a committed group of parent advocates who successfully navigated the system. The parents work in partnership with the child welfare system to provide current program participants with information, empowerment, and hope. They provide support, information, and mentorship to parents who have recently lost custody of their children, as well as parents whose children are in the foster care system without permanency. PIP program services include parent orientations, parent support groups, lobby assistance, Team Decision Making (TDM) meeting support, and a warmline (i.e., a telephone line staffed by PIP volunteers that handles nonemergency questions for parents involved in the child welfare system).

Programmatic Approach
Coaching/Peer Mentoring

Service Population
Families with a child removed from the home

Research Clearinghouse Rating
N/A

Implementation Considerations
The article and program website describe the key components of the intervention, but no additional implementation documentation was found.

Outcomes
Positive findings in rate of reunification/time to reunification

Evaluation Research Reviewed
Limitations of current research include:
* This study is unable to determine how dosage of the intervention may be related to likelihood of reunification.¹
* The small sample size was small.¹
* The study uses a nonequivalent control group design. Although the study attempted to match on some relevant factors (i.e., date entering the child welfare system, county regional office), the groups could differ on other characteristics that may have affected study findings. Parents who chose to participate may have been more motivated to reunify with their children.¹


Resources
PARENT SKILL-BUILDING INTERVENTIONS
**Overview**

Parent Management Training, the Oregon Model (PMTO)/Generation PMTO is a parent training intervention that is based on social learning theory, which asserts that parents are the agent of change. While parents are the focus of the intervention, focal children/youth and the family can all participate in and benefit from the intervention. The intervention can be delivered through individual family treatment in agencies or home-based and via telephone/video conference, books, audiotapes, and video recordings.

The goals of PMTO include increasing positive parenting practices, reducing coercive family processes, reducing and preventing internalizing and externalizing behaviors in youth, reducing and preventing substance use and abuse in youth, reducing and preventing delinquency and police arrests in youth, reducing and preventing out-of-home placements in youth, reducing and preventing deviant peer association in youth, increasing academic performance in youth, increasing social competency and peer relations in youth, and promoting reunification of families with youngsters in care.

The core components include skill encouragement; teaching positive behavior; systemic, mild consequences for negative behavior; monitoring and supervision; interpersonal problem solving; and positive involvement. The central role of the PMTO therapist is to teach and coach parents in the effective use of these core strategies. Some of the therapeutic strategies include identifying and building on strengths, supporting and encouraging effective parenting skills, active modeling and role playing, and promoting positive family system changes.

<table>
<thead>
<tr>
<th>Programmatic Approach</th>
<th>Parent Skill-Building</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Population</strong></td>
<td>Children ages 3–16 in foster care with emotional/ behavioral problems with parents having a case plan goal of reunification</td>
</tr>
<tr>
<td><strong>Research Clearinghouse Rating</strong></td>
<td>CEBC, Well Supported by Research Evidence BHYD, Model Plus</td>
</tr>
<tr>
<td><strong>Implementation Considerations</strong></td>
<td>The website includes information on training and certification and includes a variety of fact sheets and brochures that highlight the program philosophy, intended service population, description of core components, and reference materials.</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>Positive findings in rate of reunification/time to reunification$^1,2$</td>
</tr>
</tbody>
</table>

**Evaluation Research Reviewed**

Limitations of current research include:

* Post-randomization consent design may exaggerate attrition and dilute intervention effects by including participants who did not indicate an interest to participate and did not adhere to intervention protocol.$^1$
* Neither case managers nor courts were blinded to study condition.$^1$
* The study had a small sample size.$^2$


**Resources**

Generation PMTO Website: [https://www.generationpmto.org](https://www.generationpmto.org)
### Overview
Pathways Home focused on supporting parents and making the reunification transition as smooth as possible, while building a foundation of continued success in parenting. The goal was to create a safe and nurturing environment for the children and to meet the demands of parenting and daily household management, including managing stress, staying healthy, and getting appropriate support. The intervention was developed upon systematic translational research and prior evidence-based programs involving parent management approaches for biological parents and foster parent caregivers. Key foundational programs underpinning Pathways Home were Multidimensional Treatment Foster Care and Project KEEP. The structured and manualized curriculum included strategies to enhance parenting skills, encourage cooperation, teach new behaviors, set effective limits, keep track of children’s behavior and whereabouts, and help children to succeed at school. Pathways Home was delivered in two main phases during individual sessions with a trained professional family consultant. Phase 1 began just prior to reunification and included 16 weeks of parent management training and healthy self-care strategies. After an eight-week break, Phase 2 continued for an additional eight weeks and included booster sessions aimed at fine-tuning of parent management skills, assessing level of risk for future harm to family members, and developing a family protection plan to address those risks.

<table>
<thead>
<tr>
<th>Programmatic Approach</th>
<th>Parent Skill-Building</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Population</td>
<td>Families with a child age 5–12 removed from the home and mother with a substance abuse disorder</td>
</tr>
<tr>
<td>Research Clearinghouse Rating</td>
<td>N/A</td>
</tr>
<tr>
<td>Implementation Considerations</td>
<td>The article describes the intervention curriculum, but no additional implementation documentation was found.</td>
</tr>
</tbody>
</table>
| Outcomes              | Positive findings in stability of reunification¹  
Mixed findings in child well-being¹ |

#### Evaluation Research Reviewed
Limitations of current research include:
- The beneficial impact was likely underpowered given the sample size and rate of reentry in the present sample. Given the low base rate of reentry events, longer-term follow-up may also increase the power for testing the prevention of reunification failures.¹
- Substance use was measured as cravings rather than actual use, frequency, or dependence.¹
- The study was limited in its ability to understand culturally specific factors related to substance use and reunification.¹


### Resources
No additional resources found.
### Overview

Safe@Home is the community-based safety management component of a larger child welfare practice model, called Safety Assessment Family Evaluation (SAFE). Grounded in several theoretical frameworks, the SAFE model provides structured comprehensive assessments and decision-making criteria that guide case activities within the public agency. Safe@Home provides in-home safety services to assure safety while children are home with their family, and parents/caregivers make progress toward case plan goals. Case plans focus on behavioral change and are grounded in the transtheoretical model of change. The services delivered through Safe@Home are tailored to the unique needs of children and families and can vary across families with regard to service content, intensity, and duration.

<table>
<thead>
<tr>
<th>Programmatic Approach</th>
<th>Parent Skill-Building</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Population</strong></td>
<td>Children assessed to be unsafe who are at imminent risk of foster care placement, or children in foster care seeking reunification, and their parents/caregivers</td>
</tr>
<tr>
<td><strong>Research Clearinghouse Rating</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Implementation Considerations</strong></td>
<td>An extensive implementation manual is supplemented with robust implementation supports, including: Multiple assessments, training for caseworkers, training for supervisors, consultation and technical assistance, fidelity review tools, and implementation planning/support that is tailored to the needs and goals of the implementing agency.</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>Positive findings in placement prevention, rate of reunification, timeliness of reunification(^1) Non-significant findings in repeat maltreatment or stability of reunification(^1)</td>
</tr>
</tbody>
</table>

#### Evaluation Research Reviewed

Limitations of current research include:

* Retrospective design relying on administrative data.\(^1\)
* Historical comparison group raises possibility for other influences on outcomes, though children were matched on demographic and case characteristics.\(^1\)
* Study was conducted relatively early into implementation and the level of intervention fidelity could not be fully assessed or accounted for.\(^1\)

\(^1\)Kaye, S. & Reyes, L. (2021) Results of a retrospective longitudinal study examining the impact of Safe@Home on placement prevention and reunification. Technical report submitted to Action for Child Protection and Clark County Department of Family Services (MSMS = 4)

#### Resources

**Overview**

SafeCare® is an in-home parent training program that targets risk factors for child neglect and physical abuse in which parents are taught skills in three module areas: (1) How to interact in a positive manner with their children, to plan activities, and to respond appropriately to challenging child behaviors; (2) how to recognize hazards in the home in order to improve the home environment; and (3) how to recognize and respond to symptoms of illness and injury, in addition to keeping good health records. Each module is designed to be delivered in 6 sessions (18 total), but some families may need fewer or more sessions to reach skill mastery. Each session typically lasts 50 to 90 minutes and is delivered in the family’s home or at another location of the parent’s choice.

<table>
<thead>
<tr>
<th>Programmatic Approach</th>
<th>Parent Skill-Building</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Population</strong></td>
<td>Parents of children 5 years old or younger who are at-risk for or have been reported for child neglect or physical abuse</td>
</tr>
<tr>
<td><strong>Research Clearinghouse Rating</strong></td>
<td>CEBC, Supported by Research Evidence Title IV-E, Supported</td>
</tr>
<tr>
<td><strong>Implementation Considerations</strong></td>
<td>The website includes a provider curriculum, including information on inclusion and exclusion criteria for the intended service population, description of core components, and reference and parent materials. Provider and coach training information is available.</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>Positive findings in child safety(^1,2,3) Positive findings in family/parent well-being(^1)</td>
</tr>
</tbody>
</table>

**Evaluation Research Reviewed**

Limitations of current research include:

- There was no randomization of individual cases or home visitors to conditions (clusters were randomized).\(^1,2\)
- There was some covariate imbalance with the cluster randomized trial design.\(^1,2\)
- Participants were not randomly assigned.\(^3\)
- The study had a small sample size.\(^3\)
- Data limitations prevented comprehensively matching participants across groups.\(^3\)


**Resources**

SafeCare: [https://safecare.publichealth.gsu.edu](https://safecare.publichealth.gsu.edu)
### Overview
The Strengthening Families Program (SFP) is a 10- to 14-week parenting and family skills training program for high-risk and general population families. It is unique because the whole family attends and practices new relationship skills together in family groups. SFP is designed to significantly improve parenting skills and family relationships, reduce child maltreatment, children's problem behaviors, delinquency, and alcohol and drug abuse; and to improve social competencies and school performance. The program is designed to work with many different ethnicities and races. In addition, it is available as a home-use DVD for school, behavioral health, and family services to use alone or with case managers. It can also be given to families to view at home.

<table>
<thead>
<tr>
<th>Programmatic Approach</th>
<th>Parent Skill-Building</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Population</td>
<td>Available for general population families; used with families with a child removed from the home and parental substance abuse</td>
</tr>
<tr>
<td>Research Clearinghouse Rating</td>
<td>CEBC, Promising Research Evidence</td>
</tr>
<tr>
<td>Implementation Considerations</td>
<td>Implementation, training, evaluation, and fidelity materials are all available on the program website and from the organization.</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Positive(^1,2) and negative(^3) findings in rate of reunification/time to reunification</td>
</tr>
<tr>
<td></td>
<td>Negative findings in stability of reunification(^3)</td>
</tr>
</tbody>
</table>

### Evaluation Research Reviewed
Limitations of current research include:
- Limitations for the cost-benefit analysis included a lack of data for administrative costs of SFP beyond program staffing, no data on the indirect cost of other programs families were a part of.\(^1\)
- Since the study was not randomly assigned it is possible there was selection bias for families closest to reunification.\(^2\)
- There was no underlying rationale for the expectation that the program should result in shorter durations in out-of-home care.\(^3\)
- Multiple providers were assisting in the decision to reunify, and they often chose the most conservative route and waited until they all agreed on reunification.\(^3\)
- Participants may have been more closely monitored than those who did not participate; therefore, they were more likely to be identified during a relapse episode.\(^3\)


### Resources
Strengthening Families Program: [https://strengtheningfamiliesprogram.org/](https://strengtheningfamiliesprogram.org/)
ENHANCED VISITATION APPROACHES
Family Visit Coaching

Overview
Family Visit Coaching (FVC) provides an opportunity for parents with a child in out-of-home care to practice parenting and for the coaches who work with them to support skill improvement and documentation. The program uses a holistic understanding of what is required to parent effectively. The FVC model’s components include developing a visit meeting plan before FVC sessions; a pre-visit to remind parents of the child’s needs and discuss any concerns; the visit with the child, during which coaches provide support to parents so they can be responsive to the child’s needs; a post-visit to debrief; and partnering to encourage communication between parents, the child’s temporary caregivers, and the child welfare agency caseworkers to discuss the child’s needs. The FVC model recommends a one- to three-hour family visit one to three times per week for three to six months. Visit frequency may be limited by transportation challenges, the parents’ work schedules, or other life factors. Parents may still participate in the program even if visits cannot happen as frequently as intended.

<table>
<thead>
<tr>
<th>Programmatic Approach</th>
<th>Enhanced Visitation Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Population</td>
<td>Parents with at least one child in out-of-home care who are participating in visits</td>
</tr>
<tr>
<td>Research Clearinghouse Rating</td>
<td>N/A</td>
</tr>
<tr>
<td>Implementation Considerations</td>
<td>The article and program website offer descriptions of program components and a manual.</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Positive findings in family/parent well-being¹</td>
</tr>
</tbody>
</table>

Evaluation Research Reviewed
Limitations of current research include:
* The study did not use a randomized design and was limited to examining parenting skills among parents who were referred to FVC by their County of San Diego child welfare caseworkers.¹
* Program dosage was limited to number of visits, not the number of hours of the visits.¹
* It is possible that the coaches who completed the assessment were biased in their assessments of the parents or biased in perceiving improvement in parenting behaviors.¹
* Inter-rater reliability was not assessed in this study. While the tool has been validated, inter-rater reliability problems are common to all parenting assessment tools, as parenting behavior is nuanced and culturally embedded.¹


Resources
Strengths/Needs-Based Support for Children, Youth & Families, Marty Beyer, Ph.D., Visit Coaching: [https://www.martybeyer.com/content/visit-coaching](https://www.martybeyer.com/content/visit-coaching)
Strive

**Overview**
Strive is a manualized parenting program, designed to introduce and strengthen parenting skills to improve family functioning and promote child safety and well-being. The program consists of a curriculum, built around one-on-one sessions that are delivered by a Visit Supervisor who is trained in the Strive curriculum. Visit Supervisors deliver sessions to parents right before the parent-child visit, provide support to parents during the visit as they supervise, and offer feedback right after the visit. Each Strive session and visit are organized in three main parts as follows: (1) One-hour, one-on-one session between parent(s) and Visit Supervisor; (2) Visit Supervisor-supported, parent-child visit (typically 2 hours); and (3) 15-minute visit debrief between parent(s) and Visit Supervisor. The guiding principles of the intervention are: Strengths-based, relationship-focused, evidence informed, and trauma-informed practices.

<table>
<thead>
<tr>
<th>Programmatic Approach</th>
<th>Enhanced Visitation Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Population</strong></td>
<td>Parents with at least one child in out-of-home care who are participating in visits</td>
</tr>
<tr>
<td><strong>Research Clearinghouse Rating</strong></td>
<td>CEBC, NR—Not Able to Be Rated</td>
</tr>
<tr>
<td><strong>Implementation Considerations</strong></td>
<td>The articles and program website offer descriptions of program components and the program curriculum.</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>Positive findings in qualitative feedback from families/staff²</td>
</tr>
</tbody>
</table>

**Evaluation Research Reviewed**
Limitations of current research include:
- Demographic data on interview and focus group participants were not systematically collected so generalizability is unknown. Due to the vulnerability of this population, the needs of parents and children currently involved with child welfare were not included. The study was unable to assess the effectiveness of the designed intervention across systems and cultural subgroups.¹
- It is unclear what level of privacy parents were given during telephone interviews.²
- Interviews were conducted over the phone; in most cases, parents never met the interviewer in person. It is unclear whether this helped or interfered with parent-interviewer rapport.²
- Interviews occurred immediately after the parent-child visit. This could be a strength in terms of the reliability of the data. However, this raises some concerns as to the emotional vulnerability of parents after having just experienced separation from their children. Interviews took place after a long day consisting of a session, visit, and debrief with the Visit Navigator. It is reasonable to be believe that parents were likely fatigued by this point.²


**Resources**
Strive: [http://www.striveparenting.org/](http://www.striveparenting.org/)
Partners for Our Children Projects, Strive: [https://partnersforourchildren.org/projects/strive](https://partnersforourchildren.org/projects/strive)
## Overview

Video Assisted Visitation (VAV) uses real-time video technology (e.g., Skype, FaceTime, Polycomm connections, Google Hangouts) to connect a child in foster care with any number of individuals deemed important in the family reunification effort. Like a telephone conversation, VAV is real time and the parties involved can interact with each other; however, VAV adds the visual component via video feed. A child can be sitting in their foster home and be able to see and hear their parents and/or other family members who are using similar technology. Furthermore, they can view real-time images of their house, their bedroom, and any other area that is important to the child and any caseworker observing the visit.

<table>
<thead>
<tr>
<th>Programmatic Approach</th>
<th>Enhanced Visitation Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Population</td>
<td>Social workers facilitating visits with children in out-of-home care and their families</td>
</tr>
<tr>
<td>Research Clearinghouse Rating</td>
<td>N/A</td>
</tr>
<tr>
<td>Implementation Considerations</td>
<td>Positive findings in parent/child relationships/meaningful connections of children and families¹</td>
</tr>
<tr>
<td></td>
<td>Positive findings in qualitative feedback from families/staff¹</td>
</tr>
<tr>
<td>Outcomes</td>
<td>The article describes how to use the intervention, but no additional implementation documentation was found.</td>
</tr>
</tbody>
</table>

### Evaluation Research Reviewed

Limitations of current research include:
* Findings are based on survey data from a select group of social workers, not a representative sample.¹
* The study did not consider the family members or children's perception of VAV.¹


### Resources

No additional resources found.
TRAINING AND SUPPORTING FOSTER FAMILIES
## Overview
Quality Parenting Initiative (QPI) works to empower foster parents, caseworkers, and supervisors to improve child welfare outcomes within existing child welfare systems. The key elements of the QPI approach are:

- Defining the expectations of and by caregivers;
- Clearly communicating these expectations to all staff, caregivers, and other stakeholders, as well as the general public; and
- Aligning system policy and practice with those expectations.

## Programmatic Approach
| Training and Supporting Foster Families |

## Service Population
Foster parents, caseworkers, and supervisors

## Research Clearinghouse Rating
N/A

## Implementation Considerations
Key principles and components are outlined in the article and on the organization website.

## Outcomes
Positive findings in time to reunification/rate of reunification\(^1\)
Positive findings in qualitative feedback from families/staff\(^1\)

## Evaluation Research Reviewed
Limitations of current research include:

- The QPI only has a short history and limited geographical use.\(^1\)
- There are limitations of using AFCARS data.\(^1\)
- It is a challenge to measure the impact of a set of ideals, as opposed to a carefully formulated and replicable program.\(^1\)


## Resources
Quality Parenting Initiative: [https://www.qpi4kids.org/](https://www.qpi4kids.org/)
### Overview

Trauma Integrative Treatment Foster Care (TI-TFC) is a component-based treatment framework that, through specialized training for the treatment parent (foster parent) and social worker, addresses complex trauma, developmental disabilities, medically fragile conditions of children who are placed in foster care, and the children’s families. The primary focus of change in TI-TFC is the treatment parent’s relationship with the child and the child’s birth family. Key components are the recruitment, training, supervision, and support of treatment parents in developing and maintaining these relationships. Social workers provide treatment parents with in-home training, supervision, support, and interventions within the focus of change. The social worker, in collaboration with the treatment parents and team, facilitates the development of a treatment plan which integrates permanency planning, outpatient treatments, school, and community services. Assessment, treatment planning, and interventions are driven by the meaningful use of the Child and Adolescent Needs and Strengths (CANS) measure and its integration within the Attachment, Regulation, and Competency (ARC) Mapping tool.

<table>
<thead>
<tr>
<th>Programmatic Approach</th>
<th>Training and Supporting Foster Families</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Population</strong></td>
<td>Foster parents, or potential foster parents, of children and youth age 0–21 years who have experienced complex trauma or neglect and may also have developmental disabilities and/or medically fragile conditions</td>
</tr>
<tr>
<td><strong>Research Clearinghouse Rating</strong></td>
<td>CEBC, NR—Not Able to Be Rated</td>
</tr>
<tr>
<td><strong>Implementation Considerations</strong></td>
<td>While there is not a manual, a description of the program and training resources are available at the Kennedy Krieger website.</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>None of the studies reviewed shared outcomes.</td>
</tr>
</tbody>
</table>

### Evaluation Research Reviewed

Limitations of current research include:
- *Information presented represents three states, and findings cannot be generalized.*[^1]
- *Study was constrained by its descriptive and exploratory approach.*[^1,3]
- *Study was focused on implementation framework evaluation and not on a specific intervention or evaluation study findings.*[^1,2]
- *Study was hindered by a high level of turnover among TFFC staff.*[^2]
- *Introducing new protocols requires leadership, staff, foster parents, and other stakeholders to reconsider how they do their work.*[^2]


### Resources

Kennedy Krieger Institute, The TFC Trauma Integrative Model at the Therapeutic Foster Care Program: [https://www.kennedykrieger.org/community/initiatives/therapeutic-foster-care/the-tfc-trauma-integrative-model](https://www.kennedykrieger.org/community/initiatives/therapeutic-foster-care/the-tfc-trauma-integrative-model)
REFERENCES


https://doi.org/10.1016/j.childyouth.2020.105166
APPENDIX A. METHODOLOGY

Search Process

The research team used the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) flowchart to guide the selection of articles for the scoping review (Moher et al., 2009). The PRISMA process guided the team through the following steps:

Figure 1. PRISMA Flow Diagram

Search. The search process included notable evidence-based practice databases, including the California Evidence-Based Clearinghouse, Family First Prevention Services Clearinghouse, Pew Results First Clearinghouse Database, Child Welfare Information Gateway, and Washington State Institute for Public Policy databases. Search terms included: Permanency, permanency enhancement, reunification, visitation, and parent substance use.

After identifying specific models, a search of the literature was conducted in four electronic databases. Results were limited to articles published in the last 10 years and were not restricted to only peer reviewed literature. A targeted list of keywords focused on finding invention-based research on family reunification, while trying to eliminate articles that simply describe the concept. The search strategy contained the following keywords: “Family reunification” AND (intervention OR model OR practice OR program) AND (“child welfare” OR “foster care” OR visitation OR “shared parenting” OR trauma). The same search strategy was used in all four databases: Scopus, Family Studies Abstracts, PsycINFO, and SocIndex. After removing duplicate records, 270 unique articles were screened. A final search process using Google and Google Scholar was conducted for any practice model identified in the evidence-based practice databases that were not found through the scholarly database search. An additional screen was performed to filter through articles that focused explicitly on a practice model and excluded any programs that were specific to implementation at a provider organization only; focused on treating specific behavioral health needs of children; designed only for post-reunification support; focused solely on foster/ resource parents and stability in kin or foster placements; and those that required a specific number of siblings experiencing removal.

Eligibility. Inclusion criteria used to further refine the documents reviewed focused on evaluations of specific, identifiable practice models that focused on reunification. Documents were excluded for the following reasons: The intervention was specific to implementation at a provider organization; the intervention required a specific number of siblings experiencing removal; the intervention focused on treating specific behavioral health needs of children (without a focus on reunification outcomes); the intervention primarily focused on foster/resource parents or stability in kin or foster placements (without a focus on reunification outcomes); or the intervention was designed primarily for post-reunification supports.

Included. After exclusions, 63 documents were included in the final review. The team then grouped these articles according to the specific intervention they were evaluating. In many cases, there was only one article for an intervention, while some interventions were represented by three or four journal articles. The final result was a list of 32 interventions.

Data Collection Process

The review team included two team leads and three additional reviewers. The team leads developed/ piloted standard coding forms and trained the reviewers. To ensure reliability, every reviewer coded the same article/intervention during training, and a team lead provided a second-level review.

Documents and interventions were coded using standard coding forms. Each research or evaluation document was coded to gather information about that study, including:

- Article’s focus/name of intervention
- Service Population, identifying subgroups or specific target groups when appropriate
- Sample
- Study design, identifying subgroup analysis when appropriate
• Rating in Maryland Scientific Methods Scale, in order to provide the team with a standard way of comparing the robustness of the evaluation methods, ranging from 1 (least robust; e.g., cross sectional design) to 5 (most robust; e.g., RCT)
• Measures and data sources
• Outcomes, indicating positive finding, no finding, negative finding, or not addressed in each of the following areas. [Note: sub-bullets are grouped together in the summary table.]
  o Child safety (e.g., no maltreatment)
  o Reunification
    ▪ Rate of reunification with parents
    ▪ Time to reunification
  o Stability of reunification (e.g., no re-entry)
  o Rate of permanency with family members (e.g., adoption, guardianship)
  o Family well-being (e.g., family functioning, economic, and housing stability)
    ▪ Preserving or nurturing critical parent-child relationships
    ▪ Preserving or nurturing meaningful, supportive connections of children and families
    ▪ Parental well-being (e.g., parenting practices, parent mental/emotional health, parent substance use/misuse)
  o Child well-being (i.e., child and youth development in behavioral, social, emotional, physical, and cognitive domains)
  o Community-supported environments (e.g., macro, community-level outcomes)
  o Qualitative feedback from families
  o Qualitative feedback from staff
• Study limitations

In addition to coding specific research studies, each intervention was also coded using a standardized form to capture:
• Intervention overview
• Rating in the California Evidence-Based Clearinghouse for Child Welfare (CEBC)
• Rating in Rating in Title IV-E Prevention Services Clearinghouse
• Rating in the Blueprints for Healthy Youth Development (BHYD)
• Focus area addressed
• National Implementation Research Network (NIRN) usable intervention criteria
• Staff requirements
• Best practices
• Contact information/additional resources

When multiple articles were available about a single intervention, one reviewer coded all of the research articles before filling out the intervention form, in order to gain expertise on that particular intervention.
Methodological Rigor and Robustness

Each intervention was coded on whether it was rated on one of more of the three nationally recognized evidence-based practices registries for child welfare interventions: The California Evidence-Based Clearinghouse for Child Welfare (CEBC), Title IV-E Prevention Services Clearinghouse, and Blueprints for Healthy Youth Development (BHYD). While ratings on a research clearinghouse are a useful indicator of established evidence, not all of the programs reviewed as part of this scoping review have been reviewed by a clearinghouse. Furthermore, each of the clearinghouses have different eligibility criteria and standards for review, and so their evidence ratings are not directly comparable.

To help correct for these challenges, the review team rated each study’s methodological rigor, or robustness associated with the evidence about a particular study design, using the Maryland Scientific Methods Scale (MSMS) with guidance provided by the What Works Centre for Local Economic Growth (Madaleno & Waights, nd).4 The MSMS rating scale produces scores ranging from 1 (least robust; e.g., cross sectional design) to 5 (most robust; e.g., randomized control trail). To ensure all team members were using the MSMS consistently, a sample of three articles per reviewer were double-coded. There was only one rating on which team members disagreed by one point, and this was corrected by a team lead.

Focus Areas

The team also coded each intervention according to the seven focus areas it addressed. The focus areas were developed by the Children’s Bureau and were further defined by the review team leads using the guidance outlined in the table below.

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Reviewer Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Child Welfare systems’ philosophies and cultures related to working with birth families and parents with children in foster care</td>
<td>Explicit mention of mission, values, philosophy of the organization/program</td>
</tr>
<tr>
<td>2. Comprehensive assessment of family needs with meaningful input by parents, relatives, significant family supports, and children and youth</td>
<td>Consistent use of standardized assessment to drive service planning; Explicit expectations of parent and/or child involvement in assessment process</td>
</tr>
<tr>
<td>3. Provision of timely and tailored in-home and out-of-home biological family/family of origin services through collaborative practice with other service providers that intentionally support reunification and ensure the service array</td>
<td>Intentional use of in-home and out-of-home services based on family needs; could also include parents and children placed together</td>
</tr>
<tr>
<td>4. Preparation of foster families that promotes and demonstrates parental support and engagement, shared parenting, and development of meaningful connections</td>
<td>Intentional work with foster families to support collaboration and connection with parents</td>
</tr>
<tr>
<td>5. Development of reunification-centered resources and services in the neighborhoods and communities of origin and where reunified families will live</td>
<td>Community-level resource building or mobilization</td>
</tr>
</tbody>
</table>

6. Maintenance of children’s important connections by providing foster care services in their neighborhoods, keeping them in their communities and schools of origin, and facilitating participation in activities of interest that children in foster care can enjoy

Intentional efforts to maintain connections for children during out-of-home placement (e.g., kinship placements, community, siblings)

7. Comprehensively addressing both child and parental well-being, including trauma related to removal and temporary placement in foster care

Explicit discussion of child and parental well-being, often explicitly includes trauma

To support consistency of ratings of focus areas across interventions, a review team lead conducted a second-level review of the focus areas based on the intervention overviews provided one-page intervention summary documents.

**Usable Intervention Criteria**

To capture and share data about implementation considerations for each intervention, the review team coded each intervention based on usable intervention criteria developed by the National Implementation Research Network (NIRN).\(^5\) Review team leads further operationalized the NIRN criteria using the guidance provided in the table below. During analysis, these independent ratings were collapsed into a summary statement about implementation supports available.

<table>
<thead>
<tr>
<th>Usable Intervention Criteria</th>
<th>Reviewer Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Philosophy, values, and principles for the program/intervention</td>
<td>Intervention or marketing materials include an explicit statement that defines philosophy, values, or principles for the intervention</td>
</tr>
<tr>
<td>2. Inclusion and exclusion criteria for the intended service population</td>
<td>Specific criteria define which individuals are eligible for the intervention and whether any considerations or characteristics exclude individuals from the service population</td>
</tr>
<tr>
<td>3. Description of core components (e.g., features that must be present, essential functions, active ingredients, practice elements)</td>
<td>A list of key practice features or functions are defined to outline the scope of the intervention</td>
</tr>
<tr>
<td>4. Practice profiles which describe the core intervention activities</td>
<td>Documentation provides specific, detailed instructions about how to practice according to intervention standards</td>
</tr>
<tr>
<td>5. Performance assessment/fidelity assessment measures</td>
<td>Measures of performance and fidelity are available to assess the degree to which the intervention is being implemented as intended</td>
</tr>
</tbody>
</table>

**Data Analysis and Reporting**

Reviewers entered data into electronic coding forms. Aggregate data were analyzed using descriptive analysis (e.g., counts and percentages) and reported at the study and intervention level. The final report includes a descriptive summary of findings across interventions, as well as specific summaries of each intervention.

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