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Evidence-Based Elements of Child Welfare In-Home Services

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Introduction

In this manuscript we present a set of evidence-based elements of in-home child welfare services derived through a federally-funded initiative, the National Resource Center for In-Home Services. We discuss the impetus for identifying the elements, review the underlying research literature, and present five models of in-home services that demonstrate many of these elements. We describe applying the elements in technical assistance to state child welfare agencies, and conclude with recommendations on how the elements can be implemented to strengthen family centered child welfare practice.

Background

Recognizing States' and Tribes' needs for information, training and technical assistance to keep children at home, in 2009 the U.S. Children's Bureau funded a new National Resource Center for In-Home Services (NRCIHS). The Center, structured as a cooperative agreement with the University of Iowa School of Social Work in partnership with the National Indian Child Welfare Association and ICF International, serves as a national center of child welfare expertise on services to improve the well-being and safety of children and youth at home, to prevent their initial placement or re-entry into foster care, and preserve, support and stabilize families.

The Center's initial work included conducting a nationwide assessment of current practices in in-home service delivery. Given the Center's key function as a provider of technical assistance to States and Tribes, the assessment sought to understand the challenges in implementing in-home services and to identify systemic and practice issues that would need to be considered in technical assistance efforts. Through this assessment we developed a set of elements of in-home services that are supported by empirical research and are congruent with evidenced-based practices and programs.

Definition of in-home child welfare services

In-home child welfare services are best understood in terms of their target populations and goals. The target population for child welfare in-home services is families who have come to the attention of the public child welfare agency because of alleged child maltreatment. In general families receiving in-home services have an open case with the agency, whether or not the alleged maltreatment has been substantiated through

an investigative process. The goals of in-home services are to stabilize the family and ensure the safety and well-being of the children in the home in order to prevent placement or re-entry into foster care.

Family support services targeted to families deemed at risk of maltreatment may be relevant ancillary services to families with open in-home services cases. In the interest of parsimony, however, in this article we exclude family support models unless research indicated their benefit for families in which child maltreatment is believed to have already occurred. The larger nationwide assessment (National Resource Center for Family Centered Practice, 2013) discusses the intersection of family support and family preservation in greater detail.

In-home services may be technically voluntary or mandated by the court, and may be delivered directly by a child welfare agency or by a community-based agency upon referral. Notably, in-home services may be delivered in the family home, in an office or in other settings (Child Welfare Information Gateway, 2014).

An important criterion for inclusion in this review of in-home services is the ability of the program to function as a core child welfare service, that is, a service that could comprise the primary state intervention. We exclude interventions such as primarily group-based parent training programs and clinical treatment services. Further, in-home services included in this analysis are designed to be delivered to a family (at least a parent and child) rather than to a single child.

Need for an evidence-based elements approach

State child welfare agency administrators are cognizant of the need to implement service models that demonstrate positive child and family outcomes, especially outcomes measured in the federal Child and Family Services Review process (Child Welfare Information Gateway, n.d.). Federal demonstration grants and Title IV-E funding waivers are two examples of federal strategies to incentivize the adoption of evidence-based practices. Infusing evidence-based interventions into child welfare systems, however, poses both conceptual and practical challenges. As Barth (2008) notes:

> The complexity of presenting problems for children who are in the category of having been neglected, and their families, may be quite substantial and varied—a poor fit with the origins of EBP in medicine, which was very specific to narrow diagnostic categories. (p. 147)

The efficacy of evidence-based interventions often depend on careful screening of eligible participants, training, and model fidelity, including specific staff qualifications and caseload sizes. Thus, evidence-based programs that focus on specific problems and populations (often including the age of the child) are not easily translatable to the protocols of public child welfare agencies which must have a way of providing reasonable, individualized services for every family accepted for service. Copyrighted and/or manualized interventions are often costly to implement in terms of training and materials, as well as challenging to maintain at fidelity, especially when a variety of models are implemented within a single agency. Moreover, decisions about the types and intensity of child welfare services are influenced by a number of competing realities, such as legislation, regulations, political climate, client rights, funding constraints, staff turnover rates, and fluctuating caseloads (Regehr, Stern, & Shlonsky, 2007). All of these barriers likely contribute to the reasons that public child welfare has been relatively slow to implement large scale evidence-based in-home services interventions.

The technical assistance (TA) goal of the National Resource Center for In-Home Services was to work with States and Tribes to build their systems' capacity to effectively address child maltreatment while maintaining children at home. This work involved offering guidance and on- and off-site technical support aimed at strengthening jurisdictions' core in-home services practice. While a few states requested assistance in planning for implementation of specific evidence-supported interventions such as Homebuilders™, most sought to enhance rather than replace their core, typically non-intensive services. Even states which relied heavily on private agency service provision were typically more interested in strengthening their existing contractual services than in implementing targeted evidence-based interventions. Several states asked for guidance on essential components of in-home services to enable them to evaluate programs seeking funding as part of the array of in-home services.

Our review of the literature concluded that there was not one evidence-based model of in-home child welfare services that would be applicable for all situations. Therefore we approached the research by looking for common elements in programs with relatively strong outcomes. We moved beyond looking for specific evidence-based programs as described in the published literature and sought to understand the commonalities among examples of strong in-home programs currently in use across the country. Berry's (2005) review of family preservation programs provided a starting point, and the NRCIHS faculty and consultants combined our knowledge of child welfare services and family

preservation to posit a set of elements of quality child welfare in-home services.

A related common elements approach has been applied to examining evidence-based practice in parent training (Barth & Liggett-Creel, 2012); and interventions for adolescents with behavioral problems which put them at risk for out-of-home placement (Lee et al., 2014). The common elements approach does not suggest that any single element is essential, nor does it guarantee that the common components, used together, necessarily constitute an evidence-based model. Common elements can provide delineation and structure to practice and program development (Lee et al., 2014).

We refined our initial group of core elements as we evaluated the extent to which each had been isolated in research and the strength of effects, if any. This article presents that refined list and Table 1 presents a matrix of the evidence-based elements of child welfare in-home services with corresponding research support.

We note that the list presented here is a mix of what Barth and colleagues have variously termed as common practice elements (discrete techniques or strategies to be employed by caseworkers), and common program elements or common factors (holistic approaches such as family centered, culturally competent or family engagement) (Barth et al., 2012)

Review of research on core elements of in-home services

Following the core elements approach described above, we examined the empirical evidence by selecting a subset of studies that specifically examined associations between relevant service components or approaches and measured outcomes. Below we describe our literature search methods and key findings from our review of the research literature on core elements and outcomes of in-home services.

Methods

An extensive literature search was conducted to find all relevant studies published within the last 20 years using the following databases: GoogleScholar, Eric, Social Services Abstracts, Sociological Abstracts, Social Work Abstracts, CINAHL, Academic Search Elite, Family Studies Abstracts, PsychInfo, and ISI Web of Knowledge. Key terms used to conduct the literature search included "family preservation," "intensive family preservation," "in-home services," "child welfare," "child protection," "child abuse," "child maltreatment," "placement prevention," "family supportive services," "post-reunification," "family centered services," "family group decision-making," "culturally competent," "differential response," among others. We reviewed bibliographies of published

studies and the Child Welfare Information Gateway and California Evidence-Based Clearinghouse websites as sources to identify relevant articles.

We selected a study for inclusion if it was an evaluation of in-home services provided to families who were involved with the child welfare system due to allegations of child abuse and/or neglect or who had a child that was at risk of being removed from the home. In order to represent the full range of existing research we placed no limitations on research design or study methods. However, in the analysis of the included studies, we considered the study methods including sample characteristics and selection, research design and analysis, program types, measurement and measured outcomes. Studies that were primarily descriptive, as well as doctoral dissertations and master's theses, were excluded.

Evidence-Based Elements with Research Findings

The elements of child welfare in-home services are derived from empirical research examining these elements in relation to risk for subsequent maltreatment (e.g., Antle, Barbee, Christensen, & Sullivan, 2009; Miller, 2006; Chaffin, Hecht, Bard, Silovsky, & Beasley, 2012) and out-of-home placement (e.g., Kirk & Griffith, 2004; Miller, 2006; Swenson, Schaeffer, Henggeler, Faldowski, & Mayhew, 2010). In the following sections we review and summarize the empirical evidence related to each element.

We point out that despite growing interest in measuring child well-being as a key outcome of in-home services, most of the research has relied on subsequent child maltreatment reports and out-of-home placements. This is especially the case with the elements approach that we employed, as we examined program outcomes in relation to each specific element.

Family-Centered Approaches

Family centered practice focuses on the entire family system rather than on identified individuals and utilizes the power of family interactions, relationships, and supports to help the entire family system. Using shared-decision making, the focus is on goals, strengths, competencies, and resources of family members and their natural supports to generate solutions for the issues the family is facing.

The family-centered and strengths-based perspectives represent frameworks that guide service provision and are widely accepted standards of child welfare practice (Barth, 2008; Berry, 2005). However, most studies have not operationalized these approaches in ways that can be directly empirically tested. Using a randomized experimental design to

examine the effects of family preservation programs compared to usual case management services, Meezan and McCroskey (1996) found that families in the experimental family preservation condition experienced greater improvements in family functioning. They concluded that the experimental service models that emphasized a family-centered approach and that focused on developing positive relationships between the worker and families likely accounted for a larger proportion of variation in outcomes than differences in specific service characteristics. Family-centered approaches are directly related to family engagement, which research findings support as a key element of effective in-home services (Fraser, Nelson, & Rivard, 1997; Dawson & Berry, 2002). In their meta-analysis of family support and intensive family preservation programs, MacLeod and Nelson (2000) found that family-centered IFPS that successfully increased family involvement in services demonstrated larger effect sizes in improved family functioning and decreased out-of-home placements. Landsman (2013) noted family-centered child welfare systems reforms including increased implementation of alternative/differential response systems and the use of family-team conferencing. Both approaches represent an increased focus on the family as a whole and supporting and strengthening the family's capacity to make informed decisions. Evidence supporting the benefits of differential response (e.g., Kaplan & Rohm, 2010) and family-team conferencing continues to grow (e.g., Crea, Crampton, Abramson-Madden, & Usher, 2008) and although limited in rigor, lends some support for family-centered and strengths-based child welfare practice.

Challenges in targeting services to population(s)

Targeting the intended populations for in-home services is an identified challenge in the field and in research literature. Problems in targeting have contributed to difficulty in drawing conclusions concerning service effectiveness in preventing subsequent placements and with identifying which services are most effective with different client subpopulations (Al et al., 2012; Denby & Curtis, 2003; Nelson, Walters, Schweitzer, Blythe, & Pecora, 2009). Caseworkers' reluctance to limit services to a select subset of clients is recognized as among the factors contributing to problems with targeting in randomized experimental studies (Denby & Curtis, 2003). In studies that addressed targeting issues researchers found intensive family preservation services based on the Homebuilder's® model moderately to highly effective in preventing out-of-home placement among families who are at high risk for having a child removed (Kirk & Griffith, 2004; WSIPP, 2006).

Two meta-analyses of family preservation studies found that out-of-home placement (Al et al., 2012), maltreatment, and family well-being (MacLeod & Nelson, 2000) outcomes were significantly moderated by child/family characteristics and problem types. For example, families with mental health and substance abuse problems appear to be less responsive to non-intensive (Bagdasaryan, 2005; Bitonti, 2002) and intensive (Littell & Tajima, 2000) family preservation services. In a randomized trial of state family preservation and reunification programs in Kentucky, New Jersey, Tennessee, and Pennsylvania, Westat (2002) examined whether services were more effective with certain subtypes of clients, finding that the results were inconclusive due to inconsistencies across program sites that included variations in targeting service recipients. Overall, existing research supports that correctly targeting populations for in-home services is challenging for child welfare agencies but may be important in achieving desired results.

Assessment of family strengths and needs and safety planning

Increasingly, states are requiring the use of assessments to identify safety, risks, and to assess family strengths and needs to guide decision-making and better match families with services (Child Welfare Information Gateway, 2010; Johnson et al., 2006). Ongoing efforts to develop standardized reliable instruments are underway to help determine which families are or are not at high risk of future harm.

Johnson et al. (2006) conducted a comprehensive review of family assessments in four domains: patterns of social interaction; parenting practices; background and history of the parents or caregivers; and problems in access to basic necessities such as income, employment, and adequate housing. The authors noted that the use of valid and reliable instruments holds promise for guiding the decision-making process and for demonstrating connections between service provision and outcomes. For example, in an experimental evaluation of family preservation services, Meezan and McCroskey (1996) found that the use of the Family Assessment Form to identify family strengths and needs enhanced workers' ability to match families to services; which in turn resulted in significant improvements in family functioning. Berry (1992) also found evidence supporting that the use of a comprehensive assessment and safety management services led to significant improvements in family functioning. Further research is needed to identify assessments best suited to families referred to in-home services.

Family Engagement and Voluntary Services

Building trust-based relationships is a first step in developing effective, respectful practice. A report of suspected child maltreatment often creates a crisis for a family, potentially creating a "window" for engagement. An early offer to help the family access useful services on a voluntary basis contributes to family ownership through active choice and shared-decision making. However the notion of *voluntary* services must be understood in the context of a broader coercive child welfare system, and a family may rightfully question whether a proposed offer of service is truly voluntary.

Engaging clients in case planning and services is widely accepted as key to successful case outcomes (Landsman & Boel-Studt, 2011; Fraser et al., 1997). Engagement is a term that is used frequently in the literature, is often left undefined, and when defined has been used in multiple ways ranging from compliance with case goals to collaboration in setting case goals and active participation in services (Landsman & Boel-Studt, 2011). Researchers have found that engaging families early on in the life of the case predicts a greater likelihood of successful outcomes (Berry, 1992; Bitonti, 2002; Kinney, Haapala, & Booth, 1991; Lewis, 1991). Berry et al. (2000) found that among families that received intensive family preservation services, a greater amount of direct contact with IFPS workers was associated with statistically significant improvements in family functioning. DePanfilis and Zuravin (2002) found that families who attended the services that were identified in their case plans were 32% less likely to experience recurrence of maltreatment during the time that their child welfare case was open.

Given the connection between client engagement and case outcomes, the task of engaging families is a high priority (Dawson & Berry, 2002). Some researchers have identified factors associated with family engagement in services. Littell and Tajima (2000) found that characteristics of the clients, case workers, and programs were all associated with variation in client engagement—in this case, measured as collaboration and compliance. For example, they found that involvement of extended family, provision of concrete and advocacy services, small case loads, and common race/ethnicity between case worker and client were associated with increased levels of engagement. Conversely, a deficit orientation among case workers, worker burnout, client mental health and substance abuse problems, and child behavior problems were associated with decreased engagement.

Differential response systems offer an opportunity to examine the use of voluntary services and compare maltreatment recidivism across

response tracks. For example in California, a quasi-experimental study of families assessed out of traditional services through an alternative track found no differences in repeat maltreatment among those who received home visiting services and those who did not receive the services due to limited program capacity (Conley & Berrick, 2010). Evaluations of differential response systems in Minnesota (Loman & Siegal, 2004; 2006) and Ohio (Kaplan & Rohm, 2010) showed that families assessed as low to moderate risk and offered services as an alternative response demonstrated greater involvement in the decision-making process and experienced fewer placements and subsequent reports of maltreatment. A quasi-experimental study of a multiple response system in North Carolina also found reduced repeat maltreatment (Lawrence, Rosanbalm, & Dodge, 2011). Results support the benefits of using family assessments to target service approaches to subtypes of clients and offering voluntary community-based services that are focused on engaging families.

Family-team meetings (or family group conferencing, family team decision-making) are another widely used approach to engaging families in the case planning and decision-making process (Munson & Freundlich, 2008). Although extant research focuses primarily on use of these strategies following placement and to facilitate reunification, there are a few examples from research that apply to in-home services. One six-site study reported that team decision meetings were held for all cases when placement was being considered, and in 48-50% of the cases, the child remained at home (Wildfire, Rideout, & Crampton, 2010). Furthermore, the percent of cases remaining at home increased to 70% when model fidelity was strong. One quasi-experimental study that examined family group decision-making with a sample that included children at home found greater reductions in maltreatment events (Pennell & Burford, 2000). A study of team decision-making implementation in three agencies noted that the agency having the most experience with team decision-making reported sizable decreases in initial entries into out-of-home care over time (Crea et al., 2008). The research on the impact of differential response systems and family-team meetings for in-home service cases is still in the beginning phases.

Quality Worker-Client Relationship

The quality of the helping relationship that is formed between the child welfare worker and the family is an often implied condition that underlies the success of interventions or even the effectiveness of individual service components. Few studies of in-home services have focused on examining how the quality of the helping relationship affects

outcomes. However, existing empirical evidence supports that a high quality helping relationship is associated with increased client engagement and positive outcomes (Maiter, Palmer, & Manji, 2006). Lee and Ayón (2004) interviewed 100 clients who had received either family preservation services or family maintenance services to examine the relation between child welfare outcomes and the client-worker relationship. They found that higher scores on the *Relationship with Worker Instrument* were associated with statistically significant improvements in parenting skills. Key predictors of higher scores included clients feeling they could communicate openly with their workers, more frequent visits between the worker and client, and whether the client received public assistance. Ryan, Garneir, Zyphur, and Zhai (2006) examined the extent to which case worker characteristics influenced length of stay in the child welfare system and the likelihood of reunification. Among their key findings was that having multiple caseworkers during the life of the case was significantly associated with longer length of stay in child welfare and decreased likelihood of reunification. Thus, high turnover may have an impact on the ability to establish stable relationships between workers and clients and may have detrimental effects on client outcomes.

Qualitative research methods have been used to investigate the key characteristics of quality worker-client relationships from the perspectives of the client and worker. Open communication, nonjudgmental attitudes, flexibility, and a sense of equanimity within the relationship were all consistent themes researchers have identified from in-depth interviews of clients and workers (de Boer & Coady, 2007; Drake, 1994; Maiter et al., 2006; Ribner & Knei-Paz, 2002).

Cultural Competency

Culturally competent practice relies on the ability to understand, communicate with, and effectively interact with people across cultures; and providing culturally relevant and effective services and interventions to a family within the context of their cultural beliefs, behaviors, and needs. Given the diversity of families that come into contact with the child welfare system, the use of approaches that infuse cultural awareness and sensitivity are necessary to making informed assessments and providing relevant services that meaningfully engage families.

Reviews of family-based services reveal that cultural competency is a common element among programs with promising findings (Berry, 2005; Fraser et al., 1997; Nelson et al., 2009). Yet, research examining different approaches or elements of culturally competent practice in child welfare is needed. Varying and sometimes conflicting views on how to define and

implement culturally competent services has been observed between agencies and service providers (Nybell & Gray, 2004). Such conflicts are indicative of the some of the practical challenges to achieving widespread and universal implementation in the field.

In one study, Kirk and Griffith (2008) found evidence suggesting that intensive family preservation services may have reversed racial disproportionality in placement. They found that nonwhite children were at higher risk for removal compared to white children when receiving traditional child welfare services while the opposite was found among those receiving intensive family preservation services. In the intensive family preservation condition white children were found to be at greater risk for removal compared to nonwhite children. Using data (n = 1,305) from a randomized study of family preservation programs (SafeCare[®] versus traditional services), Damashek, Bard, and Hecht (2012) found that higher scores on client ratings of their provider's level of cultural competency were associated with increased success in meeting case goals and satisfaction with services. Further, the effect of perceived cultural competency partially accounted for differences in program outcomes. Despite a general consensus on the need to take culture into account and put forth efforts to integrate such approaches into child welfare systems and services, few studies have examined implementation progress and the relation of such efforts to client outcomes.

Case coordination

Families involved with the child welfare system often have complex needs and involvement in other systems of care. Developing a plan for intervention strategies that are sequenced and coordinated is an important function of case management. Partnering with the family and other service providers enhances the consistency and unity of efforts and interventions.

Research examining the connection between case management practices and approaches in child welfare as a component of in-home services has produced mixed results and represents an underdeveloped area of research. Findings from some studies support that including case coordination as part of service delivery positively contributes to client outcomes. Using data from the National Survey of Child and Adolescent Well-being, Bia, Wells, and Hillemeier (2009) found that higher levels of inter-agency service coordination and communication between child welfare agencies and mental health service providers was significantly associated with greater use of mental health services and improved mental health outcomes in children and adolescents. On the basis of her meta-analysis of family preservation models, Berry (2005) cautioned,

however, against the use of *case management* models which rely primarily on referrals as a primary mode for delivery on the basis that that effective child welfare in-home services require a more "hands-on" approach and individualization:

> Given what parents say about the importance of a trusting relationship with their caseworker, it appears important that… skills are taught and modeled by the family preservation caseworker. Once family preservation work moves to a model of case management, the central behavioral tenets, supported by research to be critical to success, have evaporated. (p. 331)

Three evidence-based casework models have emerged in the literature in recent years. Solution-Based Casework, Family Connections and SafeCare have all been identified as promising practices according to California Evidence-Based Clearinghouse (CEBC) criteria. Solution-Based Casework has been adapted and integrated into state child welfare systems and demonstrated positive results (Antle et al., 2009). Detailed descriptions of these three models are presented later in this article.

Matching Services to Population/Individualized Services

Accessible and available services to respond in a timely way to child and family needs are necessary to keep children at home. Providing individualized services that are matched to client types, as well as the specific family strengths and needs, aim to prevent maltreatment, improve family functioning, and keep families together (Berry, 2005; Fraser et al., 1997).

Providing problem-specific services to families involved with CPS are found to be significantly associated with improvement in family functioning (Berry, 1992; Berry, Cash, & Brook, 2000; Meezan & McCroskey, 1996). Some studies have shown that providing services to help families overcome economic hardship and meet basic needs (i.e., food, clothing, housing assistance, etc.) reduces risk for subsequent maltreatment and out-of-home placements (Ryan & Schuerman, 2004; Westat, 2002).

Results from similar analyses with other client subgroups defined by the primary concern (i.e., depression, child discipline) revealed highly varied results, with some problem specific services being significantly associated with increased risk for maltreatment and placement while others were associated with decreased risk (Westat, 2002). Further, there were inconsistent and un-patterned differences in results across service

sites, leading to inconclusive results regarding which types of services are most effective for specific subtypes. Evidence suggests that individualizing services to families' needs may be related to improvements in multiple key outcomes, yet the effects may be contingent upon the family subtypes and the specific issues they are dealing with and/or variations in how interventions are implemented.

Individualized services matched to specific family needs may include evidence-based interventions designed for specific diagnostic groups. Evaluation of targeted evidence-based practices by organizations such as the California Evidence-Based Clearinghouse for Child Welfare has increased exponentially in the past several years. A full review of these interventions is beyond the scope of the current study.

Service Intensity/Duration

Several studies have examined the relationship between service intensity and duration and outcomes; however, study methods tend to vary widely, ranging from one group post-test only designs (e.g., Bagdasaryan, 2005) to randomized controlled trials (e.g., Westat, 2002).

Results from much of the research on non-intensive family preservation services (Chaffin, Bonner, & Hill, 2001) and intensive family preservation services (Littell & Schuerman, 2002; Schuerman, Rzepnicki, & Littell, 1994; Westat, 2002) show that neither service intensity nor duration are significantly related to maltreatment outcomes. Al, Stams, Asscher, and van der Laan (2014) evaluated the Family Crisis Intervention Program (FCIP), a program modeled after Homebuilders® that targets families in crisis who are referred due to concerns over child safety, yet may not be at-risk of imminent removal. Results showed statistically significant improvements in provider ratings of child safety and parent ratings of parent-child interactions and child behaviors from pretest to post-test.

Findings of studies that examined the relation between service intensity and duration and prevention of out-of-home placement are mixed. Some studies, including those using more rigorous designs, have found intensity and duration are not significantly related to placement prevention (Bitonti, 2002; Chaffin et al., 2001; Littell & Schuerman, 2002; Schuerman et al., 1994; Westat, 2002). Conversely, findings from other studies support that longer service duration is associated with decreased or delayed placement (Bagdasaryan, 2005; Berry et al., 2000), with one investigation finding that the positive effects of service duration appeared to level off around 12 months (Bagdasaryan, 2005). In their meta-analysis of 20 family preservation programs Al et al. (2012) found that smaller

caseloads resulted in larger effect sizes for placement outcomes. They concluded that fewer cases may have allowed for workers to provide more intensive services and that intensity may be a key factor in placement prevention.

Intensive family preservation research most strongly supports that greater service intensity and longer duration are related to improved family and child well-being. Cash and Berry (2003) found that families that made more positive gains in family functioning and child well-being were those that received more total contact time with their workers and for whom the proportion of services that were directly provided by their worker was greater. They also found that less successful families had higher overall intensity of services per day measured in minutes of contact, but Berry (2005) pointed out that this could reflect either more severe family problems or ineffective services for the types of problems the family experienced. In an earlier study, Berry et al. (2000) found higher service intensity was associated with improved family functioning and that families who experienced removals were those who received shorter duration and lower intensity of services. Rofuth and Connors (2007) found longer service duration was associated with decreased risk as measured by the *Child Well-Being Scales*. Lee and Ayón (2004) found that frequency of worker visits significantly predicted client reports of having a good relationship with family preservation workers among families who were court mandated.

There is a growing consensus that the short-term nature of Homebuilders (60-90 days) may not be sufficient to meet the longer term needs of families who suffer from serious and persistent mental health disorders, including substance abuse; best practice now indicates that short-term intensive services should be followed by longer term aftercare. A study of an intensive family preservation program for African American families, the Family Enhancement Program in Portland, Oregon, found significantly fewer placements and fewer reports of substantiated neglect post intervention (Nelson & Nash, 2008), and significant improvement in child well-being. Placement rates between families who received aftercare services and those who received only intensive services differed significantly. More recent research on the Homebuilders® model, now termed *Intensive Family Preservation Services*, supports a move away from closing the intensive cases at 90 days and toward transitioning the family to aftercare or step-down services.

Research identifying a connection between service intensity and duration and placement and maltreatment outcomes has produced some promising yet mixed results, thus there is no current empirical knowledge

that can definitively determine the optimal length of service or number of contacts necessary to achieving desired outcomes in general or with specific client subgroups. However, some evidence suggests that higher service intensity and duration followed by some form of aftercare service may result in increased benefits in the area of family well-being and may foster more positive client-worker relationships.

Direct Teaching and Problem-Solving Skills

Child rearing includes a complex set of skills. Building on parents' strengths, direct teaching and coaching can help parents acquire and demonstrate key skills and behavioral patterns necessary for daily functioning in parental activities and caregiving roles. This not only includes basic child care, (e.g., nutrition, hygiene, health, nurturing, development), but also discipline, supervision, and household management. Teaching and coaching must be at a level commensurate with the parents' intellectual functioning and abilities.

In reviewing family preservation programs, Fraser et al. (1997) identified teaching families problem-solving skills and parenting as among the common and essential components of promising programs. Evaluations of intensive family preservation services have found that providing direct services and/or mentoring to teach families parenting, basic household management and problem-solving skills were associated with improved family functioning (Berry, 1992; Berry et al., 2000), reduced risk of subsequent maltreatment (Chaffin et al., 2001), and out-of-home placement (Hanssen & Epstein, 2007). Berry (1992) found that no placements occurred in families when over half of the service time was spent in the family's home, thus highlighting the importance of directly providing services.

Concrete Services

Maintaining situational stability for a family includes stability of basic necessities, including income, housing, utilities, transportation, health care, child care, and other essentials. Family crises are often related to unmet concrete needs.

The bulk of existing research on this issue supports a positive association between case outcomes and providing concrete services to help families meet basic needs. Studies of intensive family preservation programs have found supportive evidence that providing concrete services is associated with improved family functioning (Berry, 1992; Berry et al., 2000; MacLeod & Nelson, 2000). For example, using a randomized modified experimental design to evaluate family preservation programs in

two services areas in Los Angeles County, Meezan and McCroskey (1996) found significant improvements in interpersonal relations among families that received concrete services. Results from a randomized experiment (Westat, 2002) and a randomized quasi-experiment (Chaffin et al., 2001) found that receipt of concrete services was associated with reduced risk of placement. Westat (2002) found this outcome held only for families whose primary problem area was identified as economic hardship. Other associated outcomes include reduced risk of subsequent maltreatment (Chaffin et al., 2001; Ryan & Schuerman, 2004) and increased client collaboration (Littell & Tajima, 2000). However, in two controlled evaluations of intensive family preservation, concrete services were not associated with placement outcomes or subsequent reports of maltreatment (Littell & Schuerman, 2002; Schuerman et al., 1994).

Community Resources and Social Supports

Community resources, along with sustainable family social supports, help to build family capacity for long-term self-sufficiency. Teaching families to access and use community resources allows them to independently meet their needs without the intervention of the child welfare system. For successful transition to independence from child welfare intervention, a family needs to develop and maintain a healthy social support system, which may include extended family, development of personal friendships, and both formal and informal community supports and services.

One of the secondary objectives of in-home services is to help connect families with community resources and social supports to generate a strong and lasting support network (Fraser et al., 1997; Nelson et al., 2009). Findings from two studies suggest that increasing access to resources is associated with improvement in family functioning (Berry, 1992; Berry et al., 2000). In her review of community-based programs for families, Cox (2005) concluded that few studies have clearly identified the extent to which natural supports were actually involved in the case; thus, evidence on the effects of including family's natural support networks as a key component to service remains weak. Nonetheless, some promising evidence has been found. For example, Littell and Tajima (2000) found that increased involvement of extended family was positively associated with client collaboration. MacLeod and Nelson (2000) reported that family preservation interventions that included a social support component demonstrated larger effect sizes for reduced out-of-home placements.

Five Evidence-Based Models of Family Centered In-Home Services

This section highlights five evidence-based in-home program models – Solution-Based Casework, SafeCare, Family Connections, Homebuilders, and Multi-Systemic Therapy – that could be integrated into the core practice of public child welfare.   We follow this discussion with a matrix (Table 2) highlighting the extent to which the five models include what NRCIHS has proposed as evidence-based elements of in-home services.   The point of the matrix is not to evaluate the evidence-based models, but rather to examine the relevance of our approach and to assist child welfare decision-makers in targeting the types of programs that meet their constituents' service needs.

Solution Based Casework

Solution Based Casework (SBC) is a casework model for working with families who experience maltreatment. Since initial studies of SBC showed its effectiveness with families experiencing different types of maltreatment, co-morbid factors and other demographic variables, the model was eventually implemented across the child welfare system in the Commonwealth of Kentucky as the core practice approach. The state of Washington has also implemented the solution based casework model.

Solution Based Casework expands the family-centered perspective of building on strengths, with a strong focus on developing solutions to the presenting problem, setting specific, measurable outcomes, and using cognitive-behavioral relapse prevention techniques.   SBC is based on the theoretical foundations of solution-focused family therapy, family life cycle theory and relapse prevention. The model seeks to establish working partnerships with families after reaching a consensus about individual and family issues. While not ignoring risks and deficits in family functioning, there is an attempt to reframe problems in a way they can be solved and to look for those positive efforts the family is already making to solve them. A central feature of SBC is the use of *relapse prevention techniques* based in cognitive-behavioral theory.   These techniques focus on four areas: recognition of personal behavior patterns, the details of high risk patterns, practicing small steps toward changing those patterns, and then using that information to develop a long-term plan to prevent reoccurrence of destructive behavior.

In a study extracting data from client chart files, workers using an SBC model were more likely to be involved in case planning and service acquisition by directly contacting resources, attending initial sessions with their clients and developing collaborative service plans than were their counterparts (Antle, Barbee, Christensen, & Martin, 2008). Families

completed more tasks and followed more visitation guidelines. They also achieved more goals and objectives and experienced greater success. In subsequent research, SBC was associated with better outcomes for child maltreatment recidivism (Antle et al., 2009), and in improvements on federal child welfare indicators of well-being, permanency, and safety (Antle, Christensen, van Zyl, & Barbee, 2012). Solution Based Casework has achieved a rating of Promising Practice in the area of casework practice by the California Evidence-Based Clearinghouse for Child Welfare.

SafeCare

A variety of populations have been served by SafeCare, including parents at high risk of maltreatment, parents involved with child protective services, parents of children with autism and related disabilities; and several racial and ethnic groups. SafeCare uses an eco-behavioral approach to helping child welfare families, based on behavioral and social learning theories. Using a very structured behavioral format, it targets three areas of family functioning most commonly associated with abuse and neglect: the child's health care, home safety, and parent-child interaction. The protocol for teaching each set of behaviors to families is specifically spelled out using discussion of the issue, modeling and practice, along with final testing to assure the parents' understanding of what they need to do. The model is supported by a manual and a thirteen-day training for home visitors, by training coaches, and by supervisors who observe practice, offer suggestions and assure adherence to the program (Edwards & Lutzker, 2008). There is also a National SafeCare® Training and Research Center. Emphasis is placed on conformity to the model as well as strong oversight by coaches and trainers to assure that each team member is applying the skills and interventions.

Research comparing SafeCare to usual or no services indicates that SafeCare reduces child maltreatment reports as much as 75% (Chaffin et al., 2012; Gershater-Molko, Lutzker & Wesch, 2002), reduces risk factors for abuse and neglect, reduces parental depression, and increases perceived parental social support (Gershater-Molko, Lutzker, & Wesch, 2003). Parents rate SafeCare as more satisfying and more culturally competent than standard services (Damashek et al., 2012). SafeCare has been rated by the California Evidence-Based Clearinghouse for Child Welfare as an evidence-supported intervention for neglect, parent training, and secondary prevention. As of July 3013, twelve states were implementing SafeCare, and four had formerly implemented the model (D. Whitaker, personal communication, July 9, 2013).

Family Connections

Family Connections (FC) was designed to serve families with a high risk of neglect who were not currently involved in the child welfare system, although families may have had previous contact with the system. Services are voluntary, and a high priority has been placed on family engagement in the process. The Family Connections Program was first developed in 1996 with partial support from the Office of Child Abuse and Neglect at the Children's Bureau, DHHS. It operates from an ecological developmental framework using Bronfenbrenner's (1979) theory of social ecology as a foundation and incorporating psychosocial theory, problem-solving theory, life model theory, crisis theory, systems theory, role theory, behavior theory and cognitive theory. Nine practice principles guide FC interventions: community outreach, individualized family assessment, tailored interventions, helping alliances, empowerment approaches, a strengths-base perspective, cultural competence, developmental congruence, and outcome-driven service plans. The goals of intervention are to increase protective factors and decrease risk factors. The core components of the program include emergency assistance, home-visiting intervention, advocacy and service coordination targeted to risk and protective factors, and multi-family supportive and recreational activities.

Family Connections services begin with a screening process. Inclusion criteria include the presence of at least one type of neglect and at least two additional risk factors associated with child maltreatment; in the projects in which the research is published, the family must not have been currently involved with CPS (but there are additional trials currently being undertaken with CPS-involved families). FC therapists make face-to-face contact with family on the first day of acceptance. Meetings take place in a community-based setting, often the family's home, and occur at least once per week for approximately three months. A minimum of one hour per week of direct contact is required. Clinical assessments are used to identify client needs and strengths and to develop an individualized, outcomes driven cases plan. Depending on the families' needs, FC therapists provide direct therapy along with emergency and concrete services, community advocacy on the families' behalf, and coordinate services with other community providers.

The initial Family Connections Program was implemented in Baltimore's Westside Empowerment Zone, an urban area with extreme poverty, unemployment and general economic distress. Most services were provided by graduate social work interns supervised by a faculty member. Later, in a multi-site research study over a five year period,

programs were implemented in urban and rural locations including Los Angeles, Detroit, Knoxville, Houston, San Antonio, Baltimore, and West Virginia. The length of programs varied from 3 months to 6 months to 9 months depending on the individual demonstration site. On occasion, the program was enhanced with other components such as motivational interviewing, legal or health services but groups were kept distinct for research purposes. Caseload sizes for workers were 3-5 families or 5-7 families depending on length of service.

The first study of 154 families and 473 children who received Family Connections in the Baltimore area showed positive changes in protective factors (parenting attitudes, parenting competence, social support); diminished risk factors (parental depressive symptoms, parenting stress, life stress); and improved child safety (physical and psychological care of the children) and decreased externalizing and internalizing behavior (DePanfilis & Dubowitz, 2005). The study showed no significant difference in outcomes of families who were served for 3 months or 9 months, making the 3-month intervention more cost effective. However, a subsequent study of FC in multiple sites showed increased reduction of risk factors over the longer 9-month period (DePanfilis, Filene, & Smith, 2010). As in Baltimore, the multi-site study showed positive change in risk, protection, and child behavior measures for families served by FC vs. regular services. The research has been inconclusive about an actual reduction in child maltreatment reports or child welfare recidivism, possibly due to relatively small sample sizes (DePanfilis & Dubowitz, 2005) and flawed CPS data systems (DePanfilis et al., 2010). Researchers were also concerned about fidelity to the model in multiple sites, as workers did not always use the study instruments for family assessments. Future replications are planned involving families which have already experienced maltreatment. Family Connections has been rated by the California Evidence-Based Clearinghouse for Child Welfare as a Promising Practice in three areas: interventions for neglect, casework practice and secondary prevention.

Intensive Family Preservation Services

Intensive Family Preservation Services (IFPS) are designed to support families in crisis which have come to the attention of child welfare and in which children are perceived to be at imminent risk of placement. Intensive family preservation services are intended to be used as part of a continuum of in-home services.

The most well researched model of intensive family preservation is the Homebuilders® program. Homebuilders® has been designated a model

family strengthening program by the United States Office of Juvenile Justice and Delinquency Prevention and the Center for Substance Abuse Prevention and is rated as an evidence-based practice by the California Evidence-Based Clearinghouse for Child Welfare. Homebuilders is based on crisis intervention theory, which holds that families are most open to change during a period of crisis when typical coping patterns can no longer maintain family stability and independence (Nelson, Landsman & Deutelbaum, 1990). To take advantage of this opening, the program provides intervention within 24 hours of referral, around-the-clock (24/7) availability of therapists, low caseloads and brief, but intensive services. Families typically are seen between 6 and 10 hours per week (many IFPS programs report a range of 8-20 hours per week), and services are time-limited, usually 1-4 months (Haapala & Kinney, 1979; Kinney, Haapala, Booth, & Leavitt, 1990; Kinney, Haapala, & Gast, 1981; Walton, Sandau-Beckler, & Mannes, 2001). Concrete forms of supportive services such as food and transportation are provided along with clinical services. Intensive Family Preservation Services programs attend closely to safety and contingency planning but generally not use the formal term *safety plan*. The intensity of this in-home service also allows close monitoring of potentially dangerous situations and the family's implementation of the plan for safety. In a meta-analysis of intensive family preservation services research by Washington State Institute for Public Policy (2006), findings suggest that programs that "adhere closely to the Homebuilders[®] model significantly reduce out-of-home placement."

Social learning theory, which stresses the importance of expectations, behavior modification, and skill development, provides the theoretical base for the interventions most frequently employed in Homebuilders' programs (Nelson et al., 1990). Workers emphasize psychoeducational services such as tracking behaviors, reinforcement, environmental controls, parent-effectiveness training, and self-management training (Kinney et al., 1981). Homebuilders[®] also uses strategies from other schools of thought, such as values clarification, active listening, cognitive restructuring, hypnosis, reframing, and paradox. Treatment goals are set according to the family's priorities and their perception of the problem, and workers are encouraged to create interventions that fit each family's needs and perceptions (Haapala & Kinney, 1979). The provision of concrete and supportive services is also important in the crisis intervention model and may include transportation, homemaker services, financial aid, housing assistance, day care, and shopping or cleaning with the family.

Intensive family preservation services came under heavy criticism in the mid- to late-1990's when experimental studies of IFPS failed to document superior outcomes for children receiving IFPS compared with standard child welfare services. More recent meta-analyses have concluded that IFPS programs that adhere to Homebuilders' standards effectively achieve their intended outcomes (Nelson et al., 2009; Washington State Institute for Public Policy, 2006). Nelson et al. (2009) found a range of effect sizes across IFPS studies in a variety of outcome measures including repeat maltreatment, placement avoidance, and improvement in social support, and concluded that continued research is needed to identify program components most effective for various sub-groups and populations including racial and ethnic minorities, different age groups, and different presenting problems. Earlier we noted the "step down" approach in which less intensive services follow the period of intensive services, particularly for families with recurring problems such as substance abuse or serious mental illness.

As part of the nationwide assessment, in 2011 NRCIHS commissioned a survey of states by the National Family Preservation Network with the goal of understanding the extent of implementation of intensive family preservation services in the Homebuilders model. In 2011, 14 states were implementing intensive family preservation programs with fidelity to the Homebuilders model, compared with 20 states which were offering Homebuilders when NFPN surveyed in 2007 (NRFCP, 2013). At the same time, there was currently more uniformity of standards in the exemplary IFPS states than there was in 2007.

Multisystemic Therapy for Child Abuse and Neglect (MST-CAN), adapted from Multisystemic Therapy (MST)

MST-CAN represents an adaptation of Multisystemic therapy (MST), an intensive family and community-based treatment model developed for adolescents aged 12-17 who were involved in the juvenile justice system (Henggeler & Borduin, 1990). The original model was designed to reduce adolescents' involvement in violent and delinquent behaviors and to treat substance abuse problems, and was subsequently adapted to treat sexual behavior problems (MST-PBS). MST has been tested in many randomized clinical trials, making it one of the most extensively researched evidence-based treatment models to date (see for example, Schoenwald & Henggeler, 2005; Henggeler, Melton, & Smith, 1992; Borduin et al., 1995). Since the focus of the current review is on in-home services with families that come to the attention of the public child

welfare agency because of alleged child maltreatment, we emphasize MST-CAN here.

The model adapted for child maltreatment populations shares some commonalities with the original MST, such as: home-based service delivery with sessions convened to fit families' schedules; a social ecological approach addressing multiple factors affecting child maltreatment at the level of individual, family, and social system; provision of intensive clinical services that incorporate evidence-based interventions selected to meet the needs of each family; services provided through a team model; and a rigorous quality assurance process involving training, supervision, and fidelity (Swenson et al., 2010).

In tailoring the MST approach to a child maltreatment population and testing this in a randomized control trial, some modifications were made. The target population consisted of families in which child physical abuse was the precipitating incident, and length of service was permitted to extend beyond the four to six month standard service period for MST. A psychiatrist was included on the clinical team, and specific evidence-based interventions using cognitive behavioral counseling and parent training were included as key interventions (Swenson et al., 2010). Results of this trial found that MST-CAN was more effective than standard services in decreasing mental health symptoms for both parents and youth, reducing harsh parenting practices, developing family social support networks, and reducing the likelihood of out-of-home placement. There were no significant effects of MST-CAN, however, on subsequent maltreatment reports. The California Evidence-Based Clearinghouse for Child Welfare rates MST-CAN as supported by research evidence and highly relevant to child welfare; the original MST designed for families in which youth have exhibited behavior problems is rated as well-supported by research evidence

Applying the Elements to Technical Assistance Efforts

Public child welfare agencies approach system improvement in a variety of ways, with different impetuses, and within substantial systemic constraints. Reform efforts may be implemented as part of the state's five-year Child and Family Services Plan, in response to federal child and family services monitoring, to legislative mandates including decreases in funding or demands for more evidence-based practice, to class action lawsuits, or as part of ongoing agency quality improvement. An increasingly common thread is the demand or desire to implement evidence-based practice. In some cases, an uncritical call for implementing only evidence-based practice ignores the realities within

which public child welfare functions (USDHHS, 2007). For example, in providing technical assistance to states through NRCIHS we encountered a jurisdiction in which the proposal was to fund two evidence-based practices– MST and Homebuilders– and only these, without any provision for funding essential functions such as intake, assessment and referral.

While state agencies in Kentucky and Washington have implemented an evidence-based model (Solution-Based Casework) across the child welfare system, most state agencies approach system improvement incrementally, and with broad outcomes in mind. Indeed, in the second round of the Program Improvement Plans (PIPs) following Child and Family Services Reviews, states were encouraged to focus on broad themes for system improvement such as strengthening family engagement or supervision, rather than committing to a plan with objectives so numerous that they would be difficult to accomplish within the two-year period in which federal PIPs are implemented and measured.

Lee et al. (2014) point out the benefits of a modular approach to evidence-based decision-making, by which clinicians can choose among common evidence-supported elements to individualize treatment to a specific client's needs. There may be similar benefits to a modular approach to system improvement, providing child welfare policymakers with a set of elements from which to tailor a program which best fits the agency's organizational, legal, social and political context.

We have proposed a set of evidence-based elements of in-home services that jurisdictions can use to incrementally align their current in-home services with the best available evidence of what works. Where elements are missing or relatively weak, the agency may prioritize resources toward strengthening the element. Where elements are strong, the agency may commit to maintaining or enhancing that strength. Some elements complement each other; for example, the worker-family alliance may be strengthened by early provision of concrete services or by more direct teaching or working with families to identify solutions. In our technical assistance, NRCIHS has provided jurisdictions with a matrix of elements that they can use as part of a self-assessment process. We have used the matrix to lead focused discussions with stakeholders and key agency decision-makers about the strengths and gaps in their current services. One state agency used the matrix to inform their evaluation of proposed home-grown, culturally based in-home services programs. Our technical assistance customers have reported that the matrix is useful as a way to take stock of their current practice and prioritize change efforts.

An examination of evidence-based elements in relation to the agency's current strengths and gaps may point to adoption of an

evidence-based in-home services model such as the five we have discussed here. Some jurisdictions implementing broad system reform have implemented two or more complementary evidence-based components, such as family team meetings or structured decision-making protocols. Another way to enhance an existing model is the adoption of components of an evidence-based model. Illinois, for example, adopted various teaching components of SafeCare (in its initial stages as Project 12-Ways) into several in-home services programs targeted to families with substance affected infants, elderly caregivers, and teen parents in foster care. Yet another approach worth considering is replication of a promising program model for which there is not enough evidence to merit designation as an evidence-supported intervention, but which contains a number of evidence-based in-home service elements that may fit the agency's goals. Rofuth and Connors' (2007) study of a non-intensive, longer-term family preservation program, for example, showed promising findings in the area of child well-being and improved family functioning. The primary finding of the study was the positive impact of longer-term family involvement in a complex service process that included both direct services to families and developing or advocating for community services to fill gaps. The program, the New Haven Family Alliance, shares several of the elements we propose- strength-based, solution-focused approach, direct teaching of parenting and coping skills, and case management- with a strong focus on community networking and resource development. Agencies looking for a longer-term, non-intensive model with a community component and a focus on child well-being might find such a program a good fit.

Conclusion

There are of course limitations to an elements approach. While we focused our literature review on studies that examined one or more specific element, the findings do not lead to the conclusion that implementation of a single evidence-based element within in an in-home services approach would result in the outcomes achieved in the studies of that element, nor do they point to one or a few essential elements without which the intervention is likely to fail. It is also important to note that the inclusion of evidence-based in-home services elements does not guarantee an effective program much less an effective in-home child welfare *system*. Effective child welfare systems require, among other things, means of identifying and referring families into programs, securing resources, forging and maintaining relationships with community

providers, consistent supervision, and strong leadership to adapt to changing conditions.

The evidence-base for in-home services is evolving. Existing studies demonstrate that in-home services have been effective for some families and not for others. There is an ongoing need for evaluations that identify for whom or what types of families in-home services are most effective and what service approaches and/or components are essential to providing effective services for families/children with different needs (Al et al., 2012; Bagdasaryan, 2005; Nelson et al., 2009). Answering these questions will require better population definition, service targeting, and much more detailed delineation of the components of the intervention and specific worker activities. Our proposed matrix of evidence-based elements of in-home services is not meant to diminish the importance of these inquiries. At the same time, there will always be a need for a flexible approach to program improvement. It is our hope that additional research may contribute to refinement of evidence-based in-home services elements, and that an elements approach can serve as a complement to efforts to better understand what works in child welfare in-home services.

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Table 1. Evidence-Based Elements of Child Welfare In-Home Services

Elements of In-home Services	Supported Outcomes [1]	Evidence Base
Family-centered, strength-based case planning, including family decision-making	[A]-Placement prevention [B]-Maltreatment [C]-Family functioning [D]-Family cohesion	[A] Crea et al., 2008 [A B]-MacLeod & Nelson, 2000 [A, C]-Meezan & McCroskey, 1996 [D]-Pennell & Burford, 2000
Targeting services to in-home populations	[A] Placement prevention [B] Successful program completion [C]-Re-entry [D]-Maltreatment [E] Family Well-being [F]-Participation in services [G]-Family Functioning	[A] Al et al., 2012 [B]-Bagdasaryan, 2005 [A]-Bitonti, 2002 [C]-Courtney, 1995 [A]-Kirk & Griffith, 2004 [F]-Littell & Tajima, 2000 [D, E] MacLeod & Nelson, 2000 [G] Meezan & McCroskey, 1996 [A, D]-Westat, 2002 [A]-WSIPP, 2006
Comprehensive assessments of family strengths and needs	[A]-Living conditions/safety [B]-Decision-making [C]-Service Matching/Risk level	[A]-Berry, 1992 [B]-Johnson et al., 2006 [C]-Meezan & McCroskey, 1996 [C]-Thleman & Dail, 1992
Emphasis on family engagement and voluntary services	[A]-Placement prevention [B]-Family functioning [C]-Recurrent maltreatment [D]-Collaboration/compliance [E]-Engagement	[A, B]-Berry, Cash, & Brook, 2000 [A]-Bitonti, 2002 [A]-MacLeod & Nelson, 2000 [C]-DePanfilis & Zuravin, 2002 [D]-Littell & Tajima, 2000 [E]-Kaplan & Rohm, 2010 [E]-Loman & Siegal, 2004; 2006

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[1] Outcomes supported by research literature in this column correspond by letter to the references listed in the evidence base column.

Elements of In-home Services	Supported Outcomes [2]	Evidence Base
High quality worker-client relationship	[A]Good/effective worker-client relationships [B]Parenting skills [C]Length of stay in child welfare [D]Reunification	[A]de Boer & Coady, 2007 [A]Drake, 1994 [B]Lee & Ayón, 2004 [A]Ribner & Knei-Paz, 2002 [C, D]Ryan et al., 2006
Culturally competent models	[A]Racial disproportionality in placement	[A]Kirk & Griffith, 2004
Case coordination	[A]Subsequent referral [B]Child mental health [C]Engagement	[A]Antle et al., 2009 [B]Bia, Wells, & Hillemeier, 2009 [C]Dawson & Berry, 2002
Matching services to population and individualized services	[A]Family functioning [B]Placement prevention [C]Maltreatment	[A]Berry, 1992 [A]Berry, Cash, & Brook, 2000 [A]Meezan & McCroskey, 1996 [B, C]Ryan & Schuerman, 2004 [B, C]Westat, 2002
Intensity/Duration of service fits family needs	[A]Maltreatment [B]Placement prevention [C]Family care skills [D]Family functioning/child well-being [E]Foster care reentry [F]Worker-Client relationship	[A]Al et al., 2012 [B]Bagdasaryan, 2005 [B, C]Berry, Cash, & Brook, 2000 [B]Bitonti, 2002 [A, B]Chaffin, Bonner, & Hill, 2001 [D]Cash & Berry, 2003 [E]Courtney, 1995 [B]Kirk & Griffith, 2004 [F]Lee & Ayón, 2004 [A, B]Littell & Schuerman, 2002 [A]MacLeod & Nelson, 2000 [D]Rofuth & Connors, 2007 [A, B]Schuerman, Rzepnicki, & Littell, 1994 [A, B, D]Westat, 2002

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[2] Outcomes supported by research literature in this column correspond by letter to the references listed in the evidence base column.

Elements of In-home Services	Supported Outcomes [3]	Evidence Base
Availability and use of interventions aimed at specific parent/family/child issues (problem-specific services)	[A]-Family Functioning [B]-Maltreatment [C]-Placement prevention	[A]-Berry, 1992 [A]-Berry, Cash, & Brook, 2000 [A]-Littell & Schuerman, 2002 [A]-Meezan & McCroskey, 1996 [B, C]-Ryan & Schuerman, 2004 [B, C]-Westat, 2002
Direct teaching/coaching, problem solving skills	[A]-Family functioning [B]-Placement prevention [C]-Maltreatment	[A]-Berry, 1992 [A]-Berry, Cash, & Brook, 2000 [C]-Chaffin, Bonner, & Hill, 2001 (mentoring) [B]-Hanssen & Epstein, 2007
Accessing and use community resources and increasing social support	[A]-Family functioning [B]-Collaboration [C]-Placement prevention	[A]-Berry, 1992 [A]-Berry, Cash, & Brook, 2000 [B]-Littell & Tajima, 2000 [C]-MacLeod & Nelson, 2000
Availability of concrete services (cash assistance, housing, emergency needs, recreation, respite)	[A]-Family functioning [B]-Placement prevention [C]-Maltreatment [D]-Collaboration	[A]-Berry, 1992 [A]-Berry, Cash, & Brook, 2000 [B, C]-Chaffin, Bonner, & Hill, 2001 [B, C] Littell & Schuerman, 2002 [D]-Littell & Tajima, 2000 [A]Meezan & McCroskey, 1996 [B, C]Ryan & Schuerman, 2004 [B, C] Schuerman, Rzepnicki, & Littell, 1994 [B, C]Westat, 2002

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[3] Outcomes supported by research literature in this column correspond by letter to the references listed in the evidence base column.

Table 2. Evidence-Based Elements in Five Models of Family Centered In-Home Services

Evidence-based elements	Five Models of Family Centered In-Home Services				
	Intensive Family Preservation Services	SafeCare®	Family Connections	Solution-Based Casework	Multisystemic Therapy-CAN
Family centered/strength-based/family systems approach; family involvement in decision-making	The family is the focus of attention. Services are determined based on needs and preferences of the family	The focus is on parents and teaching parenting skills	Services are family-centered; service planning includes assessment of family strengths and maximizing strengths	Uses family-centered approach; family included in developing solution-focused case plan	Treatment is family-focused, delivered in home and/or other contexts relevant to the child/family; collaborative relationships with family and stakeholders are key
Target services to in-home populations	Families facing imminent risk of child placement or families working toward reunification	Families considered to be at risk of or with history of child maltreatment	Families considered to be at risk of child maltreatment (use of screening criteria at least one type of neglect and at least two additional risk factors)	Families with history of child maltreatment	Child maltreatment (especially physical abuse) in the last 180 days and where child is still residing in the home or being reunified
Comprehensive assessment of family strengths, needs, safety	Use of assessments that tap into family strengths and needs (e.g., Family Assessment Form,	Observational checklists are used to assess health, safety, parenting activities and parent-child interactions. Areas	Comprehensive family assessment instrument used to identify risk and protective factors associated with child maltreatment	Assessment of family needs and strengths. Develop plan to avoid situations that trigger negative behavior patterns,	Assessments used to identify factors driving clinical problems and then to guide selection of evidence-based

Evidence-based elements	Five Models of Family Centered In-Home Services				
	Intensive Family Preservation Services	SafeCare®	Family Connections	Solution-Based Casework	Multisystemic Therapy-CAN
	North Carolina Family Assessment Scale). Services include a safety assessment and planning.. IFPS providers are available on a 24/7 basis for crisis intervention and teaching clients self-management to enhance safety.	of strengths are identified and reinforced while problem behavior/needs are addressed through in-home training sessions. Intervention focus is identifying home safety hazards and providing training in home safety and parent skills to reduce risk of maltreatment		and interrupt patterns if not avoided, and develop a back-up plan to "escape" if the plan fails	interventions that fit the problems. Use of extensive safety protocols aimed at preventing re-abuse and child's placement.
Emphasis on family engagement/voluntary services offered at time of assessment	IFSP providers focus on client engagement and increasing motivation to change; no specific data regarding voluntary services	No specific data regarding voluntary services	Establishing a helping alliance with client is among the guiding principles; FC typically offered as a voluntary family support service	Engagement is core component of model; no specific data regarding voluntary services	Family engagement is a key feature of MST models; no specific data on voluntary services
Culturally competent models		SafeCare has shown success with several ethnic populations.	Cultural competency is a key model component		

Evidence-based elements	Five Models of Family Centered In-Home Services				
	Intensive Family Preservation Services	SafeCare®	Family Connections	Solution-Based Casework	Multisystemic Therapy-CAN
Case management/case coordination	A single IFPS provider delivers services with the use of "backup" providers as needed. Some models use paraprofessionals to deliver "hard" services		Offers case advocacy and coordination with referral services	Case management model	MST is not a case management model but may be offered as a clinical component of in-home services
Matching services to population and individualized services	IFPS providers partner with families to provide "hard" (e.g., cash assistance, transportation) and "soft" (e.g., counseling, direct teaching) services designed to meet individual families' needs.	A common set of skill based criteria are established for each of the three SafeCare® modules (health, safety, parenting)-training is focused on addressing behaviors to help parents meet the established skill-based criteria	Comprehensive assessment is used to tailor intervention to family needs (i.e., decrease risk and increase protective factors)	Case plan is developed in consensus with family around identified needs	A clinical assessment is conducted to identify and match problems with services. MST has been adapted to serve different populations
Intensity/Duration of service optimal for family needs	Services are intensive and typically 'front-loaded' and time-limited. IFSP providers usually	Weekly 1.5 sessions offered for 18-20 weeks	One hour of face-to-face contact per week for between 3-9 months	Service intensity and duration are targeted to family needs	Services are intensive. MST clinical team members are available 24/7. Therapists carry a

Evidence-based elements	Five Models of Family Centered In-Home Services				
	Intensive Family Preservation Services	SafeCare®	Family Connections	Solution-Based Casework	Multisystemic Therapy-CAN
	have 6-10 hours of weekly contact for 1-4 months. Providers available to families 24/7. Low case loads of 2-6 families per provider allow for greater intensity.				maximum caseload of 4 and duration of services ranges from 6 to 9 months.
Availability and use of interventions aimed at specific parent/family/child issues	Services are tailored to the need of each family	Services designed to improve parenting behaviors with a specific focus on health, safety, and parent-child interaction-the focus of training may be individualized to specific client need to meet a standard set of skills applied to all clients	Delivers individually tailored services aimed at decreasing risk and increasing protective factors	Case plan is developed in consensus with family around identified needs-goal development and services is match to identified needs	Services are individualized to meet the needs of family and children
Direct teaching/coaching, problem solving skills	IFPS provide direct teaching and mentoring including teaching a range of life	Direct teaching, coaching, and modeling skills are primary intervention model. Training	Direct therapeutic services are offered. Empowerment approach used to teach families how	Service plans include developing and teaching solutions to existing problems and	

Evidence-based elements	Five Models of Family Centered In-Home Services				
	Intensive Family Preservation Services	SafeCare®	Family Connections	Solution-Based Casework	Multisystemic Therapy-CAN
	skills based on individual needs. Teach range of life skills aimed at problem solving.	emphasizes teaching families structured problem-solving skills using a five-steps approach	to address problems.	teaching relapse prevention using established four step approach	
Accessing community resources and building social support	IFPS help connect families community resources and supports and teach them how to access supports on their own and connect to support systems		Empowerment approach used to connect and teach families how to access community resources. Emphasis on increasing social supports and involvement in recreational activities		MST-CAN helps families to build lasting social support networks
Availability of concrete services (e. g., cash assistance, housing, emergency needs, recreation, respite)	Concrete services are provided based on family needs		Emergency concrete services are offered initially and then on an on-going basis		