Parent-Training Programs in Child Welfare Services: Planning for a More Evidence-Based Approach to Serving Biological Parents

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Child welfare service agencies provide parent training as part of their legally mandated responsibility to provide services to assist families to keep their children at home or to achieve reunification. The use of parent-training programs for families in the child welfare system has undergone relatively little examination. Mental health, special education, and juvenile justice have been identifying evidence-based approaches that have demonstrated effectiveness with children and families with conduct disorders and other behavioral problems, although few of these interventions have been tested with child welfare services clientele. This article brings together evidence about the most promising programs from other child service sectors with information about the current parent training approaches in child welfare and generates a range of proposals about next steps to enhance the capacity of parent training and fulfill the high expectations set in law and practice.

Keywords: *parent training; child welfare services; evidence-based practice*

More than 800,000 children annually receive child welfare agency provided in-home services and another 230,000 children who are in child welfare supervised out-of-home care will be reunified to the home of a parent each year (U.S. Department of Health and Human Services, 2003). A sizable proportion of these child welfare services (CWS) recipients, at least 400,000 a year (U. S. DHHS, 2005), will participate in voluntary or mandated parent training. In addition, among the nearly two thirds of cases of families whose CWS cases were closed following investigation, approximately 28% (or about 448,000) will have parenting classes provided, referred to, or arranged by the child welfare agency. Parent-training programs are clearly a linchpin of governmental responsibility, first codified in 1980, to provide reasonable efforts to preserve, maintain, or reunify families who become involved with CWS.

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Effective CWS must rely on effective parent training and support—as this is the primary intervention that child welfare agencies provide in trying to preserve or reunify families. Without effective interventions there is no chance of operating an equitable child welfare system (Currie, 1997). Historically, there have been many efforts to develop and deliver effective parenting interventions. Most notably, several decades of services included homemaker services, which worked directly with parents in their own homes to teach home economics skills and provide assistance with parenting (Hutchinson & Sudia, 2002; Kadushin, 1961). Intensive family preservation programs, especially the homebuilder's model programs with their crisis-oriented, home-based, and social learning-based interventions, had relatively widespread use in the 1980s and 1990s. Their intended use is to teach enough parenting skills and coping strategies, within a month of intensive ecologically based services, to steer families out of their crisis and into a prolonged period of successful parenting. Yet the amount and model of parent training that occurs in intensive family preservation programs has been poorly documented. In any event, intensive family preservation programs have not shown robust effects in preventing the placement of children or reducing reabuse in the most rigorous statewide and national evaluations (Schuerman, Rzepnicki, & Littell, 1994; Westat, Chapin Hall Center for Children, & James Bell Associates, 2002). Intensive family preservation programs continue to be used across the United States, although with declining support. At the same time, federal funds for such programs are increasing, offering growing opportunities for instituting more effective approaches.

Toward Evidence-Based Parent Training in CWS

The search for effective parent-training programs for child welfare families has been long and slow. Berry's (1988) review of such programs includes no peer-reviewed studies of the general child welfare population. She finds a few promising efforts (Reid & Kavanagh, 1985) but argues that they lack good fit with the general CWS population because they require more resources and time than is generally available in child welfare agencies. A new generation of parent-training programs has emerged and warrants another look. This analysis builds on recent reviews of the evidence base for parent-training programs with other audiences, primarily mental health providers working with conduct-disordered children (Brestan & Eyberg, 1998; Farmer, Compton, Burns, & Robertson, 2002; Kazdin & Weisz, 1998; Nixon, 2002). This article extends these highly competent reviews and addresses additional questions germane to the evidence-directed development of parent training in CWS.

Parent training has, essentially, four components: (a) Parenting problems are assessed, (b) parents are taught new skills, (c) they apply the skills with their children, and (d) they receive feedback about that application. Some of the interventions described herein have broader goals and activities and include elements that transcend parent training (e.g., *Multisystemic Therapy*: Burchard, Bruns, & Burchard, 2002; Henggeler et al., 2003), whereas other programs do not include all primary components.

Although parent training is also a component of services to foster parents as well as biological parents (Chamberlain, 2003) and an important part of reunification services (Maluccio, Fein, & Davis, 1994; Walton & Dodini, 1999), we will not include these topics in this review. This is primarily because of the differences in the context of such training because foster parents have considerably different status, life circumstances, age, and role than do biological caregivers (Barth et al., under review).

Also ignored in this review are an emerging group of manualized and well-evaluated approaches to meeting the clinical needs of maltreated children and families. These include work with physically and sexually abused children—described in Swenson and Kolko (2002); Saunders, Berliner, and Hanson (2003); and Cohen, Mannarino, Zhitova, and Capone (2003)—that has been shown to have clinical efficacy. The need for complementary interventions to address children's difficulties is evinced by results of many other studies (Burns et al., in press; Garland et al., 2001) that indicate the substantial mental health and behavioral problems of children involved with CWS. Parent training almost certainly needs to include adequate assessment to determine the need for referral to evidence-based interventions for children's disorders as well as those for their parents. We expect that there will be many cases in which the child treatment component may be a more significant contributor to improved family functioning than will parent training alone (Barth, Wildfire, & Green, in press). Comprehensive parent-training programs also need to attend to the comorbid conditions in parents involved with CWS. Parents involved with CWS have disproportionately high rates of domestic violence, serious mental health problems, drug abuse, alcohol abuse, and problems paying for basic needs (U. S. DHHS, 2005). Many abused and neglected children show trauma symptoms. Each of these has substantial implications for parenting that need to be

addressed to achieve desired outcomes (DeGarmo & Forgatch, 1997; Oyserman, Bybee, Mowbray, & Hart-Johnson, 2004; Pears & Capaldi, 2001).

The central questions of this review are different than prior reviews and finding their answers requires a tailored approach. The questions are (a) What are the current purposes of parent-training programs in CWS? (b) What are the characteristics of parent training relevant to characteristics of families involved with CWS? (c) Which parent training and support efforts show the greatest promise for helping families involved with CWS? (d) What are the parent training and support programs now in use by CWS groups and what characterizes them? (e) Which parent training and support efforts have the greatest likelihood of being integrated into the delivery of CWS programs? and (f) How can we accelerate the development of evidence based parent-training programs?

The sources for this article include the scholarly peer-review literature, state reports and unpublished findings, Web sites for parent-training programs, national and international child maltreatment Web sites, and unpublished data from the NSCAW and the Caring for Children in Child Welfare (CCCW) study. Briefly, NSCAW is a national probability study of services for families with opened and closed cases following an investigation for child maltreatment in 92 counties (NSCAW Research Group, 2002); NSCAW includes items about the receipt of parent training answered by child welfare workers and by families. CCCW is a partner study, funded by National Institute of Mental Health, examining the organization, financing, and delivery of county-level CWS including issues about parent training in those same counties. Space constraints limit our discussion of the methods used in these studies; these are described elsewhere (Landsverk, Garland, & Leslie, in press; Mitchell et al., in press; NSCAW Research Group, 2002).

THE PURPOSES OF CHILD WELFARE–SPONSORED PARENT TRAINING

The development and implementation of effective parent-training programs requires comprehension of the diverse functions that parent training currently plays in CWS. CWS parent-training programs are expected to provide different functions than they provide in the mental health or educational systems, from which several of these programs evolved. These functions range from direct improvement of parenting to successfully negotiating the labyrinthine rules of CWS and the courts. The success of parent-training programs in achieving these functions is likely to be key to their dissemination and implementation.

Improving Parental Performance With Children at Home

The ostensible purpose of CWS parent training is to improve parenting. More than 95% of children who are reported to CWS as abused or neglected will remain in their home of origin following that report. Most reports are processed and closed following a brief telephone screening or investigation (NSCAW Research Group, 2003). Only a small proportion of children will be placed into foster care, although the public often calls the CWS agency the foster care system. Although many child abuse reports will nbe followed by court-ordered services, families frequently experience repeated reports and eventually end up receiving court-ordered services (English, Marshall, Brummel, & Orme, 1999; Kitzmann, Gaylord, Holt, & Kenny, 2003). Parent training is a routine component of judicial orders to parents. Completion of parent training is typically given as essential to the dismissal of the case. Cases are frequently dismissed, however, even if parent training is not completed, as long as parents are judged to pose no substantial and immediate threat to their children's welfare (Frame, Berrick, & Brodowski, 2000). Some estimates are that nearly half of parents who begin parent-training programs do not complete them (J. Lutzker, personal communication, April 4, 2003) and one study found an 80% dropout rate (Wolf, Aragona, Kaufman, & Sander, 1980). The intention of these programs, which aim to help keep parents and children together is to help caregivers provide a minimum sufficient level of care following their CWS case closing. This standard is much lower, in many ways, than we might expect from parent training provided as part of children's mental health services or as an adjunct to the educational system. In those cases, the goal is more likely to be to help children to achieve a normal range of functioning.

Improving Parental Performance to Achieve Reunification

Parent training is also often required of parents who are no longer caring for their children on a day-to-day basis. Although teaching parenting skills when the child is in absentia presents special challenges to parent trainers, these families and those who are still caring for their children at home are very often combined together in parent-training programs. Parents are also primarily

trained prior to their children's return home (Barth, Blythe, Schinke, & Schilling, 1983). In rare cases, reunification parent training is a well-structured in-home service provided after the children return home (Walton, 1998). Completion of parent training, however delivered, is often considered to be a critical component of achieving family reunification.

Monitoring Parental Commitment and Safety

Parent training is also intended to provide information to the child welfare agency and juvenile court about the progress of families and their apparent motivation to change. Although completion of parent training does not assure a favorable resolution of cases for biological parents (i.e., that the child welfare complaints will be dropped, cases will be closed, or children will be reunified), the failure to complete parent training may still be grounds for an unfavorable case resolution for the biological parent (W. Jones, personal communication, June 21, 2003). Murphy and Bryant's (2002) chronicle of the key issues in providing leadership to a parenting group indicates the substantial impact that parent training has in documenting whether parents are compliant with the court order to attend and to complete parent training. For example, much dialogue between the coleaders and between the leaders and clients focuses on whether credit will be given for course attendance if clients are late for class. Whereas parent trainers typically do provide an accounting of the attendance of each caregiver, we see little evidence of reports by parent trainers about changes in parental competence. Inquiries to child maltreatment listservs identified only one program—involving the reporting of competencies learned in *Parent-Child Interaction Therapy*—that had a systematic way of assessing and communicating information about parenting as part of the legal process.

Assessing Parent's Cooperation and Engagement

Programs that provide more varied approaches to client engagement, that meet families at home instead of in a clinic, and that have less precise time and duration requirements until program completion may be less able to dispassionately observe some aspects of parent compliance and cooperation. Because we understand that the child welfare worker's perception of client cooperation shapes the future of the case (English, Marshall, Coghlan, Brummel, & Orme, 2002), we recognize that the parent trainer may have a significant role communicating to the child welfare worker about parent cooperation. Assessing the motivation and ability of the parent to provide a consistent level of safe care to children is not a trivial concern, but this assessment should primarily be the responsibility of the child welfare worker, not that of the parent trainer. The development of a relationship between client and clinician has long been understood as critical to parent training (Patterson & Chamberlain, 1988; Patterson & Forgatch, 1985; Wachtel, 1977). Parent trainers need to have the freedom to engage families in the process of change and not worry that this effort might contaminate their assessment of a client's motivation.

There are undoubtedly other functions of parent-training programs in CWS. One of these is to screen for significant problems likely to affect parenting—especially, substance impairment or intimate partner violence. Another apparent function of parent training is to explain the way that the child welfare system operates, so that parents understand the respective roles of the child welfare agency, courts, guardian ad litems, and legal mandates (Murphy & Bryant, 2002). Although this function should be addressed by child welfare workers rather than parent trainers, accurate explanations of CWS functions by parent trainers may serve to engage caregivers in the change process and reduce their alienation from the process (Dawson & Berry, 2002).

CHARACTERISTICS AND PARENTING PROBLEMS OF MALTREATING PARENTS

Interventions are generally assumed to be based on an analysis of the underlying epidemiology of the problem (Rothman & Thomas, 1994). Yet little evidence has accumulated about the parenting problems of caregivers involved with CWS. It seems obvious that parents involved with the child welfare system have parenting problems, although only 33% of caregivers who are caregivers of allegedly maltreated children are identified by child welfare workers as having poor parenting (see Table 1). Among these biological parents, only about 1 in 12 are identified with the problem of using excessive discipline. About one third are identified as lacking the motivation to change. Rates of problems with parenting among caregivers of children currently receiving CWS are about one third higher than for those of all children, and rates among caregivers attempting to get their children back were about twice what they were for parents whose children

TABLE 1: ***Parenting Problems of Caregivers of Allegedly Maltreated Children***

	Setting															
	For Biological Children In-Home								*For Biological Parents of Children Now in Out-of-Home Care*							
	*Total**		*No On-Going CWS*		*Open CWS*		*Total In-Home**		*Foster Care*		*Kinship Foster Care*		*Group Care*		*Total Out-of-Home**	
	%	*SE*	*%*	*SE*	*%*	*SE*	*%*	*SE*	*%*	*SE*	*%*	*SE*	*%*	*SE*	*%*	*SE*
Poor parenting	33.2	1.9	20.4	2.3	47.4[a]	2.6	27.6	2.0	85.3	2.2	79.7	4.0	79.9	6.7	79.1[b]	2.3
Unrealistic expectations	17.4	1.2	9.4	1.3	28.1[c]	2.0	14.4	1.2	51.7	3.8	35.0	6.3	64.7	10.9	43.6[d]	2.6
Improper or excessive discipline	8.3	0.8	4.9	1.2	12.9[e]	1.6	7.0	0.9	23.6	2.2	16.2	2.5	18.7	6.1	18.8[f]	1.5
No motivation to change excessive or improper discipline	35.1	3.2	21.5	5.7	29.3	4.5	25.0	4.0	77.4	5.2	71.8	8.5	81.5	9.1	71.6[g]	3.6

NOTE: CWS = child welfare services.
a, c, e = Open CWS cases are significantly more likely to indicate parenting problems than closed cases ($p < .01$)
b, d, f, g = Parents with children in out of home care were significantly more likely than those receiving in-home services to be rated as demonstrating parenting problems ($p < .01$).
*Total includes a small percentage of placements in other types of facilities—these are included in the total percentage.

TABLE 2: ***Proportion and Standard Error of Parent Training by Child Maltreatment for All In-Home Cases***

	Physical Maltreatment		Sexual Maltreatment		Neglect: Failure to Provide		Neglect: Failure to Supervise		Total: Proportion of Parents Receiving	
Parent-Training Type	*%**	*SE*	*%**	*SE*	*%**	*SE*	*%**	*SE*	*%**	*SE*
Conventional parent training	25	3.5	30	5.5	26	4.0	30	2.8	27	1.8
Intensive family preservation services	7	1.7	3	1.0	8	1.7	10	2.7	8	1.0
Family preservation	12	3.5	15	4.5	14	3.2	14	2.7	13	1.4
Total any of above	28	3.4	32	5.3	28	3.7	32	2.9	30	1.6

TABLE 3: ***Most Serious Type of Abuse of Children Involved With the Child Welfare System by Age***

	Physical Maltreatment		Sexual Maltreatment		Neglect: Failure to Provide		Neglect: Failure to Supervise		Other		
	*%**	*SE*	*%**	*SE*	*%**	*SE*	*%**	*SE*	*%**	*SE*	*Total*
Age											
0 to 2	22.6	2.2	6.1	1.7	29.9 [a, b]	2.5	36.6 [c]	3.0	4.8	1.7	100
3 to 5	23.6	2.9	12.8	2.8	23.8	3.8	30.3	2.6	9.5	2.3	100
6 to 10	31.2 [d]	2.6	11.1	2.4	18.9	2.4	26.1	2.4	12.7 [e]	2.1	100
11+	32.7	3.1	14.9 [f]	2.1	12.7	2.3	29.7	2.5	10.0	1.8	100
TOTAL	28.4	1.5	11.5	1.2	20.4	1.5	29.8	1.5	9.9	1.2	100

SOURCE: U.S. DHHS, 2005.
* Percentages may not total to 100 because of rounding.
a. Children 0 to 2 are more likely than children 6 to 10 to have a most serious abuse type of failure to provide ($p < .01$).
b. Children 0 to 2 are more likely than children 11+ to have a most serious abuse type of failure to provide ($p < .001$).
c. Children 0 to 2 are more likely than children 6 to 10 to have a most serious abuse type of failure to supervise ($p < .01$).
d. Children 6 to 10 are more likely than children 0 to 2 to have a most serious abuse type of physical maltreatment ($p < .01$).
e. Children 6 to 10 are more likely than children 0 to 2 to have a most serious abuse type of Other ($p < .01$).
f. Children 11+ are more likely than children 0 to 2 to have a most serious abuse type of sexual maltreatment ($p < .001$).

remained at home. This suggests that combining open and closed in-home cases or in-home and out-of-home cases in parenting groups generates substantial heterogeneity with regard to motivation and issues of expectations (Smith & Howard, 1999).

Current parent training for caregivers of allegedly maltreated children may stand alone as a class or course at a local community facility to which parents are sent, or may be embedded in intensive family preservation services or family-centered in-home services. Caregivers may participate in more than one parent-training model during the course of their involvement with the child welfare system and 30% of all caregivers for in-home cases received at least one parent-training type during an 18-month period (see Table 2). These are shown by the type of maltreatment identified as the most serious type (about one in four cases had multiple types identified in the case record). The proportion of physical abuse cases that had excessive discipline as a parenting problem was far greater for physical abuse cases (15%) than for sexual abuse (1.59), failure to provide (3.25), or failure to supervise (3.67) (not shown in Table 2).

The largest group of children involved with CWS experienced neglect (failure to supervise; 30%), with neglect (failure to provide basic necessities) comprising an additional 20% (U. S. DHHS, 2005). Physical abuse is the most serious type of abuse for 28% of children, with sexual abuse accounted for 11% of the total population of children whose families experienced an investigation. Only 20% of the cases involved more than one type of maltreatment. The type of maltreatment is not associated with the likelihood that families will receive ongoing in-home services rather than have their cases closed. Physical abuse cases are, however, less likely than failure to supervise cases to result in an out-of-home placement—physical abuse cases also stay in out-of-home care the shortest time. Yet, parent-training programs in CWS are, generally, designed to address alternatives to excessive discipline.

There are also substantial interactions between age and type of maltreatment—developmental interactions that parent training should also take into account (See Table 3, from U. S. DHHS, 2005). Sexually abused children are, as might be predicted, the oldest group. Other age by

maltreatment type interactions are less well known. Children 0 to 2 are more likely than children 6 to 10 or 11 and older to have a most serious abuse type involving neglect (failure to provide) and neglect (failure to supervise). Conversely, children 6 to 10 are more likely than the youngest children to have a most serious abuse type of physical maltreatment.

Yet there is little written in the parent-training literature about working with neglecting parents, or parents of children younger than 3. Only *Project 12-Ways* has made child neglect its explicit focus. NSCAW caregivers were assessed by the child welfare worker for their risk of engaging in inappropriate discipline. Nearly 82% of all caregivers for in-home cases assessed to be at high risk for inappropriate discipline received at least one of the parent-training types. These caregivers received conventional parent training in 76% of all in-home cases and may also have recived parent traning during Intensive family preservation services in 44% of in-home cases, and family preservation in 52% of in-home cases (U. S. DHHS, 2005).

WHICH PARENT TRAINING AND SUPPORT EFFORTS SHOW THE GREATEST PROMISE?

The interventions with the greatest promise to improve the delivery of CWS are, conceivably, the interventions that have shown the greatest overall evidence of influencing children with behavioral problems. Who gets to wear the evidence-based badge varies, somewhat, by review (Chambless & Ollendick, 2001) and by rater (Levin, 2002), although there is some general consensus about the levels of evidence that do apply across studies (Kratochwill & Stoiber, 2002). This review is not intended to draw too sharp a line between the levels of intervention because none of the interventions have met the midlevel standards of evidence set by the American Psychological Association (Chambless & Hollon, 1998) for parent training for children involved with CWS.

Evaluating parenting programs for use in CWS requires the choice of a standard for determining which have an evidence base for effectiveness or, at least, which are efficacious enough to be promising programs. Hoagwood (2003) has concluded that there is currently no consensus on how to define *evidence-based* or on when the evidence base, however it is defined, is ready to be deployed, moved out, and used in community settings. Many and varied criteria are being used by the scientific community to denote evidence-based from nonevidence-based interventions (see, Thomlison's [2003] use of a four level classification for child maltreatment interventions).

The criteria identified by Chambless and Hollon (1998) and the Cochrane Collaborative (Clarke & Oxman, 2003) are commonly used to define levels of evidence, although their usefulness for this review is limited because there are no parent-training programs that meet the Chambless and Hollon's criteria for effective programs or that reach the *A* level on the Cochrane scale. There is not a single intervention that has generated a published peer-review article based on a study in which they accepted referrals from a child welfare agency, randomly assigned them to a treatment condition, and evaluated the outcome. Whereas several randomized clinical trials of parent-training interventions have included maltreated children in their samples (Reid & Kavanagh, 1985; Webster-Stratton, 1998), the intent of these studies was not to understand the effectiveness of the intervention with child welfare clientele, per se. For example, Webster-Stratton (1998) employed a randomized clinical trial to evaluate an abbreviated version of *The Incredible Years* with children in Head Start centers. Families with recent involvement with CWS for child abuse and neglect comprised nearly a quarter of the sample. The short- and long-term intervention effects were promising. One randomized clinical trial (Chaffin et al., 2004) tested an intervention with physically abused children. They were referred from CWS to *Parent-Child Interaction Training* or a standard treatment control group.

In our efforts to identify parent-training programs currently showing the greatest promise for use in child welfare settings, we established four levels of evidence based on an integration of these previously developed criteria.

We have chosen to further group the programs along two dimensions: the evidence base with child welfare like clientele and the actual use by child welfare agencies. First are the leading evidence-based parent-training interventions, which have at least some evaluation using randomized clinical trials that have included children involved with CWS in their study populations (even if this was not the express group being evaluated in the randomized clinical trial). These well-established interventions meet part of the Chambless and Hollon criteria of a minimum of two randomized clinical trials with other at-risk populations and two independent replications of the research.

Although there are many ways to rank the effectiveness of intervention programs on behalf of children, a few interventions have been repeatedly highly ranked. Four interventions have been repeatedly nominated as meeting the highest standards of evidence in a variety of reviews.

These are clearly the leading evidence-based parent-training programs. *The Incredible Years* (Webster-Stratton & Hammond, 1997), *Multisystemic Therapy* (Henggeler et al., 2003), Oregon Social Learning Center's *Parent Management Training* (Forgatch & Martinez, 1999; Patterson, Chamberlain, & Reid, 1982), and *Parent-Child Interaction Training* (Eyberg & Robinson, 1982). The many evidence-based reviews that cite these programs indicate substantial consensus about their high ranking. These reviews include: *U.S. Office of Juvenile Justice and Delinquency Prevention Bulletin* (Mihalic, Irwin, Elliott, Fagan, & Hansen, 2001, *The Incredible Years*, *Multisystemic Therapy*, *Parent Management Training*, and *Parent-Child Interaction Training*), *Journal of Child Clinical Psychology* (Brestan & Eyberg, 1998; *Parent Management Training*, *The Incredible Years*, *Multisystemic Therapy*, and *Parent-Child Interaction Therapy*); *Journal of Consulting and Clinical Psychology* (Farmer et al., 2002: *The Incredible Years* and *Multisystemic Therapy*; Kazdin & Weisz, 1998: *Parent Management Training*, *Multisystemic Therapy*); the Center for Evidence-Based Practice's *Young Children with Challenging Behavior*, funded by the U.S. Office of Special Education Programs (Dunlap, Strain, & Kern, 2003; *The Incredible Years*); and *Clinical Psychology Review* (Nixon, 2002; *Parent-Child Interaction Therapy*, *Parent Management Training*).[1]

Time and family-tested parent-training programs described above are poised for adaptation for greater use with CWS. Each has already had clinical trials that included maltreated children. Although only *Parent-Child Interaction Therapy* has met the most stringent criteria for effectiveness—involving randomized clinical trials with a target population of maltreated children—the evidence from studies on each of these interventions points to their likely success with CWS families. This evidence, developed during as long as three decades of study, positions these interventions as the most promising starting points for the rapid development of effective interventions with maltreating families.

Possibly efficacious and commonly used in child welfare are the programs in the next classification and are composed of interventions working with the target population of child welfare cases and employing quasi-experimental designs or a series of single-subject designs. These designs have the capacity to show substantial likelihood of benefit but are not sufficiently definitive. We find only four interventions that fall into this second level—*Parenting Wisely* (Gordon, 2003), *Nurturing Parent* (Bavolek, 2002), STEP (Adams, 2001), and *Project 12-Ways* (Lutzker & Rice, 1984). Each of these parent-training programs has been used in substantial amounts of research with child welfare populations; however, the research designs would only meet the level of evidence for a grade of *B* or *C* using the criteria of the Cochrane collaboration (Clarke & Oxman, 2003). This would include those using single-subject designs, matched comparison control groups, pretest and posttest designs, consumer satisfaction surveys, and evaluations for master's theses. The strength of the methodology varies significantly within this category and some evaluations have shown treatment improvements using standardized measures (Eyberg Child Behavior Inventory: Eyberg & Pincus, 1999). Yet the evaluations at this level allow many challenges to the findings. These programs are what we might call welcomed and promising parent-training programs because they have met the test of implementation (perhaps better than they have met the test of evidence). From our preliminary CCCW interviews, STEP appears to be commonly used in child welfare agencies, but the more than 40 evaluations of STEP are primarily those done as master's or doctoral theses and have not been rigorous or focused on child welfare populations.

The *Parenting Wisely* (Kacir & Gordon, 1997) Web site indicates that it has been selected as a Substance Abuse and Mental Health Services Administration and Center for Substance Abuse Prevention and Office of Juvenile Justice and Delinquency Prevention model program and is in use in nearly every state. Yet a review of the research articles presented show no rigorous evaluations involving a randomized or quasi-experimental clinical trial. The research reports provided by the developers on the use of *Parenting Wisely* include applications with high-risk populations (e.g., teenage parents, parents with children with conduct disorders, and poor families in Appalachia), but none with child welfare populations appear.

Project 12-Ways has not had widespread use but has undergone a long period of testing. This approach has been in operation for nearly two decades, in partnership with CWS in Illinois and, more recently, in California and Oklahoma. Although the evidence base consists, largely, of a series of single-subject designs showing that social and cognitive principles (Bandura, 1976) can work with multiproblem families who are being served at home, several quasi-experimental studies also support the efficacy of *Project 12-Ways* (Lutzker, Tymchuk, & Bigelow, 2001). "The effect of the program . . . is supported by a pattern of findings, including both liberal and, more importantly, conservatively biased quasi-experimental comparison studies. To date, the SC/12 model has been

implemented by small-scale university-affiliated projects using high levels of protocol adherence and service monitoring. The model has not been disseminated on a large scale to actual agency settings" (M. Chaffin, personal communication, June 18, 2003).

A third classification of programs is conventional child welfare parent training including those ad hoc programs that operate in many agencies and have virtually no evaluation support. These classroom-based interventions would be described in the Cochran collaborative literature as interventions with expert opinion without critical appraisal (Clarke & Oxman, 2003). A literature review of these parent-training interventions revealed limited, if any, efforts to demonstrate program effectiveness with child welfare cases. Yet these programs appear to be meeting other standards that are also important to the dissemination of evidence-based interventions. They are interventions that have enough face validity to have gained agency adoption; have features that have allowed them to be broadly used, including the development of manuals and Web sites; and have been tailored to the time, resources, and trainer skill levels that child welfare agencies now have available for parent training. Some relatively well-disseminated interventions are omitted from our review—most purposively, corrective attachment therapy—because this approach has an unacceptably high level of risk (Saunders et al., 2003).

These interventions, and some key descriptive dimensions, are shown in Table 4. The dimensions include the age and population focus of the studies on which the evidence base was primarily developed; the setting, duration and goals of the intervention (including whether the child is involved as a participant in the parent training); how the training is delivered (e.g., whether there is a manual or an engagement component, and how training is supervised); and evidence of application of the methods to multiple cultures. The table also offers estimates of the approximate program length (ranging from 6 sessions to 11 months) and the approximate cost per parent (ranging from about $100 per family to as much as $4,500).

The previously described classification of evidence-based interventions is supported by work in progress from a major forthcoming meta-analysis of interventions for emotional or behavioral problems under way by John Weisz and his colleagues. *Parent Management Training*, *The Incredible Years*, and *Parent-Child Interaction Therapy* have each been examined in at least one published, peer-reviewed, randomized, between-group design study, and they have each shown efficacy with youth conduct problems (J. Weisz, personal communication, August 8, 2003). *Parenting Wisely*, *Nurturing Parent*, *Project 12-Ways*, *STEP*, *Active Parenting*, *Parenting 123*, *Love and Logic*, and *Common Sense Parenting* were all excluded from this review because their efficacy (or lack thereof) has not been examined and reported in at least one published, peer-reviewed, randomized, between-group study design.

PARENT-TRAINING INTERVENTIONS WITH SIGNIFICANT USE BY CHILD WELFARE AGENCIES

Although we do not yet have national probability data about the types of training programs used by providers working with CWS clientele, early results from CCCW interviews with key informants in counties indicate that respondents repeatedly nominated several interventions. These were largely confirmed by responses to our email queries and internet searches. These are *Parenting Wisely*, *Common Sense Parenting*, *Love and Logic* (Cline & Fay, 1990), and *STEP* (Adams, 2001). Each has met some basic requirements of programs that become widely implemented. We draw on Gordon and Stanar's (in press) review and our own experience to indicate areas that may make them easily accessible. For example, they all have Amazon.com accessible manuals, have good administrative support, have enough face validity to convince program managers to try them out, have acceptable on-the-ground performance to garner continued use, and provide a modicum of reassuring basic evaluation data.

Common components of these programs should be considered for their value in indicating characteristics of programs that will be incorporated into child welfare agencies. Among them are brevity, low cost per family, not requiring advanced degrees for trainers, applicability to families with children at home and those endeavoring to achieve reunification of their out-of-home children, and concepts that are easy to communicate. Although we lack empirical evidence on this point, part of the ease of communication results from not requiring people to change parenting practices very much. Approaches such as *Love and Logic* emphasize that parenting can be fun and that by choosing your battles and giving up some control, parents often gain more influence. This is an appealing message to deliver and receive, and may lead to some reductions in aversive parenting practices. Although this program lacks scientific support, the substantial sales of *Love and Logic* materials to the lay public and via parent trainers evinces the appeal of their message. One CWS agency supervisor indicated that *Love and Logic* is used in all parenting groups in her midsized county, regardless

(text continues on p. 366)

TABLE 4: ***Relevance of Clinical Trials Research to Parents and Children Receiving Child Welfare***

Programs and Citations to Key Studies	*Research Design*	*Age and Population Focus*	*Setting, Duration and Goals of Intervention*	*Training Resources*	*Use With Varied Cultural/Ethnic Groups*	*Cost*
Leading evidence-based parent training						
Parent-Child Interaction Therapy Eisenstadt, Eyberg, McNeil, Newcomb, & Funkerburk (1993) McNeil, Eyberg, Eienstadt, Newcomb, & Funderburk (1991)	Randomized clinical trial with behavior problems Randomized clinical trials with physical abuse[a]	Age 3 to 9 Young children with behavior problems	Clinic (optimal setting with two-way mirror and microphone device so therapist (coach) is in another room; 14 weekly, 1-hour sessions Builds parent skills for reducing behavior problems and addresses family relationships Parent and child engaged in therapy	Prescribed treatment process Has engagement and assessment components Master's-level therapist trained in Parent-Child Interaction Therapy www.pcit.org	No differences across ethnic groups[b]	$3,638 per family[c]
Parent Management Training Patterson, Reid, & Eddy (2002)	Numerous randomized clinical trials	Age 3 to 18 Children with conduct problems	One to one 9 weekly 2-hour sessions No direct child involvement, except some supervised use of time-out	No manual for in-home services, although Living with Children,[d] Families[e], and Parents[f] and Adolescents Living Together may serve that function www.oslc.org	Not available	Mean cost per family is $318 (supervision and assessment costs not included)
The Incredible Years Webster-Stratton (1984) Webster-Stratton (1998) Webster-Stratton & Hammond (1997)	Six randomized clinical trials by developers Five independent replications with children with conduct problems	Age 2 to 8 Research is with 2 to 8 age group; age range for the programs: 2 to 7, 4 to 10, and 5 to 12 Young children at risk of exhibiting conduct problems	Community setting Group format 22 weekly sessions, 1.5 to 2 hrs per session Parent, teacher, and child component Builds parent and teacher skills for reducing problem behavior in home and classroom Child involved	Video-based series Groups led by trained therapists www.incredibleyears.com	Effective with multiethnic families Videos available in Spanish and British dialect	Cost for parent training: about $600; child training: about $240 per child, including videos[g]

Multisystemic Therapy Borduin et al. (1995)	Numerous randomized clinical trials with adolescents with conduct disorder	Age: adolescent Adolescents with severe behavior problems, at risk for out-of-home placement	Home with therapist available 24 hrs a day, 7 days a week Average length of duration: 4 months Adolescent involved	Published treatment manual[h] Clearly defined assessment process Ongoing, active engagement Master's level or bachelor's level with supervision by master's level 5-day intensive training, booster trainings, and ongoing telephone consultation www.mstservices.com	Yes	$4,500[i]
Possibly efficacious and commonly implemented child welfare populations						
Parenting Wisely Kacir & Gordon (1997) Kacir & Gordon (1999)	Eight controlled evaluations, one with court mandated parents (juvenile justice or children's services)	Age: 8 to 18 Delinquent or at-risk youth	Home or group Computer-based Builds parent skills for reducing problem behavior, addresses family relationships, and promotes support at school and with peers Children and parents use the program together	Program on computer disk and available on video No training for service providers necessary www.familyworksinc.com	Identified on Web site as appealing to African American, Hispanic, and White families	$599 for materials for five ($120 each)
Nurturing Parent Bavolek (2002)	Pre- and posttest design using standardized measures Evaluation of nurturing parenting program for adolescents included child welfare population	Separate components for birth to 5, 5 to 11, and adolescents Families with risk or histories of abuse and neglect	Group format or home-based 12 to 45 weeks Parent-child activities are included in each weekly session	Assessment done with standardized tests Program manual, parent handbooks, and videotapes Professionals and paraprofessionals, 2- to 4--day instructor workshops www.nurturingparenting.com	Programs for Hmong, Hispanic, and African American families	Cost of group $1,000 to $2,000, plus staff time

(continued)

TABLE 4 ***(continued)***

Programs and Citations to Key Studies	*Research Design*	*Age and Population Focus*	*Setting, Duration and Goals of Intervention*	*Training Resources*	*Use With Varied Cultural/Ethnic Groups*	*Cost*
Project 12-Ways Lutzker, Bigelow, Doctor, & Kessler (1998)	Single-subject designs With families at high risk for child abuse or neglect, including referrals from Department of Children and Family Services	Involvement with CWS[j]	Home and community settings One-to-one format 19 sessions, 1 to 2 hrs long Builds parent skills for reducing problem behavior and addresses family relationships Includes counseling, alcoholism referral, job finding, money management, health and safety training	Book describes the most recent version of the program (includes Project 12-Ways and Project SafeCare)[k] Recommend graduate assistants but none required http://www.p12ways.siu.edu/	Video available for Spanish project care	Not available
STEP Gibson (1999) Fennell & Fishel (1998)	Multiple studies (40+) with wide range of methodology: master's thesis, quasi-experimental and populations Pre- and posttest control group design with small sample of abusive parents (Note: n = 10 in treatment group; n = 8 in control group)	Not for children with psychological problems	Group format 9 weekly 1.5 hr sessions	Leader's resource guide, parent handbooks, and videocassettes No training is required but 1-day workshops available http://www.agsnet.com/Group.asp?nGroupInfoID=a16200	Complete set of resources available in Spanish	STEP complete set $389
Conventional child welfare parent training						
Active Parenting	Not Available	Age 5 to 12 No specific population targeted	Group format with videos Online groups also available Six sessions Child not involved	No assessment or engagement process No training required www.activeparenting.com	Web indicates that 2001 version of video series uses multicultural families[l]	Not available
Parenting 123	Not available	Age 2 to 12 Typically developing children (vs. children with behavior problems)	Community setting Group format	Books, audio, and video No training required www.thomasphelan.com	Not available	$295 for group, plus trainer costs
Love and Logic	Not available	Not available	Group 12 to 15 hours	Parent handbooks, instructional videocassettes, and transparencies No engagement process No training required www.loveandlogic.com	Video in Spanish, but no plans to develop languages[n]	$500 for materials for a group of 10

Common Sense Parenting Ruma, Burke, & Thompson (1996)	Pre- and posttest using total problem t score from Child Behavior Checklist Children ages 2 to 16 years (n = 206) All age groups improved	Age 2 to 16	Clinic and community Group format Six 2-hr sessions Builds parent skills for reducing problem behavior and addresses family relationships	Curriculum-based video tape series No educational requirements 4-day training of parent trainers www.girlsandboystown.org	Said to be effective across racial and socioeconomic groups Spanish version of video tape available	Not available
Generic	Not available	Unspecified	Community setting 6 to 10 sessions Child not involved	Relies on court order to motivate participation Trainer education varies Contract with community agency; child welfare workers on site Children's mental health clinic	Unclear	> $100

NOTE: CWS = child welfare services.
a. Chaffin et al. (2003)
b. Chaffin et al. (2003)
c. Chaffin et al. (2003)
d. Patterson (1976)
e. Patterson (1975)
f. Patterson & Forgatch (1987)
g. www.incredibleyears.com/products/prices.htm
h. Henggeler, Schoenwald, Borduin, Rowland, & Cunningham (1998)
i. Mihalic, Irwin, Elliott, Fagen, & Hanson (2001)
j. http://www.p12ways.siu.edu/eligibility.htm
k. Lutzker & Bigelow (2002)
l. www.activeparenting.com
m. www.thomasphelan.com/123LeadersGuide.html
n. www.bveandlogic.com/Pages/0600faq.html/#languages

of children's age or presenting problems, because everyone seemed to like it and no one had complained. The importance of this appeal should not be lost on those endeavoring to develop evidence-based and popular approaches.

These programs also commonly omit key elements from the general approach of the evidence-based parent-training programs cited above. There is no assessment of the reasons that families became involved with child welfare and building of instructional material based on that assessment. There is no *in vivo* parent training in the home or with children in real-world settings. There is almost no flexibility about the length of services provided. Existing programs are indiscriminant about which ages and diagnostic categories of children they are able to serve. They offer a predetermined program length that is unaffected by the needs of the family. These programs also have the common feature of not having been subjected to rigorous evaluation (evidence-based evaluation standards of Burns & Hoagwood, 2002).

DIRECTIONS FOR THE FUTURE

The field must better understand what child welfare agencies currently expect from parent-training programs and what they are willing to offer, in time and resources, to transform the current approaches to something more effective. At this time, agencies may have one, two, three or more parent-training offerings. Almost every agency would seem to have basic classroom-centered parent training; some also have home-based homemaker chore services, although these are dwindling fast (Hutchinson & Sudia, 2002); some offer flexible and somewhat open-ended family-based services that mix systems therapy and case management; and some offer behaviorally oriented intensive family preservation training. Although the cost data for parent-training programs is not easily obtained or compared, there is little doubt that the evidence-based parent-training programs suggested here as deserving of child welfare trials would fall along the more intensive and expensive side of this array. If agencies are to implement these programs, they will need to reallocate some resources away from conventional parent training. This could be done by not prescribing parent training to so many families—instead, focusing on those families in which children's problem behavior and evidence of poor parenting skills are clearly evident. This would have to be supported by the juvenile court, given their historic referral of the preponderance of families to classroom-centered parent training as well as the CWS agency.

The transition to using these interventions with maltreatment will not be seamless, however, because they have been developed to address the needs of children who are referred with disruptive behavior, whereas child welfare-oriented parent training focuses on parents who are identified as having provided inadequate parenting. As an example of the complication that such a transition requires, the *Parent-Child Interaction Therapy* intervention tested successfully in Chaffin et al. (2004) had to be modified because many children did not show high enough rates of disobedient behavior, which reduced the value of the bug-in-the-ear coaching (M. Chaffin, personal communication, June 18, 2003). Other strategies had to be developed to teach parenting skills. Still, these interventions have substantial promise and should be reviewed for ways to realize that potential.

If the court does expect parent training to meet the obligations described above—to use parent training as a test of parental commitment, cooperation, and organization—then some other mechanism must be developed to do that. Haight et al. (2002) argue that parent training should be separated from standard observed visiting between parent and child, with the latter providing functions related to case management and material for recommendations for court. Although information from parent trainers should, arguably, be used more centrally in making court recommendations, this could be accomplished with better measurement of changes in parent and child behavior that occur, with less reliance on the formalities of attendance and punctuality (Murphy & Bryant, 2002). This would also allow parent trainers to do their utmost to engage parents, a fundamental requirement of helping people change when they are under massive legal and personal pressure (Dawson & Berry, 2002).

One of the requirements for designing fully effective child welfare parent-training programs may be to step outside the conventional way of thinking—that is, that we wait for the court to mandate parent training and then start from scratch providing it—and find a more integrative way to offer this intervention. Walton's (2001) work on integrating the initial assessment of parents with intensive family preservation services is an exemplar. Perhaps, evidence-based parent training can become part of the new generation of timely and responsive services that CWS is striving for. Additionally, the configuration of parent training that a family might need can be identified by parent trainers involved with the initial investigation and included in the subsequent recommendation to the court.

Despite the easy-to-generate disdain for all things unexamined, we would do well to learn from clinicians

and consumers involved with existing interventions (Bickman, 2002). Some of the strong features of the existing and unstudied efforts that dominate child welfare might also befit the next generation of parent-training models.

It is necessary to bring a developmental sensitivity to the interventions by arraying interventions by ages that available interventions have successfully addressed, at least for other populations, and those that need to be developed. Age is a very salient factor in parent training (Dishion & Patterson, 1992) but is largely overlooked in parenting classes used in child welfare agencies. Specifically, evidence exists of efficacy for *Parent-Child Interaction Therapy* for children 3 to 11 (Chaffin et al., 2003), *The Incredible Years* for children 4 to 8 (Webster-Stratton & Hammond, 1997), and *Parent Management Training* for children 3 to 18 (Patterson, Reid, & Eddy, 2002). Stretching the age range for programs is not a simple matter. When *Parent-Child Interaction Therapy* was implemented with children as old as 11, much thought had to be given to how to enforce time-outs with children older than 6 (the typical *Parent-Child Interaction Therapy* upper age limit). Considering alternative methods for enforcing time-out for 11-year-olds required much reflection (M. Chaffin, personal communication, June 20, 2003).

Testing future interventions should yield the answer to a very basic question about whether the 6- to 10-session parent-training envelope most child welfare agencies now use has the potential to be effective or whether an entirely new structure needs to be developed. For the most part, short-term models of parent work have not fared well—witness the unimpressive outcomes from the Homebuilders approach (Jonson-Reid, 2003; Westat et al., 2002). Longer term versions of this approach have, however, thrived, and include *Multisystemic Therapy* and the up-to-one-year-long adoption preservation model still used in Illinois (Smith & Howard, 1999). Findings from Brunk, Henggeler, and Whelan (1987) show that maltreating families can benefit from just eight sessions of *Multisystemic Therapy* or behavioral parent training. Yet Littell and Schuerman (2002) found no advantage for subgroups of recipients receiving extended intensive family preservation services.

A parallel effort should be developed to test and, very possibly, enhance the promising child welfare training programs that fit within the existing envelope. This might include the addition of an assessment of parenting skills, perhaps done as part of the CWS investigation, that would help determine the kind and amount of parent training that is needed. Such an assessment might need to be developed but could certainly build on existing instruments.

Certainly, there is a compelling logic to the search for elements that are powerful contributors to each of the most promising interventions and that could soup up weaker interventions. Although the work on such an effort has not transformed psychotherapy research (Ahn & Wampold, 2001), less effort has been directed toward the incorporation and testing of these elements for children's services. There are several interventions that have had substantial use with child welfare like populations that have been well tested over many years and even decades, as in *Parent Management Training*. As a starting point, the field could identify mini-interventions that developers of the most evidence-based interventions believe to be supported by theory and evidence. For example, *Parent Management Training* monitors parents between sessions and *The Incredible Years* gives children practice going into time-out. Such components might be most expeditiously added to existing conventional child welfare parent training because they might most closely fit within the existing time frames and costs. These could help to spur adoption of new methods for those whom Crawford, Brown, Anthony, and Hicks (2002) call reluctant empiricists because they are committed to the overall ideology that evidence-based practice is a good thing but find that actually implementing evidence-based practice is "always that little bit too far beyond what was achievable under the current circumstances" (p. 295).

Understanding what mini-interventions might be slipped into the current parent-training role, resources, and time requires a more refined analysis of the conditions, which have resulted in their child welfare involvement. Although child welfare agencies have long categorized families by their most serious type of maltreatment, a practice we emulated in this article, the overlap in behaviors between neglecting and abusive families has long been noted (Reid & Kavanagh, 1985). Additional analyses from NSCAW may help to illuminate these relationships, but this may also require more observational approaches. These parenting behaviors may also stem from parental problems, including the three that influence so many parents involved with child welfare: domestic violence, substance abuse, and acute poverty.

These are just a few directions that the field might profitably take. Until child welfare begins to engage in this process and not leave it to the other children's services fields, the work cannot get the traction it needs. Given the routine denial of a reasonably effective parent-training program for hundreds of thousands of families each year,

a sprint toward evidence-based parent-training programs is now in order. In this way, at least, the field has made progress beyond the work of Marianne Berry—her 1988 review was able to consider the evidence base for parent-training programs for in-home services, foster parents, and adoptive parents. We are now beyond the point that we can accomplish this goal in a single review. The growth in number of parents using parent training each year and in the number of programs available has not been matched by growth in rigorous research. We dream that future reviewers will be able to offer a more conventional meta-analysis of the impact of parent-training programs for maltreating parents.

A new generation of parent-training programs might gain articulation from several available sources. The demonstrated success of evidence-based programs to address children with conduct disorders is one such source. The possibly effective interventions that have been accepted by child welfare agencies for classroom-based parent training may have important lessons to offer. Finally, interventions that have not been effective, especially intensive family preservation services, but have become established as a resource that courts and agencies rely on offer the possibility for a more effective reformulation of programs that could fit within the funding and referral streams already in place.

The evolution of effective child welfare parent training will require several parallel efforts. One is to develop expectations in agencies and courts that parent training should meet the specific developmental and parenting needs of families and should be required and evaluated on a case-by-case basis, accordingly. A second is to develop the assessments necessary to determine the type of parent training that is optimal. A third is to create and test interventions that have the greatest likelihood of success with families and being adopted into agency practice.

Basic guidelines that judges can use to assess what has been learned are needed. One retired juvenile court judge indicated that they only wanted to know if parents had *not* completed parent training because, given his lack of confidence that completion of parent training had a case-transforming capacity, knowing that parents complete parent training had virtually no information value (B. Jones, personal communication, June 18, 2003). Certainly good practice dictates that we know more about the likelihood of successful use of safe parenting approaches than can be concluded from knowing whether parents completed a parenting program.

We must also jettison the assumption that nearly every child welfare family needs or can benefit from parenting classes. The empirical evidence presented above simply does not support this belief. Whether a family needs parent training and the form and duration of this training should be determined on a case-by-case basis. This should not be based solely on the maltreatment type alone, as considerable evidence indicates that maltreatment types shift over time (English, 2003; M. Jonson-Reid, personal communication, July 9, 2003) and are not reliably coded during routine child welfare practice (Runyan, 2003). Instead, an assessment process is needed that determines which skills are available to families, what deficits in parenting exist, and what circumstances seem to elicit maltreating responses. The process for these assessments needs to be developed. They should be conducted by the same provider that provides the parent training and may need to be done via in-home visits early in the case assessment (Walton, 2001).

If we continue to provide parent training with the current level of resources, then we will need to cut back on the number of families that receive this routine, low-budget, low-impact intervention. Such an approach would require more triaging of resources, as we currently do in deciding which families receive in-home services (e.g., family preservation) and which simply receive classroom-based conventional parent training. A two-stage approach might also be needed, in which classroom instruction is followed with more extensive parent training for some families. Only when we have the full complement of parent-training elements in operation for each parent can CWS go beyond their current mission to provide reasonable efforts on behalf of parents and to begin providing reasonably effective efforts on behalf of parents.

NOTES

1. In her structured review of *Multisystemic Therapy*, Littell (2003) cautions against assessing the effectiveness of *Multisystemic Therapy* or other interventions based on nominations by review panels and argues persuasively that this process often ignores key information needed to assess the validity of intervention effectiveness.

References

Adams, J. F. (2001). Impact of parent training on family functioning. *Child & Family Behavior Therapy*, *23*, 29-42.

Ahn, H. N., & Wampold, B. E. (2001). Where oh where are the specific ingredients? A meta-analysis of component studies in counseling and psychotherapy. *Journal of Counseling Psychology*, *48*, 251-257.

Bandura, A. (1976). *Social learning theory*. London: Prentice Hall.

Barth, R. P., Blythe, B. J., Schinke, S. P., & Schilling, R. F. (1983). Self-control training for maltreating parents. *Child Welfare*, *62*, 313-324.

Barth, R. P., Green, R., Wall, A., Webb, M. B., Gibbons, C., & Craig, C. D. (in press). Characteristics of out-of-home caregiving environments provided under child welfare services. *Child Welfare*.

Barth, R. P., Wildfire, J., & Green, R. (in press). Placement into foster care and the interplay of urbanicity, child behavior problems, and poverty. *American Journal of Orthopsyhiatry.*

Bavolek, S. J. (2002). *Research and validation report of the nurturing parenting programs*. Retrieved March 16, 2003, from http://www.nurturingparenting.com/npp/Research%20&%20Validation%20of%20NPP.pdf

Berry, M. (1988). A review of parent training programs in child welfare. *Social Services Review*, *62*, 303-323.

Bickman, L. (2002). The death of treatment as usual: An excellent first step on a long road. *Clinical Psychology: Science and Practice*, *9*, 195-199.

Borduin, C. M., Mann, B. J., Cone, L. T., Henggeler, S. W., Fucci, B. R., Blaske, D. M., et al. (1995). Multisystemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence. *Journal of Consulting and Clinical Psychology*, *63*, 569-578.

Brestan, E. V., & Eyberg, S. M. (1998). Effective psychosocial treatments of conduct-disordered children and adolescents: 29 years, 82 studies, and 5,272 kids. *Journal of Clinical Child Psychology*, *27*, 180-189.

Brunk, M., Henggeler, S. W., & Whelan, J. P. (1987). Comparison of multisystemic therapy and parent training in the brief treatment of child abuse and neglect. *Journal of Consulting and Clinical Psychology*, *55*, 171-178.

Burchard, J. D., Bruns, E. J., & Burchard, S. N. (2002). The wraparound approach. In B. J. Burns & K. Hoagwood (Eds.), *Community treatment for youth* (pp. 69-90). New York: Oxford University Press.

Burns, B. J., & Hoagwood, K. (2002). *Community treatment for youth: Evidence-based interventions for severe emotional and behavior disorders*. New York: Oxford University Press.

Burns, B. J., Phillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., et al. (2004). Mental health need and access to mental health services by youth involved with child welfare. *Journal of the American Academy of Child and Adolescence Psychiatry, 43*(8), 960-970.

Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Breston, E. V., Balachova, T., et al. (2004). Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology, 72(3)*, 500-510.

Chamberlain, P. (2003). Multidimensional treatment foster care program components and principles of practice. In P. Chamberlain (Ed.), *Treating chronic juvenile offenders: Advances made through the Oregon multidimensional treatment foster care model* (pp. 1-22). Washington, DC: American Psychological Association.

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, *66*, 7-18.

Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological, interventions: Controversies and evidence. *Annual Review of Psychology*, *52*, 685-716.

Clarke, M., & Oxman, A. D. (2003, March). *Cochrane reviewers' handbook 4.2.0*. Retrieved September 15, 2003, from http://www.cochrane.dk/cochrane/handbook/handbook.htm

Cline, F., & Fay, J. (1990). *Parenting with love and logic: Teaching children responsibility*. Colorado Springs, CO: Pinon.

Cohen, J. A., Mannarino, A. P., Zhitova, A. C., & Capone, M. E. (2003). Treating child abuse-related posttraumatic stress and comorbid substance abuse in adolescents. *Child Abuse & Neglect*, *27*, 1345-1366.

Crawford, P., Brown, B., Anthony, P., & Hicks, C. (2002). Reluctant empiricists: community mental health nurses and the art of evidence-based praxis. *Health & Social Care in the Community*, *10*, 287-298.

Currie, J. M. (1997). Choosing among alternative programs for poor children. *Future of Children*, *7*, 113-131.

Dawson, K., & Berry, M. (2002). Engaging families in child welfare services: An evidence-based approach to best practice. *Child Welfare*, *81*, 293-317.

DeGarmo, D. S., & Forgatch, M. S. (1997). Confidant support and maternal distress as predictors of parenting practices for divorced mothers. *Personal Relationships*, *4*, 303-317.

Dishion, T. J., & Patterson, G. R. (1992). Age effects in parent training outcome. *Behavior Therapy*, *23*, 719-729.

Dunlap, G., Strain, P., & Kern, L. (2003). *Evidence-based practice for young children with challenging behavior.* Retrieved July 24, 2003, http://www.challengingbehavior.org/presentations.html

Eisenstadt, T. H., Eyberg, S. M., McNeil, C. B., Newcomb, K., & Funderburk, B. (1993). Parent-child interaction therapy with behavior problem children: Relative effectiveness of two stages and overall treatment outcomes. *Journal of Clinical Child Psychology*, *22*, 42-51.

English, D. J. (2003, July). *Defining maltreatment chronicity: Are there differences in outcomes?* Paper presented at the Eighth International Family Violence Research Conference, Portsmouth, NH.

English, D. J., Marshall, D. B., Brummel, S., & Orme, M. (1999). Characteristics of repeated referrals to child protective services in Washington state. *Child Maltreatment*, *4*, 297-309.

English, D. J., Marshall, D. B., Coghlan, L., Brummel, S., & Orme, M. (2002). Causes and consequences of the substantiation decision in Washington State Child Protective Services. *Children & Youth Services Review*, *24*, 817-851.

Eyberg, S. M., & Pincus, D. (1999). *Eyberg child behavior inventory & Sutter-Eyberg student behavior inventory–revised*. Odessa, FL: Psychological Assessment Resources.

Eyberg, S. M., & Robinson, E. A. (1982). Parent-child interaction therapy: Effects on family functioning. *Journal of Clinical Child Psychology*, *11*, 130-137.

Farmer, E. M. Z., Compton, S. N., Burns, B. J., & Robertson, E. (2002). Review of the evidence base for treatment of childhood psychopathology: Externalizing disorders. *Journal of Consulting and Clinical Psychology*, *70*, 1267-1302.

Fennell, D. C., & Fishel, A. H. (1998). Parent education: An evaluation of STEP on abusive parents' perceptions and abuse potential. *Journal of Child and Adolescent Psychiatric Nursing*, *11*, 107-120.

Forgatch, M. S., & Martinez, C. R., Jr. (1999). Parent management training: A program linking basic research and practical application. *Journal of Consulting and Clinical Psychology*, *67*, 711-724.

Frame, L., Berrick, J. D., & Brodowski, M. L. (2000). Understanding reentry to out-of-home care for reunified infants. *Child Welfare*, *79*, 339-369.

Garland, A. F., Hough, R. L., McCabe, K. M., Yeh, M., Wood, P. A., & Aarons, G. A. (2001). Prevalence of psychiatric disorders in youths across five sectors of care. *Journal of the American Academy of Child and Adolescent Psychiatry*, *40*, 409-418.

Gordon, D. A. (2003). Intervening with troubled youth and their families: Functional family therapy and parenting wisely. In J. McGuire (Ed.), *Treatment and rehabilitation of offenders* (Vol. 2003, pp. 193-220). Sussex,UK: Wiley.

Gordon, D. A., & Stanar, C. R. (in press). Lessons learned from the dissemination of Parenting Wisely, a parent training program. *Cognitive Behavior and Practice*.

Haight, W. L., Black, J. E., Mangelsdorf, S. C., Giorgio, G., Tata, L., Schoppe, S. J., et al. (2002). Making visits better: The perspectives of parents, foster parents, and child welfare workers. *Child Welfare*, *81*, 173-202.

Henggeler, S. W., Rowland, M. D., Halliday-Boykins, C., Sheidow, A. J., Ward, D. M., Randall, J., et al. (2003). One-year follow-up of multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis. *Journal of the American Academy of Child and Adolescent Psychiatry*, *42*, 543-551.

Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (1998). *Multisystemic treatment of antisocial behavior in children and adolescents*. New York: Guilford.

Hoagwood, K. (2003). Evidence-based practice in children's mental health services: What do we know? Why aren't we putting it to use? *Data Matters*, *6*, 4-5.

Hutchinson, J. R., & Sudia, C. E. (2002). *Failed child welfare policy: Family preservation and the orphaning of child welfare*. New York: University Press of America.

Jonson-Reid, M. (2003). Foster care and future risk of maltreatment. *Children & Youth Services Review*, *25*, 271-294.

Kacir, C. D., & Gordon, D. A. (1997). Interactive videodisk parent training for parents of difficult pre-teens. *Child and Family Behavior Therapy*, *21*, 1-22.

Kacir, C. D., & Gordon, D. A. (1999). Parenting adolescents wisely: The effectiveness of an interactive videodisk parent training program in Appalachia. *Child & Family Behavior Therapy*, *21*(4), 1-22.

Kadushin, A. (1961). *Child welfare services*. New York: Prentice Hall.

Kazdin, A. E., & Weisz, J. R. (1998). Identifying and developing empirically supported child and adolescent treatments. *Journal of Consulting and Clinical Psychology*, *66*, 19-36.

Kitzmann, K. M., Gaylord, N. K., Holt, A. R., & Kenny, E. D. (2003). Child witnesses to domestic violence: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *71*, 339-352.

Kratochwill, T. R., & Stoiber, K. C. (2002). Evidence-based interventions in school psychology: Conceptual foundations of the procedural and coding manual of division 16 and the Society for the Study of School Psychology Task Force. *School Psychology Quarterly*, *17*, 341-389.

Landsverk, J., Garland, A., & Leslie, L. K. (2002). Mental health services for children reported to child protection services. In E. Myers & J. Briere (Eds.), *The APSAC Handbook on Child Maltreatment* (2nd ed., pp. 487-508). Thousand Oaks, CA: Sage.

Levin, J. R. (2002). How to evaluate the evidence of evidence-based interventions? *School Psychology Quarterly*, *17*, 483-492.

Littell, J. H., & Schuerman, J. R. (2002). What works best for whom? A closer look at intensive family preservation services. *Children and Youth Services Review*, *24*, 673-699.

Lutzker, J. R., & Bigelow, K. M. (2002). *Reducing child maltreatment: A guidebook for parent services*. New York: Guilford.

Lutzker, J. R., Bigelow, K. M., Doctor, R. M., & Kessler, M. L. (1998). Safety, health care, and bonding within an ecobehavioral approach to treating and preventing child abuse and neglect. *Journal of Family Violence*, *13*, 163-185.

Lutzker, J. R., & Rice, J. M. (1984). Project 12-Ways: Measuring outcome of a large in-home service for treatment and prevention of child abuse and neglect. *Child Abuse & Neglect*, *8*, 519-524.

Lutzker, J. R., Tymchuk, A. J., & Bigelow, K. M. (2001). Applied research in child maltreatment: Practicalities and pitfalls. *Children's Services: Social Policy, Research, and Practice*, *4*, 141-156.

Maluccio, A. N., Fein, E., & Davis, I. P. (1994). Family reunification: New directions. *Child Welfare*, *73*, 489-504.

McNeil, C. B., Eyberg, S. M., Eisenstadt, T., Newcomb, K., & Funderburk, B. (1991). Parent-child interaction therapy with behavior problem children: Generalization of treatment effects to the school setting. *Journal of Clinical Child Psychology*, *20*, 140-151.

Mihalic, S., Irwin, K., Elliott, D. S., Fagan, A., & Hansen, D. (2001, July). *Juvenile justice bulletin: Blueprints for violence prevention*. Retrieved July 24, 2003, from http://www.ncjrs.org/html/ojjdp/jjbul2001_7_3/contents.html

Mitchell, L. B., Barth, R. P., Green, R., Wall, A., Biemer, P., Berrick, J. D., et al. (2005). Child welfare reform in the United States: Findings from a local agency survey. *Child Welfare, 84,* 5-24.

Murphy, S. M., & Bryant, D. (2002). The effect of cross-cultural dialogue on child welfare parenting classes: Anecdotal evidence in black and white. *Child Welfare*, *81*, 385-405.

National Survey of Child and Adolescent Well-Being Research Group. (2002). Methodological lessons from the national survey of child and adolescent well-being: The first three years of the USA's first national probability study of children and families investigated for abuse and neglect. *Children & Youth Services Review*, *24*, 513-543.

National Survey of Child and Adolescent Well-Being Research Group. (2005). *National survey of child and adolescent well-being: The characteristics of children and families entering child welfare services*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.

Nixon, R. D. V. (2002). Treatment of behavior problems in preschoolers: A review of parent training programs. *Clinical Psychology Review*, *22*, 525-246.

Oyserman, D., Bybee, D., Mowbray, C., & Hart-Johnson, T. (2004). Parenting practices matter: Parenting as a mediator of the effect of maternal mental health on teen academic outcomes. Manuscript submitted for publication.

Patterson, G. R. (1975). *Families: Applications of social learning to family life*. Champaign, IL: Research.

Patterson, G. R. (1976). *Living with children: New methods for parents and children* (Rev. ed.). Champaign, IL: Research.

Patterson, G. R., & Chamberlain, P. (1988). Treatment process: A problem at three levels. In L. Wynne (Ed.), *The state of the art in family therapy research: Controversies and recommendations*. (pp. 189-223). New York: Family Process.

Patterson, G. R., Chamberlain, P., & Reid, J. B. (1982). A comparative evaluation of parent training procedures. *Behavior Therapy*, *13*, 638-650.

Patterson, G. R., & Forgatch, M. (1987). *Parents and adolescents: Living together.* (Rev. ed.). Eugene, OR: Castalia.

Patterson, G. R., & Forgatch, M. S. (1985). Therapist behavior as a determinant for client noncompliance: A paradox for the behavior modifier. *Journal of Consulting and Clinical Psychology*, *53*, 846-851.

Patterson, G. R., Reid, J. B., & Eddy, M. J. (2002). A brief history of the Oregon model. In J. B. Reid, G. R. Patterson, & J. Snyder (Eds.), *Antisocial behavior in children and adolescents: A*

developmental analysis and model for intervention. Washington, DC: American Psychological Association.

Pears, K. C., & Capaldi, D. M. (2001). Intergenerational transmission of abuse: A two-generation, prospective study of an at-risk sample. *Child Abuse & Neglect: The International Journal*, *25*, 1439-1461.

Reid, J. B., & Kavanagh, K. (1985). A social interactional approach to child abuse: Risk, prevention, and treatment. In M. A. Chesney & R. H. Rosenman (Eds.), *Anger and hostility in cardiovascular and behavioral disorders* (pp. 113-134). Washington, DC: Hemisphere.

Rothman, J., & Thomas, E. J. (Eds.). (1994). *Intervention research: Design and development for human services*. Binghamton, NY: Haworth.

Ruma, P. R., Burke, R. V., & Thompson, R. W. (1996). Group parent training: Is it effective for children of all ages? *Behavior Therapy*, *27*, 159-169.

Runyan, D. (2003, July). *Refining the research definitions of child maltreatment using child outcome data*. Paper presented at the Eighth International Family Violence Research Conference, Portsmouth, NH.

Saunders, B. E., Berliner, L., & Hanson, R. F. E. (2003). *Child physical and sexual abuse: Guidelines for treatment (Final report: January 15, 2003)*. Charleston, SC: National Crime Victims Research and Treatment Center.

Schuerman, J. R., Rzepnicki, T. L., & Littell, J. H. (1994). *Putting families first: An experiment in family preservation*. Hawthorne, NY: Aldine de Gruyter.

Smith, S. L., & Howard, J. A. (1999). *Promoting successful adoptions: Practice with troubled families*. Thousand Oaks, CA: Sage.

Swenson, C. C., & Kolko, D. J. (2002). *Assessing and treating physically abused children and their families: A cognitive-behavioral approach*. Thousand Oaks, CA: Sage.

Thomlison, B. (2003). Characteristics of evidence-based child maltreatment interventions. *Child Welfare*, *82*, 541-569.

U.S. Department of Health and Human Services Administration for Children Youth and Families. (2003). *Child Maltreatment 2001*. Washington, DC: Government Printing Office.

Wachtel, P. L. (1977). *Psychoanalysis and behavior therapy: Toward an integration*. New York: Basic Books.

Walton, E. (1998). In-home family-focused reunification: A six-year follow-up of a successful experiment. *Social Work Research*, *22*, 205-214.

Walton, E. (2001). Combining abuse and neglect investigations with intensive family preservation services: An innovative approach to protecting children. *Research on Social Work Practice*, *11*, 627-644.

Walton, E., & Dodini, A. C. (1999). Intensive in-home family based services: Reactions from consumers and providers. *Family Preservation Journal*, *4*, 31-51.

Webster-Stratton, C. (1984). A randomized trial of two parent training programs for families with conduct-disordered children. *Journal of Consulting and Clinical Psychology*, *52*, 666-678.

Webster-Stratton, C. (1998). Preventing conduct problems in Head Start children: Strengthening parenting competencies. *Journal of Consulting and Clinical Psychology*, *66*, 715-730.

Webster-Stratton, C., & Hammond, M. (1997). Treating children with early-onset conduct problems: A comparison of child and parent training interventions. *Journal of Consulting and Clinical Psychology*, *65*, 93-99.

Westat, Chapin Hall Center for Children, & James Bell Associates. (2002, December). *Evaluation of family preservation and reunification programs: Final report*. Retrieved September 15, 2003, from http://aspe.hhs.gov/hsp/evalfampres94/final/

Wolf, D. A., Aragona, J., Kaufman, K., & Sander, J. (1980). The importance of adjudication in the treatment of child abusers: Some preliminary findings. *Child Abuse & Neglect*, *4*, 127-135.