Regional Partnership Grants Cross-Site Evaluation and Evaluation-Related Technical Assistance

October 7, 2013

Serving Child Welfare Families with Substance Abuse Issues: Grantees' Use of Evidence-Based Practices and the Extent of Evidence

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Serving Child Welfare Families with Substance Abuse Issues: Grantees' Use of Evidence-Based Practices and the Extent of Evidence

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We dedicate this report to the 17 Regional Partnership Grant programs and the families they plan to serve through the evidence-based program and practice models described in this report.

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EXECUTIVE SUMMARY

To better allocate sometimes scarce resources, funders and other stakeholders are increasingly interested in identifying and supporting evidence-based practices (EBPs), which have research demonstrating their effectiveness. This focus has influenced the Regional Partnership Grants (RPG) program, administered through the Children's Bureau within the Administration for Children and Families, at the U.S. Department of Health and Human Services, which supports the collaboration and integration of agencies to increase the well-being, improve the permanency, and enhance the safety of children who are in, or at risk of, out-of-home placements as a result of a parent or caretaker's substance abuse. As a stipulation of the grant, the 17 grantees have identified and proposed services or activities that were evidence-based or informed. A scan of these practices showed a wide range of proposed services, but little overlap. The grantees proposed 51 EBPs, with most offering at least 2 EBPs to families and some offering 10 or more. Of the 51 EBPs, 32 were proposed by only one grantee, suggesting little commonality in services, as defined by the EBPs.

To better understand the existing evidence base for selected EBPs, we prioritized a subset of nine on which we compiled information from several sources. The most common source of an evidence-rating was the California Evidence-Based Clearinghouse for Child Welfare. Other sources included the National Registry of Evidence-based Programs and Practices, Office of Juvenile Justice and Delinquency Prevention Model Program Guide, Home Visiting Evidence of Effectiveness, and the Promising Practices Network. Because it was beyond the scope of the review to assess the results for all 51 EBPs, 9 were prioritized based on the number of sites implementing the EBP and the importance to the field of child welfare and substance abuse treatment. The assessment of "importance" included whether the EBPs addressed common reasons for involvement with the child welfare system (for example, remedying neglect), elements that define RPG (such as parental substance abuse), and priority areas for the Children's Bureau (including trauma treatment). The nine

EBPs were: (1) Celebrating Families!, (2) Child-Parent Psychotherapy, (3) Family Treatment Drug Court (also called Dependency Drug Court), (4) Hazelden Living in Balance Program, (5) Matrix Model, (6) Nurturing Parenting Programs, (7) Strengthening Families Program, (8) Seeking Safety, and (9) Trauma-Focused Cognitive Behavioral Therapy.

The review of the nine EBPS revealed both strengths—such as the existence of rigorous trials—and gaps in our knowledge, particularly related to the effectiveness of these practices among families most likely to be served by RPG programs. Six of the nine EBPs had at least one randomized controlled trial (RCT), one of the strongest designs for determining whether the program (rather than other factors) caused observed outcomes. Further, several program models—including Child-Parent Psychotherapy, Strengthening Families Program, and Trauma-Focused Cognitive Behavioral Therapy—were studied with more than five RCTs, which increases our confidence in the effectiveness by demonstrating replication of results. Evidence of effectiveness with families involved in child welfare because of substance abuse, however, is lacking. Six of the nine included studies of families with substance abuse issues and five included studies with families involved in child welfare, but most did not include families in both categories. Although two program models (Celebrating Families! and Family Treatment Drug Courts) were supported by studies with families with substance abuse issues and involved in child welfare, neither were studied with an RCT, so evidence of effectiveness on any population is somewhat limited.

The 17 current RPG-funded grantees have all proposed an evaluation of their services, as required by the grant. A cross-site evaluation will also be conducted. Given the gaps in knowledge and the clear need for more information to guide both practice and research, RPG local and cross-site evaluations have an opportunity to build on the existing evidence base and extend our knowledge about program effectiveness for these vulnerable families.

I. INTRODUCTION

In recent years, federal policymakers have expressed a growing interest in and commitment to promoting practices and interventions with scientific evidence of effectiveness (Haskins and Baron 2011). For example, the Office of Management and Budget (OMB) strongly encourages using evidence and rigorous evaluation to make government work effectively, especially in the current fiscal environment. Acting director Jeffrey D. Zients explains, "Where evidence is strong, we should act on it. Where evidence is suggestive, we should consider it. Where evidence is weak, we should build the knowledge to support better decisions in the future" (OMB 2012). These "better decisions" include, critically, what types of health and human services to fund and deliver for better outcomes for families, communities, and the nation. OMB says grant-making agencies should demonstrate that they are increasing the use of evidence in formula and competitive programs. Research evidence is being sought for prevention, treatment, public health, and social service program models (Puddy and Wilkins 2011).

Along with federal agencies and policymakers, funders, practitioners, and providers are also seeking to identify, implement, scale-up, and sustain evidence-based practices. Yet evidence is not always readily available. For instance, a CDC-sponsored initiative to implement proven approaches for primary prevention of intimate-partner violence faltered when participants were unable to find intervention models having any evidence base for use in primary prevention (Strong 2006). Even treatments or programs based on sound theory need time to build an evidence base. Further, when evidence exists, it may not extend to particular settings and populations, such as tribal settings (Del Grosso et al. 2012). In its reviews of substance abuse treatment programs, the California Evidence-Based Clearinghouse for Child Welfare (CEBC) found that the programs varied in their relevance to child welfare. For example, Motivational Interviewing, the only adult substance abuse treatment program classified by CEBC as "*well-supported* by research evidence," had medium relevance to child

welfare.[1] Among an additional six models *supported* by research evidence, one (Family Behavior Therapy for Adults) had high relevance; the others offered only medium relevance. Conversely, although the Reno Family Drug Court is rated as highly relevant to child welfare, it lacked the necessary research evidence to achieve a scientific rating.

This intensified focus on evidence-based and evidence-informed practices has also influenced the Regional Partnership Grants (RPG) program, which was initially funded in 2007. Through RPG grants, the Children's Bureau (CB) within the Administration on Children, Youth and Families at the U.S. Department of Health and Human Services supports interagency collaborations and program integration designed to increase the well-being, improve the permanency, and enhance the safety of children who are in, or at risk of, out-of-home placements as a result of a parent or caretaker's substance abuse.[2] To qualify for a second round of five-year RPG grants made in 2012, applicants were required to adopt and implement specific, well-defined program services and activities that were evidence-based or evidence-informed. They were also expected to ensure their programs were an appropriate fit for the characteristics and needs of the groups targeted for services (Administration for Children and Families 2012).

To understand the evidence base behind programs and services planned for implementation by the 17 applicants that were awarded RPG grants, CB asked the RPG cross-site evaluation contractor, Mathematica Policy Research, and its partner Walter R. McDonald & Associates (WRMA) to compile information on the existing evidence with respect to grantees' proposed

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[1] Relevance to child welfare was based on the program's target population and goals. A high rating indicated that the program was designed, or is commonly used, to meet the needs of children, youth, young adults, and/or families receiving child welfare services. Medium relevance indicates that the program was designed, or is commonly used, to serve children, youth, young adults, and/or families who are similar to child welfare populations (in their history, demographics, or presenting problems) and likely include current and former child welfare services recipients. A program had low relevance if it was designed, or is commonly used, to serve children, youth, young adults, and/or families with little or no similarity to the child welfare services population. See http://www.cebc4cw.org.

[2] Federal legislation established the RPG program in 2007. It was reauthorized in 2011 with passage of the Child and Family Services Improvement and Innovation Act (Pub. L. 122-34).

interventions, including evaluation methods that have been utilized and outcomes that have been demonstrated for the target populations. Mathematica/WRMA received guidance in these efforts from Cheryl Smithgall, Ph.D., of Chapin Hall and Joseph Ryan, Ph.D., of the School of Social Work and Center for Political Studies, Institute for Social Research at the University of Michigan. This report describes the evidence-based or evidence-informed programs or practices identified by the 17 RPG grantees in their applications (Chapter II); how the programs were selected for review (Chapter III); the review process for the selected programs (Chapter IV); and, briefly, the findings (Chapter V). Appendix A enumerates the EBPs selected by each RPG grantee, while Appendix B describes each of the review sources included in this report. Appendix C provides the detailed evidence reviews for the nine EBPs that were examined.

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II. EVIDENCE-BASED PROGRAMS AND PRACTICES SELECTED BY RPG GRANTEES

Many definitions of evidence-based programs (EBPs) or practice models refer to effectiveness or rigorous evaluations. The Administration for Children and Families, Family, and Youth Services Bureau describes evidence-based programs and practices as interventions that are "shown to have positive effects on outcomes through rigorous evaluations" (FYSB 2012). The Substance Abuse and Mental Health Administration (SAMHSA) says that evidence-based prevention refers to a set of prevention activities that evaluation research has shown to be effective (SAMHSA n.d.). The National Council on Aging (NCOA) says evidence-based programs are "based on research" (NCOA n.d.). The Office of Justice Programs (OJP) within the U.S. Department of Justice considers programs and practices to be evidence-based when their effectiveness "has been positively demonstrated by causal evidence, generally obtained through one or more outcome evaluations" (OJP Diagnostic Center n.d.). However, definitions of "evidence" vary (Puddy and Wilkins 2011), and formal reviews of research evidence often establish levels, depending on the ability of the medical, evaluation, or other research methodology to demonstrate a causal relationship between a treatment or program and specific outcomes.

To ensure use of evidence-based or evidence-informed services, RPG applicants were encouraged to select one or more models from several sources identified in the Funding Opportunity Announcement. Some sources were evidence reviews and others identified models

that may have been included in other reviews.[3] Alternatively, applicants could provide information on research studies to show that the services or practices to be implemented were evidence-based. If such research studies were not available, applicants could provide information from other sources, such as unpublished studies or documents describing formal consensus among recognized experts.

EBPs Proposed by Grantees

In the applications, the designation of "evidence-based" was not always clear. Therefore cross-site evaluation staff reviewed all 17 applications and grantees' first semi-annual progress reports, which covered the grant period up to April 2013. Staff then recorded each program model or service cited with a formal name (such as "Motivational Interviewing" but not "interviewing," or "Family Group Conferencing" but not "family conferences"), regardless of whether applicants described it as "evidence-based." We also asked grantees to confirm which EBPs they were using and, with the National Center on Substance Abuse and Child Welfare (NCSACW), confirmed the list of EPBs so that we did not erroneously exclude or duplicate models because of the use of different names or similar factors. Staff searched several sources that were likely to have produced a review of evidence of effectiveness of the grantee-selected models to determine whether each model received an evidence rating from one or more sources (Table II.1). This process resulted in a list of 51 EBPs proposed by RPG grantees.[4]

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[3] The Funding Opportunity Announcement identified the following six sources of information about EBPs: (1) SAMHSA's National Registry of Evidence-Based Programs and Practices (http://www.nrepp.samhsa.gov/); (2) Selecting and Identifying Evidence-Based Interventions (http://store.samhsa.gov/shin/content/SMA09-4205/SMA09-4205.pdf); (3) Evidence-based Practices for Children Exposed to Violence: a Selection from Federal Databases (http://oilspilldistress.samhsa.gov/resources/evidence-based-practices-children-exposed-violence-selection-federal-databases); (4) National Child Traumatic Stress Network Empirically Supported Treatments and Promising Practices (http://www.childwelfare.gov/responding/treatment.cfm); (5) Evidence-Based Mental Health Therapies (Child Welfare Information Gateway) (http://www.childwelfare.gov/systemwide/mentalhealth/effectiveness/evidence.cfm); and (6) Home Visiting Evidence of Effectiveness (http://homvee.acf.hhs.gov)

[4] Some grantees changed their programs during the first semi-annual reporting period, after Mathematica/WRMA had begun work on this evidence review. Therefore, numbers in this report may conflict with numbers in memos that Mathematica/WRMA previously sent to the CB.

Several sources reviewed at least one of the proposed EBPs. The most common source of an evidence rating for proposed RPG EBPs was the California Evidence-Based Clearinghouse for Child Welfare (CEBC), which rated 23. Another common source was the National Registry of Evidence-based Programs and Practices (NREPP), which included 19 EBPs. The prominence of these two sources makes sense, because RPG addresses both child welfare and substance abuse—the fields on which CEBC and NREPP focus. Seven of the proposed EBPs had been reviewed by Home Visiting Evidence of Effectiveness (HomVEE), and 13 were rated by the Office of Juvenile Justice and Delinquency Prevention (OJJDP), and/or the RAND Corporation-operated Promising Practices Network (PPN). Eighteen of the models had been rated by two or more of these five sources.

Table II.1. Potential Sources of Evidence Ratings for RPG Planned or Proposed Program Models or Services

Source	Description (for more information on each source, including ratings criteria, see Appendix A)	Number of RPG EBPs Reviewed (number rated/met criteria[a])
California Evidence-Based Clearinghouse for Child Welfare (CEBC): http://www.cebc4cw.org	Sponsored by the California Department of Social Services and operated by the Chadwick Center for Children and Families at Rady Children's Hospital San Diego	23 (19)
National Registry of Evidence-based Programs and Practices (NREPP): http://www.nrepp.samhsa.gov	Maintained by the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services	19
Office of Juvenile Justice and Delinquency Prevention Model Programs Guide (OJJDP): www.ojjdp.gov/mpg	Maintained by OJJDP, U.S. Department of Justice	10
Home Visiting Evidence of Effectiveness (HomVEE): http://homvee.acf.hhs.gov	Sponsored by the Administration for Children and Families, and operated by Mathematica Policy Research	7 (3)
Promising Practices Network (PPN): www.promisingpractices.net	Operated by the RAND Corporation	6

[a] Models listed in parentheses under CEBC had sufficient evidence to be rated. Models listed in parentheses under HomVEE met DHHS criteria for evidence-based models.

Not all of the program models grantees selected or described as "evidence-based" were included in or given an evidence rating by these sources. Evaluation staff could not find in any sources they searched two models that grantees reported being in NREPP. Six models that grantees described as evidence-based appeared to be based on program models cited in one or more source but had not been reviewed themselves. And for eight program models, the grantees provided no evidence source, nor did evaluation staff find them in the five sources that they checked. The applications did not cite research studies or other documents attesting to a research base for these models. Although we kept these models on our list of EBPs that grantees are implementing—as other sources may offer evidence of their effectiveness—we did not consider them for further review unless we could identify other reviews of evidence on their effectiveness.[5]

EBPs varied in their popularity among grantees. Of the 51 EBPs proposed, 32 were proposed by just one grantee. The remaining program models were proposed by two or more grantees (Table II.2). As of April 2013, the most common EBPs were Nurturing Parenting Programs (seven grantees), Trauma-Focused Cognitive Behavior Therapy (seven grantees), Motivational Interviewing (seven grantees), Seeking Safety (six grantees), and the Matrix Model (five grantees).

[5] Three additional EBPs were reviewed but not rated by CEBC and did not appear in the other four sources that staff checked. Family Treatment Drug Court is the only model included in this review that was not rated by any of the sources in Table II.1.

Table II.2. Number of RPG Grantees that Proposed Each Selected EBP

Evidence-Based Program/Practice	Number of Grantees that Proposed this EBP
Celebrating Families!	4
Child-Parent Psychotherapy	4 [a]
Cognitive Behavior Therapy	4
Family Treatment Drug Court	2
Hazelden Co-Occurring Disorders Program	2
Hazelden Living In Balance Program	3
Homebuilders Intensive Family Preservation Services	2
Incredible Years Parenting Class	2
Matrix Model	5
Modified Therapeutic Community	2
Motivational Enhancement Therapy	3 [a]
Motivational Interviewing	7
Nurturing Parenting Programs	7 [a]
Parent and Child Interactive Therapy	2
Relapse Prevention Therapy	2
Seeking Safety	6 [a]
Strengthening Families	3
Trauma-Focused Cognitive Behavior Therapy	7
Trauma Recovery and Empowerment Model	2 [a]

Source: Grantees' applications for RPG funding, first semi-annual progress reports, and informal reports.

Note: 32 EBPs proposed by only one grantee are not included in the above table.

[a] One grantee that proposed this EBP (Children's Research Triangle in Illinois) reported in April 2013 that it had not yet implemented the EBP but planned to if the intervention proved appropriate for future clients.

A distinguishing feature of the interventions proposed by RPG grantees is their use of multiple EBPs.[6] Only two grantees are implementing just one EBP: Nurturing Parent Programs and Child-Parent Psychotherapy, respectively. Three grantees are implementing 10 or more, and one additional grantee reported it is prepared to implement as many as 10 EBPs depending on client needs. Eight grantees are implementing between 4 and 7, and the remaining three grantees proposed 2 or 3 EBPs as part of their RPG projects (Table II.3). Although proposing to provide 15 EBPs to program participants, one grantee mentioned 7 additional EBPs that "may be offered to participants" but were not part of core programming, for a total of 22 EBPs (because of this uncertainty, Table II.3 excludes these 7 program models). The two grantees who identified Family Treatment Drug Court as one of the EBPs are, respectively, also implementing (a) Celebrating Families, Strengthening

[6] Integrated substance abuse treatment programs may include with their addiction services on-site pregnancy, parenting, or child-related services. These interventions may be added to a comprehensive menu of services, such as intake assessments, treatment plans, pharmacotherapy and/or behavioral therapy and counseling, for example. Thus, some RPG grantees proposed a menu of EBPs, even though only a few might serve the majority of their planned clients.

Families, and Trauma-Focused Cognitive Behavioral Therapy or (b) Modified Therapeutic Community, Nurturing Parenting Programs, and Trauma-Focused Cognitive Behavior Therapy.

Table II.3. Number of EBPs Each RPG Grantee is Implementing, as of April 2013

Grantee	Number of EBPs Grantee is Implementing (or prepared to implement)
The Center for Children and Families, Montana	15
Alternative Opportunities, Inc., Missouri	13
Child & Family Tennessee	13
Children's Research Triangle, Illinois	3 (10) [a]
Rockingham Memorial Hospital, Virginia	7
Center Point, Inc., California	6
Georgia State University Research Foundation, Inc.	5
Kentucky Department for Community Based Services	6
Commonwealth of Massachusetts	5
State of Nevada Division of Child and Family Services	4
Northwest Iowa Mental Health Center/Seasons Center	4
Tennessee Department of Mental Health and Substance Abuse Services	4
Judicial Branch, State of Iowa	3
Oklahoma Department of Mental Health and Substance Abuse Services	2
Summit County Children's Services, Ohio	2
Families and Children Together, Maine	1
Health Federation of Philadelphia, Inc., Pennsylvania	1

Source: Grantees' applications for RPG funding, first semi-annual progress reports, and informal reports.

[a] Children's Research Triangle reported in April 2013 that it is prepared to implement 10 EBPs but has only used 3 so far because it tailors services to each client.

EBP Categories

To better understand the range of EBPs being implemented for RPG, we categorized them based on their substantive focus. This organization resulted in a limited number of broad categories that are easily explained. For EBPs that could fit into more than one category, we selected the most appropriate category. In addition, we excluded from our categories (and hence from further review) two evidence-based approaches that grantees are also using: (1) recovery coaches and (2) Screening, Brief Intervention, and Referral to Treatment (SBIRT). These approaches are distinct from the other EBPs in that they are flexible protocols rather than treatments or programs.

The six broad groups below present the EBPs by their substantive focus (Table II.4). The two largest categories are broken down into subcategories.

- **Family strengthening programs (25 EBPs total, proposed by 14 grantees).** This category includes program models that focus on at least one of the following goals: increasing family functioning, promoting family group decision making, improving parenting and/or life skills, and supporting children's emotional and behavioral

development. They may include a home visiting component. We subdivide EBPs in this group into those that include a full-family or child component, and those that do not.

- **Programs with a full-family/child component (15 EBPs proposed by 14 grantees).** EBPs in this category treat both adults and children as their clients. Most are curricula that include sessions for parents, as well as separate sessions for children and/or group sessions with parents and children. For example, in several of these treatments, parent sessions focus on parenting and life skills training, and sessions for children focus on behavioral themes such as anger management. This category also includes family group conferencing, an approach to developing permanency plans for children in the child welfare system that engages multiple family members, child welfare workers, and other stakeholders in working together.
- **Parenting (only) programs (10 EBPs proposed by 3 grantees).** Program models that provide parenting skills education and support to adults but do not treat children as clients.

- **Response to trauma (7 EBPs proposed by 11 grantees).** Individual therapies or group curricula designed to help clients cope with trauma and develop resilience. EBPs included in this group serve parents and/or children.
- **Child-caregiver therapy (4 EBPs, proposed by 7 grantees).** Therapeutic treatments focused on the child-caregiver relationship; treatments include elements of family functioning, therapy, and in some cases, substance abuse treatment and response to trauma. Rather than include them in one of those categories, we have grouped them separately because of their shared characteristics. These EBPs focus directly on improving the child-caregiver relationship, whereas family strengthening EBPs focus on developing skills, including parenting, that can improve family functioning.
- **Therapy or counseling styles (7 EBPs total proposed by 10 grantees).** Evidence-based approaches to therapy or counseling that providers may use in various substantive areas.
  - **Cognitive behavior therapy (CBT) (4 EBPs proposed by 6 grantees; 3 program models in other categories are related).** CBT is a form of time-limited psychotherapy that focuses on teaching rational self-counseling skills and unlearning unwanted emotional and behavioral reactions. This category includes CBT itself, dialectical behavior therapy, and two similar program models, moral reconation therapy and prolonged exposure.[7]
  - **Other counseling styles (3 EBPs proposed by 8 grantees).** This category includes counseling styles that can be used in a variety of settings and for various purposes: Motivational Interviewing and Motivational Enhancement Therapy (an

[7] We could include Alternatives for Families-CBT and Trauma-Focused CBT in this category, but because they are both extensions of the CBT model for purposes that align with our other categories, we included them in the Child-Caregiver Therapy and Response to Trauma categories, respectively. Seeking Safety, which we have categorized as a Response to Trauma EBP, contains many elements in common with CBT.

adaptation of Motivational Interviewing), as well as Solution Focused Brief Therapy.

- **Substance abuse treatment (7 EBPs proposed by 7 grantees).** These program models are designed to help clients overcome substance addiction and avoid relapse. These EBPs vary in whether they serve individuals or groups and whether their designers intended them for outpatient, residential, or both settings. Most of these EBPs are intended for outpatient use.
- **Family Treatment Drug Court (one EBP proposed by 2 grantees).** We placed this EBP in its own group due to its unique and cross-cutting nature. Family Treatment Drug Courts (FTDCs) are specialized courts designed to work with families involved in the child welfare system due primarily to parental substance abuse. The court serves as a vehicle through which parents enter substance abuse treatment and receive wraparound services, and through which parents' progress is monitored.

Table II.4. Number of EBPs of Each Type, and Number of Grantees Proposing EBPs of Each Type

Category	Number of EBPs	Number of Grantees Proposing One or More EBP of this Type	Sample EBPs in this Category
Family Strengthening	25	14	
Full-family/child component	15	14	Celebrating Families!, Homebuilders Intensive Family Preservation Services, Incredible Years Parenting Class, Nurturing Parenting Programs, Strengthening Families
Parenting (only)	10	3	Centering Pregnancy, Healthy Families
Response to Trauma	7	11	Seeking Safety, Trauma-Focused Cognitive Behavior Therapy
Child-Caregiver Therapy	4	7	Child-Parent Psychotherapy, Parent and Child Interactive Therapy
Therapy or Counseling Style	7	10	
Cognitive behavior therapy	4[a]	6	Cognitive Behavior Therapy
Other counseling style	3	8	Motivational Enhancement Therapy, Motivational Interviewing
Substance Abuse Treatment	7	7	Hazelden Co-Occurring Disorders, Hazelden Living in Balance, Matrix Model, Modified Therapeutic Community, Relapse Prevention Therapy
Family Treatment Drug Court	1	2	Family Treatment Drug Court

Source: Authors' tabulations based on grantees' applications and informal updates made in February 2013.

Note: EBPs listed in the far right column appear in Table II.2, except for parenting (only) program models. No EBPs in this category were implemented by more than one grantee, so the EBPs listed are intended to be examples.

[a] Three program models in other categories are related to cognitive behavior therapy.

Categorizing the EBPs helped us ensure that the models we selected for further evidence review captured the full range of interventions that grantees offer. After finalizing the categories, we worked with CB to identify a subset of models for more in-depth reviews.

III. EBPS SELECTED FOR EVIDENCE REVIEW

In planning the RPG grant program, the CB sought to understand the interventions proposed by grantees. This understanding would help the CB and its federal contractors provide appropriate programmatic and evaluation-related technical assistance (TA).[8] Therefore, the cross-site evaluation statement of work required the contractor to review, analyze, and compile information on the existing evidence with respect to grantees' proposed interventions, including evaluation methods that had been utilized and outcomes that were demonstrated for the target populations. The CB also intended the review to help inform the design of the cross-site evaluation, and to inform policymakers, funders, and practitioners more broadly about the evidence base for programs and practices addressing family needs related to child welfare and substance abuse.

As described in Chapter II, the first step in the review was to determine which program models constituting the RPG interventions were included in existing evidence reviews. During this process, Mathematica/WRMA obtained a description of each EBP and noted the ratings it received from the relevant review sources. (Appendix A provides the descriptions and ratings, and Appendix B describes the rating systems used by CEBC, NREPP, and the other review sources.) Detailed examination of all 51 of the proposed EBPs was outside the scope of the cross-site evaluation. Therefore, evaluation project staff, including our expert consultants, determined priorities for further review. Priority was based on (a) the number of sites implementing the EBP, and (b) the EBP's importance to the fields of child welfare and substance abuse. "Importance" reflected the team's and consultants' judgment regarding the types of EBPs that address common reasons that families become involved with the child welfare system (for example, parenting EBPs that could

[8] The National Center for Substance Abuse and Child Welfare (NCSACW), funded jointly by SAMHSA and the CB, provides TA aimed at helping grantees and their partners implement RPG-funded services and activities. Mathematica/WRMA provides TA on planning and conducting local outcome evaluations required under the terms of the RPG grants.

help remedy neglect), elements that define the RPG grants (including parental substance abuse), and priority areas for the CB (such as trauma treatment).

We judged four types of EPBs (see Chapter II, Table II.3 for types of EBPs) to be of greatest interest and importance: (1) cognitive behavior therapy; (2) family strengthening; (3) response to trauma; and (4) substance abuse treatment. Because this task was intended to gather information about some of the more common practices that grantees were using, we dropped from consideration for further review EBPs in these categories that were being implemented by only one RPG grantee. Within these categories, we recommended eight EBPs for additional, in-depth review. The CB added another model and approved the list of nine EBPs for review (Table III.1).

Table III.1. EBPs Selected for In-Depth Evidence Review

EBP Name	Category	Number of Grantees that Proposed this EBP
Celebrating Families!	Family strengthening (full-family/child component)	4
Child-Parent Psychotherapy	Child-caregiver therapy	4
Family Treatment Drug Court	Family Treatment Drug Court	2
Hazelden Living in Balance Program	Substance abuse treatment	3
Matrix Model	Substance abuse treatment	5
Nurturing Parenting Programs	Family strengthening (full-family/child component)	7
Seeking Safety	Response to trauma	5
Strengthening Families	Family strengthening (full-family/child component)	3
Trauma-Focused Cognitive Behavior Therapy	Response to trauma	7

IV. THE RPG EVIDENCE REVIEW PROCESS

For each of the selected EBPs, we gathered information from the evidence reviews or original sources to summarize the extent of existing evidence and highlight results relevant for RPG. The reviews include results for each identified study and a summary of the research designs used to examine the EBP and favorable findings. The summary highlights findings from research that was better designed to identify effects of the EBPs, namely randomized controlled trials (RCTs) and quasi-experimental designs (QEDs). In RCTs, participants are assigned by chance to receive the treatment of interest or other services. In QEDs, a treatment group and matched comparison group are formed using a nonrandom process, such as matching on demographic elements. Our evidence reviews focus on these two types of studies because they have the potential to isolate from other factors the effects of the program model, such as natural change over time or participant motivation. Results from other studies are included to enhance understanding of the current body of evidence for each EBP.

For eight of the nine EBPs, we collected from the review sources relevant information on the included studies, such as study design, sample, and outcomes measured. The exception to this process was the ninth EBP, Family Treatment Drug Courts (FTDCs), which were not reviewed by any of the identified sources. For FTDCs, we identified several recent sources, including two literature reviews. We then extracted information from the literature reviews or abstracts of those original studies. For all of the selected EBPs, once we had collected the information from each study, we prepared a brief summary of each EBP, highlighting the strength of the research evidence and results relevant for RPG, such as the use of samples involved in the child welfare system.

Because this is a summary, we were limited to the results presented in the review sources, although in a few cases, we also consulted the original articles. Further, because this review was not independent, we cannot verify the accuracy of its results. Nonetheless, the identified systematic

review sources are longstanding and well-known. We cite the sources of the information in each review.

We present the results of our review in Appendix C. For each EBP, we include a summary table that incorporates findings from all studies reviewed, followed by a series of tables that further detail each study. The summary table includes the following elements:

- **Level of evidence** identifies which evidence sources (CEBC, NREPP, OJJDP, HomVEE, or PPN) reviewed the program model, and, if applicable, how they rated it.
- **Study designs** indicates the number of RCTs, QEDs, and studies with other designs included in our review.
- **Demonstrated effects** lists program impacts that rigorous studies (RCTs or QEDs) found differed significantly between the treatment and control/comparison group, in a way favorable to the treatment group. The list notes favorable effects on parents and children separately.
- **Sample characteristics** cites the number of studies with samples in which a majority or subgroup of participants were parents with substance abuse issues or families involved in child welfare or child protective services. These sample characteristics are relevant because RPG grantees serve these populations.
- **Relevance for RPG** combines the "demonstrated effects" and "sample characteristics" sections and notes favorable relevant findings in RCTs or QEDs with samples that have substance abuse issues and/or child welfare involvement. We include this field to distinguish EBPs on which we found favorable evidence directly relevant to the RPG population.
- **Other information** identifies the developer and intended outcomes of the EBP, as stated by an evidence review source or by the program developer.

For each study reviewed, we present a table containing the following information, which provides more detail about the study design, context, and findings:

- **Study and review information** includes study citation, evidence review source or sources (for example, CEBC) that included the study, and study rating assigned by the evidence review source, if applicable.
- **Study design** identifies whether the study is classified as an RCT, QED, or other design.
- **Sample characteristics** provides basic information about the sample to allow the reader to assess the study power and its relevance to the broader RPG population (or to a specific population served by a specific grantee). These data includes sample size, racial and ethnic composition, socioeconomic status, number and ages of children, whether parents had substance abuse problems, and whether families were involved with the child welfare system.

- **Favorable results** notes statistically significant outcomes that were favorable to the treatment group in RCTs or QEDs. We assess statistical significance at the $p \leq 0.05$ level. We categorize these outcomes using the RPG outcome domains: child well-being, permanency/safety, recovery, and family functioning, and note outcomes in other domains separately. Within each domain, we report the favorable outcomes—for example, increased likelihood of family reunification or a decrease in children's angry behavior—and the magnitude of the difference between the treatment and control/comparison group, if available. Where possible, we report standardized coefficients. Studies that were not RCTs or QEDs, or that had no statistically significant favorable results, are marked "not applicable."
- **Other comments** notes information that does not fit into the above categories but may help the reader better understand the context of the study. These data may include additional information about the sample, issues the evidence review source raised about the study (for example, lax fidelity checks), or other information, such as the developer's involvement in conducting the study. This field may also list negative results.

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V. FINDINGS AND DISCUSSION

The RPG-funded programs include a range of interventions and services supported by existing research. Grantees identified in their applications a total of 51 program models deemed EBPs, with most grantees proposing more than one EBP. Overlap across grantees, however, was not common; of the 51 models, 32 were proposed by only one grantee.

To enhance our understanding of the proposed EBPs, we selected nine for further review. Each of these EBPs was proposed by more than one grantee and identified as important to the fields of child welfare services and substance abuse treatment. The review process included gathering and summarizing information on studies identified and in some cases rated by existing evidence reviews, such as the California Evidence-Based Clearinghouse for Child Welfare and the National Registry of Evidence-based Programs and Practices.

The review of the nine selected evidence-based practices (detailed in Appendix C) revealed both strengths of the existing research and gaps in our knowledge, particularly related to the effectiveness of these practices among families most likely to be served by RPG programs (Table V.1). More specifically, we found the following:

- Six of the nine prioritized EBPs have at least one randomized-controlled trial, reflecting the field's commitment to conducting rigorous research on effectiveness. Randomized controlled trials are one of the strongest research designs for determining whether the program model—instead of other factors, such as participants' motivation, natural change over time, or other programs in the area—caused observed outcomes. Thus, the RCTs provide valuable information regarding the models' effectiveness among the families studied. The EBPs with RCTs were Child-Parent Psychotherapy, Hazelden Living in Balance Program, the Matrix Model, Seeking Safety, Strengthening Families, and Trauma-Focused Cognitive Behavior Therapy.
- Several program models—including Child-Parent Psychotherapy, Strengthening Families Program, and Trauma-Focused Cognitive Behavioral Therapy—were studied with more than five randomized controlled trials. Multiple rigorous studies increase our confidence in the effectiveness of the EBPs by demonstrating replication of results with different samples.
- Three of the nine prioritized EBPs (Family Treatment Drug Court, Nurturing Parenting Programs, and Seeking Safety) had at least one QED study. Although QEDs are not as rigorous as RCTs, they are notable because, rather than simply observing a program's

pre- and post-treatment effects on a sample, they include comparison groups. However, the rigor of a QED depends on the similarity of the comparison group to the treatment group; if the two groups are not similar, it is difficult to argue that treatment caused the difference in their outcomes.

- Across the nine program models, six included studies with families experiencing substance abuse issues and five included studies with families involved in child welfare. However, most did not include families in both categories and not all of the studies were well-designed to detect effects of the EBPs.
- Generally, there is more rigorous evidence of effectiveness of program models serving families with substance abuse issues (four EBPs) relative to those serving families involved in child welfare (two EBPs).
- Two program models (Celebrating Families! and Family Treatment Drug Courts) were supported by studies with samples that were most relevant for RPG: families with substance abuse issues and involvement in the child welfare system. However, neither of those models was studied with a randomized controlled trial, so evidence of effectiveness on any population is somewhat limited.

In sum, most of the program models included in this review are supported by rigorous research that demonstrated favorable effects, but gaps remain. Some models have limited evidence of effectiveness overall, and none has strong evidence that the EBPs work well for families likely to be served by RPG—that is, those families struggling with substance abuse issues and involved with the child welfare system. Given these gaps and the clear need for more information to guide both practice and research, RPG local and cross-site evaluations have an opportunity to build on the existing evidence base and extend our knowledge about program effectiveness for these vulnerable families.

Table V.1. Summary of Research for Selected EBPs

Program/Practice Name	Number of Studies			Majority of Sample		Summary of Research	
	RCTs	QEDs	Other	Substance abuse	Child welfare involvement	Strengths	Gaps
Celebrating Families!	0	0	2	2	1	Studies include samples highly relevant to RPG: families involved with child welfare and substance abuse issues	No rigorous research on program effectiveness
Child-Parent Psychotherapy	7	0	0	0	3	Numerous rigorous studies, some of which include families involved in child welfare	Effectiveness with families with substance abuse issues is unknown
Family Treatment Drug Court (FTDC, also called Dependency Drug Court)	0	10	0	10	10	Studies include samples highly relevant to RPG: families involved with child welfare and substance abuse issues	No rigorous research on program effectiveness
Hazelden Living in Balance Program (LIB)	1	0	0	1	0	One rigorous study that included families with substance abuse issues	Effectiveness with families involved with child welfare is unknown; one rigorous study of program effectiveness
Matrix Model (Adult Program)	2	0	1	2	0	More than one rigorous study that included families with substance abuse issues	Effectiveness with families involved with child welfare is unknown
Nurturing Parenting Programs (NPP)	0	1	6	0	6	Many studies included families involved in the child welfare system	No rigorous research on program effectiveness
Strengthening Families Program (SFP)	6	0	1	1	0	Numerous rigorous studies	Effectiveness with families involved with child welfare is unknown and the evidence on families with substance abuse issues is limited
Seeking Safety	4	4	5	13	0	Multiple rigorous studies, all of which included families dealing with substance abuse issues	Effectiveness with families involved with child welfare is unknown
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	8	0	2	0	6	Numerous rigorous studies; many included families involved in the child welfare system	Effectiveness for families with substance abuse issues not known

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APPENDIX A

EBPS BY GRANTEE

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RPG: Evidence-Based Programs/Practices (EBPs) by Grantee, Updated July 15, 2013		Center Point	Georgia State University Research Foundation	Judicial Branch, State of Iowa	Northwest Iowa Mental Health Center	Children's Research Triangle	Department for Community-Based Services	Commonwealth of Massachusetts	Families and Children Together	Alternative Opportunities*	The Center for Children and Families**	State of Nevada Division of Child and Family Services	Summit County Children's Services	Oklahoma Department of Mental Health & Substance Abuse Services	Health Federation of Philadelphia	Child & Family Tennessee	Tennessee Department of Mental Health and Substance Abuse Services+	Rockingham Memorial Hospital	Grantees Implementing
EBP	**Category**	**CA**	**GA**	**IA_JB**	**IA_ Seasons**	**IL**	**KY**	**MA**	**ME**	**MO**	**MT**	**NV**	**OH**	**OK**	**PA**	**TN_CF**	**TN_ DMHSAS**	**VA**	**Number**
24/7 Dad	FS: Parent Only									X									*1*
Alternatives for Families–Cognitive Behavioral Therapy (AF–CBT)	CCT++				X														*1*
Attachment, Self-Regulation, and Competence (ARC)	RTT							X											*1*
Celebrating Families!	FS: Full/Child	X	X	X							X								*4*
Centering Pregnancy	FS: Parent Only															X			*1*
Child-Parent Psychotherapy (CPP)	CCT						X	X							X				*3*
Cognitive Behavior Therapy (CBT)	CS						X				X					X	X		*4*
Dialectical Behavior Therapy (DBT)	CS										X								*1*
Family Behavior Therapy (FBT)	CCT															X			*1*
Family Group Conferencing	FS: Full/Child									X									*1*
Family Treatment Drug Court (FTDC)	FTDC			X								X							*2*
Guiding Good Choices (GGC)	FS: Parent Only									X									*1*
Hazelden Co-Occurring Disorders Program (CDP)	SAT										X					X			*2*
Hazelden Living Balance Program (LIB)	SAT	X								X	X								*3*
Helping Men Recover	SAT						X												*1*
Head Start	FS: Full/Child	X																	*1*
Healthy Families	FS: Parent Only																	X	*1*

RPG: Evidence-Based Programs/Practices (EBPs) by Grantee, Updated July 15, 2013		Center Point	Georgia State University Research Foundation	Judicial Branch, State of Iowa	Northwest Iowa Mental Health Center	Children's Research Triangle	Department for Community-Based Services	Commonwealth of Massachusetts	Families and Children Together	Alternative Opportunities*	The Center for Children and Families**	State of Nevada Division of Child and Family Services	Summit County Children's Services	Oklahoma Department of Mental Health & Substance Abuse Services	Health Federation of Philadelphia	Child & Family Tennessee	Tennessee Department of Mental Health and Substance Abuse Services+	Rockingham Memorial Hospital	Grantees Implementing
EBP	**Category**	**CA**	**GA**	**IA_JB**	**IA_ Seasons**	**IL**	**KY**	**MA**	**ME**	**MO**	**MT**	**NV**	**OH**	**OK**	**PA**	**TN_CF**	**TN_ DMHSAS**	**VA**	**Number**
Homebuilders Intensive Family Preservation Services	FS: Full/Child									X							X		*2*
Incredible Years Parenting Class	FS: Full/Child										X							X	*2*
Kelly Bear	FS: Full/Child										X								*1*
Keys for Interactive Parenting (KIPS)	FS: Full/Child															X			*1*
Lifespan Integration	RTT				X														*1*
Matrix Model	SAT	X					X			X	X					X			*5*
MindUP	FS: Full/Child										X								*1*
Modified Therapeutic Community (MTC)	SAT	X										X							*2*
Moral Reconation Therapy	CS									X									*1*
Motivational Enhancement Therapy (MET)	CS															X		X	*2*
Motivational Interviewing (MI)	CS					X	X	X			X					X	X	X	*7*
Multisystemic Family Therapy (MST)	FS: Full/Child																		*Potential service at 1*
My Baby and Me (ages 0-3)	FS: Parent Only									X									*1*
Nurse Family Partnership (NFP)	FS: Parent Only															X			*1*
Nurturing Parenting Programs (NPP)	FS: Full/Child		X					X	X	X		X				X			*6*
Parent and Child Interactive Therapy (PCIT)	CCT				X					X									*2*
Parent Child Assistance Program (PCAP)	FS: Parent Only									X									*1*

RPG: Evidence-Based Programs/Practices (EBPs) by Grantee, Updated July 15, 2013		Center Point	Georgia State University Research Foundation	Judicial Branch, State of Iowa	Northwest Iowa Mental Health Center	Children's Research Triangle	Department for Community-Based Services	Commonwealth of Massachusetts	Families and Children Together	Alternative Opportunities*	The Center for Children and Families**	State of Nevada Division of Child and Family Services	Summit County Children's Services	Oklahoma Department of Mental Health & Substance Abuse Services	Health Federation of Philadelphia	Child & Family Tennessee	Tennessee Department of Mental Health and Substance Abuse Services+	Rockingham Memorial Hospital	Grantees Implementing
EBP	**Category**	**CA**	**GA**	**IA_JB**	**IA_ Seasons**	**IL**	**KY**	**MA**	**ME**	**MO**	**MT**	**NV**	**OH**	**OK**	**PA**	**TN_CF**	**TN_ DMHSAS**	**VA**	**Number**
Parents and Children Together (PACT)	FS: Full/Child																		*Potential service at 1*
Parents as Teachers Curriculum	FS: Parent Only																	X	*1*
Partners in Parenting	FS: Full/Child	X																	*1*
Prolonged Exposure	CS		X																*1*
Relapse Prevention Therapy (RPT)	SAT					X					X								*2*
Resource Mothers	FS: Parent Only																	X	*1*
SafeCare	FS: Full/Child		X																*1*
Seeking Safety	RTT++						X	X		X	X					X	X		*6*
Solution Focused Brief Therapy (SFBT)	CS													X					*1*
Staying Connected with Your Teen	FS: Parent Only																	X	*1*
Strengthening Families	FS: Full/Child			X									X	X					*3*
Strong Kids	FS: Full/Child										X								*1*
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)	RTT																		*Potential service at 1*
Supportive Education for Children of Addicted Parents	RTT										X								*1*
Trauma Focused Cognitive Behavior Therapy (TF-CBT)	RTT++		X		X	X				X		X	X			X			*7*
Trauma Recovery and Empowerment Model (TREM)	RTT															X			*1*

RPG: Evidence-Based Programs/Practices (EBPs) by Grantee, Updated July 15, 2013		Center Point	Georgia State University Research Foundation	Judicial Branch, State of Iowa	Northwest Iowa Mental Health Center	Children's Research Triangle	Department for Community-Based Services	Commonwealth of Massachusetts	Families and Children Together	Alternative Opportunities*	The Center for Children and Families**	State of Nevada Division of Child and Family Services	Summit County Children's Services	Oklahoma Department of Mental Health & Substance Abuse Services	Health Federation of Philadelphia	Child & Family Tennessee	Tennessee Department of Mental Health and Substance Abuse Services+	Rockingham Memorial Hospital	Grantees Implementing
EBP	**Category**	**CA**	**GA**	**IA_JB**	**IA_ Seasons**	**IL**	**KY**	**MA**	**ME**	**MO**	**MT**	**NV**	**OH**	**OK**	**PA**	**TN_CF**	**TN_ DMHSAS**	**VA**	**Number**
Untangling Relationships	SAT										X								*1*
Total per Grantee		**6**	**5**	**3**	**4**	**3**	**6**	**5**	**1**	**13**	**15**	**4**	**2**	**2**	**1**	**13**	**4**	**7**	
Total EBPs Identified by Any Grantee																			**51**
Evidence-Based Approach or Staffing																			
Recovery Coach				X			X	X		X						X			5
Screening, Brief Intervention, and Referral to Treatment (SBIRT)		X						X	X										3
Organization-Focused EBP																			
Sanctuary Model									X										1

Notes: The pink shaded cells represent services that are either (1) not part of the grantee's core programming but may be offered to participants (GA, MT) or (2) services the grantee is prepared to offer in the future (IL).

Green shaded cells identify programs that grantees added during the first reporting period, after the January 2013 version of this list.

* Alternative Opportunities (MO) will offer participants services based on the following EBPs: Hazelden Living in Balance Program, Matrix Model, Moral Reconation Therapy, and Seeking Safety.

However, the grantee will take parts of each of those programs and combine them with the substance abuse treatment that will be offered to participants.

** In addition to the noncore EBPs listed above, the following services are also available to participants in the Center for Children and Families (MT) RPG program:

- Functional Family Therapy
- Circle of Security
- Addictions and Trauma Recovery Integration Model (ATRIUM)
- Safety, Emotions, Loss and Future Curriculum (S.E.L.F.)

MT will offer Untangling Relationships combined with Seeking Safety.

\+ Tennessee Department of Mental Health and Substance Abuse Services offers a program that is similar to, but not, Homebuilders.

++These EBPs overlap with or contain elements of the cognitive behavior therapy counseling style category.

CCT = child-caregiver therapy; CS = counseling style; FS = family strengthening (full/child = has a full-family or child component; parent only = has only parent component); FTDC = Family Treatment Drug Court; RTT = response to trauma; SAT = substance abuse treatment.

APPENDIX B

EVIDENCE SOURCES – RATING APPROACHES AND SCALES

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EVIDENCE SOURCES – RATING APPROACHES AND SCALES

This appendix provides information on the rating approaches and scales of each of the five evidence sources used in this report:

1. California Evidence-Based Clearinghouse for Child Welfare
2. Home Visiting Evidence of Effectiveness
3. National Registry of Evidence-based Programs and Practices
4. Office of Juvenile Justice and Delinquency Prevention Model Program Guide
5. Promising Practices Network on Children, Families, and Communities

Information is drawn from each evidence source's website.

California Evidence-Based Clearinghouse for Child Welfare (CEBC)

Programs are rated on a Scientific Rating Scale. This scale is a 1 to 5 rating of the strength of the research evidence supporting a practice or program. A scientific rating of 1 represents a practice with the strongest research evidence, and a 5 represents a concerning practice that appears to pose substantial risk to children and families. Some programs that lack adequate research evidence to be rated on the Scientific Rating Scale are classified as NR (not able to be rated).

How Interventions are Chosen for Review

The CEBC Advisory Committee is consulted annually to determine the topic areas that will be added to the website. Once those topic areas are chosen, a topic expert for each area is recruited. After the definition of the topic area is finalized, the topic expert generates a list of relevant potential programs. CEBC staff also conducts an extensive literature search to identify relevant programs. The lists are then combined and reviewed with the topic expert to determine a final list.

Scientific Rating Scale

The CEBC conducts periodic re-reviews to search for newly published, peer-reviewed research on already-rated programs. Program representatives may also submit newly published, peer-reviewed studies to initiate the re-review process at any time.

For the practice to be rated, it must meet the following criteria:

- A book, manual, and/or other writings must be available that specify components of the service and describes how to administer it.
- There can be no case data suggesting a risk of harm that was (a) likely caused by the treatment and (b) severe or frequent.
- There can be no legal or empirical basis suggesting that compared with its likely benefits, the practice constitutes a risk of harm to those receiving it.

For ratings of 1-3,

- Outcomes of research studies must be published in peer-reviewed journal.
- Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects.
- If multiple outcome studies have been published, the overall weight of the evidence must support the benefit of the practice. There can be no case data suggesting a risk of harm that was (a) likely caused by the treatment and (b) severe or frequent.

1. Well-Supported by Research Evidence

- Multiple Site Replication: At least two rigorous randomized controlled trials (RCTs) in different usual care or practice settings have found the practice to be superior to an appropriate comparison practice.
- In at least one RCT, the practice has been shown to have a sustained effect at least one year beyond the end of treatment.

2. Supported by Research Evidence

- At least one rigorous randomized controlled trial (RCT) in usual care or a practice setting has found the practice to be superior to an appropriate comparison practice.
- In at least one RCT, the practice has been shown to have a sustained effect at least six months beyond the end of treatment.

3. Promising Research Evidence

- At least one study utilizing some form of control (for example, untreated group, placebo group, matched wait-list study) has established the practice's benefit over the control, or found it to be comparable to a practice rated a 1, 2, or 3 on this rating scale or superior to an appropriate comparison practice.
- In at least one RCT, the practice has been shown to have a sustained effect of at least six months beyond the end of treatment.

4. Evidence Fails to Demonstrate Effect

- Two or more randomized controlled trials (RCTs) have found the practice has not resulted in improved outcomes, when compared to usual care. The studies have been reported in published, peer-reviewed literature.
- If multiple outcome studies have been conducted, the overall weight of evidence does not support the benefit of the practice. The overall weight of evidence is based on the preponderance of published, peer-reviewed studies, and not a systematic review or meta-analysis. For example, if there have been three published RCTs and two of them showed the program did not have the desired effect, then the program would be rated a 4.

5. Concerning Practice

- If multiple outcome studies have been conducted, the overall weight of evidence suggests the intervention has a negative effect upon clients served; and/or
- There is case data suggesting a risk of harm that was (a) likely caused by the treatment and (b) severe or frequent; and/or
- There is a legal or empirical basis suggesting that, compared with its likely benefits, the practice constitutes a risk of harm to those receiving it.

NR. Not Able to be Rated

- There is no case data suggesting a risk of harm that was (a) likely caused by the treatment and (b) severe or frequent.
- There is no legal or empirical basis suggesting that, compared with its likely benefits, the practice constitutes a risk of harm to those receiving it.
- A book, manual, and/or other publication specifies the components of the practice protocol and describes how to administer it.
- The practice is generally accepted in clinical administration as appropriate for use with children receiving services from child welfare or related systems and their parents/caregivers.
- The practice has no published, peer-reviewed study utilizing some form of control (for example, untreated group, placebo group, matched wait-list study) that has established the practice's benefit over the placebo, or found it to be comparable to or better than an appropriate comparison practice.
- The practice does not meet criteria for any other level on the CEBC Scientific Rating Scale.

Home Visiting Evidence of Effectiveness (HomVEE)

HomVEE conducts a thorough and transparent review of the home visiting research literature and provides an assessment of the evidence of effectiveness for home visiting programs models that target families with pregnant women and children from birth to age 5. Studies receive a rating of (1) high, (2) moderate, or (3) low. Programs are assessed to determine whether they meet DHHS' criteria for an "evidence-based early childhood home visiting service delivery model."

How Interventions Are Chosen for Review

Each year, the HomVEE team conducts a broad search for literature on home visiting program models serving pregnant women or families with children from birth to age 5. At the beginning of each calendar year, HomVEE issues a call for studies. To prioritize home visiting models for inclusion in the review, the HomVEE team created a point system for ranking models. Points are assigned to models based on the following:

- The number and design of impact studies (three points for each randomized controlled trial and two points for each quasi-experimental design)

- Sample sizes of impact studies (one point for each study with a sample size of 50 or more; starting in 2013, this cutoff will increase to 250)

During the prioritization process, the HomVEE team also tries to determine whether the program appears to be operational and identify the availability of implementation information on the model.

Information Provided in Review

The **program model reports** provide a brief program model description, a review of studies, evidence of program model effectiveness, and a summary of findings by outcome domain. They also include details about the studies reviewed.

Outcome domain reports provide a brief overview of the outcome domain, measurement considerations, evidence of effectiveness for outcomes in the domain, and a summary of findings for the domain by program model. They also include details on specific outcomes, outcome measures used in the studies, and review procedures.

Implementation profiles provide a description of the program model, prerequisites for implementation, training requirements, materials and forms, estimated costs, implementation experiences, and program model contact information.

Study Ratings

The study-level ratings—(1) high, (2) moderate, and (3) low—provide a measure of how well the study design could provide unbiased estimates of model impacts. In brief, the high rating is reserved for random assignment studies with low attrition of sample members and no reassignment of sample members after the original random assignment, and single case and regression discontinuity designs that meet the What Works Clearinghouse (WWC) design standards (Table B.1). The moderate rating applies to random assignment studies that, due to flaws in the study design or analysis (for example, high sample attrition), do not meet all the criteria for the high rating; matched comparison group designs; and single case and regression discontinuity designs that meet WWC design standards with reservations. Studies that do not meet all of the criteria for either the high or moderate ratings are assigned the low rating.

Table B.1. Summary of Study Rating Criteria for the HomVEE Review

HomVEE Study Rating	Randomized Controlled Trials	Quasi-Experimental Designs		
		Matched Comparison Group	Single Case Design	Regression Discontinuity
High	Random assignment Meets WWC standards for acceptable rates of overall and differential attrition [a] No reassignment; analysis must be based on original assignment to study arms No confounding factors; must have at least two participants in each study arm and no systematic differences in data collection methods Controls for selected measures if groups are different at baseline	Not applicable	Timing of intervention is systematically manipulated Outcomes meet WWC standards for interassessor agreement At least three attempts to demonstrate an effect At least five data points in relevant phases	Integrity of forcing variable is maintained Meets WWC standards for low overall and differential attrition Relationship between the outcome and the forcing variable is continuous Meets WWC standards for functional form and bandwidth
Moderate	Reassignment OR unacceptable rates of overall or differential attrition Baseline equivalence established on selected measures No confounding factors; must have at least two participants in each study arm and no systematic differences in data collection methods	Baseline equivalence established on selected measures and controls for baseline measures of outcomes, if applicable No confounding factors; must have at least two participants in each study arm and no systematic differences in data collection methods	Timing of intervention is systematically manipulated Outcomes meet WWC standards for interassessor agreement At least three attempts to demonstrate an effect At least three data points in relevant phases	Integrity of forcing variable is maintained Meets WWC standards for low attrition Meets WWC standards for functional form and bandwidth
Low	Studies that do not meet the requirements for a high or moderate rating			

"Evidence-Based Early Childhood Home Visiting Service Delivery Model"

To meet DHHS' criteria for an "evidence-based early childhood home visiting service delivery model," program models must meet at least one of the following criteria:

- At least one high- or moderate-quality impact study of the model finds favorable, statistically significant impacts in two or more of the eight outcome domains.
- At least two high- or moderate-quality impact studies of the model use nonoverlapping analytic study samples with at least one favorable, statistically significant impact in the same domain.

In both cases, the impacts must either (a) be found in the full sample or (b) if found for subgroups but not for the full sample, be replicated in the same domain in two or more studies using nonoverlapping analytic study samples. Additionally, following the legislation, if the program model meets the above criteria based on findings from only randomized controlled trials, then at least one favorable, statistically significant impact must be sustained for at least one year after program enrollment, and at least one favorable, statistically significant impact must be reported in a peer-reviewed journal.

Assessing Evidence of Effectiveness

After completing all impact study reviews for a program model, the HomVEE team evaluated the evidence across all studies of the model that received a high or moderate rating and measured outcomes in at least one of the eligible outcome domains. In addition to assessing whether each model met the DHHS criteria for an evidence-based early childhood home visiting service delivery model, the HomVEE team examined other aspects of the evidence for each model, including the following:

- **Quality of outcome measures.** HomVEE classified outcome measures as primary if data were collected through direct observation, direct assessment, or administrative records; or if self-reported data were collected using a standardized (normed) instrument. Other self-reported measures are classified as secondary.
- **Duration of impacts.** To provide information on the length of follow-up, HomVEE noted when the outcomes were measured.
- **Sustained impacts.** HomVEE classified impacts as sustained if they were measured at least one year after program enrollment.
- **Replication of impacts.** HomVEE classified impacts as replicated if favorable, statistically significant impacts were shown in the same outcome domain in at least two nonoverlapping analytic study samples.
- **Subgroup findings.** HomVEE reports subgroup findings if such findings are replicated in the same outcome domain in at least two studies using different analytic samples.
- **Unfavorable impacts.** In addition to favorable impacts, HomVEE reports unfavorable, statistically significant impacts on full sample and subgroup findings. Although some outcomes are clearly unfavorable (such as an increase in children's behavior problems), others are ambiguous. For example, an increase in the number of days mothers are hospitalized could indicate an increase in health problems or increased access to needed health care due to participation in a home visiting program.
- **Evaluator independence.** HomVEE reported the funding source for each study and whether any of the study authors were program model developers.
- **Magnitude of impacts.** HomVEE reported effect sizes when possible, either those calculated by the study authors or HomVEE-computed findings

National Registry of Evidence-Based Programs and Practices (NREPP)

SAMHSA's NREPP is a searchable online registry of mental health and substance abuse treatment interventions that have been independently reviewed and rated. NREPP's Quality of Research ratings are indicators of the strength of the evidence supporting the outcomes of the

intervention. Higher scores indicate stronger, more compelling evidence. Each outcome is rated separately, because interventions may target multiple outcomes (for example, alcohol use, marijuana use, behavior problems in school), and the evidence supporting the different outcomes may vary. NREPP ratings do not reflect an intervention's effectiveness.

How Interventions Are Chosen for Review

NREPP is a voluntary, self-nominating system in which intervention developers elect to participate.

Information Provided in Review

NREPP publishes a report called an intervention summary for every intervention it reviews. Each intervention summary includes the following:

- General information about the intervention
- A description of the research outcomes reviewed
- Quality of Research and Readiness for Dissemination ratings
- A list of studies and materials reviewed
- Contact information to obtain more information about implementation or research

Criteria for Rating Quality of Research

Each reviewer independently evaluates the Quality of Research for an intervention's reported results using the following six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

Reviewers use a scale of 0.0 to 4.0, with 4.0 being the highest rating given.

1. Reliability of Measures

Outcome measures should have acceptable reliability to be interpretable. "Acceptable" here means reliability at a level that is conventionally accepted by experts in the field.

- 0 = Absence of evidence of reliability or evidence that some relevant types of reliability (for example, test-retest, inter-rater, inter-item) did not reach acceptable levels.
- 2 = All relevant types of reliability have been documented to be at acceptable levels in studies by the applicant.

- 4 = All relevant types of reliability have been documented to be at acceptable levels in studies by independent investigators.

2. Validity of Measures

Outcome measures should have acceptable validity to be interpretable. "Acceptable" here means validity at a level that is conventionally accepted by experts in the field.

- 0 = Absence of evidence of measure validity, or some evidence that the measure is not valid.
- 2 = Measure has face validity; absence of evidence that measure is not valid.
- 4 = Measure has one or more acceptable forms of criterion-related validity (correlation with appropriate, validated measures or objective criteria); OR, for objective measures of response, there are procedural checks to confirm data validity; absence of evidence that measure is not valid.

3. Intervention Fidelity

The "experimental" intervention implemented in a study should have fidelity to the intervention proposed by the applicant. Instruments that have tested acceptable psychometric properties (for example, inter-rater reliability, validity as shown by positive association with outcomes) provide the highest level of evidence.

- 0 = Absence of evidence or only narrative evidence that the applicant or provider believes the intervention was implemented with acceptable fidelity.
- 2 = Evidence of acceptable fidelity in the form of judgments by experts, systematic collection of data (for example, dosage, time spent in training, adherence to guidelines or a manual), or a fidelity measure with unspecified or unknown psychometric properties.
- 4 = Evidence of acceptable fidelity from a tested fidelity instrument shown to have reliability and validity.

4. Missing Data and Attrition

Study results can be biased by participant attrition and other forms of missing data. Statistical methods as supported by theory and research can be employed to control for missing data and attrition that would bias results, but studies with no attrition or missing data needing adjustment provide the strongest evidence that results are not biased.

- 0 = Missing data and attrition were taken into account inadequately, OR there was too much to control for bias.
- 2 = Missing data and attrition were taken into account by simple estimates of data and observations, or by demonstrations of similarity between remaining participants and those lost to attrition.
- 4 = Missing data and attrition were taken into account by more sophisticated methods that model missing data, observations, or participants, OR there were no attrition or missing data needing adjustment.

5. Potential Confounding Variables

Often variables other than the intervention may account for the reported outcomes. The degree to which confounding variables are accounted for affects the strength of causal inference.

- 0 = Confounding variables or factors were as likely to account for the outcomes reported as were the hypothesized causes.
- 2 = One or more potential confounding variables or factors were not completely addressed, but the intervention appears more likely than these confounding factors to account for the outcomes reported.
- 4 = All known potential confounding variables appear to have been completely addressed to allow causal inference between the intervention and outcomes reported.

6. Appropriateness of Analysis

Appropriate analysis is necessary to make an inference that an intervention caused reported outcomes.

- 0 = Analyses were not appropriate for inferring relationships between intervention and outcome, OR sample size was inadequate.
- 2 = Some analyses may not have been appropriate for inferring relationships between intervention and outcome, OR sample size may have been inadequate.
- 4 = Analyses were appropriate for inferring relationships between intervention and outcome. Sample size and power were adequate.

Reviewer Selection and Training

All NREPP reviewers are recruited, selected, and approved by SAMHSA based on their experience and areas of expertise. Once approved by SAMHSA, reviewers participate in at least two hours of training on the procedures and criteria they will use to rate interventions. SAMHSA does not assign reviewers to specific interventions. Instead, assignments are made by NREPP contract staff. Interventions are matched with reviewers having appropriate qualifications and the most relevant experience and content knowledge. The identity of assigned reviewers is kept confidential from both SAMHSA and the applicant.

Qualifications/Minimum Requirements for Reviewers

Quality of Research reviewers must possess the following:

- A doctoral-level degree
- A strong background and understanding of current methods of evaluating prevention and treatment interventions

In addition, candidates who have direct experience providing prevention and/or treatment services are preferred.

Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Program Guide (MPG)

The MPG evidence ratings are based on the evaluation literature of specific prevention and intervention programs. The overall rating is derived from four summary dimensions of program effectiveness:

1. Conceptual framework
2. Program fidelity
3. Evaluation design
4. Empirical evidence demonstrating the prevention or reduction of problem behavior; the reduction of risk factors related to problem behavior; or the enhancement of protective factors related to problem behavior

The effectiveness dimensions as well as the overall scores are used to classify programs into three categories that are designed to provide the user with a summary knowledge base of the research supporting a particular program. A brief description of the rating criteria is provided below.

Exemplary. In general, when implemented with a high degree of fidelity, these programs demonstrate robust empirical findings using a reputable conceptual framework and an evaluation design of the highest quality (experimental).

Effective. In general, when implemented with sufficient fidelity, these programs demonstrate adequate empirical findings using a sound conceptual framework and an evaluation design of high quality (quasi-experimental).

Promising. In general, when implemented with minimal fidelity, these programs demonstrate promising (perhaps inconsistent) empirical findings using a reasonable conceptual framework and a limited evaluation design that requires causal confirmation using more appropriate experimental techniques.

Promising Practices Network on Children, Families and Communities (PPN)

Evidence Levels

Proven and Promising Programs. Programs are generally assigned either a "Proven" or a "Promising" rating, depending on whether they have met the evidence criteria below. In some cases, a program may receive a Proven rating for one indicator and a Promising rating for a different indicator. In this case, the evidence level assigned will be Proven/Promising, and the program summary will specify by indicator how the evidence levels were assigned.

Other Reviewed Programs. Some programs on the PPN site are identified as "Other Reviewed Programs." These programs have not undergone a full review by PPN, but evidence of their effectiveness has been reviewed by one or more credible organizations that apply similar evidence criteria. Other Reviewed Programs may be fully reviewed by PPN in the future and identified as Proven or Promising, but will be identified in the interim as Other Reviewed Programs.

Table B.1. PPN Evidence Criteria

Type of Information	Proven Program	Promising Program	Not Listed on Site
Number of Criteria Program Must Meet	Program must meet all of these criteria to be listed as "Proven."	Program must meet at least all of these criteria to be listed as "Promising."	If a program meets any of these conditions, it will not be listed on the site.
Type of Outcomes Affected	Program must directly impact one of the indicators used on the site.	Program may impact an intermediary outcome for which there is evidence that it is associated with one of the PPN indicators.	Program impacts an outcome that is not related to children or their families, or for which there is little or no evidence that it is related to a PPN indicators (such as the number of applications for teaching positions).
Substantial Effect Size	At least one outcome is changed by 20%, 0.25 standard deviations, or more.	Change in outcome is more than 1%.	No outcome is changed more than 1%.
Statistical Significance	At least one outcome with a substantial effect size is statistically significant at the 5% level.	Outcome change is significant at the 10% level (marginally significant).	No outcome change is significant at less than the 10% level.
Comparison Groups	Study design uses a convincing comparison group to identify program impacts, including randomized-control trial (experimental design) or some quasi-experimental designs.	Study has a comparison group, but it may exhibit some weaknesses; for example, the groups lack comparability on pre-existing variables, or the analysis does not employ appropriate statistical controls.	Study does not use a convincing comparison group—for example, the use of before and after comparisons for only the treatment group.
Sample Size	Sample size of evaluation exceeds 30 in both the treatment and comparison groups.	Sample size of evaluation exceeds 10 in both the treatment and comparison groups.	Sample size of evaluation includes less than 10 in the treatment or comparison group.
Availability of Program Evaluation Documentation	Publicly available.	Publicly available.	Distribution is restricted, for example to only the sponsor of the evaluation.

Note: Additional considerations made on a case-by-case basis and may include attrition, quality of outcome measures, and others.

Currently, PPN does not require programs to meet the following criteria:

- Be currently implemented in some location and provide technical assistance or support.
- Have been replicated numerous times. (Although PPN recognizes the importance of program replication and fidelity to program success, it believes there is value to including information about programs that have successfully improved outcomes for children and families but have not been replicated.)
- Have articulated as program goals the outcomes they impact. (For example, if a program was designed to reduce violence but met the criteria for a proven program because it reduced drug use, PPN would list the program as a "Proven" program under the drug use reduction indicator, even though the program did not intend to reduce drug use.)
- Have an evaluation published in a peer-reviewed journal. Nor does PPN count as "Proven" every evaluation that has been published in a peer-reviewed journal.

SOURCES

California Evidence-Based Clearinghouse for Child Welfare. "Scientific Rating Scale." San Diego, CA: California Evidence-Based Clearinghouse for Child Welfare, 2009. Available at [http://www.cebc4cw.org/ratings/scientific-rating-scale/]. Accessed July 7, 2013.

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RAND Corporation. "Promising Practices Network: How Programs Are Considered." Santa Monica, CA: RAND Corporation and Promising Practices Network, 2012. Available at [http://www.promisingpractices.net/criteria.asp]. Accessed July 7, 2013.

U.S. Department of Health and Human Services. "Home Visiting Evidence of Effectiveness: Review Process." Washington, DC: DHHS, Administration for Children and Families, n.d. Available at [http://homvee.acf.hhs.gov/document.aspx?rid=4&sid=19]. Accessed July 7, 2013.

APPENDIX C

EVIDENCE REVIEWS

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EVIDENCE REVIEWS

This appendix contains our evidence reviews of each program. It contains a summary table for each EBP, followed by a series of tables that provide details on the individual studies reviewed by evidence sources.

For explanations of the ratings systems used by various evidence sources, see Appendix B. Tables indicate that study ratings are not available if the evidence review source does not rate studies, or if a rating was not available for the study discussed.

We use the following abbreviations for evidence sources:

- CEBC: California Evidence-Based Clearinghouse for Child Welfare
- HomVEE: Home Visiting Evidence of Effectiveness
- NREPP: SAMHSA's National Registry of Evidence-based Programs and Practices
- OJJDP: Office of Juvenile Justice and Delinquency Prevention Model Program Guide
- PPN: Promising Practices Network on Children, Families, and Communities

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Table C.1. Celebrating Families! Evidence Summary

Level of Evidence	
NREPP Review Ratings *(0.0–4.0 scale, 4.0 = highest quality)*	2.1–2.6 (Review last updated in April 2008)
Study Designs	
Number of randomized controlled trials (RCTs)	None
Number of quasi-experimental designs (QEDs)	None
Number of studies with other designs	2
Demonstrated Effects	
Favorable effects in RCTs or QEDs on parents	Not applicable
Favorable effects in RCTs or QEDs on children (specify children's age)	Not applicable
Sample Characteristics	
Samples with majority (or subgroups) of parents with substance abuse issues	2 studies
Samples with majority (or subgroups) of families involved in child welfare or child protective services	1 study
Relevance for RPG	
Favorable relevant findings in RCT or QED with sample that has substance abuse issues and/or child welfare involvement	Not applicable
Other Information	
Program developer	Rosemary Tisch and Linda Sibley of Prevention Partnership International and Family Resources International for Judge Edward's Family Dependency Treatment Court
Intended program outcomes	According to NREPP, the program aims to break the cycle of substance abuse and dependency within families, decrease substance use and reduce relapse, and facilitate successful family reunification.

Study and Review Information: Celebrating Families!	
Study citation	Lutra Group. (2006). *Year One (FY 05–06) evaluation report for the Celebrating Families! grant.* Unpublished report. Salt Lake City, UT: Author.
Source	NREPP
Study rating	Outcomes rated 2.1–2.6 out of 4
Study Design	
Approach to assessing impacts	Other design: Pre/post study
Sample Characteristics	
Sample size	Not reported
Race and ethnicity	42.9% White 37.1% Hispanic or Latino 20.0% race/ethnicity unspecified Note: unclear if reported race/ethnicity is of parents or children.
Socioeconomic status	Not reported
Number and age of children	The child sample fell within NREPP's childhood (6–12 years) and adolescent (13–17) age categories. The sample size is not reported.
Whether parent(s) has substance use problems	The sample comprised parents in early recovery from substance dependence. Some of the sample was recruited from a women's residential treatment facility.
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	Not applicable
Permanency and safety	Not applicable
Recovery	Not applicable
Family functioning	Not applicable
Other	Not applicable

Other Comments

- Too little information is available to assess most of the measures used; the measures represent selected items from larger scales or were developed by the principal evaluator without any independent testing of validity and reliability.
- Assessment instruments were changed to a retrospective pre-/post-assessment due to a lack of confidence in the truthful response rate of the pre-test data.
- While fidelity checks were in place, the authors acknowledged that not all content was delivered; it is unclear what content was not delivered as planned and why. The study had a weak design with multiple threats to internal validity.
- Although the sample size was not reported, NREPP described it as "small," and that the "authors were aware that cases had missing values, yet no analytic strategies were used to address missing data."
- The developer contracted with the Lutra Group to conduct the evaluation.

Information accessed at http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=100 on April 3, 2013.

* Includes statistically significant outcomes (p-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Celebrating Families!	
Study citation	Quittan, G. A. (2004). *An evaluation of the impact of the Celebrating Families Program and Family Drug Treatment Court on parents receiving Family Reunification Services.* (Unpublished master's thesis). San Jose State University, San Jose, California.
Source	NREPP
Study rating	The single outcome rated 2.1 out of 4.
Study Design	
Approach to assessing impacts	Quasi-experimental design: matched comparison group
Sample Characteristics	
Sample size	Not reported
Race and ethnicity	44.9% Hispanic or Latino 39.7% White 7.7% Black or African American 6.4% race/ethnicity unspecified 1.3% American Indian or Alaska Native
Socioeconomic status	Not reported
Number and age of children	Not reported
Whether parent(s) has substance use problems	The sample comprised parents with a history of participation in one of three treatment programs: CF!, Family Treatment Drug Court, or the traditional child welfare case plan.
Involvement with child welfare system	The sample comprised mothers involved in the child welfare system.
Favorable Results*	
Child well-being	None
Permanency and safety	None
Recovery	None
Family functioning	None
Other	None

Other Comments

- The study was described as having a weak design with multiple threats to internal validity.
- The author used retrospective chart review to identify women with a history of participation in one of three treatment programs: CF!, Family Treatment Drug Court, or the traditional child welfare case plan.
- Although the sample size was not reported, it was described as “small.”
- Treatment and comparison groups were matched on only a small number of variables.

Information accessed at http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=100 on April 3, 2013.

* Includes statistically significant outcomes (p-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

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Table C.2. Child-Parent Psychotherapy Evidence Summary

Level of Evidence	
CEBC Review Rating (1–5 scale, 1 = best supported)	2: Supported by Research Evidence
NREPP Review Ratings (0.0–4.0 scale, 4.0 = highest quality)	3.3–3.9
Study Designs	
Number of randomized-controlled trials (RCTs)	7
Number of quasi-experimental designs (QEDs)	None
Number of studies with other designs	None
Demonstrated Effects	
Favorable effects in RCTs or QEDs on parents	• PTSD symptoms • Other mental health symptoms • Avoidance symptoms • Empathetic responsiveness and goal-corrected partnership
Favorable effects in RCTs or QEDs on children (specify children's age)	• Angry behavior (11–14 months, 3–5 years) • Secure attachment to mother (13 months, 20 months) • Intelligence (20 months—note: found only in study with nonlow SES sample) • Maternal representation (4–5) • Self-representation (4–5) • PTSD symptoms (3–5 years)
Sample Characteristics	
Samples with majority (or subgroups) of parents with substance abuse issues	Substance abuse prevalence among study populations is not discussed in the CEBC or NREPP evidence reviews.
Samples with majority (or subgroups) of families involved in child welfare or child protective services	3 studies
Relevance for RPG	
Favorable relevant findings in RCT or QED with sample that has substance abuse issues and/or child welfare involvement	Unclear because no information about substance abuse is available in summaries.
Other Information	
Program developer	University of California, San Francisco Child Trauma Research Program (Personnel: Alicia F. Lieberman, Patricia Van Horn, and Chandra Ghosh Ippen)
Intended program outcomes	According to NREPP, Child-Parent Psychotherapy aims to support and strengthen the child-caregiver relationship in order to restore the child's sense of safety, attachment, and appropriate affect, as well as improve the child's cognitive, behavioral, and social functioning.

Study and Review Information: Child-Parent Psychotherapy	
Study citation	Lieberman, A. F., Weston, D. R., & Pawl, J. H. (1991). Preventive interaction and outcome with anxiously attached dyads. *Child Development, 62,* 199–209.
Source	CEBC
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Randomized controlled trial
Sample Characteristics	
Sample size	59 mother-child pairs
Race and ethnicity	Not reported
Socioeconomic status	Study population comprised low SES mothers and their children
Number and age of children	59 children, 11 to 14 months at baseline
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	Angry behavior (compared to anxious control group)
Permanency and safety	None
Recovery	None
Family functioning	Empathetic responsiveness (compared to anxious control group) Goal-corrected partnership (compared to anxious control group)
Other	None

Other Comments

- Study population consisted of recent immigrants from Mexico and Central America.
- 93 mother-infant pairs were assessed for attachment. Anxiously attached pairs were randomly assigned to an intervention or control group (intervention group numbered 34 mother-child pairs; anxious control group numbered 25). A second control group of 34 pairs found to be securely attached at baseline was also formed.

Information accessed at http://www.cebc4cw.org/program/child-parent-psychotherapy/detailed on April 1, 2013.

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Child-Parent Psychotherapy	
Study citation	Cicchetti, D., Toth, S. L., & Rogosch, F. A. (1999). The efficacy of toddler-parent psychotherapy to increase attachment security in off-spring of depressed mothers. *Attachment & Human Development, 1*(1), 34-–66.
Source	CEBC
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Randomized controlled trial
Sample Characteristics	
Sample size	63 mothers and their young children
Race and ethnicity	Not reported
Socioeconomic status	Sample did not include low SES mothers.
Number and age of children	63 children, 20.4 months at baseline, on average
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	Secure attachment to mother (compared to depressed control group)
Permanency and safety	None
Recovery	None
Family functioning	None
Other	None
Other Comments	

- Specific intervention was Toddler-Parent Psychotherapy.
- Sample comprised 63 depressed mothers who were randomly assigned to receive the treatment or not. A second control group of 45 nondepressed mothers and their children was also formed.
- At baseline, both the intervention and depressed control groups had a higher proportion of insecurely attached children than the nondepressed control group. At follow-up, the intervention group's proportion of insecurely attached children had decreased to the point that it was no longer significantly different from that of the nondepressed group, while the depressed control group experienced an increase in insecure attachment.
- Review notes that study is "somewhat limited … by the use of a more subjective method of classifying children's attachment."

Information accessed at http://www.cebc4cw.org/program/child-parent-psychotherapy/detailed on April 1, 2013.

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Child-Parent Psychotherapy	
Study citation	Cicchetti, D., Rogosch, F. A., & Toth, S. L. (2000). The efficacy Toddler-Parent Psychotherapy for fostering cognitive development in offspring of depressed mothers. *Journal of Abnormal Child Psychology, 28*(2), 135–148.
Source	CEBC
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Randomized controlled trial
Sample Characteristics	
Sample size	158 mother-child pairs
Race and ethnicity	92.4% Caucasian
Socioeconomic status	Sample did not include low SES mothers.
Number and age of children	20.5 months, on average
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	Child intelligence (compared to depressed control group)
Permanency and safety	None
Recovery	None
Family functioning	None
Other	None
Other Comments	

- Study includes participants from the sample described in Cicchetti et al., 1999.
- Specific intervention was Toddler-Parent Psychotherapy.

Information accessed at http://www.cebc4cw.org/program/child-parent-psychotherapy/detailed on April 1, 2013.

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Child-Parent Psychotherapy	
Study citation	Toth, S. L., Maughan, A., Manly, J. T., Spagnola, M., & Cicchetti, D. (2002). The relative efficacy of two interventions in altering maltreated preschool children's representational models: Implications for attachment theory. *Development and Psychopathology, 14*, 877–908.
Sources	1. NREPP 2. CEBC (information from this source noted with [CEBC] below) 3. Study abstract on PubMed (information from this source noted with [Abstract] below)
Study rating	3.8 (NREPP)
Study Design	
Approach to assessing impacts	Randomized controlled trial
Sample Characteristics	
Sample size	87 mother-child pairs (Abstract)
Race and ethnicity	23.8% White 76.2% race/ethnicity unspecified
Socioeconomic status	Not reported
Number and age of children	87 children, age 4–5 (CEBC & NREPP)
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Families in the study had a documented history of maltreatment and were recruited through the Department of Social Services.
Favorable Results*	
Child well-being	Maternal representations (compared to psychoeducational home visiting group) (CEBC) Self-representation (compared to children in all three comparison groups)
Permanency and safety	None
Recovery	None
Family functioning	None
Other	None

Other Comments

- Specific intervention was Parent Preschooler Psychotherapy (PPP).
- 87 mother-child pairs from maltreating families were randomly assigned to receive PPP, a psychoeducational home visitation (PHV) program, or the community standard. The study also included a comparison group of 35 mother-child pairs from nonmaltreating families.

Information accessed at http://www.cebc4cw.org/program/child-parent-psychotherapy/detailed, http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=194#std464, and http://www.ncbi.nlm.nih.gov/pubmed/12549708 on April 2, 2013.

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Child-Parent Psychotherapy	
Study citation	Lieberman, A. F., Van Horn, P., & Ghosh Ippen, C. (2005). Toward evidence-based treatment: Child-Parent Psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*(12), 1241–1448. *Follow-up:* Lieberman, A. F., Ghosh Ippen, C., & Van Horn, P. (2006). Child-Parent Psychotherapy: 6-month follow-up of a randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*(8), 913–918.
Sources	1. NREPP 2. CEBC (information from this source noted with [CEBC] below; all other information is from NREPP)
Study rating	3.3–3.7 (NREPP)
Study Design	
Approach to assessing impacts	Randomized controlled trial
Sample Characteristics	
Sample size	75 mother-child pairs in initial evaluation, 59 mother-child pairs in follow-up
Race and ethnicity	Mothers were: 14.7% African-American 37.3% Hispanic 24% White 10.7% Asian 13.3% mixed race or other
Socioeconomic status	Not reported
Number and age of children	75 children, ages 3–5
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Families in the study were referred by a court, child protective services, or other community service provider after the child witnessed marital violence.
Favorable Results*	
Child well-being	• PTSD symptoms (child): standardized coefficient = 0.63 • Behavior problems: standardized coefficient = 0.24 from pre- to post-test, 0.41 from pre-test to 6-month follow-up
Permanency and safety	None
Recovery	None
Family functioning	• Maternal avoidance/PTSD symptoms: standardized coefficient = 0.50 • Maternal mental health symptoms not related to PTSD: standardized coefficient = 0.38
Other	None
Other Comments	
Information accessed at http://www.cebc4cw.org/program/child-parent-psychotherapy/detailed and http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=194#std464 on April 1, 2013.	

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Child-Parent Psychotherapy	
Study citation	Cicchetti, D., Rogosh, F. A., & Toth, S. L. (2006). Fostering secure attachment in infants in maltreating families through preventive interventions. *Development and Psychopathology, 18*, 623–649.
Source	CEBC
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Randomized controlled trial
Sample Characteristics	
Sample size	137 mother-child pairs
Race and ethnicity	74.1% minority on average
Socioeconomic status	Description indicates sample members were low-SES. A nonmaltreating comparison group comprised TANF participants; maltreating families were recruited through a Department of Human Services liaison.
Number and age of children	137, 13.3 months on average at baseline
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Mother-child pairs that were randomly assigned were from maltreating families.
Favorable Results*	
Child well-being	Secure attachment (compared to community standard and nonmaltreating groups; children in PPI group also showed significant increase)
Permanency and safety	None
Recovery	None
Family functioning	None
Other	None

Other Comments

- Specific intervention was Infant Parent Psychotherapy (IPP).
- Participants from 137 maltreating families were randomly assigned to receive IPP, a psychoeducational parenting intervention (PPI), or community standard services. An additional comparison group of 52 mother-child pairs was also included.

Information accessed at http://www.cebc4cw.org/program/child-parent-psychotherapy/detailed on April 1, 2013.

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Child-Parent Psychotherapy	
Study citation	Toth, S. L., Rogosch, F. A., Manly, J. T., & Cicchetti, D. (2006). The efficacy of Toddler-Parent Psychotherapy to reorganize attachment in the young offspring of mothers with major depressive disorder: A randomized preventive trial. *Journal of Consulting and Clinical Psychology, 74*(6), 1006–1016.
Sources	1. NREPP 2. CEBC (information from this source noted with [CEBC] below; all other information is from NREPP)
Study rating	3.9 (NREPP)
Study Design	
Approach to assessing impacts	Randomized controlled trial
Sample Characteristics	
Sample size	130 mothers and their children (CEBC)
Race and ethnicity	Not reported
Socioeconomic status	Mothers were not of low SES (CEBC).
Number and age of children	130, 20.3 months on average at initial assessment (CEBC)
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	Attachment security: 54.3% of children in intervention group went from insecure to secure attachment, compared to 7.4% of the depressed comparison group and 14.3% of the nondepressed comparison group
Permanency and safety	None
Recovery	None
Family functioning	None
Other	None

Other Comments

- Sample includes participants from the sample described in Cicchetti et al., 1999 (CEBC).
- Specific intervention was Toddler Parent Psychotherapy (TPP).
- 130 depressed mothers were randomly assigned to receive TPP or not; the study also included a nondepressed comparison group of 68 mothers. (CEBC)

Information accessed at http://www.cebc4cw.org/program/child-parent-psychotherapy/detailed and http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=194#std464 on April 1, 2013.

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

Table C.3. Family Treatment Drug Court (FTDC, also called Dependency Drug Court) Evidence Review

Level of Evidence	
Review ratings	This review includes impact evaluations of FTDC identified using the following sources: 1. A 2012 research update from the National Association of Drug Court Personnel (NADCP) 2. An 2011 article by Oliveros and Kaufman reviewing research on programs to address the needs of substance abusing parents involved with the child welfare system 3. An annotated bibliography on child welfare and substance used disorders from the National Center on Substance Abuse and Child Welfare 4. A search for publications by 11 prominent organizations involved in child welfare and/or substance abuse programs. These sources did not rate studies. A full list and full citations appear at the end of this summary.
Study Designs	
Number of randomized-controlled trials (RCTs)	None
Number of quasi-experimental designs (QEDs)	10 matched and nonmatched comparison group studies identified
Number of studies with other designs	Not applicable
Demonstrated Effects	
Favorable effects in RCTs or QEDs on parents	Treatment completion by parent/guardian
Favorable effects in RCTs or QEDs on children (specify children's age)	• Time child is in out-of-home care • Likelihood of family reunification • Likelihood of termination of parental rights • Age not reported
Sample characteristics	
Samples with majority (or subgroups) of parents with substance abuse issues	To be eligible for FTDC, families must have substance abuse issues.
Samples with majority (or subgroups) of families involved in child welfare or child protective services	To be eligible for FTDC, families must be involved with child welfare.
Relevance for RPG	
Favorable relevant findings in RCT or QED with sample that has substance abuse issues and/or child welfare involvement	All findings noted above are relevant.
Other Information	
Program developer	Not applicable
Intended program outcomes	According to Oliveros and Kaufman, FTDCs aim to improve substance abuse treatment compliance and reduce substance use in parents, and ultimately increase family reunification/decrease the risk of out-of-home placement.

Sources: (1) Marlowe, D., & Carey, S. (2012, May). Research update on family drug courts. Alexandria, VA: National Association of Drug Court Professionals. (2) Oliveros, A., & Kaufman, J. (2011, January). Addressing substance abuse treatment needs of parents involved with the child welfare system. *Child Welfare, 90*(1), 25–41. (3) National Center on Substance Abuse and Child Welfare. (2009, August). Child welfare, substance use disorders, and dependency courts: A cross-system annotated bibliography (http://www.ncsacw.samhsa.gov/resources/AnnotatedBiblio.aspx#s2p1). (4) Search of the following organizations' websites for publications evaluating family treatment drug courts: Child and Family Futures, Department of Justice, Office of Justice Programs, NPC Research, Urban Institute, National Center on Substance Use and Child Welfare, Child Welfare Information Gateway, National Drug Court Resource Center, National Association of Drug Court Professionals, National Drug Court Institute, National Criminal Justice Reference Service, National Center for State Courts.

Study and Review Information: Family Drug Treatment Court	
Study citation	Ashford, J. (2004). Treating substance abusing parents: A study of the Pima County Family Drug Court approach. *Juvenile & Family Court Journal, 55*, 27–37.
Sources	NADCP research update on family drug courts
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Quasi-experimental design: Contemporary nonmatched comparison
Sample Characteristics	
Sample size	FTDC: 33, comparison: 45
Race and ethnicity	Not reported
Socioeconomic status	Not reported
Number and age of children	Not reported
Whether parent(s) has substance use problems	Presumed: family drug courts are designed to serve families in which the parent has substance abuse problems
Involvement with child welfare system	Presumed: family drug courts are designed to serve families involved with the child welfare system
Favorable Results*	
Child well-being	None
Permanency and safety	None
Recovery	None
Family functioning	None
Other	None
Other Comments	
• The study found favorable impacts on family reunification and treatment completion, but they were not statistically significant Information accessed at http://www.nadcp.org/sites/default/files/nadcp/Reseach%20Update%20on%20Family%20Drug%20Courts%20-%20NADCP.pdf on May 22, 2013.	

* Includes statistically significant outcomes (*p*-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Family Drug Treatment Court	
Study citation	Boles, S., & Young, N.K. (2011, July). Sacramento County Dependency Drug Court year eight outcome and process evaluation findings. Irvine, CA: Children and Family Futures.
Source	NADCP research update on family drug courts
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Quasi-experimental design: Historical nonmatched comparison
Sample Characteristics	
Sample size	FDTC: 4,858, comparison: 173
Race and ethnicity	Not reported
Socioeconomic status	Not reported
Number and age of children	Not reported
Whether parent(s) has substance use problems	Presumed: family drug courts are designed to serve families in which the parent has substance abuse problems
Involvement with child welfare system	Presumed: family drug courts are designed to serve families involved with the child welfare system
Favorable Results*	
Child well-being	None
Permanency and safety	Family reunification: 45% of treatment group families reunified vs. 27% of comparison group
Recovery	Guardian treatment completion: 66% vs. 57%
Family functioning	None
Other	None

Other Comments

- Treatment completion results include participants who left treatment before completion but made satisfactory progress.

Information accessed at http://www.nadcp.org/sites/default/files/nadcp/Reseach%20Update%20on%20Family%20Drug%20Courts%20-%20NADCP.pdf on May 22, 2013.

* Includes statistically significant outcomes (*p*-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Family Drug Treatment Court	
Study citation	Bruns, E. J., Pullman, M. D., Weathers, E. S., Wirschem, M. L., & Murphy, J. K. (2012). Effects of a multidisciplinary family treatment drug court on child and family outcomes: Results of a quasi-experimental study. *Child Maltreatment, 17*(3), 218–30.
Source	NADCP research update on family drug courts
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Quasi-experimental design: Contemporary matched comparison
Sample Characteristics	
Sample size	FDTC: 76, comparison: 182
Race and ethnicity	Not reported
Socioeconomic status	Not reported
Number and age of children	Not reported
Whether parent(s) has substance use problems	Presumed: family drug courts are designed to serve families in which the parent has substance abuse problems
Involvement with child welfare system	Presumed: family drug courts are designed to serve families involved with the child welfare system
Favorable Results*	
Child well-being	Time in out-of-home placements: Children in the treatment group spent an average of 481 days in out-of-home care vs. 689 days among comparison group children
Permanency and safety	Family reunification: 41% vs. 24%
Recovery	Guardian treatment completion: 62% vs. 29%
Family functioning	None
Other	None
Other Comments	
Information accessed at http://www.nadcp.org/sites/default/files/nadcp/Reseach%20Update%20on%20Family%20Drug%20Courts%20-%20NADCP.pdf on May 22, 2013.	

* Includes statistically significant outcomes (*p*-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Family Drug Treatment Court	
Study citation	Burrus, S. W. M., Mackin, J. R., & Aborn, J. A. (2008, August). Baltimore City Family Recovery Program (FRC) independent evaluation: Outcome and cost report. Portland, OR: NPC Research.
Source	NADCP research update on family drug courts
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Quasi-experimental design: Historical matched comparison
Sample Characteristics	
Sample size	FDTC: 200, comparison: 200
Race and ethnicity	Not reported
Socioeconomic status	Not reported
Number and age of children	Not reported
Whether parent(s) has substance use problems	Presumed: family drug courts are designed to serve families in which the parent has substance abuse problems
Involvement with child welfare system	Presumed: family drug courts are designed to serve families involved with the child welfare system
Favorable Results*	
Child well-being	Time in out-of-home care: Children in the treatment group spent an average of 252 days in out-of-home care vs. 346 days among comparison group children
Permanency and safety	Family reunification: 70% vs. 45%
Recovery	Guardian treatment completion: 64% vs. 36%
Family functioning	None
Other	None
Other Comments	
Information accessed at http://www.nadcp.org/sites/default/files/nadcp/Reseach%20Update%20on%20Family%20Drug%20Courts%20-%20NADCP.pdf on May 22, 2013.	

* Includes statistically significant outcomes (*p*-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Family Drug Treatment Court	
Study citation	Carey, S. M., Sanders, M. B., Waller, M. S., Burrus, S. W. M., & Aborn, J. A. (2010, June). Jackson County Community Family Court process, outcome, and cost evaluation: Final Report. Portland, OR: NPC Research.
Source	NADCP research update on family drug courts
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Quasi-experimental design: Contemporary and historical matched comparison
Sample Characteristics	
Sample size	FDTC: 329, comparison: 340
Race and ethnicity	Not reported
Socioeconomic status	Not reported
Number and age of children	Not reported
Whether parent(s) has substance use problems	Presumed: family drug courts are designed to serve families in which the parent has substance abuse problems
Involvement with child welfare system	Presumed: family drug courts are designed to serve families involved with the child welfare system
Favorable Results*	
Child well-being	None
Permanency and safety	None
Recovery	Substance abuse treatment completion: 73% vs. 44%
Family functioning	Likelihood of guardian criminal arrests: 40% vs. 63%
Other	None
Other Comments	
Information accessed at http://www.nadcp.org/sites/default/files/nadcp/Reseach%20Update%20on%20Family%20Drug%20Courts%20-%20NADCP.pdf on May 22, 2013.	

* Includes statistically significant outcomes (p-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Family Drug Treatment Court	
Study citation	Carey, S. M., Sanders, M. B., Waller, M. S., Burrus, S. W. M., & Aborn, J. A. (2010, March). Marion County Fostering Attachment Treatment Court—Process, outcome and cost evaluation: Final report. Portland, OR: NPC Research.
Source	NADCP research update on family drug courts
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Quasi-experimental design: Contemporary and historical matched comparison
Sample Characteristics	
Sample size	FDTC: 39, comparison: 49
Race and ethnicity	Not reported
Socioeconomic status	Not reported
Number and age of children	Not reported
Whether parent(s) has substance use problems	Presumed: family drug courts are designed to serve families in which the parent has substance abuse problems
Involvement with child welfare system	Presumed: family drug courts are designed to serve families involved with the child welfare system
Favorable Results*	
Child well-being	Time in out-of-home care: Children in the treatment group spent an average of 211 days in out-of-home care vs. 383 days among comparison group children
Permanency and safety	Termination of parental rights: 8% vs. 35%
Recovery	Guardian treatment completion: 59% vs. 33%
Family functioning	None
Other	None
Other Comments	
Information accessed at http://www.nadcp.org/sites/default/files/nadcp/Reseach%20Update%20on%20Family%20Drug%20Courts%20-%20NADCP.pdf on May 22, 2013.	

* Includes statistically significant outcomes (p-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Family Drug Treatment Court	
Study citation	Children and Family Futures. (2012, September). Sonoma County Dependency Drug Court (DDC): Year Three Evaluation Findings. Irvine, CA.
Source	CFF's report on this evaluation
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Quasi-experimental design: historical nonmatched comparison group
Sample Characteristics	
Sample size	FTDC: 69 parents, comparison: 30
Race and ethnicity	Treatment group was 74% White; comparison group, 63% White
Socioeconomic status	Women in the sample were described as having high unemployment, low educational attainment, and "numerous other challenges" (according to the executive summary).
Number and age of children	Treatment group included 108 children; 31% were infants or newborns, 42% were ages 1–5, and 27% were 6 years or older. Comparison group included 61 children; age was not reported for comparison group, but report notes that treatment group children were significantly younger than comparison group.
Whether parent(s) has substance use problems	Yes
Involvement with child welfare system	Yes
Favorable Results*	
Child well-being	• Time in foster care: treatment group children were in foster care for 326 days on average vs. 554 days for comparison group children. • Removal from home: on average, treatment group children experienced fewer removals from their parents (1.04 vs. 1.31) and significantly fewer placement changes (2.08 vs. 2.93) than comparison group counterparts.
Permanency and safety	Family reunification: by 18 and 24 months past the child welfare case start date, treatment group families were more likely to be reunified than comparison families (magnitude not given in executive summary)
Recovery	None
Family functioning	None
Other	None
Other Comments	

- Treatment group was more likely than comparison group to receive public assistance, be unemployed, have a disability, or have a secondary drug problem. Treatment group children were also significantly younger than comparison children.

Information accessed at https://www.ncjrs.gov/pdffiles1/ojjdp/grants/241057.pdf on May 22, 2013.

* Includes statistically significant outcomes (p-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Family Drug Treatment Court	
Study citation	Harwin, J., Ryan, M., Tunnard, J., Pokhrel, S., Alrouh, B., Matias, C., & Momenian-Shneider, S. (2011, May). The Family Drug and Alcohol Court (FDAC) evaluation project final report. London: Brunel University.
Source	NADCP research update on family drug courts
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Quasi-experimental design: Contemporary nonmatched comparison
Sample Characteristics	
Sample size	FDTC: 55, comparison: 31
Race and ethnicity	Not reported
Socioeconomic status	Not reported
Number and age of children	Not reported
Whether parent(s) has substance use problems	Presumed: family drug courts are designed to serve families in which the parent has substance abuse problems
Involvement with child welfare system	Presumed: family drug courts are designed to serve families involved with the child welfare system
Favorable Results*	
Child well-being	None
Permanency and safety	None
Recovery	None
Family functioning	None
Other	None

Other Comments

- According to NADCP, the study reports favorable results on time in out-of-home care and family reunification, but no *p*-values.

Information accessed at http://www.nadcp.org/sites/default/files/nadcp/Reseach%20Update%20on%20Family%20Drug%20Courts%20-%20NADCP.pdf on May 22, 2013.

* Includes statistically significant outcomes (p-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Family Drug Treatment Court	
Study citation	Worcel, S. D., Green, B. L., Furrer, C. J., Burrus, S. W. M., & Finigan, M. A. (2007, March). Family Treatment Drug Court Evaluation: Final report. Portland, OR: NPC Research.
Source	NADCP research update on family drug courts
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Quasi-experimental design: Contemporary matched comparison
Sample Characteristics	
Sample size	FTDC: 739, comparison: 1124
Race and ethnicity	Not reported
Socioeconomic status	Not reported
Number and age of children	Not reported
Whether parent(s) has substance use problems	Presumed: family drug courts are designed to serve families in which the parent has substance abuse problems
Involvement with child welfare system	Presumed: family drug courts are designed to serve families involved with the child welfare system
Favorable Results*	
Child well-being	Time in out-of-home care: Children in the treatment group in two of four sites averaged less time in out-of-home care than those in the comparison group (437 vs. 504 days, 301 vs. 466 days)
Permanency and safety	Family reunification: Treatment group families in two sites reunified at a higher rate than comparison group families (76% vs. 44%, 91% vs. 45%)
Recovery	Substance abuse treatment completion: Treatment group guardians in three sites completed treatment at higher rates than the comparison group (69% vs. 32%, 61% vs. 32%, 62% vs. 37%)
Family functioning	None
Other	None
Other Comments	
Information accessed at http://www.nadcp.org/sites/default/files/nadcp/Reseach%20Update%20on%20Family%20Drug%20Courts%20-%20NADCP.pdf on May 22, 2013.	

* Includes statistically significant outcomes (*p*-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Family Drug Treatment Court	
Study citation	Zeller, D., Hornby, H., & Ferguson, A. (2007, January). Evaluation of Maine's Family Treatment Drug Courts: A preliminary analysis of short and long-term outcomes. Portland, ME: Hornby Zeller Associates.
Source	NADCP research update on family drug courts
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Quasi-experimental design: Contemporary and historical nonmatched comparison
Sample Characteristics	
Sample size	FTDC: 49, Comparison (2 groups): 38 and 55
Race and ethnicity	Not reported
Socioeconomic status	Not reported
Number and age of children	Not reported
Whether parent(s) has substance use problems	Presumed: family drug courts are designed to serve families in which the parent has substance abuse problems
Involvement with child welfare system	Presumed: family drug courts are designed to serve families involved with the child welfare system
Favorable Results*	
Child well-being	None
Permanency and safety	None
Recovery	Guardian treatment completion: 55% of guardians in the treatment group completed treatment vs. 23% in the contemporary matched comparison group
Family functioning	None
Other	None
Other Comments	
• Treatment group guardians completed treatment at a higher rate than the historical matched comparison group, too, but the difference was not statistically significant. Information accessed at http://www.nadcp.org/sites/default/files/nadcp/Reseach%20Update%20on%20Family%20Drug%20Courts%20-%20NADCP.pdf on May 22, 2013.	

* Includes statistically significant outcomes (*p*-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

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Table C.4. Hazelden Living in Balance Program (LIB) Evidence Review

Level of Evidence	
NREPP Review Ratings *(0.0–4.0 scale, 4.0 = highest quality)*	2.7–3.3 (Review last updated in 2007)
Study Designs	
Number of randomized-controlled trials (RCTs)	1
Number of quasi-experimental designs (QEDs)	None
Number of studies with other designs	None
Demonstrated Effects	
Favorable effects in RCTs or QEDs on parents	• Treatment retention and exposure • Treatment completion
Favorable effects in RCTs or QEDs on children (specify children’s age)	Not applicable—program is for adults
Sample Characteristics	
Samples with majority (or subgroups) of parents with substance abuse issues	Adults in the study reviewed in NREPP used cocaine, primarily crack cocaine
Samples with majority (or subgroups) of families involved in child welfare or child protective services	None
Relevance for RPG	
Favorable relevant findings in RCT or QED with sample that has substance abuse issues and/or child welfare involvement	LIB was associated with higher treatment retention, exposure, and completion rates, but not with decreased drug use.
Other Information	
Program developer	Hazelden drug addiction treatment center (Contact: Richard Solly)
Intended program outcomes	According to NREPP, the program aims to treat addiction, reduce substance use, and avoid relapse.

Study and Review Information: Hazelden Living in Balance	
Study citation	Hoffman, J. A., Caudill, B. D., Koman, J. J., III, Luckey, J. W., Flynn, P. M., & Hubbard, R. L. (1994). Comparative cocaine abuse treatment strategies: Enhancing client retention and treatment exposure. Co-published simultaneously in the *Journal of Addictive Diseases, 13*(4), 115–128; and In S. Magura & A. Rosenblum (Eds.), *Experimental therapeutics in addiction medicine* (pp. 115–128). New York: The Haworth Press. Hoffman, J. A., Caudill, B. D., Koman, J. J., III, Luckey, J. W., Flynn, P. M., & Mayo, D. W. (1996). Psychosocial treatments for cocaine abuse: 12-month treatment outcomes. *Journal of Substance Abuse Treatment, 13*(1), 3–11.
Sources	1. NREPP 2. Study abstracts on PubMed
Study rating	2.7–3.3 (NREPP)
Study Design	
Approach to assessing impacts	Randomized controlled trial
Sample Characteristics	
Sample size	303 in initial study, 184 in 12-month follow-up.
Race and ethnicity	Clients in 12-month follow-up study were 95% African American
Socioeconomic status	Not reported
Number and age of children	Not applicable
Whether parent(s) has substance use problems	All sample members used cocaine, but parental status was not reported
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	None
Permanency and safety	None
Recovery	• Treatment retention and exposure: for example, clients in any LIB group attended 25 sessions on average, compared to 12 sessions for clients in any of the usual conditions • Treatment completion: 45.2% for LIB-only group vs. 19% for usual group therapy only group.
Family functioning	None
Other	None

Other Comments

- Study focused on cocaine-abusing clients, primarily crack smokers.
- RCT compared the effects of six treatment conditions, each 4 months in duration: (1) LIB only, (2) LIB with individual psychotherapy, (3) LIB with individual psychotherapy and family therapy, (4) usual group therapy only, (5) usual group therapy with individual psychotherapy, and (6) usual group therapy with individual psychotherapy and family therapy
- At the 12-month follow-up, no significant differences were found by treatment condition in drug use, illegal activities, or drug sales.

Information accessed at http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=72#std200, http://www.ncbi.nlm.nih.gov/pubmed?Db=pubmed&Cmd=ShowDetailView&TermToSearch=8699540&ordinalpos=3&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_++RVDocSum , and http://www.ncbi.nlm.nih.gov/pubmed?Db=pubmed&Cmd=ShowDetailView&TermToSearch=7734463&ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum on April 4, 2013.

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

Table C.5. Matrix Model (Adult Program) Evidence Review

Level of Evidence	
CEBC Review Rating *(1–5 scale, 1 = best supported)*	3: Promising Research Evidence (Review last updated June 2012)
NREPP Review Ratings *(0.0–4.0 scale, 4.0 = highest quality)*	1.9–2.4 (Review last updated December 2006)
Study Designs	
Number of randomized-controlled trials (RCTs)	2 *(1 additional RCT is discussed but does not test the Matrix Model vs. standard treatment)*
Number of quasi-experimental designs (QEDs)	None
Number of studies with other designs	1 plus RCT that does not test the Matrix Model vs. standard treatment
Demonstrated Effects	
Favorable effects in RCTs or QEDs on parents	• Treatment retention • Treatment completion • Substance use (methamphetamine) during treatment (treatment-control difference did not hold at discharge or 6-month follow up) • Longer periods of methamphetamine abstinence
Favorable effects in RCTs or QEDs on children (specify children's age)	Not applicable
Sample Characteristics	
Samples with majority (or subgroups) of parents with substance abuse issues	All participants were substance dependent.
Samples with majority (or subgroups) of families involved in child welfare or child protective services	Not reported
Relevance for RPG	
Favorable relevant findings in RCT or QED with sample that has substance abuse issues and/or child welfare involvement	• Treatment retention • Treatment completion • Substance use (methamphetamine) during treatment (treatment-control difference did not hold at discharge or 6-month follow up) • Longer periods of methamphetamine abstinence
Other Information	
Program developer	Michael McCann, Charles Anderson Matrix Institute on Addictions, www.matrixinstitute.org
Intended program outcomes	According to CEBC, the Matrix Model's goals are treatment retention and completion, reduced substance use, or abstinence from substance use.

Study and Review Information: Matrix Model (Adult Program)	
Study citation	Rawson, R. A., Obert, J. L., McCann, M. J., & Ling, W. (1991). Psychological approaches to the treatment of cocaine dependence—A neurobehavioral approach. *Journal of Addictive Diseases, 11*(2), 97–120.
Source	CEBC
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Other design: pre/post
Sample Characteristics	
Sample size	486
Race and ethnicity	15% African American 8% Hispanic 76% White 1% other
Socioeconomic status	Not reported
Number and age of children	Not applicable
Whether parent(s) has substance use problems	All participants were substance dependent.
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	Not applicable
Permanency and safety	Not applicable
Recovery	Not applicable
Family functioning	Not applicable
Other	Not applicable

Other Comments

- This trial was conducted to provide a foundation for future studies of the Matrix Model using participant volunteers. About 40 percent of participants who completed the 6-month phase of treatment had no cocaine use detected by urinalysis or self report.

Information accessed at http://www.cebc4cw.org/program/matrix-model-for-adults/detailed and http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=87 on April 17, 2013.

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Matrix Model (Adult Program)	
Study citation	Shoptaw, S., Rawson, R. A., McCann, M. J., & Obert, J. L. (1994). The Matrix Model of outpatient stimulant abuse treatment: Evidence of efficacy. *Journal of Addictive Diseases*, 13(4). 129–141.
Source	CEBC
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Randomized-controlled trial, but study does not compare Matrix Model vs. no Matrix Model (see "Other Comments")
Sample Characteristics	
Sample size	146
Race and ethnicity	26.7% African American 11.7% Latino 61.6% White
Socioeconomic status	Not reported
Number and age of children	Not applicable
Whether parent(s) has substance use problems	Common problems included methamphetamine dependence and cocaine dependence
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	None
Permanency and safety	None
Recovery	None
Family functioning	None
Other	None

Other Comments

- This study compares the effectiveness of the treatment with and without an antidepressant to reduce withdrawal, not the effectiveness of the treatment vs. standard services. Participants were randomly assigned to receive Matrix Model only, Matrix Model plus an antidepressant that may reduce cocaine withdrawal, or Matrix Model plus placebo.
- Those who received longer treatment episodes had better abstinence outcomes. However, length of treatment episode was not randomly assigned.
- Methamphetamine-dependent participants showed better abstinence outcomes than cocaine-dependent participants.
- Patients who received longer treatment episodes demonstrated better abstinence outcomes (*p* value not given).

Information accessed at http://www.cebc4cw.org/program/matrix-model-for-adults/detailed and http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=87 on April 17, 2013.

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Matrix Model (Adult Program)	
Study citation	Rawson, R. A., Shoptow, S. J., Obert, J. L., McCann, M. J., Hasson, A. L., Marinelli-Casey, P. J., & Ling, W. (1995). An intensive outpatient approach for cocaine abuse treatment: The Matrix Model. *Journal of Substance Abuse Treatment, 12*(2), 117–127.
Sources	1. CEBC 2. NREPP
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Randomized-controlled trial
Sample Characteristics	
Sample size	100
Race and ethnicity	27% African American 23% Latino 50% White
Socioeconomic status	Not reported
Number and age of children	Not applicable
Whether parent(s) has substance use problems	Participants were all cocaine abusers seeking treatment.
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	None
Permanency and safety	None
Recovery	None
Family functioning	None
Other	None

Other Comments

- Both groups of subjects (those who were assigned to receive the Matrix Model and those who were assigned to treatment as usual) reported significant reductions in their cocaine use over the 12-month study period.

Information accessed at http://www.cebc4cw.org/program/matrix-model-for-adults/detailed and http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=87 on April 17, 2013.

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Matrix Model (Adult Program)	
Study citation	Rawson, R. A., Marinelli-Casey, P., Anglin, M. D., Dickow, A., Frazier, Y., & Gallagher, C., The Methamphetamine Treatment Project Corporate Authors. (2004). A multi-site comparison of psychosocial approaches for the treatment of methamphetamine dependence. *Addiction, 99*, 708–717.
Sources	1. CEBC 2. NREPP 3. Study abstract
Study rating	1.9–2.4 (NREPP)
Study Design	
Approach to assessing impacts	Randomized-controlled trial
Sample Characteristics	
Sample size	978
Race and ethnicity	17% Asian/Pacific Islander 18% Hispanic 60% White
Socioeconomic status	Not reported
Number and age of children	Not applicable
Whether parent(s) has substance use problems	All participants were seeking treatment and were methamphetamine dependent.
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	None
Permanency and safety	None
Recovery	• Treatment retention (treatment group was 38% more likely to stay in treatment than control group) • Treatment completion • Methamphetamine use during treatment (treatment-control difference did not hold at discharge or 6-month follow up) • Longer periods of methamphetamine abstinence
Family functioning	None
Other	None

Other Comments

- Participants were randomly assigned to receive either treatment as usual or 16 weeks of Matrix Model treatment.
- Receiving the matrix model was associated with decreased methamphetamine use (as measured by methamphetamine-negative urine samples) during treatment, but at discharge and 6-month follow up, participants in both conditions demonstrated a significant reduction in methamphetamine use.

Information accessed at http://www.cebc4cw.org/program/matrix-model-for-adults/detailed, http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=87 and http://www.ncbi.nlm.nih.gov/pubmed?Db=pubmed&Cmd=ShowDetailView&TermToSearch=15139869&ordinalpos=3&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum on April 17, 2013.

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

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Table C.6. Nurturing Parenting Programs (NPP) Evidence Review

Level of Evidence	
CEBC Review Rating (1–5 scale, 1 = best supported)	3: Promising Research Evidence (Review last updated 6/2012)
NREPP Review Ratings (0.0–4.0 scale, 4.0 = highest quality)	2.9–3.2 (Review last updated 4/2010)
(HomVEE Rating	Does not meet criteria (Review last updated 7/2011)
Study Designs	
Number of randomized-controlled trials (RCTs)	None
Number of quasi-experimental designs (QEDs)	1
Number of studies with other designs	6
Demonstrated effects	
Favorable effects in RCTs or QEDs on parents	None
Favorable effects in RCTs or QEDs on children (specify children's age)	None
Sample Characteristics	
Samples that include majority (or subgroups) of parents with substance abuse issues	None
Samples that include majority (or subgroups) of families involved in child welfare or child protective services	6
Relevance for RPG	
Favorable relevant findings in RCT or QED with sample that has substance abuse issues and/or child welfare involvement	None identified in studies reviewed
Other Information	
Program developer	Stephen J. Bavolek, Family Development Resources, Inc.
Intended program outcomes	According to CEBC, NPP aims to improve parents' expectations of children's development, empathy, and knowledge of age-appropriate parenting techniques, while reducing corporal punishment and attitudes reflecting parent-child role reversal.

Study and Review Information: Nurturing Parenting Programs	
Study citation	Cowen, P. S. (2001). Effectiveness of a parent education intervention for at-risk families. *Journal of the Society of Pediatric Nursing, 6*(2), 73–82
Source	CEBC
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Other design: pre/post
Sample Characteristics	
Sample size	154 families
Race and ethnicity	92% White
Socioeconomic status	Not reported
Number and age of children	Not reported
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Program was implemented at the National Committee for the Prevention of Child Abuse, Iowa Chapter. Families who participated were self-referred, "in crisis," or court-referred for mandatory attendance.
Favorable Results*	
Child well-being	Not applicable
Permanency and safety	Not applicable
Recovery	Not applicable
Family functioning	Not applicable
Other	Not applicable
Other Comments	

- Post-test found significant improvement in parenting attitudes, but the study did not include a comparison group.

Information accessed at http://www.cebc4cw.org/program/nurturing-parenting-programs/detailed on April 4, 2013.

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Nurturing Parenting Programs	
Study citation	Devall, E. L. (2004). Positive parenting for high-risk families. *Journal of Family and Consumer Sciences, 96*(4), 22–28
Source	CEBC
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Other design: pre/post
Sample Characteristics	
Sample size	323 parents
Race and ethnicity	60% Hispanic 10% Native American 21% European American 4% African American 3% Asian American or other
Socioeconomic status	Not reported
Number and age of children	Not reported
Whether parent(s) has substance use problems	Some families had substance abuse issues
Involvement with child welfare system	According to the CEBC summary, "at-risk families, including teen parents, unmarried parents, single or divorced parents, foster parents, parents referred by social services, families with substance abuse issues, and incarcerated parents."
Favorable Results*	
Child well-being	Not applicable
Permanency and safety	Not applicable
Recovery	Not applicable
Family functioning	Not applicable
Other	Not applicable

Other Comments

- Post-test found significant improvement in parenting attitudes, but the study did not include a comparison group.

Information accessed at http://www.cebc4cw.org/program/nurturing-parenting-programs/detailed on April 4, 2013.

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Nurturing Parenting Programs	
Study citation	Maher, E. J., Marcynyszyn, L. A., Corwin, T. W., & Hodnett, R..(2011). Dosage matters: The relationship between participation in the Nurturing Parenting Program for infants, toddlers, and preschoolers and subsequent child maltreatment. *Children and Youth Services Review, 33*(8), 1426–1434.
Source	CEBC
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Other design: pre/post
Sample Characteristics	
Sample size	528 parents/caregivers
Race and ethnicity	58% White 42% nonwhite
Socioeconomic status	Not reported
Number and age of children	Not reported
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Participants were referred to NPP for allegations of abuse and neglect
Favorable Results*	
Child well-being	Not applicable
Permanency and safety	Not applicable
Recovery	Not applicable
Family functioning	Not applicable
Other	Not applicable
Other Comments	
• At 2-year follow-up, caregivers attending more sessions were significantly less likely to have a substantiated maltreatment incidence (after controlling for other family characteristics), but there is caregivers were not randomly assigned to receive the treatment or not.	

Information accessed at http://www.cebc4cw.org/program/nurturing-parenting-programs/detailed on April 4, 2013.

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Nurturing Parenting Programs	
Study citation	Hodnett, R. H., Faulk, K., Dellinger, A., & Maher, E. (2009). Evaluation of the statewide implementation of a parent education program in Louisiana's child welfare agency: The Nurturing Parent Program for infants, toddlers, and preschool children. Final evaluation report submitted to Casey Family Foundations.
Source	NREPP
Study ratings	2.9–3.2
Study Design	
Approach to assessing impacts	Other design: pre/post
Sample Characteristics	
Sample size	Not reported
Race and ethnicity	Not reported
Socioeconomic status	Not reported
Number and age of children	Not reported
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Participating families were referred to NPP by the state child welfare agency because of child abuse/neglect allegations.
Favorable Results*	
Child well-being	Not applicable
Permanency and safety	Not applicable
Recovery	Not applicable
Family functioning	Not applicable
Other	Not applicable
Other Comments	
• Post-test found significant improvement in parenting attitudes, but the study did not include a comparison group.	
Information accessed at http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=171 on April 4, 2013.	

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Nurturing Parenting Programs	
Study citation	Bavolek, S. J., Comstock, C. M., & McLaughlin J. W. (1983). The Nurturing Program: A validated approach for reducing dysfunctional family interactions. Final report submitted to the National Institute of Mental Health.
Source	NREPP
Study ratings	2.9–3.2
Study Design	
Approach to assessing impacts	Other design: pre/post
Sample Characteristics	
Sample size	Not reported
Race and ethnicity	Not reported
Socioeconomic status	Not reported
Number and age of children	Not reported
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Participating families were referred to NPP by a state social services agency or Parents Anonymous groups due to abusive parent-child interactions.
Favorable Results*	
Child well-being	Not applicable
Permanency and safety	Not applicable
Recovery	Not applicable
Family functioning	Not applicable
Other	Not applicable

Other Comments

- Post-test found significant improvement in parenting attitudes and children's self awareness and attitudes reflecting role reversal, but the study did not include a comparison group.

Information accessed at http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=171 on April 4, 2013.

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Nurturing Parenting Programs	
Study citation	Bavolek, S. J., Henderson, H. L., & Schultz, B. B. (1988). Reducing chronic neglect in Utah. Summary of neglect project from September 30, 1985, to December 30, 1987. Grant #90 CA 1161.02. Final report submitted to the U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect.
Source	NREPP
Study ratings	2.9–3.2
Study Design	
Approach to assessing impacts	Other design: pre/post
Sample Characteristics	
Sample size	Not reported
Race and ethnicity	Not reported
Socioeconomic status	Not reported
Number and age of children	Not reported
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Participating families were referred to NPP by a state social services agency or nonprofit social services organization because of child neglect or neglect and abuse. Some were court-ordered to attend the program based on (according to NREPP) "their long-standing inability to change their neglecting parenting pattern."
Favorable Results*	
Child well-being	Not applicable
Permanency and safety	Not applicable
Recovery	Not applicable
Family functioning	Not applicable
Other	Not applicable

Other Comments

- Post-test found significant improvement in parenting attitudes, but the study did not include a comparison group.

Information accessed at http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=171 on April 4, 2013.

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Nurturing Parenting Programs	
Study citation	Bavolek, S., Keene, R., & Weikert, P. (2004). The Florida study: A comparative examination of the effectiveness of the Nurturing Parenting Programs (Final report). Tallahassee: Florida Department of Children and Families.
Source	HomVEE
Study rating	Low
Study Design	
Approach to assessing impacts	Quasi-experimental design
Sample Characteristics	
Sample size	Not reported
Race and ethnicity	Not reported
Socioeconomic status	Not reported
Number and age of children	Not reported
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	Not applicable
Permanency and safety	Not applicable
Recovery	Not applicable
Family functioning	Not applicable
Other	Not applicable
Other Comments	

- Study was rated low because baseline equivalence was not established on race/ethnicity, SES, or outcomes

Information accessed at http://homvee.acf.hhs.gov/document.aspx?rid=1&sid=36 on April 4, 2013.

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

Table C.7. Seeking Safety Evidence Review

Level of Evidence	
CEBC Review Rating (1–5 scale, 1 = best supported)	Adolescents—3: Promising Research Evidence (Review last updated 5/2012) Adults—2: Supported by Research Evidence (Review last updated 4/2012)
NREPP Review Ratings *(0.0–4.0 scale, 4.0 = highest quality)*	2.1–2.3 (Review last updated 10/2006)
Study Designs	
Number of randomized-controlled trials (RCTs)	4
Number of quasi-experimental designs (QEDs)	4
Number of studies with other designs	5
Demonstrated Effects	
Favorable effects in RCTs or QEDs on parents	• Substance use • Trauma-related symptoms • PTSD symptoms • Psychiatric distress • Depression • Psychopathology • Coping skills • Social support • Interpersonal functioning • Employment
Favorable effects in RCTs or QEDs on children (specify children's age)	• Personal Experience Inventory subscales • Loss of Control subscale • Sexual concerns • Sexual distress • Anorexia • Somatization • Major depression (Adolescent girls, mean age 16 years)
Sample Characteristics	
Samples with majority (or subgroups) of parents with substance abuse issues	Seeking Safety is a substance use treatment therapy. All 13 studies reported substance using samples.
Samples with majority (or subgroups) of families involved in child welfare or child protective services	Not reported
Relevance for RPG	
Favorable relevant findings in RCT or QED with sample that has substance abuse issues and/or child welfare involvement	All findings noted above are relevant.
Other Information	
Program developer	Lisa M. Najavits, professor of psychiatry, Boston University School of Medicine
Intended program outcomes	Seeking Safety is designed to help people attain safety in their relationships, thinking, behavior, and emotions.

Study and Review Information: Seeking Safety	
Study citation	Hien, D. A., Cohen, L. R., Miele, G. M., Litt, L. C., & Capstick, C. (2004). Promising treatments for women with comorbid PTSD and substance use disorders. *American Journal of Psychiatry, 161*, 1426–1432.
Sources	1. NREPP 2. CEBC
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Randomized controlled trial
Sample Characteristics	
Sample size	107 women were randomized to one of three groups: Seeking Safety (41), Relapse Prevention (34), or a community care control condition (32).
Race and ethnicity	49% African American 24% Caucasian 24% Hispanic 2% other and/or multiracial (Seeking Safety group)
Socioeconomic status	Low-income urban women
Number and age of children	Not applicable
Whether parent(s) has substance use problems	100% of sample
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	Not applicable
Permanency and safety	None
Recovery	Substance use at end of treatment and 6-month follow-up
Family functioning	• Trauma-related symptoms at end of treatment, 6-month follow-up, and 9-month follow-up • Psychopathology at end of treatment
Other	None

Other Comments

- Sample only included women.
- Note: Participants in both Seeking Safety and Relapse Prevention groups sustained greater improvement in substance use and PTSD symptoms at 6-month and 9-month follow-ups than subjects in the community care group.

Information accessed at http://www.nrepp.samhsa.gov/viewintervention.aspx?id=139 and http://www.cebc4cw.org/program/seeking-safety-for-adults/detailed on 4/10/13.

* Includes statistically significant outcomes (*p*-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Seeking Safety	
Study citation	Holdcraft, L. C., & Comtois, K. A. (2002). Description of and preliminary data from a women's dual diagnosis community mental health program. *Canadian Journal of Community Mental Health, 21*, 91–109.
Source	NREPP
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Other design: pre/post
Sample Characteristics	
Sample size	Not reported
Race and ethnicity	80% White 15% Black or African American 5% Asian
Socioeconomic status	Not reported
Number and age of children	Not applicable
Whether parent(s) has substance use problems	100% of sample
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	Not applicable
Permanency and safety	Not applicable
Recovery	Not applicable
Family functioning	Not applicable
Other	Not applicable

Other Comments

- Sample only included women.

Information accessed at http://www.nrepp.samhsa.gov/viewintervention.aspx?id=139 on 4/10/13.

* Includes statistically significant outcomes (*p*-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Seeking Safety	
Study citation	Morrissey, J. P., Jackson, E. W., Ellis, A. R., Amaro, H., Brown, V. B., & Najavits, L. M. (2005). Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders. *Psychiatric Services, 56*, 1213–1222.
Sources	1. NREPP 2. CEBC
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Quasi-experimental design
Sample Characteristics	
Sample size	2,026 women across all sites (Seeking Safety at four of the nine study sites); 1,018 Seeking Safety, 1,008 comparison
Race and ethnicity	50% White 25% Black or African American 17% Hispanic or Latino 7% race/ethnicity unspecified
Socioeconomic status	Not reported
Number and age of children	Not applicable
Whether parent(s) has substance use problems	100% of sample
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	Not applicable
Permanency and safety	Not applicable
Recovery	Not applicable
Family functioning	Not applicable
Other	Not applicable

Other Comments

- Sample only included women.
- Note: According to CEBC, results specific to the four Seeking Safety sites cannot be attributed directly to Seeking Safety. Analysis of key program elements demonstrated that integrating substance abuse, mental health, and trauma-related issues into counseling yielded greater improvement, whereas the delivery of numerous core services yielded less improvement relative to the comparison group. Relevant outcomes were in the areas of:
  - Trauma-related symptoms at 12-month follow-up
  - PTSD-related symptoms at 12-month follow-up
  - Psychopathology at 12-month follow-up: Cohen's d = 0.18

Information accessed at http://www.nrepp.samhsa.gov/viewintervention.aspx?id=139 and http://www.cebc4cw.org/program/seeking-safety-for-adults/detailed on 4/10/13.

* Includes statistically significant outcomes (p-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Seeking Safety	
Study citation	Najavits, L. M., Gallop, R. J., & Weiss, R. D. (2006). Seeking Safety therapy for adolescent girls with PTSD and substance use disorder: A randomized controlled trial. *Journal of Behavioral Health Services and Research, 33*, 453–463.
Sources	1. NREPP 2. CEBC
Study rating	Not rated
Study Design	
Approach to assessing impacts	Randomized controlled trial
Sample Characteristics	
Sample size	33 adolescent girls
Race and ethnicity	78.8% White 12.1% Asian 3% Black or African American 3% Hispanic or Latino 3% race/ethnicity unspecified
Socioeconomic status	Not reported
Number and age of children	33 adolescent girls; average age 16.06 years
Whether parent(s) has substance use problems	100% of the adolescent sample had a substance use disorder.
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	• Personal Experience Inventory subscales: Cohen's d = 0.37 to 1.17 • Loss of Control subscale at 3-month follow-up: Cohen's d = 0.37 • Sexual concerns 2 months after intake • Sexual distress 2 months after intake • Anorexia: Cohen's d = 2.02 • Somatization: Cohen's d = 1.27 • Major depression: Cohen's d = 0.40
Permanency and safety	None
Recovery	None
Family functioning	None
Other	None

Other Comments

- Sample only included adolescent girls.
- The personal experience inventory was included as a substance abuse outcome.
- Study was conducted by the developer.

Information accessed at http://www.nrepp.samhsa.gov/viewintervention.aspx?id=139 and http://www.cebc4cw.org/program/seeking-safety-for-adolescents/detailed on 4/10/13.

* Includes statistically significant outcomes (*p*-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Seeking Safety	
Study citation	Najavits, L. M., Schmitz, M., Gotthardt, S., & Weiss, R. D. (2005). Seeking Safety plus exposure therapy: An outcome study on dual diagnosis men. *Journal of Psychoactive Drugs, 37*, 425–435.
Source	NREPP
Study rating	Not rated
Study Design	
Approach to assessing impacts	Other design: pre/post
Sample Characteristics	
Sample size	5 men
Race and ethnicity	100% White
Socioeconomic status	Not reported
Number and age of children	Not applicable
Whether parent(s) has substance use problems	100% of sample
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	Not applicable
Permanency and safety	Not applicable
Recovery	Not applicable
Family functioning	Not applicable
Other	Not applicable

Other Comments

- Sample only included men.
- Outcome results showed statistically significant improvement in drug use, family/social functioning, trauma symptoms, anxiety, dissociation, sexuality, hostility, overall functioning, meaningfulness, and feelings and thoughts related to safety. However, there was no comparison group.
- Study was conducted by the developer.

Information accessed at http://www.nrepp.samhsa.gov/viewintervention.aspx?id=139 on 4/10/13.

* Includes statistically significant outcomes (p-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Seeking Safety	
Study citation	Najavits, L. M., Weiss, R. D., Shaw, S. R., & Muenz, L. R. (1998). "Seeking Safety": Outcome of a new cognitive-behavioral psychotherapy for women with post-traumatic stress disorder and substance dependence. *Journal of Traumatic Stress, 11*, 437–456.
Sources	1. NREPP 2. CEBC
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Other design: pre/post
Sample Characteristics	
Sample size	17 women
Race and ethnicity	88.2% White 11.8% Black or African American
Socioeconomic status	Not reported
Number and age of children	Not applicable
Whether parent(s) has substance use problems	100% of sample
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	Not applicable
Permanency and safety	Not applicable
Recovery	Not applicable
Family functioning	Not applicable
Other	Not applicable

Other Comments

- Sample only included women.
- Results showed significant improvements in substance use, trauma-related symptoms, suicide risk, suicidal thoughts, social adjustment, family functioning, problem solving, depression, cognitions about substance use, and didactic knowledge related to the treatment. However, there was no comparison group.
- Study was conducted by the developer.

Information accessed at http://www.nrepp.samhsa.gov/viewintervention.aspx?id=139 and http://www.cebc4cw.org/program/seeking-safety-for-adults/detailed on 4/10/13.

* Includes statistically significant outcomes (p-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Seeking Safety	
Study citation	Weller, L. A. (2005). Group therapy to treat substance use and traumatic symptoms in female veterans. *Federal Practitioner*, 27–38.
Source	NREPP
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Case study
Sample Characteristics	
Sample size	Other design: pre/post
Race and ethnicity	83.3% White 16.7% American Indian or Alaska Native
Socioeconomic status	Not reported
Number and age of children	Not applicable
Whether parent(s) has substance use problems	100% of sample
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	Not applicable
Permanency and safety	Not applicable
Recovery	Not applicable
Family functioning	Not applicable
Other	Not applicable
Other Comments	

- Sample only included women.

Information accessed at http://www.nrepp.samhsa.gov/viewintervention.aspx?id=139 on 4/10/13.

* Includes statistically significant outcomes (p-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Seeking Safety	
Study citation	Zlotnick, C., Najavits, L. M., Rohsenow, D. J., & Johnson, D. M. (2003). A cognitive-behavioral treatment for incarcerated women with substance abuse disorder and post-traumatic stress disorder: Findings from a pilot study. *Journal of Substance Abuse Treatment, 25*, 99–105.
Source	NREPP
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Other design: pre/post
Sample Characteristics	
Sample size	17 incarcerated women
Race and ethnicity	66.7% White 16.7% race/ethnicity unspecified 11.1% Black or African American 5.6% Hispanic or Latino
Socioeconomic status	Not reported
Number and age of children	Not applicable
Whether parent(s) has substance use problems	100% of sample
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	Not applicable
Permanency and safety	Not applicable
Recovery	Not applicable
Family functioning	Not applicable
Other	Not applicable

Other Comments

- Sample only included incarcerated women.
- Participants showed improvement in PTSD symptoms (half no longer met criteria for PTSD at the end of treatment, and nearly as many still did not meet criteria at 3-month follow-up). Return to prison was 33 percent at 3-month follow-up. However, the study did not include a comparison group
- Study was conducted by the developer.

Information accessed at http://www.nrepp.samhsa.gov/viewintervention.aspx?id=139 and http://www.cebc4cw.org/program/seeking-safety-for-adults/detailed on 4/10/13.

* Includes statistically significant outcomes (p-value ≤ 0.05) from RCTS or QEDs, which are favorab le to the treatment group.

Study and Review Information: Seeking Safety	
Study citation	Gatz, M., Brown, V., Hennigan, K., Rechberger, E., O'Keefe, M., Rose, T., et al. (2007). Effectiveness of an integrated trauma-informed approach to treating women with co-occurring disorders and histories of trauma. *Journal of Community Psychology, 35*, 863–878.
Sources	1. CEBC 2. Study abstract
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Quasi-experimental design
Sample Characteristics	
Sample size	313 women (136 Seeking Safety; 177 comparison)
Race and ethnicity	39% Caucasian 27% Hispanic 21% African American 11% Native American 2% biracial 0.53% Asian (Seeking Safety group)
Socioeconomic status	Not reported
Number and age of children	Not applicable
Whether parent(s) has substance use problems	100% of sample
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	Not applicable
Permanency and safety	None
Recovery	None
Family functioning	None
Other	• PTSD symptoms • Coping skills

Other Comments

- Study was conducted with nine sites; four sites used Seeking Safety and the other sites used other programs.
- Participants received Seeking Safety either in a residential or outpatient setting.
- There was no difference in the improvement experienced by women in the treatment and comparison groups on substance abuse problems or symptoms of psychological stress.

Information accessed at http://www.cebc4cw.org/program/seeking-safety-for-adults/detailed, http://www.ncbi.nlm.nih.gov/pubmed?Db=pubmed&Cmd=ShowDetailView&TermToSearch=16215186&ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum on 4/10/13.

* Includes statistically significant outcomes (p-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Seeking Safety	
Study citations	Desai, R. A., Harpaz-Rotem, I, Najavits, L.M., & Rosenheck, R. A. (2008). Treatment for homeless female veterans with psychiatric and substance abuse disorders: Impact of "Seeking Safety" on one-year clinical outcomes. *Psychiatric Services, 59*, 996–1003. Desai, R. A. et al. (2009). Seeking Safety therapy: Clarification of results. *Psychiatric Services, 60*, 125.
Source	CEBC
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Quasi-experimental design
Sample Characteristics	
Sample size	450 women (91 Seeking Safety; 359 comparison)
Race and ethnicity	46% African American 42% Caucasian 3% Hispanic 9% other and/or multiracial (Seeking Safety group)
Socioeconomic status	The sample comprises homeless veterans.
Number and age of children	Not applicable
Whether parent(s) has substance use problems	100% of sample
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	Not applicable
Permanency and safety	None
Recovery	None
Family functioning	• Social support • Psychiatric distress • PTSD symptoms
Other	Employment

Other Comments

- Study was conducted with 11 programs for homeless women veterans. Comparison group consisted of the clients served before Seeking Safety was implemented.

Information accessed at http://www.cebc4cw.org/program/seeking-safety-for-adults/detailed on 4/10/13.

* Includes statistically significant outcomes (p-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Seeking Safety	
Study citation	Zlotnick, C., Johnson, J., & Najavits, N. M. (2009). Randomized controlled pilot study of cognitive-behavioral therapy in a sample of incarcerated women with substance use disorder and PTSD. *Behavioral Therapy, 40*(4), 325–336.
Source	CEBC
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Randomized controlled trial
Sample Characteristics	
Sample size	49 women
Race and ethnicity	47% Caucasian 33% African American 14% Hispanic 6% other
Socioeconomic status	Not reported
Number and age of children	Not applicable
Whether parent(s) has substance use problems	100% of sample
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	Not applicable
Permanency and safety	None
Recovery	None
Family functioning	None
Other	None

Other Comments

- All women in the study were incarcerated.
- Results indicated that there were no significant differences between conditions on all key domains (PTSD, SUD, psychopathology, and legal problems), but both conditions showed significant improvements on all of these outcomes over time.

Information accessed at http://www.cebc4cw.org/program/seeking-safety-for-adults/detailed on 4/10/13.

* Includes statistically significant outcomes (p-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Seeking Safety	
Study citation	Boden, M. T., Kimerling, R., Jacobs-Lentz, J., Bowman, D., Weaver, C., Carney, D., et al. (2012). Seeking Safety treatment for male veterans with a substance use disorder and PTSD symptomatology. *Addiction, 107*(3), 578–586.
Source	CEBC
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Randomized-controlled trial
Sample Characteristics	
Sample size	98 men
Race and ethnicity	65.3% African American 14.3% Caucasian 8.2% Hispanic 4.1% Native American 4.1% other (Seeking Safety group)
Socioeconomic status	Not reported
Number and age of children	Not applicable
Whether parent(s) has substance use problems	100% of sample
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	Not applicable
Permanency and safety	None
Recovery	Drug use
Family functioning	Active coping
Other	None

Other Comments

- Sample only included men.
- Alcohol use and PTSD decreased under both Seeking Safety and treatment as usual.

Information accessed at http://www.cebc4cw.org/program/seeking-safety-for-adults/detailed on 4/10/13.

* Includes statistically significant outcomes (*p*-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Seeking Safety	
Study citation	Lynch, S. M., Heath, N. M., Mathews, K. C., & Cepeda, G. J. (2012). Seeking Safety: An intervention for trauma exposed incarcerated women? *Journal of Trauma and Dissociation, 13*(1), 88–101.
Source	CEBC
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Quasi-experimental design
Sample Characteristics	
Sample size	114 incarcerated women
Race and ethnicity	84% Caucasian 15% Native American 12% Hispanic 3% African American 3% Asian American/Pacific Islander
Socioeconomic status	Not reported
Number and age of children	Not applicable
Whether parent(s) has substance use problems	100% of sample
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	Not applicable
Permanency and safety	None
Recovery	None
Family functioning	• PTSD symptoms • Depression • Interpersonal functioning • Coping
Other	None
Other Comments	

- Sample only included incarcerated women.
- Limitations included lack of randomization and lack of assessment for substance abuse, according to CEBC.

Information accessed at http://www.cebc4cw.org/program/seeking-safety-for-adults/detailed on 4/10/13.

* Includes statistically significant outcomes (p-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Table C.8. Strengthening Families Program (SFP) Evidence Review

Level of Evidence	
OJJDP Review Rating (exemplary, effective, promising, no effects)	Original SFP—No effects SFP 10–14—Promising (Review last updated in June 2011)
NREPP Review Ratings (0.0–4.0 scale, 4.0 = highest quality)*	3.1 (Review last updated in December 2007)
Study Designs	
Number of randomized-controlled trials (RCTs)	6 (3 looked specifically at SFP 10–14)
Number of quasi-experimental designs (QEDs)	None
Number of studies with other designs	1
Demonstrated Effects	
Favorable effects in RCTs or QEDs on parents	• Inconsistent discipline: standardized coefficient = –.088 • Verbal abuse: standardized coefficient = –.095 • Parenting behaviors • Parenting competencies—SFP 10–14
Any favorable effects in RCTs or QEDs on children (specify children's age)	• Conduct disorder symptoms: standardized coefficient = –.096 (6–12 age range) • Oppositional defiance symptoms: standardized coefficient = –.071 (6–12 age range) • Behavior problems: standardized coefficient = –.078 (6–12 age range) • Child participation in family meetings—SFP 10–14 (mean age was 10.5 years) • Targeted child behaviors—SFP 10–14 group (mean age was 10.5 years) • Lifetime use of alcohol, cigarettes, and marijuana 6 years after baseline—SFP 10–14 (6th grade students) • Substance-related risk—SFP 10–14 (6th grade students) • School engagement in the 8th grade,—SFP 10–14 (program administered to 6th grade students; effect measured in follow-up) • Academic success in 12th grade—SFP 10–14 (program administered to 6th grade students; effect measured in follow-up) • Negative peer associations (7–11 age range)
Sample Characteristics	
Samples with majority (or subgroups) of parents with substance abuse issues	One of the RCT samples comprised families with a parent who had problems with alcohol in the past 5 years.
Samples with majority (or subgroups) of families involved in child welfare or child protective services	Not reported
Relevance for RPG	
Favorable relevant findings in RCT or QED with sample that has substance abuse issues and/or child welfare involvement	• Parents who received SFP had lower inconsistent discipline (coefficient = –0.088) and verbal abuse (coefficient = –0.095) scores than control group. • Children who received SFP had lower scores on conduct disorder symptoms (coefficient = –0.096), oppositional defiance symptoms (coefficient = –0.071), and behavior problems (coefficient = –0.078) than children in the control group. The sample children were ages 6–12.
Other Information	
Program developer	• Developed by Karol Kumpfer, Department of Health Promotion and Education, University of Utah • Distributed by the LutraGroup
Intended program outcomes	According to NREPP, SFP aims to (1) help parents learn to increase desired behaviors in children by using attention and rewards, clear communication, effective discipline, substance use education, problem solving, and limit setting; and (2) help children learn effective communication, understand their feelings, improve social and problem-solving skills, resist peer pressure, understand the consequences of substance use, and comply with parental rules.

*The NREPP review did not identify which version of the program was evaluated.

Study and Review Information	
Study citation	Maguin, E., Nochajski, T., DeWit, D., Macdonald, S., Safyer, A., & Kumpfer, K. (2007). The Strengthening Families Program and children of alcoholic's families: Effects on parenting and child externalizing behavior. Manuscript submitted for publication.
Source	NREPP
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Randomized controlled trial
Sample Characteristics	
Sample size	Not reported
Race and ethnicity	50% non-U.S. population (Canadian) 29.7% Black or African American 15.9% White 2.4% American Indian or Alaska Native 1.9% Hispanic or Latino 0.1% Asian Note: unclear if reported race and ethnicity is of parents or children.
Socioeconomic status	Not reported
Number and age of children	The child sample was within NREPP's childhood category (6–12 years). The number of children participating was not reported.
Whether parent(s) has substance use problems	The sample comprised families with a parent who had problems with alcohol in the past 5 years.
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	• Conduct disorder symptoms: standardized coefficient = –0.096 • Oppositional defiance symptoms: standardized coefficient = –0.071 • Behavior problems: standardized coefficient = –0.078
Permanency and safety	None
Recovery	None
Family functioning	• Inconsistent discipline: standardized coefficient = –0.088 • Verbal abuse: standardized coefficient = –0.095
Other	None

Other Comments

- Study took place in U.S. and Canada; families were randomly assigned to receive SFP or a control condition: receiving free and widely available education materials on parenting and family life skills.
- The psychometric properties of the outcome measures used were generally well established.
- Use of a manualized curriculum, staff training and supervision, and a fidelity measure and process evaluations helped ensure fidelity.

Information accessed at http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=44 on 3/29/13.

* Includes statistically significant outcomes (p-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Strengthening Families	
Study citation	Kumpfer, K. L., Greene, J. A., Bates, R. F., Cofrin, K., & Whiteside, H. (2007). *State of New Jersey DHS Division of Addiction Services Strengthening Families Program Substance Abuse Prevention Initiative: Year three evaluation report* (Reporting period: July 1, 2004–June 30, 2007). Salt Lake City, UT: LutraGroup.
Source	NREPP
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Other design: pre/post
Sample Characteristics	
Sample size	Not reported
Race and ethnicity	43% White 36% Black or African American 17% Hispanic or Latino 3% race/ethnicity unspecified 0.5% American Indian or Alaska Native 0.5% Asian
Socioeconomic status	Not reported
Number and age of children	The child sample was within NREPP's childhood category (6–12) and adolescent category (13–17). The number of children participating was not reported.
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	Not applicable
Permanency and safety	Not applicable
Recovery	Not applicable
Family functioning	Not applicable
Other	Not applicable

Other Comments

- In the study, which occurred over four years in real-world settings, fidelity and results improved each year.
- Four annual cohorts of families completed retrospective pre-tests to assess change from baseline.
- The study used retrospective pre-tests to assess program effects (i.e., questionnaires administered following the intervention asked respondents to recall, for example, child behaviors at baseline as a pre-test measure). According to NREPP, retrospective pre-tests are best used as measures of perceived change, rather than actual change, because they tend to inflate program effects.

Information accessed at http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=44 on 3/29/13.

* Includes statistically significant outcomes (p-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Strengthening Families	
Study citation	Spoth, R. L., Guyll, M., Trudeau, L., & Goldberg–Lillehoj, C. J. (2002). Two studies of proximal outcomes and implementation quality of universal preventive interventions in a community–university collaboration context. *Journal of Community Psychology, 30*(5), 499–518.
Source	OJJDP
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Randomized controlled trial
Sample Characteristics	
Sample size	446 families (238 SFP; 208 control)
Race and ethnicity	Nearly all parents (97.8%) were White.
Socioeconomic status	Nearly all parents (98% of mothers and 95% of fathers) completed high school, and about half reported some post–high school education.
Number and age of children	The number and age of children was not reported, but they completed the Young Adolescent Substance Refusal and Substance Resistance measure.
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	None
Permanency and safety	None
Recovery	None
Family functioning	Parenting behaviors: while both the SFP intervention and control group improved, the amount by which the SFP group had improved was statistically significantly greater at both post-test and 1.5-year follow-up.
Other	None

Other Comments

- The authors measured improvement in parenting behaviors targeted by the SFP program using self-reports.
- Parenting behaviors assessed included application of substance-related rules and consequences, positive involvement with the target child, communication, and anger or conflict management.
- The study assessed only parent-reported outcomes.

Information accessed at http://www.ojjdp.gov/mpg/Strengthening%20Families%20Program-MPGProgramDetail-429.aspx on 3/29/13.

* Includes statistically significant outcomes (p-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Strengthening Families	
Study citation	Gottfredson, D. C., Kumpfer, K. L., Polizzi Fox, D., Wilson, D., Puryear, V., Beatty, P. D., & Vilmenay, M. (2006). Strengthening Washington, DC, Families Project: A randomized effectiveness trial of family-based prevention. *Prevention Science, (7)*1, 57–74.
Source	OJJDP
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Randomized controlled trial
Sample Characteristics	
Sample size	715 families (188 SFP, 176 CT, 177 PT, and 174 MT—see abbreviations under "Other Comments")
Race and ethnicity	Participating parents were predominately African American (75%).
Socioeconomic status	More than half of participants (52%) reported a combined family annual income of less than $20,000.
Number and age of children	Eligible families had a child between the ages of 7 and 11 years. The number of participating children was not reported.
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	Negative peer associations
Permanency and safety	None
Recovery	None
Family functioning	None
Other	None

Other Comments

- Families were assigned to one of four groups: parent/child/family skills training, a group that received SFP, and three control groups: child skills training only (CT), parent skills training only (PT), or minimal treatment (MT).
- The study included both parent- and student-reported outcomes. Although both sources of data produced reasonably reliable measurement, parent and child reports of similar behaviors were not highly correlated, and parent reports generated more positive effects than child reports.
- Negative peer associations were measured by child reports.
- The study found no statistically significant effects on child problem behavior, child risk and protective factors, or family factors.

Information accessed at http://www.ojjdp.gov/mpg/Strengthening%20Families%20Program-MPGProgramDetail-429.aspx on 3/29/13.

* Includes statistically significant outcomes (*p*-value ≤ 0.05) from RCTs or QEDs, which are favorable to the treatment group.

Study and Review Information: Strengthening Families	
Study citation	Spoth, R. L., Guyll, M., Chao, W., and Molgaard, V. K. (2003). Virginia Molgaard exploratory study of a preventive intervention with general population African American families. *Journal of Early Adolescence, 23*(4), 435–486.
Source	OJJDP
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Randomized-controlled trial
Sample Characteristics	
Sample size	200 families were randomly assigned; 85 (34 SFP 10–14; 51 control) provided sufficient data for inclusion in the analyses
Race and ethnicity	The SFP 10–14 program was adapted for an African American sample.
Socioeconomic status	Not reported
Number and age of children	The mean age of participants was 10.5 years. The number of participating children was not reported.
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	• Child participation in family meetings • Targeted child behaviors
Permanency and safety	None
Recovery	None
Family functioning	None
Other	None

Other Comments

- The study evaluated the 10–14 version of SFP, and the treatment group received a slightly revised program (6 weekly sessions, rather than 7).
- The authors found no significant differences between the groups for parenting behaviors the intervention targeted or for alcohol-related skills.
- Treatment group members showed some fade-out in the favorable results mentioned above from the post-test to the follow-up (time to follow-up is not given): at follow-up, treatment group youth participated significantly less in family meetings than they had at post-test, and child behaviors no longer differed significantly between the treatment and control groups at follow-up.

Information accessed at http://www.ojjdp.gov/mpg/Strengthening%20Families%20Program%20For%20Parents%20and%20Youth%2010–14-MPGProgramDetail-696.aspx on 3/29/13.

* Includes statistically significant outcomes (p-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Strengthening Families	
Study citation	Spoth, R. L., Redmond, C., Shin, C., and Azevedo, K. (2004). Brief family intervention effects on adolescent substance initiation: School-level growth curve analyses 6 years following baseline. *Journal of Consulting and Clinical Psychology, 72*(3), 535–542. Spoth, R. L., Randall, G. K., and Shin, C. (2008). Increasing school success through partnership-based family competency training: Experimental study of long-term outcomes. *School Psychology Quarterly, 23*(1), 70–89. (This paper reports results of the 6-year follow-up study.)
Source	OJJDP
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Randomized controlled trial
Sample Characteristics	
Sample size	667 families (238 SFP 10–14 group families, 221 Preparing for the Drug-Free Years group families, and 208 control group families). Of 374 families in the SFP and control groups who completed the pre-test, 308 completed the 6-year follow-up assessments. The sample size per condition was not reported.
Race and ethnicity	Follow-up study was 98% White.
Socioeconomic status	Selected schools were located in rural communities with populations of fewer than 8,500 and a relatively high percentage of low-income families. Among participants in the follow-up study, most of the parents (98% of mothers and 95% of fathers) completed high school, and more than half reported some post-high school education.
Number and age of children	The child sample comprised 6th-grade students. The number of participating children was not reported.
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	• Substance use, as well as substance-related risk in 6th grade • School engagement in the 8th grade • Academic success in 12th grade
Permanency and safety	None
Recovery	None
Family functioning	Parenting competencies
Other	None

Other Comments

- Study evaluated the 10–14 version of SFP.
- Relative to the control group at six years following baseline, the authors found that overall growth in lifetime use of alcohol, cigarettes, and marijuana among SFP youth was slower.
- OJJDP reports that direct and positive impacts of the program on parenting competencies and student substance-related risk led to increases in school engagement in 8th grade and improved academic success in 12th grade
- Four measures of parental competency were used: rules and consequences regarding alcohol use, parental efforts to involve the child in family activities and decisions, parental management of anger and strong emotion in the parent–child relationship, and parental activities to communicate understanding of children's feeling and goals as well as parental intentions.

Information accessed at http://www.ojjdp.gov/mpg/Strengthening%20Families%20Program%20For%20Parents%20and%20Youth%2010–14-MPGProgramDetail-696.aspx on 3/29/13.

* Includes statistically significant outcomes (p-value ≤ 0.05) from RCTS or QEDs, which are favorable to the treatment group.

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Table C.9. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Evidence Review

Level of Evidence	
CEBC Review Rating *(1–5 scale, 1 = best supported)*	1 (Review last updated May 2011)
NREPP Review Ratings *(0.0–4.0 scale, 4.0 = highest quality)*	3.6–3.8 (Review last updated June 2008)
OJJDP Model Programs Guide	Effective (Review last updated June 2011)
Study Designs	
Number of randomized-controlled trials (RCTs)	8 that randomly assigned participants to receive TF-CBT or not
Number of quasi-experimental designs (QEDs)	None
Number of studies with other designs	1 RCT that randomly assigned participants to receive versions of TF-CBT with shorter or longer trauma narrative components (but did not assess the effectiveness of TF-CBT vs. another program)
Demonstrated Effects	
Favorable effects in RCTs or QEDs on parents	• Post-traumatic stress disorder (PTSD) symptoms • Distress and other negative emotional reactions • Parenting skills
Favorable effects in RCTs or QEDs on children (specify children's age)	• PTSD symptoms (ages 5–17) • Depression (ages 7–14) • Fear, anxiety, shame, and other psychological problems (ages 5–17) • Problem behaviors (ages 3–17) • Body safety skills (ages 2–8)
Sample Characteristics	
Samples with majority (or subgroups) of parents with substance abuse issues	None
Samples with majority (or subgroups) of families involved in child welfare or child protective services	6 studies
Relevance for RPG	
Favorable relevant findings in RCT or QED with sample that has substance abuse issues and/or child welfare involvement	• PTSD symptoms (ages 5–17) • Depression (ages 7–13) • Other psychological problems (ages 5–17) • Problem behaviors (ages 3–17) • Body safety skills (ages 2–8) • Mothers' parenting skills • Mothers' negative emotional reactions
Other Information	
Program developer	Allegheny General Hospital, Drexel University College of Medicine (Judith Cohen, Anthony Mannarino, and Esther Debinger)
Intended program outcomes	Improve child PTSD, depressive, and anxiety symptoms; improve child externalizing behavior problems; improve parenting skills and parental support of the child; reduce parental stress; enhance parent-child communication and attachment; improve children's adaptive functioning; reduce shame and embarrassment related to traumatic experiences.

Study and Review Information: Trauma-Focused Cognitive Behavioral Therapy	
Study citation	Deblinger, E., Lippmann, J., & Steer, R. (1996). Sexually abused children suffering post-traumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment, 1*(4), 310–321. Deblinger, E., Steer, R. A., & Lippmann, J. (1999). Two-year follow-up study of cognitive behavioral therapy for sexually abused children suffering from post-traumatic stress symptoms. *Child Abuse & Neglect, 23*(12), 1371–1378.
Sources	1. CEBC 2. NREPP 3. OJJDP 4. Study abstracts
Study rating	3.6–3.8 (NREPP)
Study Design	
Approach to assessing impacts	Randomized controlled trial
Sample Characteristics	
Sample size	100 children (75 with data available through 2-year follow-up) and their parents
Race and ethnicity	70% Caucasian 21% African American 7% Hispanic 2% other
Socioeconomic status	Not reported
Number and age of children	100, age 7–13
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Yes (see “Other Comments” for details)
Favorable Results*	
Child well-being	None
Permanency and safety	None
Recovery	None
Family functioning	None
Other	None

Other Comments

- The Department for Youth and Family Services or prosecutor’s office had substantiated a claim of sexual abuse of each participating child.
- Participants were randomly assigned to one of four treatment conditions: parent and child intervention (TF-CBT), child only intervention (several cognitive behavioral therapy methods), parent only intervention (teaching mothers to respond therapeutically to their children), and a group that received standard community services.
- Children assigned to either the parent-child or child-only condition showed fewer PTSD symptoms after treatment than those assigned to the parent-only or community conditions. Parents assigned to either the parent-child or parent-only conditions showed increases in use of effective parenting skills and reported fewer externalizing behaviors for their children than those in the child-only or community conditions. However, no outcomes appear to have been significantly different for the treatment group as compared to all others.

Information accessed at http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/detailed, http://www.nrepp.samhsa.gov/viewintervention.aspx?id=135, http://www.ojjdp.gov/mpg/Trauma-Focused%20Cognitive%20Behavioral%20Therapy-MPGProgramDetail-453.aspx, http://cmx.sagepub.com/content/1/4/310.short, and http://www.nctsnet.org/nctsn_assets/Articles/32.pdf on April 5 and 9, 2013.

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Trauma-Focused Cognitive Behavioral Therapy	
Study citation	Cohen, J. A., & Mannarino, A. P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*(1), 42–50. Cohen, J. A., & Mannarino, A. P. (1997). A treatment study for sexually abused preschool children: Outcome during a one-year follow-up. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36(9), 1228–1235.
Sources	1. CEBC 2. NREPP 3. OJJDP (Only CEBC reported on 2-year follow-up study.)
Study rating	3.8 (NREPP)
Study Design	
Approach to assessing impacts	Randomized controlled trial
Sample Characteristics	
Sample size	67 children and their parents
Race and ethnicity	54% Caucasian 42% African American 4% other
Socioeconomic status	Not reported
Number and age of children	67, ages 3–6
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Yes (see “Other Comments” for details)
Favorable Results*	
Child well-being	Problem behaviors (at post-treatment and 2-year follow-up)
Permanency and safety	None
Recovery	None
Family functioning	None
Other	None

Other Comments

- Participants were families and children with histories of sexual abuse trauma who were recruited through rape crisis centers, child protective services, pediatricians, psychologists, community mental health agencies, police, or judicial system
- Treatment was 12 individual sessions for both child and parent of CBT adapted for sexually abused preschool children. Control group received nondirective support therapy.

Information accessed at http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/detailed, http://www.nrepp.samhsa.gov/viewintervention.aspx?id=135, and http://www.ojjdp.gov/mpg/Trauma-Focused%20Cognitive%20Behavioral%20Therapy-MPGProgramDetail-453.aspx on April 5, 2013.

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Trauma-Focused Cognitive Behavioral Therapy	
Study citation	King, N. J., Tonge, B. J., Mullen, P., Myerson, N., Heyne, D., Rollings, S., ... Ollendick, T. H. (2000).Treating sexually abused children with post-traumatic stress symptoms: A randomized clinical trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*(11), 1347–1355.
Source	CEBC
Study rating	Note applicable
Study Design	
Approach to assessing impacts	Randomized controlled trial
Sample Characteristics	
Sample size	36 children and their parents
Race and ethnicity	Not reported
Socioeconomic status	Not reported
Number and age of children	36 children, ages 5–17
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Yes (see "Other Comments" for details)
Favorable Results*	
Child well-being	• PTSD symptoms • Fear and anxiety • Problem behaviors
Permanency and safety	None
Recovery	None
Family functioning	None
Other	None

Other Comments

- Participants were children with histories of sexual abuse trauma and post-traumatic stress disorder who were referred by sexual assault centers, Department of Disability, Housing and Community Services (DHCS), mental health professionals, medical practitioners, or school authorities. Study was conducted in Australia.
- Children and parents were randomly assigned to receive TF-CBT or to a wait-list control group.

Information accessed at http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/detailed on April 5, 2013.

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Trauma-Focused Cognitive Behavioral Therapy	
Study citation	Deblinger, E., Stauffer, L. B., & Steer, R. A. (2001). Comparative efficacies of supportive and cognitive behavioral group therapies for young children who have been sexually abused and their nonoffending mothers. *Child Maltreatment, 6*(4), 332–343.
Sources	1. CEBC 2. Study abstract
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Randomized controlled trial
Sample Characteristics	
Sample size	44 children and their mothers
Race and ethnicity	64% White 21% Black 2% Hispanic 14% other
Socioeconomic status	Not reported
Number and age of children	44 children, ages 2–8
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Yes (see “Other Comments” for details)
Favorable Results*	
Child well-being	Body safety skills
Permanency and safety	None
Recovery	None
Family functioning	Mothers’ negative emotional reactions to sexual abuse
Other	None

Other Comments

- Participating children had histories of sexual abuse trauma and were referred to the Regional Child Abuse Diagnostic and Treatment Center for a forensic medical examination.
- Participants were randomly assigned to receive CBT group therapy or supportive counseling group therapy.

Information accessed at http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/detailed and http://www.ncbi.nlm.nih.gov/pubmed/11675816 on April 5, 2013.

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Trauma-Focused Cognitive Behavioral Therapy	
Study citation	Cohen, J. A., Mannarino, A. P., & Knudsen K. (2005). Treating sexually abused children: One year follow-up of a randomized controlled trial. *Child Abuse & Neglect, 29*, 135–146.
Sources	1. CEBC 2. Study abstract
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Randomized controlled trial
Sample Characteristics	
Sample size	82 children and their primary caretakers
Race and ethnicity	60% Caucasian 37% African-American 2% biracial 1% Hispanic
Socioeconomic status	Not reported
Number and age of children	82 children, ages 8–15
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	Psychological problems, including anxiety and depression
Permanency and safety	None
Recovery	None
Family functioning	None
Other	None

Other Comments

- Participants were mothers and children with histories of sexual abuse trauma and post-traumatic stress disorder.

Information accessed at http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/detailed on April 5, 2013.

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Trauma-Focused Cognitive Behavioral Therapy	
Study citation	Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. A. (2004). A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(4), 393–402. Deblinger, E., Mannarino, A. P., Cohen, J. A., & Steer, R. A. (2006). A follow-up study of a multi-site, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*, 1474–1484.
Sources	1. CEBC 2. NREPP 3. OJJDP, 1st paper only
Study rating	3.6–3.8 (NREPP)
Study Design	
Approach to assessing impacts	Randomized controlled trial
Sample Characteristics	
Sample size	180 children and their mothers or female guardians
Race and ethnicity	60% Caucasian 28% African-American 9% Hispanic 7% biracial 1% other (data from follow-up)
Socioeconomic status	Not reported
Number and age of children	180, ages 8–14
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Yes (see “Other Comments” for details)
Favorable Results*	
Child well-being	• PTSD symptoms • Feelings of shame • Depression symptoms • Problem behaviors
Permanency and safety	None
Recovery	None
Family functioning	Parents’ distress specific to children’s abuse
Other	None

Other Comments

- Participants had experienced sexual abuse by an adult or older person, confirmed by child protective services, law enforcement, or an independent forensic professional.
- Participants were randomly assigned to receive TF-CBT or child-centered therapy (CCT).

Information accessed at http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/detailed, http://www.nrepp.samhsa.gov/viewintervention.aspx?id=135, http://www.ojjdp.gov/mpg/Trauma-Focused%20Cognitive%20Behavioral%20Therapy-MPGProgramDetail-453.aspx on April 5, 2013.

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Trauma-Focused Cognitive Behavioral Therapy	
Study citation	Deblinger, E., Mannarino, A. P., Cohen, J. A., Runyon, M. K., & Steer, R. A. (2011). Trauma-Focused Cognitive Behavioral Therapy for children: Impact of the trauma narrative and treatment length. *Depression and Anxiety, 28*, 67–75.
Source	CEBC
Study rating	Not applicable
Study Design	
Approach to assessing impacts	This was a randomized controlled trial, but the researchers sought to assess the impact of the length of the trauma narrative (TN) component of TF-CBT rather than the overall effectiveness of the program.
Sample Characteristics	
Sample size	210 children and their mothers
Race and ethnicity	65% Caucasian 14% African American 7% Hispanic 14% other
Socioeconomic status	Not reported
Number and age of children	210, ages 4–11
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Yes (see “Other Comments” for details)
Favorable Results*	
Child well-being	None
Permanency and safety	None
Recovery	None
Family functioning	None
Other	None

Other Comments

- Participating children had experienced sexual abuse; child protective services was likely involved.
- Children were randomly assigned to one of four treatment conditions: 8 sessions with no trauma narrative (TN) component, 8 sessions with TN, 16 sessions with no TN, and 16 sessions with TN.
- 8-session TN condition seemed most effective at reducing parents’ abuse-specific distress and children’s abuse-related fear/general anxiety. However, parents assigned to the 16-session, no narrative condition “reported greater increases in effective parenting practices and fewer externalizing child behavioral problems at posttreatment.”

Information accessed at http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/detailed on April 5, 2013.

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

Study and Review Information: Trauma-Focused Cognitive Behavioral Therapy	
Study citation	Cohen, J. A., Mannarino, A. P., & Iyengar, S. (2011). Community treatment of post-traumatic stress disorder for children exposed to intimate partner violence. *Archives of Pediatrics & Adolescent Medicine, 165*(1), 16–21.
Source	CEBC
Study rating	Not applicable
Study Design	
Approach to assessing impacts	Randomized controlled trial
Sample Characteristics	
Sample size	124 children and their mothers
Race and ethnicity	56% Caucasian 33% African American 11% biracial
Socioeconomic status	Not reported
Number and age of children	124, 7 to 14 years
Whether parent(s) has substance use problems	Not reported
Involvement with child welfare system	Not reported
Favorable Results*	
Child well-being	PTSD symptoms
Permanency and safety	None
Recovery	None
Family functioning	Parents' PTSD symptoms
Other	None

Other Comments

- Participants were children with mental health symptoms whose mothers had been referred to an intimate partner violence center.
- Children and mothers were randomly assigned to receive 8 sessions of TF-CBT or child-centered therapy (care as usual).

Information accessed at http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/detailed on April 5, 2013.

* Includes statistically significant outcomes from RCTS or QEDs, which are favorable to the treatment group.

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