Northern California Training Academy

The Importance of Family Engagement in Child Welfare Services

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Overview

Engagement in child welfare services has been associated with positive outcomes for child welfare services, drug treatment programs and mental health services. However, effective engagement between the worker and biological parent is often elusive for a variety of reasons, including severe parent problems such as drug and alcohol abuse, parent mental health problems and worker and agency characteristics that serve as barriers to effective engagement. Differential Response has been identified as one approach to help overcome barriers to effective engagement as well as to promote positive child and family development.

Characteristics of children and families associated with effective engagement are identified. For example, substance abuse, mental illness and interpersonal violence, as well as the co-occurring contexts of poverty, social problems and cultural differences are discussed. The complex interaction of psychological states and presenting problems for referral are documented, especially in relation to parental substance use.

Extensive review of the literature on engagement is presented. Critical features of engagement, such as early and intensive client involvement, are outlined. Notably, research includes both client and worker views of effective engagement practices as well as barriers to effective engagement. Overall, a strengths-based, collaborative approach to service is supported.

Introduction

Parent involvement is reported to be the "gold standard" for child welfare services (Kemp, Marcenko, Hoagwood & Vesneski, 2009). Cunningham, Duffee, Huang, Steinke and Naccarato (2008) generally define engagement as commitment and active participation. After a thorough review of the literature and confirmatory factor analysis, Cunningham and colleagues (2008) argue that engagement consists of attitudes (e.g., denial, hope, motivation), relationships (e.g., bond, respect, caring) and behaviors (e.g., goal setting, participation, letting guard down). Although engagement is often discussed, there remains little empirical evidence linking engagement practices with child welfare outcomes (Altman, 2005). However, because engagement takes many forms, parents may be differentially engaged in the child welfare process.

There are many obstacles to parent involvement. The National Center on Addiction and Substance Abuse reports the primary obstacle to parent involvement is substance abuse and addiction (CASA, 1999). Indeed, research indicates that approximately 70% of child welfare spending is associated with parental substance abuse and addiction (CASA, 1999). In California, approximately 39% of child welfare cases involve parental substance use, and 16% identify substance abuse as the primary reason for referral (Young, Gardner, Whitaker, Yeh, & Otero, 2005). Additionally, Phillips, Barth, Burns, and Wagner (2004) report that 12.5% of child welfare reports are

attributed to parents who were recently arrested. Nonetheless, there are a variety of reasons for referral to child welfare services, each with its own implications for engagement.

Differential response is a relatively new development in California intended to consider individual differences in the concerns and needs of children and families under stress. California focuses these services on early intervention to prevent child welfare referral and involvement. This enables child welfare to become partners with parents to engage, and for child welfare, to serve as a resource rather than as an adversary. Indeed, engagement has been identified as a core value for differential response in California (Kaplan & Merkel-Holguin, 2008). Similarly, there are increasing calls for child welfare services to become family-centered with an emphasis on the family system rather than any one individual (Johnson, 1998). Thus, Differential Response is intended to address the circumstances of each family, including fostering engagement with the family from the outset.

Core values of differential response are contrary to previous ways of delivering services and interacting with parents involved with the child welfare system. First, Differential Response is characterized by engagement versus an adversarial approach. Families are offered and provided services rather than undergoing surveillance. Individuals are identified as being "in need of services/support" rather than identified

as perpetrators. Families are encouraged to seek assistance rather than feel threatened. Families are proactively engaged to identify strengths and needs rather than experiencing punishment. Finally, response to reports is on a continuum based on the presenting risk, safety, child vulnerability, protective factors and other pertinent characteristics rather than a one-size-fits-all approach.

Importantly, children whose parents use substances have longer stays in out of home care than children whose parents abstain (Vanderploeg, Connell, Caron, Saunders, Katz, & Tebes, 2007). In addition, if parents who use alcohol and other drugs achieve reunification, their children are more likely to reenter foster care after reunification (Frame, Berrick & Brodowski, 2000; Miller, Fisher, Fetrow, & Jordan, 2006). However, children who were removed because of substance abuse were more likely to be placed in relative care than nonrelative foster care (Vanderploeg, et al., 2007). Vanderploeg and colleagues (2007) suggest that this may be an intentional strategy to allow longer treatment times as the use of nonrelative foster care permits bypassing federal guidelines for permanency. Consequently, although these children tend to be adopted at higher rates than children in foster care for other reasons, they are typically adopted later, between 12 to 18 months, than other children (Vanderploeg et al., 2007). Thus, given the complexities of drug treatment and federal permanency guidelines, effective engagement is paramount for permanent reunification.

Engagement: Characteristics of Families and Youth

The literature on characteristics of families and youth that contribute to successful engagement is sparse. However, MacKay, McCadam, and Gonzales (1996) found that child age, child gender, history of abuse or neglect, primary caregiver, court involvement, zip code, and family size were not associated with service involvement in an inner-city child mental health agency.

For families, substance abuse, mental illness and interpersonal violence are negatively associated with engagement (Littell, Alexander, & Reynolds, 2001). For people who use drugs and people who have alcoholism, the primary barrier to treatment is motivation (Porter, 1999). For example, McKay, Lynn, Hibbert, and LIFE Board Members (2000) found that negative parental attitudes and beliefs were negatively associated with initial access and follow-through. That is, when parents hold negative attitudes and beliefs about the process, they were less likely to actively participate. Moreover, Sheppard (2002) found that mothers who have depression are less likely to participate in services. In turn, authoritative interactions with the depressed mothers were related to worsening of depression and decreased rates of participation. Similarly, parental substance abuse reduces involvement due to impairment as well as through negative emotions associated with involvement in the child welfare system (Taylor, Toner, Templeton & Velleman, 2008). In addition, mothers

who use substances report higher levels of personal and environmental stress than mothers who abstain (Nair, Schuler, Black, Kettinger, & Harrington, 2003).

Insufficient skills may serve to further reduce engagement. Brown (2006) found that mothers involved in the child welfare system reported that they needed assistance in navigating the child welfare system, communicating effectively, learning policies and practices, and help with their negative and conflicting emotions so that they can help their children and achieve positive engagement with their workers. Furthermore, parents who use alcohol and other drugs have lower scores on parenting knowledge and behavior than parents who abstain (Velez, Jansson, Montoya, Schweitzer, Golden, & Svikis, 2004).

Cultural mistrust and cultural differences have also been linked with lower rates of engagement (Littell & Tajima, 2000). These factors may be exacerbated in immigrant families who may also have language barriers and even less understanding of the child welfare system than others (Kemp et al., 2009). Indeed, Hill (2006), Libby, Orton, Barth, Webb, Burns, Woods and Spicer (2006), and Rodenburg (2004) report that families of color are less likely to receive and use services and supports through the child welfare system than European American families do.

Substance abuse has been identified as an impediment to successful engagement (Littell, Alexander, & Reynolds, 2001). Rockhill, Green and Newton-Curtis (2008)

examined barriers to drug and alcohol treatment in a sample of families involved with the child welfare system. Importantly, the study was a prospective, longitudinal, qualitative design. Drug use in the sample included marijuana only, alcohol only and others used methamphetamines, heroin, cocaine or some combination. The time to enter treatment for women was 71 days with a standard deviation of 71 days. The time to enter treatment for men was 99 days with a standard deviation of 79 days. All of the parents made it through intake, and nearly 32% graduated from treatment. Other outcomes include intake only, completion without graduation, drop-out, and continued treatment. In addition, interviews were conducted with extended family members, caseworkers, parents' attorneys, treatment counselors, and other providers (i.e., a public health nurse, a child development specialist and an outreach worker).

Identified barriers to treatment include denial of the addiction (drug or alcohol) despite the substance-related referral to child welfare services and court mandates, logistical issues, child-related concerns, poverty, personal relationships and negative consequences of child welfare services involvement (Rockhill et al., 2008). Although many of the parents were in denial about their substance problems, nearly all participants were committed to entering into treatment. Conversely, denial was negatively associated with program completion rather than program entrance.

Logistical issues, also conceptualized as bureaucratic issues, included wait lists, multiple appointments for intake and eligibility requirements (Rockhill et al., 2008). However, workers' intensive concentration on facilitating treatment reduced logistic barriers. For example, workers often took the lead in making and receiving phone calls related to intake, provided transportation and attended initial appointments with the parents.

Child-related concerns were generally minimal in the study (Rockhill, 2008). However, child-related concerns were associated with treatment retention and completion. Indeed, some parents evaluated the relative costs of continued treatment with the potential benefits and concluded that the costs were greater than the benefits. More specifically, some of the parents believed that the likelihood of their children returning home within the allotted time was much lower than the effort required for remaining in and completing treatment. Another related factor considered was the negative impact of the foster experience on their children, which was considered a great cost. It should also be noted that some of the parents voluntarily placed their children so they could seek treatment. Overall, some parents did not believe their efforts would be successful in the long run (Rockhill, 2008).

Poverty was the greatest impediment for treatment (Rockhill et al., 2008). The effect of poverty was prevalent but in notable ways. Foremost, establishing eligibility

for publicly funded health insurance and lengthy delays in the application process were the most frequent barriers. Some parents were required to facilitate communication between the agency and the treatment provider, although many were without regular access to a telephone and answering machine. After some parents were in treatment, they were required to change programs due to changes in providers' policies regarding public insurance. Some parents had great difficulty due to past unpaid premiums or co-pays or failure to pay for current services, however minimal (i.e., $24). Some treatment programs refused to allow agencies or family members to pay on the parents' behalf for philosophical reasons (e.g., "enabling," Rockhill et al., 2008).

Housing and employment were interrelated and both impacted treatment (Rockhill et al., 2008). Some parents reported that if they completed all of the necessary requirements, they would not be able to continue working and would then not be able to provide stable housing and be gainfully employed as required. A notable example was a father who was laid off for missing too much work. He was required to attend hearings, participate in parenting classes and anger management classes, visit his son, have a drug and alcohol evaluation and complete treatment if necessary (Rockhill et al., 2008). For others, lack of stable housing and a telephone served as a barrier to entering treatment in a timely manner.

Although family often serves as a support, in some instances, family served as a barrier to successful treatment (Rockhill et al., 2008). For example, for some extended family members, the stigma associated with drug and alcohol abuse exacerbated denial. For others, occasional help by way of groceries and gasoline necessitated additional screening for eligibility for publicly funded health insurance. For some, the assistance they could accept from extended family who had custody of their child was limited due to regulations concerning contact between the parent and child (Rockhill et al., 2008).

For couples, most often both partners were required to seek treatment (Rockhill et al., 2008). However, as in previous research, females were more supportive of their male partners' recovery than were male partners' of their female partners' recovery. For some individuals, they had to choose between seeking and completing treatment and remaining with their partner who refused treatment and who would be unsupportive of their recovery. For many of the couples, facing an additional separation from a loved one (and an adult attachment figure) was a significant psychological barrier to completing treatment. Some of the participants noted that they would be completed separated from their families with the loss of their child(ren) and their romantic partner. With this separation, especially for the fathers, came loss of housing due to loss of income or housing and disability payments while their partners were in residential treatment. Thus, some of the women chose treatment knowing they would leave their partners homeless.

Some of the families developed strategies to accomplish the goal of reuniting with their children by having one parent complete treatment and regain custody. Meanwhile, the other parent would temporarily separate from the family and reunite later (Rockhill et al., 2008). Thus, this was one way partners could support each other and work toward reunification of the family.

Finally, the negative consequences of child welfare involvement often overlapped with logistic and poverty issues. Notably, for some parents, the negative emotions related to involvement served to impede their active participation in seeking treatment and other required programs (Rockhill et al, 2008). For some, the complexity of the child welfare system and difficulty in communication delayed entry into treatment. For many, the numerous requirements coupled with a lack of transportation and work hours proved especially difficult (Rockhill et al., 2008).

Conclusions from Rockhill and colleagues' study (2008) focus on program development and planning. The key issue to consider is the multiple needs of parents, especially ancillary poverty issues and the multiple problems in their lives. Given the timelines in the federal Adoption and Safe Families Act, case workers must work diligently and aggressively to engage families and facilitate their many needs to successfully guide them through the myriad obstacles to treatment and reunification.

Service Process and Relationships

Early engagement is associated with program success (Cash & Berry, 2003; Littell, 1997) and successful helping relationships (Chapman, Gibbons, Barth, McCrae, & National Survey of Child and Adolescent Well-Being [NSCAW], 2003). MacLeod and Nelson's (2000) meta-analysis revealed that intensive programs characterized by high levels of client involvement, an empowerment/strengths-based approach and social support had higher effect data than family preservation programs without those characteristics.

In a qualitative study of 35 parents who participated in Project Parent, a strengths-based ecological intervention focused on family preservation, Gockel, Russell and Harris (2008) report that the single most important factor reported by participating parents as being helpful is that the program personnel were like family to them. That is, the parents reported that they felt recognized, valued, cared for and supported. Because of this, they reported wanting to learning from the program personnel what they could not learn from their own families. In addition, parents reported that every staff member from the receptionist to the cook and counselor provided a nurturing family-like environment for them.

The characteristics associated with positive initial engagement were warmth, acceptance without judgment, understanding, flexibility and a strengths-based focus.

For the next step, exploration and goal-setting, integrity and respect were highlighted as paramount to active program participation. Parents also reported that personnel were empathic and focused on the intergenerational transmission of family dysfunction to help them understand the linkages with their early experiences and their current problems. Next, program personnel initiated discussions with the parents to foster a sense of empathy and understanding for their children. In turn, this focus on the parents' and children's experiences developed into motivation to learn new skills and ways of interacting with their children.

In the next phase of the program, wherein parents were expected to initiate change and build new skills, parents reported that the hands-on mentoring and support were empowering for them to effect change. The hands-on component consisted of an informal and peer-oriented approach to modeling such as enjoying meals together and other day-to-day experiences. Support consisted of encouragement, emotional support and reinforcement. Finally, parents reported the empowering impact of program personnel not only serving as their advocates in a challenging system but also mentoring them to become self-advocates.

Of note, many of the characteristics deemed helpful by program participants are documented in the literature. For example, recreating a nurturing family environment, or "reparenting" has been identified as critical to family preservation interventions (see

Bacon & Gillman, 2003). In addition, the strengths-based approach with empathy, collaboration and genuineness has been associated with parent reports of workers who are engaging and helpful (see Chapman et al., 2003; Fernandez, 2007; Harris, Poertner, & Joe, 2000; Ribner & Knei-Paz, 2002). Support and advocacy, inclusion in decision-making and trust (Jimanjee, 1999) have all been identified as important. In contrast, however, some parents have reported that although the goal is for them to be involved in planning and decision-making, they were simply informed of decisions more often than being a true participant in the process (Corby, Millar & Young, 1996).

Agency Factors

The amount of direct contact between workers and clients is positively associated with collaboration (Dawson & Berry, 2002). However, clients (Chapman et al., 2003) and workers (Smith & Donovan, 2003) report that they have insufficient time together. Institutional practices that de-emphasize work with parents may serve as a barrier to successful engagement. For example, some agencies place an emphasis on paperwork, court-related work and work with children, rather than on work with parents has been associated with the use of phone calls, letters and referrals rather than in-person meetings (Smith & Donovan, 2003). In addition, Smith and Donovan (2003) found that many workers were skeptical, at best, about the feasibility of assisting clients to make positive and successful changes in a timely fashion given the multitude of challenges (time, resources and families' extensive problems). Indeed, Littell and Tajima (2000) found that a deficit approach was associated with lower rates of collaboration and compliance. On the other hand, agency factors associated with positive engagement in a study with substance abusing parents include shared worker values and supportive work environments (Broome, Flynn, Knight, and Simpson (2007), job clarity, autonomy and adequate supervision (Littell & Tajima, 2000).

Kemp et al. (2009) developed comprehensive guidelines for family engagement (See Table 1, Kemp et al., 2009). Importantly, a key component is early, active and

persistent initial contacts which may promote an effective working alliance. Through these contacts, workers can come to understand their clients and work toward acknowledging, validating and responding to parents' cultural vulnerabilities and practical, psychological and emotional needs in relation to their child welfare status. For example, McKay and Bannon (2004) found that a thirty minute focused telephone engagement intervention that addresses these cultural, psychological, practical and emotional needs is associated with increased attendance at initial appointments among urban ethnic minority families. In addition, active attention to promoting engagement in the first interview was positively associated with ongoing attendance. Another study (Swartz, Zuckoff, Grote, Spielvogle, Bledsloe, Shear and Frank (2007) examined a face-to-face engagement intervention and found that the one hour intake session significantly increased involvement and initial treatment attendance in a sample of depressed, low-income patients. The intake interview was designed to address the psychological and emotional barriers individuals may face in entering treatment.

Similarly, focusing on the relationship between child welfare workers and clients, Kinney and Strand (2001) outline the essential characteristics and skills for child welfare workers assisting drug using or addicted parents. Child Welfare workers should be empathic and compassionate, support rather than confront and be resilient and able to maintain perspective. In addition, workers should be able to keep people safe, including children, families and themselves. Workers should also be able to form

decision-making partnerships. Workers should also be able to identify strengths in every client they assist to facilitate the change process.

Outcomes of using Family Engagement Practices

Smith, Duffee, Steinke, Huang and Larkin (2008) found that early positive engagement was associated with family trust, self-efficacy, self-esteem and school attachment at the outset, and with family trust, self-efficacy and school attachment over time in a sample of youth in a residential treatment center. Furthermore, youth who initially had low levels of engagement had greater positive change during treatment while youth who had higher levels of engagement remained consistently high over time. Thus, those who were highly engaged at the outset tended to have positive outcomes, and those who were less engaged at the outset showed positive change.

In a study of substance using mothers receiving public assistance, Morgenstern, Blanchard, McCrady, McVeigh, Morgan, and Pandina (2006) found that Intensive Case Management (ICM) consisting of longer-term, comprehensive cross-system coordination predicts greater treatment engagement, retention and completion than usual care (UC, screening and referral). In addition, 43% of ICM participants were abstinent by the 15th month compared with 26% of the UC participants. Of particular note, the women in this study had primary diagnoses of cocaine (39.13% ICM and 30.71% UC), heroin (37.27% ICM and 35.00% UC), alcohol (ICM 18.63% and 26.43% UC), and marijuana (4.97% ICM and 7.86% UC) use. Approximately 13% of all participants reported regular use (defined as at least three times per week for a year or

longer) of alcohol. Overall, these results lend support for ICM as a successful engagement strategy that facilitates access to social services and entrance into and completion of drug and alcohol treatment programs (Morgenstern, et al., 2006).

Best Practices

Romanelli, Hoagwood, Kaplan, Kemp, Hartman, Trupin, Soto, Pecora, LaBarrie, Jensen and the Child-Welfare-Mental Health Best Practices Group ("Best Practices Group;" 2009) developed consensus-based recommendations for parent engagement. The overarching goal for the guidelines is that services should be nonstigmatizing, supported by research, flexible to meet the needs of clinicians/administrators and families, cost-efficient and offered before major problems arise.

The first guideline recommends the use of peer family mentors to serve as co-advocates. These peer mentors should have experience working with birth parents, adoptive parents, foster parents, kinship or youth. The second guideline provides for the training, education and professional support of the peer mentors. The third guideline is the provision of an immediate orientation to child welfare, focusing on family rights and responsibilities, for all families experiencing removal of a child. Furthermore, there should be periodic and ongoing assessment of family understanding of their rights and responsibilities. It is recommended that peer family mentors provide the orientation and conduct the periodic assessments.

The next guideline provides for comprehensive family assessment to identify family strengths, needs and necessary support services. The assessment team should include child welfare staff, a peer family mentor and the family. The assessment should

be reviewed and updated regularly by the assessment team. The fifth guideline provides for family engagement training for child welfare staff. Such training should focus on improving the intake process, increasing attendance at appointments/meetings and fostering positive attitudes about services. Identified models include Motivational Interviewing (Miller & Rollnick, 2002), Strategic Family Therapy (Satir, Sanmen, Gerber & Gomori, 1991), Functional Family Therapy (Sexton & Alexander, 2000), Brief Strategic Family Engagement (Santisteban, Szapocznik, Perez-Vidal, Kuartines, Murray & La Pierriere, 1996) and Engagement Interventions (McKay, Hibbert, Hoagwood, Rodrigues, Murray, Legerski & Fernandez, 2004).

The sixth guideline provides referral to substance abuse and mental health treatment when needed. This includes a comprehensive service plan with appropriate linkages and referral to the needed services in addition to necessary parenting and family intervention. The seventh guideline focuses on providing early assistance and differential response services for families. Guideline eight provides for parent involvement in services for their children including education, medical services, mental and physical health promotion assessment and treatment, and other appropriate services.

Romanelli et al., (2009) also developed guidelines for youth empowerment. The goal for youth empowerment is for youth to be active in child welfare, court

proceedings related to their care and child advisory groups. In addition, youth empowerment guidelines include agency responsibilities such as prioritizing youth's academic, employment and social needs.

The first youth guideline is for child welfare agencies to include youth empowerment in their mission, values and practices. The goal is for services to become strengths-based and to foster the mental health and functioning of youth. The second guideline provides for all youth to have a specially trained youth legal advocate in all legal proceedings with opportunities to appear and participate in their legal proceedings as developmentally appropriate. The third youth empowerment guideline provides for the inclusion of youth and youth alumni in service planning, evaluation, staff development and as providers of youth services. Guideline four for youth empowerment provides for child welfare agencies to demonstrate multicultural competence. Multicultural competence especially focuses understanding, being aware of and transcending biases, assumptions and attitudes about race, religion, gender and sexual orientation.

The fifth guideline recommends that child welfare agencies foster youth understanding of their rights and entitlements. To achieve this goal, youth should be provided information, practical assistance and support. The sixth guideline recommends the provision of support through, at least, the age of 21 for youth aging

out of foster care (starting around age 13). Support should focus on health insurance, housing, education, career development and at least one significant adult relationship. Finally, the last youth empowerment guideline recommends that "the child welfare system be held accountable for measureable outcomes related to youth empowerment" (Romanelli et al., 2009).

Poertner, Roitman, Derezotes, Smith and Woolfolk (2000) assessed parents' (n = 693 families) satisfaction with child welfare services in Illinois. They found 23 caseworker behaviors reported as important to parents with children in care. The documentation of these expectations serves multiple purposes. First, the expectations can be used to inform engagement practices. Indeed, Poertner and colleagues' publication details the implications of each expectation as well as provides specific casework interventions. In addition, the list can be used as a client satisfaction survey with current clients. Baker (2007) also suggests that client feedback is a critical part of child welfare service delivery. Among the many uses of a client feedback measure, Baker recommends that a measure can be used to evaluate the effects of new programs or changes in programs. In addition, use of a client satisfaction measure can foster a sense of empowerment in the parents. Items from the Baker (2007) satisfaction survey are the following:

1. My caseworker encourages me to discuss when things were better in my family.

2. When my caseworker makes a mistake, she/he admits it and tries to correct the situation.

3. My caseworker tells me what she plans to say in court about my family and me – both negative and positive.

4. My caseworker tells me whom I can contact for help when she is gone for more than a day or two.

5. My caseworker informs me about the help that is available to complete my case.

6. My caseworker devotes enough time to my case.

7. My caseworker understands how hard it is to get your children taken away.

8. My caseworker gets me necessary services in a timely manner.

9. My caseworker cares about my kids.

10. My right to make decisions about my children has been respected during the time they have been in care.

11. My caseworker helps me talk to my child often.

12. My caseworker calms my fears about what the agency can do to my children and me.

13. My caseworker speaks up for me with other professionals involved in my case.

14. My caseworker has experience dealing with the kinds of problems my family and I are experiencing.

15. My caseworker's expectations of me are reasonable.

16. When my caseworker says she will do something, she does it.

17. Meetings with my caseworker occur at least once a month.

18. My caseworker listens to my side of the story.

19. My caseworker respects my right to privacy.

20. My caseworker returns my calls

21. My caseworker is clear about what she/he expects from me.

22. My caseworker explains to me what will happen in court.

23. I am involved in decisions made about my case.

24. My caseworker respects my social/cultural background.

The primary motivation for parents to seek and complete treatment is to be reunified with their children. However, many parents are fearful that they will not be reunified before their parental rights can be terminated. One successful program fosters motivation for treatment completion and supports the parent-child relationship by allowing parents who are making progress to live in mentor homes with their children (The David and Lucile Packard Foundation, 2004). This serves the needs of not only children and their families, but also child welfare.

Finally, all workers and staff should have sufficient knowledge of and training in working with families that have substance related problems. The Substance Abuse and Mental Health Services Administration offers an on-line tutorial for child welfare professionals:

Tutorial 2: Understanding Substance Use Disorders, Treatment and Family Recovery: A Guide for Child Welfare Professionals

http://www.ncsacw.samhsa.gov/training.asp

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Table 1. Considerations for Supporting Parent Engagement in Services (Kemp et al., 2009)

Preconditions	Strategies	Bridging Services	Treatment Services
Separation/loss	Early/structured outreach	One-to-one casework	Mental health (adult and child)
Poverty-related stress	Practical help	Instrumental help	Substance abuse
Addictions/mental health	Knowledge, skill building, empowerment	Parent/child visitation	Parent training
Family stressors	Supportive relationships	Peer-to-peer programs	Interpersonal violence
Social isolation	Consultation and inclusion	Foster/birthparent mentoring	
Client status: stigma, marginality		Conferencing	
Cultural barriers	Family-centered, culturally responsive practice	Home-based services	
Negative service experiences			