UNIVERSITY of MARYLAND
SCHOOL OF SOCIAL WORK

Family Connections

Maryland Department of Human Resources
Social Services Administration
Final Report
Contract Period July 1, 2012 to June 30, 2013

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MISSION

Family Connections Baltimore, a program of the University of Maryland School of Social Work Ruth H. Young Center for Families and Children, develops, implements, and tests community-based family strengthening services that empower vulnerable families to achieve their safety, well-being, and stability. The program is committed to educating social work and other professionals to use evidence-based models of practice.

1. Background

Family Connections at Baltimore (FCB) is an agency of the University of Maryland School of Social Work (UM SSW) Ruth H. Young Center for Families and Children. FCB began in 1996, when Drs. DePanfilis and Dubowitz developed the Family Connections intervention model to provide research-based in-home early intervention services, grounded in neglect prevention science, for families living in Baltimore, Maryland. Since that time there have been a number of replications and modifications of the FC model and FCB has engaged in a variety of service interventions, research activities, teaching and learning collaboratives, including initiatives that inform policy development (see Attachment A - Timeline). Dr. Frederick H. Strieder serves as the director of FCB including the Family Connections (FC), Grandparent Family Connections (GFC), and Trauma Adapted Family Connections (TA-FC) service initiatives. Dr. Diane DePanfilis, Director of the Ruth H. Young Center for Families and Children, continues to provide consultation and oversees related FC research activities. Dr. Kathryn S. Collins is the Principal Investigator for TA-FC and oversees those research activities. Program staff also include Maureen Tabor, Faculty Field Instructor; Kevin Wade, Social Worker, Field Instructor; Colette Eaton, Social Worker, Intake Coordinator; Christopher Beegle, Social Worker, TA-FC Counselor; Patty Greenberg, Research Project Coordinator; Dr. Pamela A. Clarkson Freeman, Research Project Coordinator; and Nancy Talbot, Social Worker. In 2002 the services were enhanced by partnering with the Maryland Department of Human Resources Social Services Administration (SSA). The support of SSA has continued since that time and most recently a contract was awarded for the July 1, 2012 to June 30, 2013 time period. This report reflects activities conducted during the SSA July 1, 2012 to June 30, 2013 contract period. In this year, the work of FCB was influenced by a number of agency initiatives that facilitated the achievement of its mission.

Grandparent Family Connections

GFC was initiated with a grant award from the United States Department of Health and Human Services Children's Bureau to serve grandparent headed households (2003-2008). Since that time, a focus on serving grandparent headed households has continued. This includes providing services to individual families, conducting grandparent groups, providing education and advocacy related to issues of grandparent headed households, and promoting the development of policy and services in Maryland on behalf of these families.

Trauma Adapted Family Connections

In 2007, University of Maryland's School of Medicine and its partners, the University of Maryland School of Social Work and the Kennedy Krieger Family Center, received a $2.4 million SAMHSA grant for the Family-Informed Trauma Treatment or FITT Center. In 2011 the FITT Center was awarded an extension for an additional year. In the fall of 2012, the FITT Center was awarded an additional grant for four years. The FITT Center is part of the National Child Traumatic Stress Network (NCTSN) and is one of 17 Category II Center's nationwide. Established in 2000, the NCTSN is a dynamic organization that has raised awareness of the impact of childhood trauma and increased access to effective trauma treatments for thousands of our nation's children and adolescents. NCTSN chose the FITT Center to serve as a national expert on the role of families in the lives of children impacted by trauma and to further the availability of effective *family* trauma treatments. Many of the resources that have been developed, including a white paper, can be found at http://fittcenter.umaryland.edu/.

FCB's participation in the FITT Center includes Trauma Adapted Family Connections (TA-FC), an intervention developed and implemented by Dr. Kathryn S. Collins, Principal Investigator, Dr. Frederick H. Strieder, Maureen Tabor, and Christopher Beegle. The intervention design team includes clinicians, researchers, and community representatives. TA-FC is grounded in public health and social work perspectives and builds on more than fourteen years of community-based family intervention, research, and the accumulated knowledge that has evolved in assisting children and families exposed to traumatic experiences. TA-FC builds on FC principles and service components to provide trauma-focused interventions across these broad domains while integrating: (1) trauma-focused family assessment and engagement; (2) psycho-education to teach family members about trauma symptomatology; (3) a focus on building safety capacity within the community and immediate environment; (4) trauma informed parenting practices and communication; and (5) trauma informed approaches to working with families. TA-FC staff members participate in training and education activities to promote an understanding of trauma and its impact on families, as well as the development of effective intervention strategies. Each year graduate social work interns also are educated to implement the TA-FC model. A conceptual model for working with families experiencing complex developmental trauma was developed that identifies the core components for such work. This is available at http://fittcenter.umaryland.edu . There has been additional focus on the experience of providers in conducting work with families who experience trauma and the special considerations for their professional development.

A Model for Child Welfare Workforce Development in Urban Areas

The UMSSW Title IV-E Program was awarded a U. S. Children's Bureau National Child Welfare Workforce Institute, 2009-2013, grant as one of nine national schools of social work traineeship sites to build the capacity of the child welfare workforce. As part of the grant UMSSW demonstrates a commitment to continue development and implementation of an integrated coursework and field instruction model that prepares social work students to practice successfully in an urban child welfare agency. Baltimore City's child welfare system serves children and families with arguably the most complex needs in the State and has the most difficulty of all Maryland jurisdictions in recruiting and maintaining a professional child welfare workforce that is trained to address these needs. A primary objective of this project is to increase the percentage of Title IV-E Program graduates who successfully complete their Title IV-E employment obligation at the Baltimore City Department of Social Services (BCDSS) from 14% to 28%. Twelve MSW and three BSW full-time students were selected from the pool of Title IV-E applicants to participate in the project in the 2009-2010 academic year and each of the following four years of the grant period. In collaboration with Baltimore City Department of Social Services and the Family Connections program in Baltimore, specific child welfare knowledge and skill competencies needed by social workers practicing in an urban child welfare system were identified and used to revise field instruction strategies and to enhance the Child Welfare curriculum at the UMSSW. Students participating in the grant are placed at Family Connections. Dr. Strieder provides instruction to participants related to trauma and practice in child welfare.

2. Program Staff and Interns

Frederick H. Strieder, PhD, LCSW-C
Program Director, Principal Investigator for FC, Clinical Associate Professor
University of Maryland School of Social Work

Diane DePanfilis, PhD
Director Ruth H. Young Center for Families and Children Professor
University of Maryland School of Social Work, Principal Investigator for FC Research

Kathryn S. Collins, MSW, PhD
Principal Investigator for TA-FC, Co-Principal Investigator FITT Center, Associate Professor
University of Maryland School of Social Work

Maureen Tabor, LCSW-C
Social Worker, Faculty Field Instructor

Kevin Wade, LCSW-C
Social Worker, Field Instructor

Christopher Beegle, LGSW
Social Worker, Counselor TA-FC

Patty Greenberg, MA
Research Project Coordinator

Nancy Talbot, LGSW
Social Worker

Jessica Leighton, MSW
Social Worker/Intake Coordinator

Colette Eaton, MSW
Social Worker, Intake Coordinator

Pamela A. Clarkson Freeman, PhD
Research Project Coordinator, Assistant Research Professor
University of Maryland School of Social Work

Jessica Leighton left Family Connections during this report period. Colette Eaton, a MSW graduate of the University of Maryland School of Social Work, was hired to fill her position as Intake Coordinator.

During this report period, ten interns continued their social work field placement at Family Connections: nine from the University of Maryland and one from Morgan State University. All ten interns were clinical second year graduate students participating in the Title IV-E Education for Public Child Welfare Program. Three of these student interns were enrolled in the UMSSW Trauma Education Connections Initiative (TECI) and their internships were focused on the TA-FC model. In addition, five of the second year interns were participating in the Public Education for the Child Welfare Workforce Project. In May 2012, these ten interns graduated and began their employment in local Maryland Departments of Social Services.

3. Family Characteristics

A total of 81 families including 224 children were served during the contract period and 45 cases were closed. During this period, 136 referrals were received and 69 new cases were opened. Ten were assigned to the GFC initiative, 39 were enrolled in FC services, and 20 were enrolled in TA-FC services. Ninety-four percent of the caregivers were African American; six % were white with an age range of 23-62. The average number of years of education was 10.8 and 74% of the caregivers were unemployed. All of the caregivers were female. Twelve percent were married, 73% had never married, 7% were separated, four % were divorced, and four % were widowed.

Forty-six percent of the children were female, with a household average of three children in each household. The average age was eight years old (range, 0-19 years). Ninety-two percent were African American, five% were white, and three% were of mixed race.

When families enter the program, they (or the referral source) were asked to identify their concerns. The total percentage can be greater than 100% since multiple needs were identified. The top ten needs identified were: delay in getting mental health care (49%), unmet special education needs (25%), unsafe household conditions (24%), witnessing violence (24%), inadequate clothing (22%), unstable living conditions (21%), permitting maladaptive behavior (17%), inadequate nutrition (16%), shuttling (9%), and inadequate/delayed health care (7%). Additional risks identified for caregivers included unemployment/underemployment (84%), mental health problem (63%), serious health challenges (25%), and alcohol and/or drug problem (3%). Risk factors identified for the household included more than three children in the household (28%), homelessness (24%), and domestic violence (12%). Risks for children included behavioral or mental health problems (73%), learning disabilities (22%), physical disabilities (12%), developmental disabilities (10%), and alcohol or drug problems (1%).

4. Services

FC/GFC/TA-FC services included various activities conducted directly with a family or on their behalf to achieve mutually defined goals. Service locations included the clients' homes, community agencies and sites (schools, legal services, mental health centers, social service offices, parks, stores and playgrounds), and the Family Connections site. Fifteen percent of the contacts serving families were conducted at Family Connections and the remaining 85% were conducted in the community. Seventy-three percent of the contacts in the community were in the clients' homes. The vast majority of services were provided either in person (88%) or over the phone (11%).

Information was also tabulated about the types of service provided. Table 1 summarizes the top six activities representing 79% of the total time spent providing services. Attached to this report is the list of all the activities and their definitions (see Attachment B – Activity Definitions).

Table 1. Service Activities

Activity	Hours	Percentage of Total
Assess	468	34%
Counsel/Support	404	29%
Program Attempts	62	4%
Plan	60	4%
Scheduling	50	4%
Providing	54	4%

Staff and students were involved in training provided by the agency for 1162 hours and training provided by other sources for 137 hours. A total of 322 hours were spent in staff meetings and committees, and 26 hours participating in community organizations and community committees. A total of 68 hours were committed to agency committees.

Other administrative activities were conducted to support clinical efforts including 615 hours conducting activities to support the operations of the program, 418 hours giving supervision, and 763 hours entering information into the management information system.

Family Connections had the capacity to either directly provide or assist families in receiving financial assistance and goods to meet their basic needs. Ninety percent of the families received concrete services for a total of $40,501.98. For the year, the Family Connections grant funds provided $15,039.89, thirty-seven percent of the financial assistance the program facilitated. Financial support for families included $3,693 from the UMSSW Swartz Fund that was provided to families at risk of becoming homeless.

5. Multi-family Events

Each year FC provides multi-family social-recreational activities. Families were included in the planning process along with interns.

Back to School Event 2012

Family Connections held a Back to School Event at Genessee Valley on August 8, 2012. The purpose of the Back to School event was to foster a sense of connectedness among the families of the program, provide them with an opportunity for a day trip away from the city,

and provide the children in the program with school supplies for the upcoming school year. The families in the program were transported by bus to the Genessee Valley site in Parkton, MD and were provided with a morning and afternoon snack and a boxed lunch. The caregivers and children participated in various field games, rope courses, and nature walks throughout the day. There were a total of 19 clients in attendance which included seven families (eight caregivers and 11 children). In addition, there were six staff members in attendance.

Holiday Event 2012

Family Connection's "Holiday Event" is meant to provide the families in the program with an opportunity to celebrate their beliefs, strengthen existing family ties, and foster a sense of community connectedness. The holiday celebration is an interactive event designed to elicit family participation — it is not meant to be a passive experience. The goal of the "Holiday Event" goes beyond providing our families with holiday gifts. It is designed to create a shared experience among family members — an experience that can serve as a future source of strength.

The celebration was held on Tuesday, December 11, 2012, from 5pm-8pm at New Song Academy in West Baltimore with 39 caregivers and 95 children in attendance. Over 17 program staff, interns, and volunteers participated to make the event a success. The event was catered by Blazing Bull Caterers and the Ava Fields Dance Troop provided entertainment. ADJ played music and involved the families in various dance activities. A local professional photographer took family portraits that were later distributed to clients.WBAL, a local radio station donated $5,536.00 to cover the cost of the event.

6. Program Activities

During the course of the grant year, staff and interns participated in project development, activities, and presentations that advocated for the provision of best practices in child welfare. These activities demonstrated the diversified nature of the Family Connections at Baltimore that includes the FC, GFC, & TA-FC service delivery models but also many other projects and activities that reflect the collaboration with the School of Social Work and the greater Baltimore community.

Student Education Activities

In September 2012, an orientation was held for all the new social work interns. This was an introduction to the FCB model of practice including training in the use of the management information system, documentation standards and practice, the development of a comprehensive assessment and goal oriented service plans. The student interns also were

trained to use observation instruments and client self report instruments in formulization of comprehensive assessments and implementation of clinical data into practice endeavors. The staff reviewed and applied the basic documentation requirements presented in the orientation. This allowed additional support to supervise skill development.

Weekly seminars began in September and continued throughout the school year, reviewing in depth the basic principles of the program. This specifically included engagement, outreach and the helping alliance, interventions/developmental appropriateness, and strengths based practice. Individual and family resilience and response to trauma was also presented with an emphasis on neglect and complex developmental trauma with specific implications for practice. Other topics included Motivational Interviewing, diversity, homelessness, and professional development. Title IV-E seminars included Foundations of Practices, Dynamics of Child Abuse and Neglect, Working Effectively with the Court, Conducting Family Centered Assessments, and Planning and Intervening with a Family. Specific Motivational Interviewing and Trauma-informed Practice themes were woven into each IV-E seminar topic. Students were given the opportunity to reflect on their use of self and personal growth as they become engaged with families and work toward achieving goals.

Family Connections staff took the lead on infusing a Motivational Interviewing (MI) curriculum into the pre-existing Title IV-E Education for Public Child Welfare monthly seminars. Staff prepared pre-reading, pre-tests, power point presentations, and activities to facilitate the students' learning process. In January, students attended a two-day, intensive IV-E sponsored training in MI presented by Dr. Ed Pecukonis, Associate Professor at UMSSW. The use of MI has expanded over the previous three years. FC staff members have experimented with different means of providing coaching and supervision at FCB and within IV-E. Live supervision has been implemented with faculty and interns.

Publications & Presentations

Brylske, P., Strieder, F., Price, C., & Mettrick, J. *Creating Trauma-Informed Child Welfare Systems of Care*. Maryland System of Care Training Institutes 2013, The Institute for Innovations and Implementation at the University of Maryland School of Social Work, June 4, 2013.

Collins, K. S., Strieder, F. H., Beegle, C. *Core Concepts of Trauma Treatment for Children, Adolescents, and their Families.* University of Maryland School of Social Work. May 20-24, 2013.

Collins, K. S., Berkowitz, S., Strieder, F. H., & Clarkson Freeman, P. *Back to the Future: Trauma-Focused Family Assessment*. National Child Traumatic Stress Network All-Network Conference New Directions: Collaboration for a Comprehensive Focus on Childhood Trauma. Philadelphia Pennsylvania, May 1, 2013.

Collins, K. S., Strieder, F. H., Freeman, P. C., and Tabor M. *Trauma Adapted Family Connections: Reducing Developmental and Complex Trauma Symptomatology to Prevent Child Abuse and Neglect.* International Society for Traumatic Stress Studies 28th Annual Meeting. Beyond Boundaries: Innovations to Expand Services and Tailor Traumatic Stress Treatments. November 3, 2012.

Connors, K. & Strieder, F.H. *Child Welfare Professional Development and Supervisors Working with Families Who Experience Trauma*, University of Maryland School of Social Work Child Welfare Academy, February 23, 2012.

Strieder, F. *Compassion Fatigue, Secondary Traumatic Stress or Burnout? Identification and Practical Strategies for Frontline Case Workers ,* University of Maryland School of Social Work Child Welfare Academy, December 3, 2012 .

Strieder, F. *Child Welfare Professional Development and Supervisors Working with Families Who Experience Trauma,* University of Maryland School of Social Work Child Welfare Academy, November 8, 2012.

Strieder, F. *Trauma-Informed Care: What Does It Mean?* 7th Annual Maryland CASA Conference, Annapolis, MD, April 6, 2013.

Strieder, F. *Strengthening Family Connections: Enhancing Our Grandchildren's Future,* Baltimore Women's Giving Circle, February 14, 2013.

Strieder, F. and Tabor, M. *Trauma-Adapted Family Connections.* University of Maryland School of Social Work Trauma Education Connection Initiative. Baltimore, MD. August 8-9, 2011.

Community Development Projects

The marketing plan for FC/GFC continued to be implemented and reviewed for areas to improve. Jessica Leighton and Colette Eaton coordinated this effort that included directly contacting each school in the area that the agency serves. This included attending summer festivals and fall back-to-school events.

Family Connections staff continued membership on the Executive Roundtable, Citywide Education Committee, Education Advocacy Coalition, and the Advisory Committee for the UM Center for Infant Study, Therapeutic Foster Care Program of the Kennedy Krieger Institute, and Board of Directors, HealthCare Access Maryland, Inc. These groups focus on issues related to the Baltimore Community and more specifically to families struggling to meet the needs of their children.

Bucknell University

Bucknell's Social Justice Residential College took a field trip to Baltimore on Saturday, October 22, 2012, for the 5th annual Baltimore trip for the Residential Social Justice College. Forty first year students, along with student leaders and faculty, went as part of a year long residential learning experience. They observed first-hand some of the economic hardships faced by residents of the city and learned about efforts for social change that corresponded to class themes. While at Family Connections, the students were able to listen to a Caregiver Panel speak about personal experiences with poverty, domestic violence, and substance abuse. In addition, Christopher Beegle spoke about broader social justice issues as they connected to the testimonies given and engaged the group in discussion about policy and action. Lastly, the group accompanied the Family Connections staff to a local community garden operated by a former Family Connections participant where they weeded, raked, and performed general maintenance. This collaboration provided a valuable learning experience for the students, motivating them to work towards social justice, as well as an opportunity for the caregivers to have their story told.

Motivational Interviewing

Staff developed manuals and training strategies to implement a random control trial study during the summer of 2013. The study compared online Motivational Interviewing training to a live supervision model of training. Sixty students were enrolled. They will be Title IV-E graduate and under graduate interns and a number of SSW students who will be placed in child welfare agencies. The study included a day of introduction to Motivational Interviewing and two additional days of training with 30 students assigned to each of the teaching designs. During the course of training, the interns will complete surveys and record live interviews that will be analyzed to compare the impact of each learning design.

Trauma-Focused Cognitive Behavioral Therapy **(TF-CBT)**

Staff members, Jessica Leighton and Christopher Beegle, participated in a two day in person training for TF-CBT provided by nationally certified trainers. Following the in person training, both staff participated in six months of consultation calls with the trainers and implemented the model with fidelity.

Evaluation Activities

Monthly reviews of data continued to promote quality assurance procedures. Development of a new Management Information System was completed during this report period. Quality assurance review and implementation of the system occurred in January 2013, with particular attention given to the application of the TA-FC protocol and the related fidelity criteria. A new computer assisted interview was also implemented during this report period.

7. Family Connections at Baltimore Initiatives

Trauma Course

In August 2012 and May 2013, Drs. Collins and Strieder, Maureen Tabor, and Christopher Beegle taught a five day, intensive clinical course "Core Concepts of Trauma Treatment with Children and Adolescents" to UMSSW advanced year clinical students enrolled in this new program.
In spring semester of 2013, Dr. Strieder taught *Core Concepts of Trauma Informed Child Welfare Practice* as a spring course at the School of Social Work for 20 students.
Participation in teaching both courses by staff is is part of our collaboration with the NCTSN.

FANS Trauma

As part of the FITT Center activities, Dr. Strieder continues as a member of a team developing an assessment instrument to be used with families who have experienced trauma. This instrument applies a "family lens" in assessing families impacted by trauma. The instrument has been completed and reliability scoring has been established. In this next year there are plans to train other organizations in the use of the instrument.

Toolkit Training

Dr. Strieder attended a national *Train the Trainer* for the Child Welfare Trauma Training Toolkit sponsored by SAMHSA National Child Traumatic Stress Network. The material will be used to consult with the Child Welfare Academy and the development of training curricula. It will also be used in other presentations to community partners to foster the development of trauma involved organizations and practice.

Training Videos

TA-FC staff completed editing and formatting videos that will be used in training. They include two interviews with clients who have graduated from the program. The tape includes their discussion of experiences with trauma and the impact on caregiver and family. Segments were created using actors to portray actual practitioner-client interviews that focused on engaging, using assessment measures, safety planning, and "family meaning making."

COPE

During the current report period, intervention groups of all three models continued and research interviews for both pre and post intervention time points were conducted. Collaboration with three other sites across the country continued as protocols for interview data transfer were implemented. Groups continued throughout the summer of 2013. A proposal was submitted to the Gerontological Society of America for the 2013 annual conference.

8. Outcomes

One of the basic practice principles of FC is to provide outcome driven practice. This is achieved by using clinical instruments in practice, integrating them into the development of comprehensive assessments, and then, based on the assessment, developing goal driven service plans with families that are used to track the direction and progress of service. The instruments are used both to inform practice for individual families and evaluate outcomes of the program as a whole. During the course of the contract, FC used a variety of caregiver and child self-report measures (see Table 2), as well as observational measures completed by the clinician – select indicators illustrating key caregiver and child constructs are provided in this report (i.e., caregiver depressive symptoms, family resources, post-traumatic checklist, RAND health survey, parenting sense of competence, parenting stress, and child behavior).

All adult self-report measures include: Post-traumatic Checklist-Civilian (PCL-C; Elhai, Gray, Kashdan, & Franklin, 2005); Center for Epidemiologic Studies – Depression Mood Scale (CES-D; Radloff, 1977); Brief Symptoms Inventory (BSI); CAGE; Parenting Stress Index – Short Form (PSI-SF; Abidin, 1995); Parenting Sense of Competence Scale (PSOC); Perceived Neighborhood Scale (PNS); Family Resource Scale (Dunst & Leet, 1988); RAND 36-item Health Survey; Everyday Stressors Index (ESI; Hall, 1983); Parent Outcome Interview; the Child Behavior Checklist (CBCL; Achenbach, 1991); and the UCLA PTSD Scale (Pynoos, Rodriguez, Steinberg, Stuber, & Frederick, 1998).

Child self-report measures include: Traumatic Events Screening Inventory for Children Form (TESI-C-Brief); Trauma Symptom Checklist (TSCC; Briere, 1996); and UCLA PTSD Scale (Pynoos, Rodriguez, Steinberg, Stuber, & Frederick, 1998) .

The two observation measures include the Family Assessment Form (FAF; CBSC, 1997) and Child Well-Being Scales (CWBS).

For FC, GFC, and TA-FC participants, all measures are completed twice, at program entry (i.e., baseline) and again at case closure (i.e., closing; see Table 2). The data presented in this report is descriptive. When participants have pre- and post-test data available, it is tested for statistically significant differences; however, given the small sample size, these results should be viewed with caution. In addition, due to the small number of GFC participants with both baseline and closing data, these individuals were combined with the FC participants for the purposes of this report.

Table 2. Summary of instruments utilized to examine caregiver and child outcomes.

	Method of Administration	Baseline	Within 30 days	Closing	Group*
Family/Caregiver Measures					
Post-traumatic Checklist – Civilian (PCL-C)	Caregiver Self-Report	X		X	3
Center for Epidemiologic Studies – Depression Mood Scale (CES-D)	Caregiver Self-Report	X		X	1,2,3
Parenting Stress Index – Short Form (PSI-SF)	Caregiver Self-Report	X		X	1,2,3
Parenting Sense of Competence (PSOC)	Caregiver Self-Report	X		X	1,2,3
Family Resource Scale	Caregiver Self-Report	X		X	1,2,3
RAND 36-item Health Survey	Caregiver Self-Report	X		X	1,2,3
Child Measures					
Child Behavior Checklist (CBCL)	Caregiver report		X	X	1,2,3

* Group 1=FC; Group 2=GFC; Group 3=TA-FC

Results

This report describes the baseline and closing characteristics of caregivers and children engaged in Family Connections (FC), Grandparent Family Connections (GFC), or Trauma Adapted Family Connections (TA-FC) during the reporting period, July 1, 2012 – June 30, 2013.

Descriptive characteristics for the families engaged in services during FY 2012-2013 are provided in Table 3. During FY 2012-2013, 79 adult caregivers participated in **either** a baseline and/or a case closure interview. Specifically, 55.7% of those families were engaged in FC (n=44), 12.7% GFC (n=10), and 31.6% TA-FC (n=25). Sixty-seven families engaged in a baseline interview and 48 families engaged in a case closure interview. Of those that engaged in baseline interviews, 56.7% received FC (n=38), 13.4 received GFC (n=9), and 29.9% received TA-FC (n=20). Of those that completed case closure interviews, 56.3% were families who received FC (n=27), 6.3% GFC (n=3), and 37.5% received TA-FC (n=18).

Overall, all caregivers were female. The majority of participants were African American (94.9%, n=75), never married (75.9%, n=60), and either unemployed and not seeking employment (44.2%, n=34) or unemployed, seeking employment (32.5%, n=25). On average, caregivers had 10.97 years of education (SD = 1.70) and were 33.88 years of age (SD = 9.57), with a range between 22-62 years. Descriptive characteristics for participants that engaged in baseline or closing interviews are also provided in Table 3. Since age represents the age of caregiver at the time of the baseline interview, age is not provided for case closure.

Table 3. Demographic Characteristics for Adult Caregivers at Baseline and Closing

	Overall (n=79)		Baseline Interviews (n=67)		Case Closure Interviews (n=48)	
	N	%	N	%	N	%
Group Assignment						
FC	44	55.7	38	56.7	27	56.3
GFC	10	12.7	9	13.4	3	6.3
TA-FC	25	31.6	20	29.9	18	37.5
Race						
African American	75	94.9	66	98.5	45	93.8
Caucasian	4	5.1	1	1.5	3	6.3
Marital Status						
Never Married	60	75.9	51	76.1	35	72.9
Married (Living Together)	8	10.1	7	10.4	5	10.4
Separated	6	7.6	4	6.0	5	10.4
Divorced	3	3.8	3	4.5	3	6.3
Widowed	2	2.5	2	3.0		
Employment Status						
Unemployed, seeking employment	25	32.5	18	27.7	16	34.0
Unemployed, not seeking employment	34	44.2	30	46.2	23	48.9
Employed < 20 hrs/wk	3	3.9	2	3.1	2	4.3
Employed 20-35 hrs/wk	6	7.8	6	9.2	3	6.4
Employed 35+ hrs/wk	9	11.7	9	13.8	3	6.4
	Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**
Caregiver education – in yrs	10.97	1.70	10.98	1.72	10.80	1.75
Caregiver age – in yrs	33.88	9.57	33.92	9.47	-	-

Descriptive characteristics for the children engaged in services during FY 2012-2013 are provided in Table 4. During FY 2012-2013, 120 children participated in **either** a baseline or closing interview, while 32 children had **both** a baseline and closing within this fiscal year. One hundred baseline interviews and 52 closing interviews were conducted. At the time of the baseline interview, on average, children were 8.17 years of age (SD=2.05), and predominantly African American (97.0%, n=97).

Table 4. Demographic Characteristics for Children at Baseline and Closing

	Overall (n=120)		Baseline Interviews (n=100)		Case Closure Interviews (n=52)	
	N	**%**	**N**	**%**	**N**	**%**
Group Assignment						
FC	64	53.3	53	53.0	26	50.0
GFC	13	10.8	11	11.0	2	3.8
TA-FC	43	35.8	36	36.0	24	46.2
Gender						
Male	68	56.7	53	53.0	32	61.5
Female	52	43.3	47	47.0	20	38.5
Race						
African American	114	95.0	97	97.0	49	94.2
Caucasian	2	1.7	1	1.0	1	1.9
Hispanic	2	1.7	-	-	2	3.8
Mixed	2	1.7	2	2.0	-	-
	Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**
Child age – in yrs	8.17	2.05	8.23	2.01	-	-

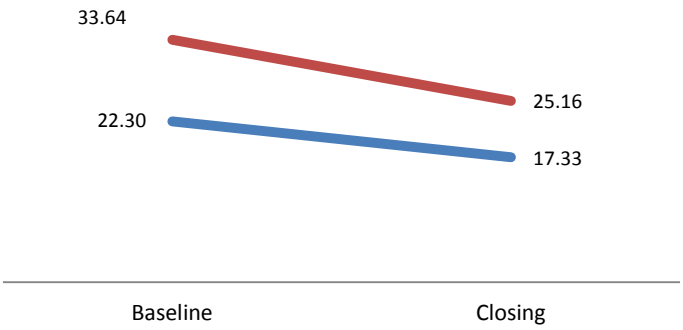
Caregiver Depressive Symptoms

The Center for Epidemiologic Studies-Depressed Mood Scale (CES-D; Radloff, 1977) is a 20-item self-report scale measuring depressed mood, feelings of guilt and worthlessness, feelings of helplessness and hopelessness, psychomotor retardation, loss of appetite, and sleep disturbance. A high total score indicates more depressive symptoms and a score of 16 or higher is used as a cut-point score to indicate high depressive symptoms (Radloff, 1977).

Figure 1 illustrates the changes in CES-D scores from baseline to closing overall, and by group (i.e., FC/GFC and TA-FC). Forty-nine families had both a baseline and closing interview during FY 2012-2013. Due to the small number of GFC families (n=10), these participants were combined with families who received FC. Nineteen TA-FC families had both a baseline and closing interview.

For all illustrations of change on standardized instruments, **FC/GFC is represented by the blue line, while TA-FC is represented by the red line**.

Figure 1. Changes in Average CES-D Scores



Overall, average scores significantly decreased between baseline and closing [F (1, 47) = 11.09, p<001]. Overall, scores decreased from 26.69 (SD=11.82) to 20.37 (SD=12.27). For FC/GFC families scores dropped from 22.30 (SD=9.83) to 17.33 (SD=10.55), and scores for TA-FC families decreased from 33.63 (SD=11.58) to 25.16 (SD=13.52). A main effect for group was also found for CES-D scores as illustrated in Figure 1. TA-FC caregivers had significantly higher levels of depression than FC/GFC caregivers [F (1,47)=13.78, p<0.01].

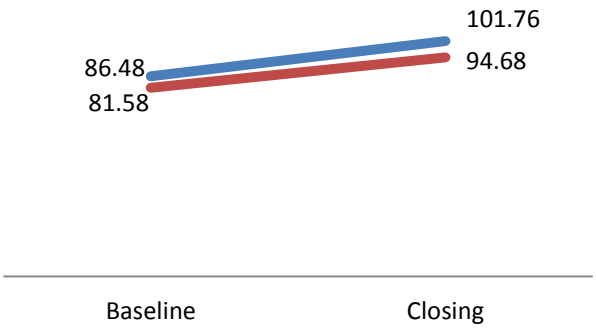
CES-D total scores greater than or equal to 16 represent scores that fall in the clinical range. At baseline, 70.9% (n=56) of cases fell in the clinical range. Sixty-one percent (n=33) of FC/GFC families had CES-D total scores ≥ 16, and 92.0% of TA-FC families had CES-D total scores in the clinical range. At closing, the proportion of caregivers that continued to have depressive symptomatology dropped to 40.5%. Fifty-three percent of FC/GFC families (n=17) continued to be symptomatic, and 46.9% of TA-FC families (n=15) remained symptomatic.

Family Resources

The Family Resource Scale (Dunst & Leet, 1988) is a 31-item scale that was used to assess the caregivers' perception of adequacy of various resources. Higher scores indicate higher levels of resource adequacy. Deficiencies of specific resources were the focus of service plans for many families.

Average scores are provided in Figure 2 by group. Scores significantly increased over time, F (1, 46) = 18.57, p < 0.01, for both groups. Overall, scores increased from 84.54 (SD=18.97) to 98.96 (SD=22.79). FC/GFC average scores increased from 86.48 (SD=18.22) to 101.76 (SD=23.79), and TA-FC average scores increased from 81.58 (SD=20.20) to 94.68 (SD=21.07).

Figure 2. Changes in Average FRS Scores



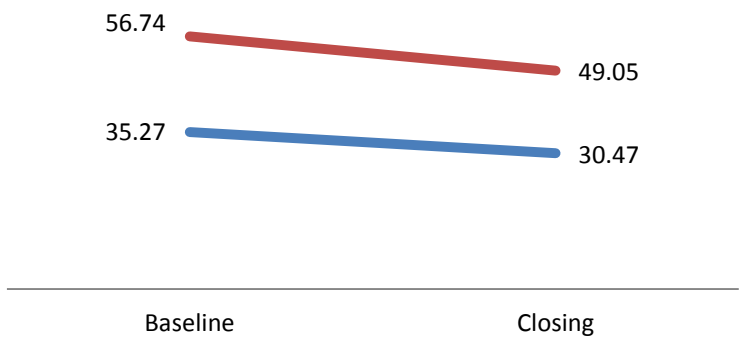
Post-Traumatic Checklist - Civilian (PCL-C)

The Post-Traumatic Checklist-Civilian (PCL-C; Elhai, Gray, Kashdan, & Franklin, 2005; Weathers, Litz, Herman, Huska, & Keane, 1993) is a 17-item checklist widely used for clinical screening, tracking of PTSD symptoms, and as a diagnostic tool to identify PTSD in research studies. The items correspond to symptoms of PTSD as presented in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychological Association, 2000). Items are rated for the past month on a 1 (not at all bothersome) to 5 (extremely bothersome). The PCL-C has a Likert type scale for a range of 17 to 85. Higher scores indicate greater symptomatology.

For clinical purposes, scores greater than or equal to 50 were used as one of the possible criteria for entry into the TA-FC group. Thirty-four percent (n=27) had a score greater than or equal to 50 on the PCL-C. Of those, 66.7% (n=18) participated in TA-FC. Although the remaining 33.3% scored greater than or equal to 50 on the PCL-C, those families were assigned to FC or GFC. While families may be eligible for TA-FC, there are a variety of reasons why families may not end up receiving TA-FC. Specifically, families may decline the offer to participate in TA-FC, or TA-FC clinicians have full caseloads and families opt to receive FC or GFC rather than wait for TA-FC services.

Results of the repeated measures ANOVA (see Figure 3) indicated that there were significant differences in the level of trauma symptomatology reported by caregivers between groups, $F(1, 47) = 29.33$, $p<0.01$, and that there was significant change over time, $F(1,47)=9.23$, $p<0.05$. There was no significant group by time interaction for FC/GFC and TA-FC, suggesting both groups changed similarly over time.

Figure 3. Changes in Average PCL-C Scores



RAND 36-item Health Survey

The RAND 36-item Health Survey assesses eight health concepts: 1) physical functioning; 2) emotional well-being; 3) social functioning; 4) role limitations due to emotional problems; 5) role limitations due to physical health problems; 6) general health perceptions; 7) energy; and 8) pain. Each items is scored on a 0 to 100 range, with 100 representing the highest level of functioning possible.

Average scores for the eight subscales are provided in Table 5. No significant change was found for physical functioning; however, marginal significance was found for change over time ($p=0.06$).

A significant main effect for time was found for emotional well-being, $F(1,47)=11.90$, $p<0.01$; however, there was a non-significant interaction term. Significant differences were found between groups, $F(1,47)=9.37$, $p<0.01$, with TA-FC caregivers rating themselves significantly poorer than FC/GFC caregivers.

Significant main effects for time, $F(1,47)=19.38$, $p<0.01$, and group, $F(1,47)=6.27$, $P<0.05$, were found or social functioning. The interaction effect was marginally significant, $F(1,47)=3.20$, $p=0.08$, suggesting that while both groups improved over time, the TA-FC caregivers had a greater increase in scores as compared to the FC/GFC caregivers.

Significant changes over time were also found for the role limitations due to emotional problems subscale, $F(1,47)=5.32$, $p<0.05$. There were no significant findings for the interaction effect or main effect of group for this subscale.

A significant main effect for time was also found for the role limitations due to physical health subscale, $F(1,47)=4.26$, $p<0.05$; however, there were no significant findings for the interaction effect or main effect of group for this subscale.

There were no significant findings for the overall physical health subscale.

Significant effects were found for the energy subscale. Specifically, a significant main effect was found for time, $F(1,47)=14.58$, $p<0.01$, a marginally significant interaction effect, $F(1,47)=2.94$, $p=0.09$, as well as a significant main effect for group, $F(1,47)=19.25$, $p<0.01$. These findings suggest that: 1) the two groups of caregivers reported significantly different scores on this subscale; 2) there was significant change over time; and 3) patterns of change were different for one group versus the other group. Specifically, the change was more substantial for TA-FC caregivers as compared to FC/GFC caregivers. These caregivers (i.e., FC/GFC) reported more overall energy than TA-FC caregivers at baseline, and remained higher at closing despite significant increases for TA-FC caregivers.

No significant findings were found for the pain subscale.

Table 5. Average Scores for RAND 36-Item Health Survey Subscales

	Baseline		Closing	
	M	SD	M	SD
Physical Functioning				
FC/GFC	74.67	29.71	78.33	31.93
TA-FC	58.16	37.28	72.11	32.80
Emotional Well-Being				
FC/GFC	60.80	21.99	67.87	23.31
TA-FC	38.95	19.59	54.74	24.73
Social Functioning				
FC/GFC	58.75	33.01	69.58	29.12
TA-FC	30.92	28.37	56.58	33.94
Role Limitations due to Emotional Problems				
FC/GFC	41.11	39.81	58.89	41.69
TA-FC	26.32	40.94	42.11	42.81
Role Limitations due to Physical Health				
FC/GFC	59.16	42.29	65.83	41.77
TA-FC	35.53	41.92	55.26	46.08
General Health				
FC/GFC	56.67	25.88	62.33	26.19
TA-FC	50.00	23.33	53.42	25.98
Energy				
FC/GFC	47.17	20.12	54.67	22.28
TA-FC	18.95	16.96	38.68	23.97
Pain				
FC/GFC	61.08	28.59	68.83	31.68
TA-FC	48.29	34.37	57.11	37.17

Parenting Sense of Competence (PSOC)

The Parenting Sense of Competence (PSOC) scale is a caregiver self-report measure that consists of 17-items designed to assess both parental satisfaction and efficacy in the parenting role. Higher scores represent greater perceived satisfaction and efficacy.

Average satisfaction scores are provided in Figure 4. A repeated measures ANOVA was conducted to examine the difference between and within groups. There were no significant findings for parenting satisfaction; however, average PSOC-Satisfaction scores were slightly higher among FC/GFC participants, and both groups improved slightly over time.

Figure 4. Changes in Average Parenting Satisfaction

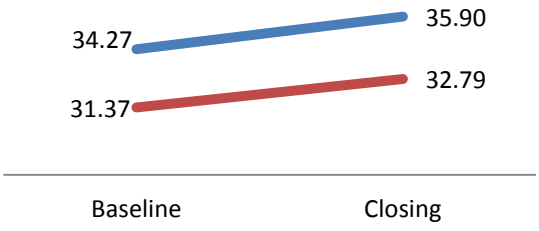
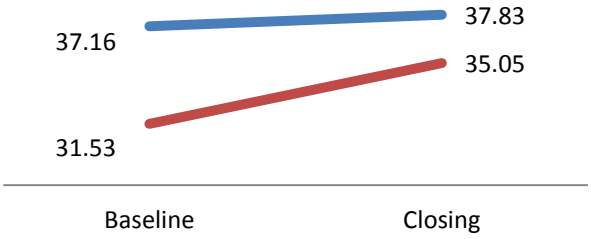


Figure 5. Changes in Average Parenting Efficacy



Average efficacy scores are provided in Figure 5. There was a significant main effect for time, $F(1,47)=8.00$, $p<0.01$, a marginal interaction effect, $F(1,47)=3.72$, $p=0.06$, and a significant main effect for group, $F(1,47)=4.48$, $p<0.05$). These findings suggest that the two groups had significant higher scores, that both groups changed significantly over time, but that the change over time was relatively the same for both groups. The TA-FC caregivers had a slightly greater increase in efficacy as compared to FC/GFC caregivers.

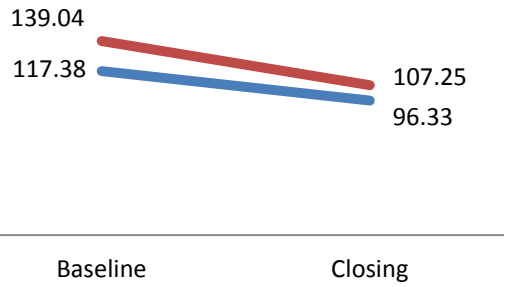
Parental Functioning

The Parenting Stress Index – Short Form (PSI-SF; Abidin, 1995) is a 36-item measure that assesses stress in the parent-child system, a risk factor for child safety. In addition to a Total Score, the PSI-SF has three clinical sub-scales: parental distress, parent-child dysfunctional interaction, and difficult child. A caregiver is asked to complete a PSI related to each child.

Total Score

Changes in total score are provided in Figure 6. The PSI total score measures overall stress within the parent system. Scores range from 36 to 180, and raw scores of 90 or above are considered high levels of stress and indicate a need for further exploration with the caregiver. As illustrated in Figure 6, all caregivers reported high levels of overall stress at baseline and closing. TA-FC participants (n=24) reported significantly higher overall stress as compared to FC/GFC participants (n=24), F (1,46)=4.95, p<0.05; however, significant decreases were identified over time for both groups, F (1,46)=40.13, p<0.01. Despite significant decreases over time, families continued to report high levels of stress at closing.

Figure 6. Changes in Average Parenting Stress

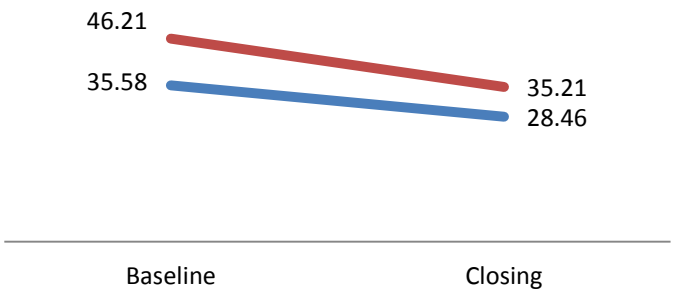


Parental Distress (PD)

Parental Distress addresses the distress a parent is experiencing in his or her role as a parent. Possible scores range from 12-60, with scores 33 or above considered high levels of stress indicating a need for further exploration with the caregiver.

Average PD scores are illustrated in Figure 7. A repeated measures ANOVA showed significant change over time, F (1.46)=23.68, p<0.01. Change was similar for both groups, and TA-FC caregivers were significantly more distressed than FC/GFC caregivers, F (1,46)=14.59, p<0.01.

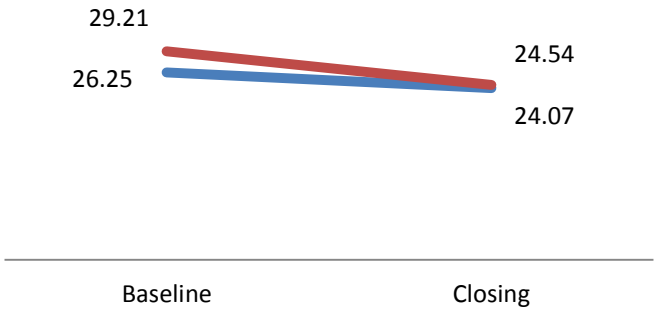
Figure 7. Changes in Average Parental Distress Scores



Parent-Child Dysfunctional Interaction (P-CDI)

The PCDI focuses on parent's perceptions that their child does not meet their expectations, and that interactions with the child are not reinforcing. Possible scores range from 12 to 60, with scores of 26 or above considered high levels of stress. A 2x2 ANOVA showed significant change over time, $F(1,50)=7.22$, $p<0.05$; however, there were no differences between groups and change was similar for both groups over time (see Figure 8).

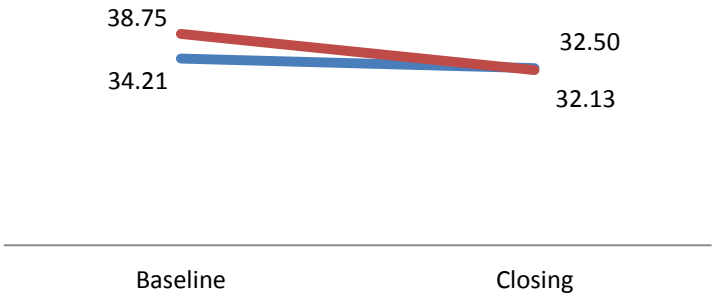
Figure 8. Average Change in Parent-Child Dysfunctional Interaction



Difficult Child (DC)

The DC subscale assesses the degree to which the child's basic behavioral characteristics make them easy or difficult to manage. Scores can range from 12 to 60. Scores of 33 or above are considered high levels of stress. Average DC scores are illustrated in Figure 9. Both groups changed significantly over time, $F(1,50)=8.34$, $p<0.01$. There was a marginally significant interaction effect suggesting that the TA-FC caregivers decreased slightly more than the FC/GFC caregivers on this subscale, $F(1,50)=2.89$, $p=0.09$. There were no significant group effects.

Figure 9. Average Changes in Difficult Child



Child Functioning

Child Behavior

The Child Behavior Checklist is designed to assess in a standardized format the behavioral problems and social competencies of children as reported by caregivers. Caregivers reported on children in their care six years of age to 18. In the analysis presented in this section, the unit of analysis is child.

The CBCL has 107 items (there are five additional items about sex problems not measured in Family Connections) that measure eight behavior syndromes: withdrawn, somatic complaints, anxious/depressed, social problems, thought problems, attention problems, delinquent behavior, and aggressive behavior. The CBCL also has three second-order problem scales: internalizing problems (composed of withdrawn, somatic complaints, and anxious/depressed behavior syndromes), externalizing problems (delinquent and aggressive behavior syndromes), and the total problems scale (composed of all items except one item which queries about allergies and a second item about asthma).

Standardized scores (T-scores) for the behavior syndromes and problem scales indicate the extent to which caregivers reported children in their care were in the clinical, borderline, or normal range. Fifty-two children had **both** a baseline and closing CBCL during FY 2012-2013 (27 FC/GFC and 25 TA-FC). Results from 2x2 ANOVAs are provided in Table 6.

Significant changes over time were found for the following subscales: anxious/depressed and somatic. For the anxious/depressed subscale, $F(1,50)=11.00$, $p<0.01$, with TA-FC caregivers reporting slightly higher levels of anxious/depressed symptoms in their children, $F(1,50)=4.35$, $p<0.05$. Significant decreases were also found on the somatic subscale. Specifically, there was significant change over time, $F(1,50)=11.65$, $p<0.01$, with TA-FC caregivers reporting significant greater change as compared to FC/GFC caregivers, $F(1,50)=7.93$, $p<0.01$.

Significant change over time was also found for the social subscale, $F(1,50)=7.76$, $p<0.01$, with TA-FC caregivers reporting significantly higher levels of social impairment, $F(1,50)=4.79$, $p<0.05$). There was no interaction effect – this suggests that change was similar across groups over time.

There was also significant change over time on the thought subscale, $F(1,50)=15.63$, $p<0.01$; however, change was similar for both groups, and although the TA-FC scores were slightly higher than FC/GFC scores at baseline, this difference was not significant.

Significant change over time was also observed for both groups on the attention subscale, $F(1,50)=6.30$, $p<0.05$; aggression subscale, $F(1,50)=5.81$, $p<0.05$; internalizing behavior subscale, $F(1,50)=12.93$, $p<0.01$; externalizing subscale, $F(1,50)=9.97$, $p<0.01$; total problem behavior, $F(1,50)=21.49$, $p<0.01$; and, PTSD symptoms, $F(1,50)=8.92$, $p<0.01$.

No significant changes over time were found for withdrawn behavior or rule-breaking behavior subscales.

Table 6. Means and Standard Deviations for CBCL Subscales at Baseline and Closing

	Baseline		Case Closure	
	M	**SD**	**M**	**SD**
*Anxious/Depression**				
FC/GFC (n=27)	55.93	6.99	53.81	5.14
TA-FC (n=25)	60.76	9.00	56.48	7.92
Withdrawn Behavior				
FC/GFC (n=27)	58.44	8.39	56.22	10.02
TA-FC (n=25)	63.36	11.88	61.28	10.57
*Somatic Complaints**				
FC/GFC (n=27)	55.22	6.20	54.78	6.66
TA-FC (n=25)	59.56	7.64	54.92	6.86
*Social Problems**				
FC/GFC (n=27)	58.15	7.81	56.15	6.30
TA-FC (n=25)	63.28	10.66	60.44	8.31
*Thought Problems**				
FC/GFC (n=27)	59.33	8.82	55.37	7.89
TA-FC (n=25)	63.44	11.28	59.52	12.12
*Attention Problems**				
FC/GFC (n=27)	62.44	12.88	58.74	9.72
TA-FC (n=25)	63.76	11.73	61.04	10.57
Rule-Breaking Behavior				
FC/GFC (n=27)	59.37	7.51	57.30	7.03
TA-FC (n=25)	63.72	10.04	62.36	9.37
*Aggressive Problems**				
FC/GFC (n=27)	60.59	10.53	56.81	6.88
TA-FC (n=25)	69.36	13.65	66.56	14.14
*Internalizing Problems**				
FC/GFC (n=27)	54.05	11.05	50.41	11.12
TA-FC (n=25)	60.40	12.55	54.50	13.60
*Externalizing Problems**				
FC/GFC (n=27)	59.19	10-.27	54.41	10.84
TA-FC (n=25)	66.32	11.68	63.20	13.41
*Total Problem Behaviors**				
FC/GFC (n=27)	57.93	12.44	52.56	13.54
TA-FC (n=25)	64.80	12.70	59.20	15.21
*Post-traumatic Stress Symptoms**				
FC/GFC (n=27)	58.44	9.12	56.19	7.29
TA-FC (n=25)	65.12	12.14	60.80	9.67

Table 7 provides the number and percent for youth that fell in the clinical, borderline, and non-clinical range for the broadband scales. For the broadband scales, scores of 64 and above are interpreted as clinical range. Scores of 60 to 63 are in the borderline clinical range, and scores below 60 are in the normal range compared to other children of the same age group and gender.

Table 7. Number and Percent of Respondents Within Clinical, Borderline, Non-Clinical Ranges Across CBCL Subscales at Baseline and Case Closure

	Clinical $t \geq 64$		**Borderline** $60 \geq t \leq 63$		**Non-Clinical** $t < 60$	
	N	**%**	**N**	**%**	**N**	**%**
Internalizing Behavior						
Baseline (n=106)	32	30.2	6	5.7	68	64.2
Case Closure (n=55)	10	18.2	5	9.1	40	72.7
Externalizing Behavior						
Baseline	43	35.8	-	-	63	59.4
Case Closure	21	38.2	7	12.7	27	49.1
Total Problem Behaviors						
Baseline	38	35.8	17	16.0	51	48.1
Case Closure	17	30.9	6	10.9	32	58.2

9. Expectations and Plans for the Future

A. Modifications will be made to the manual for the fall reflecting administrative changes that have occurred and, more significantly, modifying Chapter 10 to clarify intervention strategies. There is detail about the implementation of practice elements on three specific models: Motivational Interviewing, Narrative Interventions, and Family Work. All of these fit into a framework that conceptualizes FCB interventions as a trauma informed agency that specifically applies services to those who have experienced complex developmental trauma.

B. With the support of the SSW Teaching Scholars Award, SSW faculty, staff, and graduate students plan to develop a research agenda to study learning strategies as they apply to developing proficiency for MSW students in using Motivational Interviewing in child welfare practice. Dr. Theresa Moyers provided consultation regarding the development of the study design, its implementation, and data collection and analysis. The projected time for implementation will be prior to the graduate students' enrollment in the fall 2013 semester. Subsequent to completing the initial part of the design, tapes of interviews will be scored allowing for a comparison of intervention skills before and

after the implementation of two teaching strategies, an online course and live supervision. Also, attitudes and knowledge will be assessed based on responses to a questionnaire before and after the implementation of teaching models. The coming year will involve scoring interviews, completing analyses of data, and composing reports and articles for submission.

C. We will continue to participate with the FITT Center and carry out SAMHSA funded grant activities. We plan to replicate TA-FC at two sites in the United States, collaborate with three community based programs serving families to develop professional development tools, and complete a randomized control trial of TA-FC and TA-FC plus parenting. Also, participation in NCTSN committees that focuses on parents who have experienced trauma, and Secondary Traumatic Stress experienced by practitioners who work with families exposed to trauma.

D. The last COPE intervention groups were held the summer of 2013. Protocols will be implemented for the four follow-up interviews to be conducted over the next two years. The next set of goals will be for data analyses and submission of papers.

References

Abidin, R.R. (1995). *Parenting Stress Index* (3rd ed.). Odessa, FL: Psychological Assessment Resources, Inc.

Achenbach, T. M. (1991). *Manual for the Child Behavior Checklist: 4-1 and 1991 Profile.* Burlington: University of Vermont, Department of Psychiatry.

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text revision). Washington, DC: Author.

Briere, J. N., & Runtz, M. G. (1989). The Trauma Symptom Checklist (TSC-33): early data on a new scale. *Journal of Interpersonal Violence, 4,* 151-163.

Children's Bureau of Southern California. (1997). Family Assessment Form: A practice-based approach to assessing family functioning. Washington DC: CWLA Press.

Derogatis, L. R. (1993). Brief Symptom Inventory (BSI) administration, scoring and procedures manual (4th Edition). Minneapolis, MN: NCS Pearson Inc.

Dunst, C., Trivette, C., & Deal, A. (1988). *Enabling and empowering families principles and guidelines for practice.* Cambridge, MA: Brookline Books.

Dunst, C., J., & Leet, H. E. (1994). Measuring the adequacy of resources in households with young children. In C. J. Dunst & C. M. Trivette (Eds.), *Supporting and strengthening families*: *Methods, strategies, and practices* (pp. 105-114). Cambridge, MA: Brookline Books.

Elhai,J. D., Gray, M.J., Naifeh, J.A., Butcher, J.J., Davis, J.L. Falsetti, S.A., Best, C.L. (2005). Utility of the trauma symptom inventory's atypical response scale in detecting malingered post-traumatic stress disorder. *Assessment*, *12(2),* 210-219.

Hall, L. (1983). Social supports, everyday stressors, and maternal mental health. Unpublished doctoral dissertation. University of North Carolina at Chapel Hill.

Harper R, Kelly M. *Measuring social capital in the United Kingdom.* London: Office for National Statistics; 2003.

Magura, S., & Moses, B. S. (1986). Outcome measures for child welfare services. Washington, DC: Child Welfare League of America.

Magura, S., Moses, B. S., & Jones, M. A. (1987). Assessing risk and measuring change in families the family risk scales. Washington, DC: Child Welfare League of America.

Mannarino, A. P.; Cohen, J. A.; Berman, Susan R. (1994). The Children's Attributions and Perceptions Scale: A new measure of sexual abuse-related factors. *Journal of Clinical Child Psychology*, *23(2),* 204-211.

Martinez, M., Black, M., & Starr, H. (2002). Factorial Structure of the Perceived Neighborhood Scale (PNS); A Test of Longitudinal Invariance. Journal of Community Psychology, 30(1), 23-43.

Pynoos, R., Rodriguez, N., Steinberg, A., Stuber, M., & Frederick, C. (1998). *UCLA PTSD Index for DSM-IV*.

Radloff, L. S. (1977). The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement, 1*, 385-401.

Weathers, F., Litz, B., Herman, D., Juska, J., & Keane, T. (1993, November). The PTSD Checklist (PCL): Reliability, validity, and diagnostic utility. Poster session presented at the annual meeting of the International Society for Traumatic Studies, San Antonio, TX.