

FINAL REPORT

COVER SHEET

1. Grant Number: 90CA1580
2. Project Title: Helping Families Prevent Neglect
3. Grantee Name and Address: University of Maryland, Baltimore
Grants and Contracts
511 West Lombard Street
Baltimore, MD 21201
4. Marjorie Foster, Dir., Office of Grants & Contracts (410) 706-3559
5. Period of Performance: October 1, 1996 – June 30, 2002
6. Approved Project Period: 10/01/96 - 6/30/2002
7. Period Covered by Report: (Check One)

| | | | |
|----------------|-------|--------------|----------------------|
| First Quarter | _____ | Final Report | _____ <u>X</u> _____ |
| Second Quarter | _____ | | |
| Third Quarter | _____ | | |
| Fourth Quarter | _____ | | |
8. Principal Investigator's Name and Telephone Number: Diane DePanfilis, (410) 706-3609
9. Author Name and Telephone Number: Diane DePanfilis, (410) 706-3609
10. Date of Report: September 30, 2002
11. Report Number: 18
12. Name of Federal Project Officer: Sue Sparrow
13. Date Reviewed by Federal Project Officer: _____
14. Comments, (if any): _____

Acknowledgements

Co-Principal Investigators:

Howard Dubowitz, MD, MS

Esta Glazer-Semmel, LCSW-C

Sections of this report were contributed by (in alphabetic order):

Clara Daining, MSW, Data Manager

Esta Glazer-Semmel, LCSW-C, Program Director

Kimberly Haynes, MSW, Research Coordinator

Kimberly McCorr, BA, Office Coordinator

Eunice Park, MSW, Research Analyst

Laura Ting, LCSW-C, Research Analyst

Table of Contents

| | |
|---|-----------|
| I. INTRODUCTION | 7 |
| A. BACKGROUND INFORMATION | 8 |
| Description of the Problem | 8 |
| Rationale and Assumptions | 9 |
| Expected Impact of the Project | 10 |
| B. PROGRAM MODEL | 14 |
| Target Population | 14 |
| Service Components of the Project Model | 14 |
| <i>Emergency Assistance</i> | 21 |
| <i>Comprehensive Family Assessment</i> | 22 |
| <i>Service Planning</i> | 23 |
| <i>Direct Services</i> | 23 |
| <i>Case Management</i> | 23 |
| <i>Parenting Education and Support Groups</i> | 24 |
| C. COLLABORATIVE EFFORTS | 25 |
| D. SPECIAL ISSUES | 27 |
| E. FUNDING INFORMATION | 27 |
| F. EVALUATION INFORMATION | 28 |
| II. PROCESS EVALUATION | 28 |
| Original Project Objectives | 28 |
| | |
| III. OUTCOME EVALUATION | 38 |
| A. PROPOSED OUTCOME OBJECTIVES | 38 |
| 1. Decrease risk factors among families at risk for child neglect | 40 |
| 2. Increase protective factors among families at risk for child neglect | 41 |
| 3. Increase child safety among families at risk for child neglect | 42 |
| 4. Improve well-being of children at risk for child neglect | 43 |
| B. QUESTIONS RELATED TO OUTCOME OBJECTIVES | 43 |
| 1. Decrease risk factors among families at risk for child neglect | 43 |
| 2. Increasing protective factors among families at risk for child neglect | 47 |
| 3. Increasing child safety among families at risk for child neglect | 50 |
| 4. Increase child well-being among families at risk for child neglect | 51 |
| C. METHOD TO ANSWER OUTCOME-RELATED QUESTIONS | 54 |
| 1. Decrease risk factors among families at risk for child neglect | 55 |
| 2. Increase protective factors among families at risk for child neglect | 61 |
| 3. Increase child safety among families at risk for child neglect | 68 |
| 4. Increase child well-being among families at risk for child neglect | 72 |
| D. FINDINGS FOR OUTCOME-RELATED QUESTIONS | 75 |
| Descriptive Results – Caregivers and Families | 75 |
| Descriptive Results - Child Characteristics | 76 |
| Results Regarding Risk Factors | 77 |
| Results Regarding Protective Factors | 99 |

| | |
|--|------------|
| Results Regarding Child Safety | 121 |
| Results Regarding Child Well Being | 144 |
| IV. RELATIONSHIPS BETWEEN PROGRAM IMPLEMENTATION AND PARTICIPANT OUTCOME EVALUATION RESULTS | 150 |
| V. RECOMMENDATIONS TO PROGRAM ADMINISTRATORS OR FUNDING AGENCIES REGARDING FUTURE PROGRAM OR EVALUATION INITIATIVES | 154 |
| APPENDICES | |
| A- REFERENCE LIST | |
| B-SAMPLE NEWSLETTERS, ARTICLES, AND BACKGROUND MATERIALS | |
| C-INTERVENTION MANUAL AND OTHER PROGRAM MATERIALS | |
| D-NETWORK OF COMMUNITY RESOURCES: REFERRALS SOURCES AND ORGANIZATIONS THAT PROVIDED SERVICES TO FAMILY CONNECTIONS' CLIENTS | |
| E-PRESENTATIONS AND PAPERS | |
| F-FUNDING SOURCES | |
| G-RESEARCH TEAM MEMBERS | |
| H-FAMILY CONNECTIONS AND SOCIAL WORK INTERNS | |
| I-FAMILY CONNECTIONS MEASURES | |
| J-RESEARCH INTERVIEW MANUAL | |

List of Tables

- Table 1. Referral sources
- Table 2. Risks identified by referral sources at intake
- Table 3. Number of families enrolled per year
- Table 4. Comparison of direct services between intervention groups
- Table 5. Comparison of indirect services between intervention groups
- Table 6. Participation in parent group services by families assigned to receive parent group services
- Table 7. Direct service type by service purpose
- Table 8. Indirect service type by service purpose
- Table 9. AAPI score interpretation
- Table 10. CBCL interpretation of T scores
- Table 11. Demographic characteristics of total sample and by intervention group
- Table 12. Demographic characteristics of children
- Table 13. Differences between groups in caregiver depressive symptoms
- Table 14. Percent of caregivers with CAGE total scores
- Table 15. Self-report level of drug use/abuse at baseline by respondents reporting use of drugs five or more times
- Table 16. Caregivers' drug use within last 2 weeks of those reporting ever using drugs
- Table 17. Observation of caregivers' substance abuse within 30 days of case opening
- Table 18. Observation of caregivers' substance abuse at case closure
- Table 19. Observation of caregivers' physical health at intake and case closure
- Table 20. Observation of caregivers' mental health at intake and case closure
- Table 21. Observation of adult relationships in the household
- Table 22. Observation of caregiver capacity for child care at intake and case closure
- Table 23. Observation of caregivers' recognition of problems at intake and case closure
- Table 24. Observation of caregivers' motivation to solve problems at intake and case closure
- Table 25. Observation of caregivers' cooperation with case planning at intake and case closure
- Table 26. Number of both indicated and unsubstantiated reports made to CPS before Family Connections Intervention
- Table 27. Number of reports made to CPS that were indicated, prior to Family Connections Intervention
- Table 28. Number of both indicated and unsubstantiated reports made to CPS while Family Connections was providing services
- Table 29. Number of CPS reports determined to be indicated while Family Connections was providing services
- Table 30. Number of both indicated and unsubstantiated CPS reports made within six months of the closure of Family Connections intervention
- Table 31. CWBS seriousness scores for indicators of physical care at baseline
- Table 32. CWBS seriousness scores for indicators of psychological care at baseline

List of Figures

- Figure 1. Family Connections logic model
- Figure 2. Caregiver depressive symptoms: Significant main effect of time
- Figure 3. Observation of drug use/abuse between intake and case closure: Significant main effect of time
- Figure 4. Interaction between group and time in caregiver capacity for child care; non-significant main effect of group or time
- Figure 5. Everyday stress: Significant main effect of time
- Figure 6. PSI Difficult Child & Parental Distress subscales: Significant main effects of time
- Figure 7. Parenting stress total score: Significant main effect of time
- Figure 8. Motivation to solve problems: Significant main effect of group, non-significant effect of time
- Figure 9. Caregiver's cooperation with services: Significant main effect of time; interaction between group and time
- Figure 10. AAPI Empathy and Role Reversal subscales: Significant main effect of time Over Time
- Figure 11. PSOC Parenting Satisfaction subscale: Significant main effect of time
- Figure 12. SPS Guidance subscale scores: Significant main effect of time
- Figure 13. SPS-Attachment Subscale: Significant main effect of group, Non significant effect of time
- Figure 14. SPS Opportunity for Nurturance subscale: Significant interaction between time and group, non-significant effect of group, non-significant effect of time
- Figure 15. CWBS Household Furnishings subscale: Significant main effect of time
- Figure 16. CWBS Overcrowding in Household subscale: Significant main effect of time
- Figure 17. CWBS Household Sanitation subscale: Significant main effect of time
- Figure 18. CWBS Mental Health Care subscale: Significant main effect of time
- Figure 19. CWBS Caregiver Teaching/Stimulating of Children subscale: Significant main effect of time
- Figure 20. CWBS Adequacy of Clothing subscale: Significant main effect of group, non-significant effect of time
- Figure 21. CWBS Personal Hygiene subscale: Significant main effect of group, non-significant effect of time
- Figure 22. CWBS Supervision of Young Children subscale: Significant main effect of group, non-significant effect of time
- Figure 23. CWBS Caregiver Approval of Children subscale: Significant main effect of group, non-significant effect of time
- Figure 24. CWBS Security of Residence subscale: Significant interaction between group and time; non-significant main effect of group or time
- Figure 25. CBCL Internalizing raw score: Significant interaction between group and time
- Figure 26. CBCL Externalizing raw score: Significant main effect of time
- Figure 27. CBCL Total raw score: Significant interaction between group and time
- Figure 28. Family Risk, Child Physical Health subscale: Significant main effect of time

Helping Families Prevent Child Neglect Final Report

I. Introduction

This report presents the methodology, process, and outcome findings for the Helping Families Prevent Child Neglect (HFPPN) 5-year neglect demonstration grant. HFPPN was supported with a five-year demonstration grant from the USDHHS, Children's Bureau as part of a national initiative to demonstrate methods for preventing and responding to child neglect. This grant supported the development and testing of the Family Connections (FC) program in response to a critical need of at-risk families living in Baltimore's Westside Empowerment Zone. In an effort to prevent child neglect in Baltimore's Westside, Dr. Diane DePanfilis, Dr. Howard Dubowitz, and Ms. Esta Glazer-Semmel, having extensive knowledge and experience in research and services to families with children, collaborated with a community advisory board and a family advisory committee to create a program that was sensitive to the populations at risk in west Baltimore and one that built on the results of prior federally funded neglect demonstration programs. The multitude of stressors that families face in Baltimore's Westside Empowerment Zone suggests that without intervention, families are challenged to meet the basic needs of their children and may eventually become involved in the public Child Protective Service (CPS) system.

This project has been additionally supported, in part by the University of Maryland School of Social Work. The University's mission has been to provide leadership to the social work profession by conducting educational programs, research, scholarship, service innovation, consultation, and advocacy. The school promotes social and economic justice and emphasizes advancement of the well being of populations at

risk. The primary way it meets its mission is through a continuum of education in baccalaureate, masters and doctoral programs that produce competent and ethical social workers whose practice advances the well-being of all people served. The FC program supports the school's mission by combining education of graduate social work students, research about what components of intervention work best, and service to populations at risk in order to promote safety and well being for children, families, and communities.

A. Background Information

Description of the Problem

Baltimore, Maryland like most urban centers has many children living in at-risk families that are struggling with a broad range of problems. According to 2000 census data, the city has 654,154 residents, 66% of whom are African American. Over one-third of the city's children live in "distressed neighborhoods," which on average, are defined as neighborhoods that have 1) a poverty rate of above 24.7%; 2) over 36% of the households are headed by females; 3) over 45% of the male population are unattached to the labor force; and 4) over 17.6% of families are receiving public assistance. According to estimates for 1998, nineteen percent of the city's children live in families with incomes below the poverty line, however, among neighborhoods in the West Baltimore Empowerment Zone (the targeted communities for this project), as many as 58% live in families with incomes below the poverty line (Baltimore City Data Collaborative, 2002). These problems coupled with the highly stressed urban environments, affect a family's ability to provide a safe, nurturing environment for its children. Other disturbing trends in these neighborhoods include: high levels of truancy (as high as 36.7% children truant more than 20 days in Southwest Baltimore); only 7.2% scoring satisfactory or better on

fifth grade reading tests (in Upton/Druid Heights); child abuse and neglect rates as high as 38.5 per 1000 children (in Upton/Druid Heights); juvenile arrest rates as high as 130.3 per 1000 children (in Sandtown-Winchester/Harlem Park); and high teen birth rates (15.5% per 100 females age 10-17 in Sandtown-Winchester/Harlem Park) (Baltimore City Data Collaborative, 2002).

The field has reached some consensus that efforts to target single risk factors are not likely to be as effective in preventing neglect as are programs based on an ecological-developmental model (National Research Council, 1993). Further, due to the multiple causes of neglect, intervention and prevention programs must be individualized and offer multiple services (DePanfilis, 1996; DePanfilis, 1999; Gaudin, 1993b; Wolfe, 1993; Cohn and Daro, 1987). And, these services must be based on philosophical principles that empower families, build on strengths, and respect cultural diversity (Zuravin and Shay, 1991; DiLeonardi, 1993).

Rationale and Assumptions

The purpose of this project was to develop a multi-faceted service agency that provides assistance to families with school age children in Baltimore's Westside Empowerment Zone, neighborhoods where multiple stressors exist for families making it difficult for them to meet the basic needs of their children. The Family Connections program operates from a conceptual framework that views neglect within a system of risk and protective factors interacting across four levels: (1) the individual level; (2) the family microsystems; (3) the exosystem; and (4) the social macro system (Belsky, 1980).

Intervention is geared to increase protective factors and to reduce risk factors within these interacting systems. Assuming that highly stressed urban environments affect the ability of families to provide safe and nurturing environments for their children, it may be

further concluded that when stressful living conditions continue over time, families are more likely to be reported to Child Protective Services (CPS) for neglect of their children.

Prior to the development of Family Connections, community service providers expressed concern for families and frustration because it was necessary for the local CPS agency to screen out cases from investigation because circumstances had not yet met the CPS threshold. By the time neglectful families are served by CPS agencies, they have acute and chronic needs that require long-term intervention and are significantly more likely to experience recurrences of child maltreatment than abusive families (DePanfilis and Zuravin, 1999). These conditions suggest that to alter this picture, we must find a more cost effective way to target and serve at-risk families as soon as they are identified with risks that could lead to child neglect. Family Connections reaches out to families who are at significant risk of neglect but are not being served by CPS, with the goal of reducing the likelihood of neglect and the need for CPS intervention.

Expected Impact of the Project

The Helping Families Prevent Child Neglect demonstration project via the established Family Connections Program expected to demonstrate a positive impact on families, the community, the university, and the child maltreatment field at large.

Benefits for Families

This project has provided substantial benefits for enrolled families including: an increase in protective factors, a decrease in risk factors, and achievement of outcomes in two domains: (1) child safety and (2) child well-being. Measurement of risk, protective

factors, and outcomes are described in the outcome evaluation section of this report. A total of 154 families with 473 children were served through support from this project.

Benefits for Community

Prior to the development of FC, school and CPS personnel, health care providers, and other community agency staff expressed serious concerns that they had no place to refer at risk families for help. This FC program has given community-based providers a place to refer families who are identified with risks for child neglect before these families cross the threshold that requires CPS involvement. For the duration of the project, the FC program produced newsletters targeting community providers and families in West Baltimore. These vehicles of communication have helped the program become known in the community as well as develop connections with formal and informal providers. Families (both past and current clients) have received helpful tips for strengthening their families as well as lists of resource numbers to obtain needed services (See Appendix B). The program has also developed an automated resource directory that is constantly updated so that the program can be a resource for connecting families with other community agencies.

By helping families reduce the risk for neglect, Family Connections has prevented the need for CPS intervention, ultimately reducing the Intake workload for Baltimore City Department of Social Services (BCDSS). These promising results have led to the development of ongoing financial support for the FC program from a variety of sources including the Maryland Department of Human Resources (DHR). The collaboration with DHR has also led to featuring the FC program on a Maryland Public Television show on *Strong Families*, which aired in July 2002.

Other benefits at the community level have also been achieved as Family Connections staff have advocated in partnership with other community organizations for needed services for children and families (e.g., school, substance abuse, mental health, and housing services).

Benefits for the University of Maryland, Baltimore

Family Connections fits one of the core missions of the University of Maryland, Baltimore campus -- to offer its unique expertise in helping to shape the development of services in the surrounding neighborhoods. For the School of Social Work (SSW), it is an opportunity to evaluate the impact of its community outreach services and to educate graduate social work interns how to work successfully with vulnerable families and children. Since the program has begun, 66 MSW interns have spent 2-4 days per week in a practicum or advanced field placement in the FC program. For both the SSW and the School of Medicine, Department of Pediatrics, it is an opportunity to advance the knowledge of the child maltreatment field regarding what practice methods are most effective in helping families prevent neglect. It allows the University to use its knowledge, faculty, education, research, and student resources in order to provide consistent, strong community assistance and impact the prevention of neglect in Baltimore's Westside. The combination of these efforts have led to the recognition of the program via receipt of the University of Maryland, Baltimore Martin Luther King Diversity award and through feature articles in three University publications (See Appendix B). The collaboration between the Schools of Social Work and Medicine and the Department of Pediatrics around the development and testing of the Family Connections program has led to the creation of the University of Maryland Center for

Families across both schools to bring together a range of clinical and community services, education of interdisciplinary practitioners, research and evaluation, and policy analysis and advocacy. This Center promotes the safety, health, and well being of children, families, and communities (see Appendix B).

Benefits for the Child Maltreatment Field

The field has struggled to define, identify, and assess child neglect in its various forms. This project has used what is known about neglect by some of the best experts in the field (i.e., PI-Dr. Diane DePanfilis; Co-PI Dr. Howard Dubowitz and consultant, Dr. Susan Zuravin) along with an interdisciplinary research team and community service providers to identify a clear, concise framework for screening families at risk for neglect. It was expected that this project would refine our understanding of the antecedents of neglect and help to identify those at highest risk. If we are to effectively target prevention activities to families at risk of neglect, we must develop more precise risk assessment procedures. It was assumed that by developing a protocol comprised of instruments to assess risk and protective factors, parenting attitudes and skills, and child and family functioning, service providers would be in a better position to target intervention and measure risk reduction. A series of papers are under development that will provide the field with an enhanced understanding for identifying, assessing, and intervening with families at risk for child neglect.

The interdisciplinary nature of this project team combined with their breadth of experience in the child maltreatment field produced several key products now available to the field: (1) screening protocol; (2) three computer assisted interviews for assessing program outcomes; (3) a research interview manual; (4) an intervention manual; (5)

training about the services, education, and research components of the program; and (6) numerous presentations and reports all available on the Family Connections web site at <http://www.family.umaryland.edu>.

B. Program Model

Target Population

The targeted population for this demonstration project included families who resided in Baltimore's Westside Empowerment Zone (zip codes: 21201, 21216, 21217, 21223, 21230) with children under the age of 18 and at least one child between the ages of 5-11. These families (1) exhibited risk for one or more of 19 operationalized neglect subtypes (e.g. unmet special education needs, unsafe housing conditions, inadequate/delayed health care etc.); (2) displayed at least two additional risk factors for child neglect related to the child, caregiver, or family (e.g. more than three children in the household, unemployment/over-employed, mental health problem, learning disability of a child, etc.); (3) were not involved with CPS at the time of referral; and (4) stated a willingness to participate in the program. The intake/referral form and criteria used to screen families into the FC program is included in Appendix C.

Service Components of the Project Model

Family Connections is a community based intervention program that works with families in the context of their neighborhoods to help them meet the basic needs of their children and families and reduce the risk of child neglect. The program operates from an ecological-developmental framework and draws on concepts articulated in at least nine theoretical perspectives: (1) psychosocial theory; (2) problem-solving theory; (3) life

model theory; (4) crisis theory; (5) systems theory; (6) role theory; (7) behavior theory; (8) cognitive theory; and (9) the empowerment approach.

The Family Connections model of practice is family-centered, community-based, preventive, comprehensive, and flexible, and employs a set of practice principles that have evolved from what we have learned about what works best with vulnerable families (Dunst, Trivette, and Deal, 1988; Hopps, Pinderhughes, and Shankar, 1995; Kinney, et. al., 1994; Schorr, 1988, 1991). Nine practice principles guide FC practice:

- (1) **Community Outreach** - Extensive outreach to project participants is used to engage and maintain families' connection with the program. At the time of referral, families are often overwhelmed by a variety of challenges that threaten their well-being, and the offer of services may be experienced as yet another stressor. Phone calls, letters, home and agency visits, and collaboration with already-connected service providers are used to enable the family to accept the services they have previously said that they want. In addition, the program deliberately selected a row house in the catchment area as the base from which services are offered. This supports the staff's capacity to become known in the community and to develop informal relationships that are crucial to the successful operation of the program. The program center is also a non-threatening environment in which clients can feel comfortable and nurtured. A large kitchen table, a supply of drinks and snacks, access to toys and technology, and a friendly staff welcome children and adults.
- (2) **Family Assessment and Tailored Interventions** – Although many of the families with whom the program works may share a variety of characteristics

and challenges, each one is truly unique. The strengths and needs of each child, adult and family, the neighborhood, and the providers and programs to whom/which the family is connected combine to create a complex and distinctive system into which the FC staff member enters. An intensive assessment process (see Appendix C) within the first 30 days of service, utilizing elicited information from family members and providers, observations, and standardized clinical scales guides clients and staff in developing an accurate and comprehensive understanding of the strengths and needs of the family. That assessment guides the mutual development of agreed-upon strategies for goal achievement that are thought to be the best fit for the family at that moment in time. Assessment is an on-going process that requires re-evaluation throughout intervention, and strategies are revised accordingly. This may happen as frequently as every contact or as infrequently as every three months. In addition, the principle of tailored intervention directly impacts quantity and frequency of service, and termination decisions. The Family Connections protocol requires that services be provided on a weekly basis at minimum; it does not prescribe a maximum. Therefore, families/members may be seen once in a week for an hour, or three times for a total of twelve hours, depending on the extent and severity of need. Similarly, there is no protocol that dictates when services will be terminated early. When a family is not available for appointments and does not respond to outreach activities, the decision to continue outreach versus ending services depends on the level of assessed risk in the family.

- (3) **Helping Alliance**- Staff bring specialized knowledge and skill to the helping process. At the same time, each family member and the family as a system bring the accumulated experience and expertise that has enabled them to stay together and reach for a stronger future. It is only through the development of a partnership relationship that these strengths and capacities can be shared, and the likelihood of reaching the desired outcome(s) can be maximized. For many families, this dynamic is a new and somewhat threatening one, and staff members need to encourage and reinforce the family members' active participation in the process, especially as it relates to decision-making. For staff that have had previous experience in more traditional helping settings, this approach is sometimes equally uncomfortable, and supervision is used to encourage insight and the development of a well-matched skill set.
- (4) **Empowerment Approaches** - Family Connections' goal is to put itself out-of-business with any particular family by helping them to develop the insight, knowledge and skill to become their own effective managers and problem solvers. Often, by using a strategy of successive approximations to the goal, family members become confident in taking control of their own lives and using their personal power in a variety of situations in the home, school, and community.
- (5) **Strengths Perspective** – Virtually all program clients have worked with other providers who have been very good at telling the clients what they are doing wrong, what they should have done, and why they (the providers) know better and are right. Family Connections instead works to help clients identify

and celebrate what is good in their lives and what they are doing right. In some situations, it may be extremely challenging to initially identify strengths, but certainly the client's courage in asking for help and hope that their situation will improve has always been a place to begin. In addition, many clients easily recount a litany of their needs but are very hesitant and uncomfortable in suggesting even one possible strength. They are experienced in the former but, sadly, not in the latter. The development of comfort and skill in identifying and verbalizing strengths becomes a learning experience whose goal is sometimes included in the service plan.

(6) **Cultural Competence** - Clients present with a wealth of differences that need to be identified and celebrated, not amalgamated into the perceived status quo. Staff receive extensive, ongoing training to develop a cognitive frame that is culturally sensitive and a repertoire of skills that are culturally competent which, in turn, are utilized in their work with each other, clients, and community providers. Through individual, family and group experiences, family members are encouraged to learn about their heritage and incorporate into their lifestyles those dimensions that can be a source of strength and fulfillment.

(7) **Developmental Appropriateness** - Appreciating the difference between chronological and developmental stages, and understanding the implications for individual, family and, sometimes, organizational functioning is crucial in social work, in general, and for Family Connections, in particular. Knowing the expected physical or social skills for a typical two year old helps guide

both the psycho-educational work with a mother who is frustrated that her son is not sitting “nicely” and playing with his four year old sister for the afternoon, and the suspicion that a three year old who has only a single word vocabulary may be delayed and need specialized intervention. Further, the majority of clients with whom the program works has suffered significant, inadequate nurturance or traumatic experiences, and can identify a myriad of problems in their families of origin. Using a variety of theoretical frameworks, staff members are able to appreciate that a thirty-year-old mother of five is more likely experiencing her world as a sixteen year old would, and that intervention needs to be appropriately matched.

- (8) **Outcome Driven Service Plans** - Too often, clients and, sometimes, social workers, get lost in the helping process. There is a lack of clarity regarding the goals toward which they are working and the path they are taking to try to get there. It is crucial for the client to affirm and own the reason for work, and for the social worker to remain clear about and focused on the desired outcome(s). Family Connections developed and defined seven possible service outcomes (see Appendix C) that include the dimensions of child, adult and family functioning that are crucial for healthy families to meet their children’s needs. Using those outcomes as a frame, staff and clients work together to identify operationalized goals and intervention objectives. These service plans are reviewed and new plans developed at least every three months. More commonly, the plans are developed for shorter durations (10 days – six weeks) to facilitate the identification of smaller, achievable steps;

to provide opportunities for the client to feel capable and in control in the process; and to allow the social worker to praise the client's success. In turn, this encourages the client to continue to work toward the achievement of outcomes.

- (9) **Emphasis on Positive Attitudes and Qualities of Helpers-** Program clients usually present with a potentially overwhelming array of issues. It is crucial for staff to see the strengths and potential for growth in each individual and family, and to believe in their abilities to change. The path to change is not an even or precisely predictable one, so training focuses on the readiness to change typology and its related skill set. This has been especially challenging for staff members whose experience has been in more traditional settings that focus on pathology and rigidly adhere to termination protocols. Through individual supervision and modeling, even these staff members have embraced the set of attitudes and developed the necessary skills that reflect the program's guiding principles. In addition, staff self care is an ongoing theme, as is the value and importance of teamwork.

The core components of the Family Connections program included emergency assistance, home-based family intervention, parenting groups, and advocacy/community collaboration. Families were randomly assigned into four intervention groups as described in the October 1998 Addendum to this project proposal. Group A families were assigned to receive three months of service consisting of emergency assistance, a comprehensive family assessment, and linkage to community agencies. Group B families were assigned to receive three months of service consisting of emergency assistance, a

comprehensive family assessment, a parenting group, and linkage to community agencies. Group C families were assigned to receive emergency assistance, a comprehensive family assessment, nine months of individualized, family-focused, outcome driven intervention, and advocacy/service facilitation with community agencies. Group D families were assigned to receive emergency assistance, a comprehensive family assessment, nine months of individualized, family-focused, outcome driven intervention, a parenting group, and advocacy/service facilitation with community agencies.

Emergency Assistance: After the pretest research protocol is completed, staff reach out to families within one working day to begin work, quickly assessing and responding to any emergency needs. Many families become known to other providers and are referred to the program precisely because they are experiencing a crisis related to their concrete needs, e.g., no food, utilities turned off, eviction notice, or homelessness, etc. In those situations, the staff member often assisted by other team members, works quickly to contact potential resources to meet the identified need(s), and guides and encourages the client to take the necessary steps to connect with the other resource(s). The latter usually includes transporting and accompanying the client to what may be the days' worth of appointments necessary to put together an adequate response to resolve the issue. An extensive network of in-kind and monetary resources has been identified and informal relationships with University and community providers were developed to facilitate the program's capacity to respond effectively to these risks to basic safety. Acute individual or interpersonal challenges may also become quickly evident. The imminent risk of danger to self or others in the context of the home, school or community

(e.g. suicide, homicide, child abuse, domestic violence) requires an immediate response to insure the safety of all involved individuals. Although program services are voluntary, protocol follows the applicable laws and may indicate the need for non-voluntary intervention. Staff members are trained in the policies and procedures that direct such decisions, and interns must immediately access consultation when they suspect that such situations exist. Established relationships within the School of Medicine's Departments of Pediatrics and Psychiatry help facilitate appropriate and effective responses.

Comprehensive Family Assessment: Multiple contacts with various family and support system members, individually and in assorted combinations, over time in a range of settings have been necessary to develop a meaningful assessment. Intra-psychic, interpersonal, familial, neighborhood and community strengths and needs contribute to the comprehensive evaluation. The chronological and developmental stages of the individual family members, the developmental stage of the family, the neighborhood's formal and informal systems, and the broader community's resources are all considered in the assessment.

The majority of families are nontraditional, and are often female-headed, sometimes multi generational, and frequently change in composition over the time that service is provided. They present a range of needs that are classically addressed by the social work profession and have included the following: food, clothing, shelter, employment, education and training; legal issues; child behavior, learning and emotion; adjustment to acute and chronic illness, and death and dying; parenting knowledge and skill; psychiatric and substance abuse problems; and family and community violence. All of the families have presented with at least two identified challenges at the time of

referral; almost everyone has revealed far more complex situations that threaten their well-being and require multi-faceted intervention.

Service Planning: The mutually negotiated service plans operationally define the goals and objectives for the intervention, who is going to do what, and within what time frame. For families served beyond three months, the plans are renegotiated every three months or as needs are met, new needs are identified, or deadlines approach. Family members are encouraged and enabled to assume increasing responsibility in the process that assesses achievement of identified goals, and barriers to goal achievement and possible strategies to reduce or remove the barriers, as well as the definition of new goals and objectives.

Direct Services: Individual, conjoint, family and therapeutic group modalities are utilized. Family members may be seen for minutes or hours, daily or weekly, as the need requires. Two benefits of this project has been to develop an intervention manual that clearly describes the specific intervention strategies employed by interns and the development of a database for capturing information about all of the various interventions provided both directly and through referral.

Case Management: Service facilitation and coordination is a critical component of the model. Precisely because a family's needs are as diverse as they are unique, it is unlikely that interns are the sole resource to meet every need. Interns assume brokering and advocacy roles in identifying and accessing additional other resources that may best fit a family's particular needs. They work with the family to enable them to access and accept help from another systems. As appropriate, they assume the role of team leader to insure that services are coordinated, and continue to be provided in a manner that

enhances, rather than breaks down, the family's functioning. FC has developed a strong network of providers and programs with which it partners in meeting the needs of families. In addition, interns use a specialized database developed as a resource directory when special needs are identified.

Parenting Education and Support Groups: Over the five years of providing Family Connections services, the FC program has used three different parenting programs. The model initially used was The Positive Parenting Program, a community-based, volunteer-driven, family focused program developed by the Child Abuse Prevention Center (currently renamed the Family Tree). When the original proposal was submitted, The Child Abuse Prevention Center (CAPC) had provided the program for several years and was offering the Positive Parenting Program at eleven sites in three local jurisdictions with a staff of 19 paid employees (four full-time and fifteen part-time) and 146 volunteers. FC initially subcontracted with the Positive Parenting Program to revise the curriculum for FC clients and to deliver three parent groups per year. After a year of development and one year of pilot testing, we determined that there were too many constraints in using the program. Few clients were successfully engaged in group services and the themes addressed each week were not well integrated with FC program services.

During the second phase, a certified trainer for the nationally recognized Nurturing Program helped to develop a six-week parent group model that was facilitated by Student Interns and supervised by a Clinical Instructor. The field instructor provided clinical supervision necessary to supervise the group experience. This model permitted interns to follow-through with group themes, while in the home to maximize the

opportunity to “try out” new skills after each group session. Client engagement with this model was uneven however and even though there were prescribed themes for each week, it seemed that the fidelity of the program was compromised since different group facilitators delivered each group cycle. The FC administrative program team determined that teaching interns to facilitate a group for the first time in the context of delivering this service sometimes meant that the quality of the program was compromised.

During the final phase of this demonstration, the program selected and used a nationally recognized parenting program, Strengthening Multi-Ethnic Families and Communities, developed by Dr. Marilyn Steele. This program was identified by the Center for Substance Abuse (CSAP) as a promising family strengthening program. Family Connections applied for and received support from CSAP to replicate this program for FC families in Baltimore. Extensive work went into selecting this program model. Facilitators went through weeklong training sessions to become certified as facilitators and the last wave of Children’s Bureau funded clients who were supposed to receive a parenting group were offered opportunities to participate in this group program. The final result was that even though this model was a much better fit to the needs of our targeted families, there were still few families who were able to successfully engage in the program and graduate from the 13 session group. Despite providing transportation, childcare or child therapeutic groups, food, and scheduling sessions at convenient times and locations, the drop out rate for this specific service was high. Because families were only randomly assigned to receive group and because fewer than half of the families who were randomly assigned to receive a parent group intervention actually received the group intervention, the program was unable to follow the original plan of comparing

families who received home based services alone to families who received home based and group services.

C. Collaborative Efforts

Over the course of the demonstration, Family Connections has worked diligently in order to create a strong broad based collaborative on behalf of the families we serve. These efforts have included a variety of community based resources, agencies and organizations in order to provide the most comprehensive services possible to client families (e.g., housing, healthcare, advocacy, education, training, job placement, substance abuse assistance etc.)

FC project staff members have worked hard to establish a strong community based referral system throughout the Westside Empowerment Zone. Many clinics, schools, hospitals, and community agencies are familiar with the program and have been a consistent source of referrals. Additionally, FC staff members have developed a good rapport with community centers in order to access their resources in providing client families with additional specialized assistance. By the second year of delivering services, the program was able to recruit a Community Outreach Worker through outside funding. This role has helped us cultivate formal and informal relationships with a vast array of resources and organizations. We have partnered with community organizations such as St. Jerome's Head Start Center, the Douglas Memorial Community Church, and the House of Mercy neighborhood center to hold parent groups and other therapeutic family gatherings. Many other community resources were also used to hold special group gatherings, graduations, holiday parties, and family fun activities. Appendix D includes lists of referral resources and other resources used on behalf of the FC program.

FC staff members continue to collaborate with both formal and informal organizations in the Empowerment Zone, in particular. We provide presentations to community agencies, hospitals, clinics, and schools in order to keep the community aware of the program. FC program staff members have also delivered numerous presentations related to child neglect, the FC intervention model, and preliminary results of our research at state and national conferences. Attachment E includes a list of presentations and papers at least partially related to this project.

D. Special Issues

While there were no eligibility requirements specific to race or ethnicity, the project's targeted population, in Baltimore's Westside Empowerment Zone, is predominantly African American. In an effort to be culturally sensitive to our clients and the community, there was a deliberate attempt to recruit staff and interns that reflected the community. As described above, a critical ingredient in the program was educating interns to successfully engage families across culture and circumstances.

E. Funding Information

Besides the USDHHS, Children's Bureau five-year demonstration grant, the project has received funding through other sources including the Title IVE Education for Child Welfare program, the U.S. DHHS- Substance Abuse and Mental Health Services Administration, the Annie E. Casey Foundation, the Maryland Children's Trust Fund, and the Maryland Department of Human Resources. These additional resources enhanced several service areas to work with families more effectively and have supported the continuation of the FC program beyond this demonstration period. These grants and contracts have also created a successful process of establishing and building relationships

with a broad base of funding sources in order to further support the education, service, and research aspects of the Family Connections program. Attachment F lists these funding sources.

F. Evaluation Information

The evaluation efforts were coordinated under the supervision of Principal Investigator, Dr. Diane DePanfilis and Co-Principal Investigator, Dr. Howard Dubowitz at the University of Maryland Schools of Social Work and Medicine. A research team developed in Year 1 met weekly, bi-weekly, or monthly through Year 5 and ½ (depending on the need) to provide technical assistance in the design, implementation, analysis, and reporting of research findings. The data manager, research coordinator, and research assistants have been responsible for data entry, management, and analysis. Additionally they completed the necessary training and supervision of an assortment of research assistants and graduate students. Members of this research team continue to collaborate in the analysis of data, presentations at conferences, and development of scholarly papers. Attachment G includes a list of all the individuals that have participated in the research team over the life of this project.

II. Process Evaluation

The Helping Families Prevent Neglect project proposed to build on what we know about what works by replicating prior individualized approaches to provide home-based, family focused intervention to families at risk of neglect.

Original Project Objectives

- a. The project will serve 100 families with children within the Baltimore's Westside Empowerment Zone.

- b. Each family will receive at least one weekly home visit with a student intern during their enrollment in Family Connections.
- c. The project will provide caregivers, who have been assigned to group, the opportunity to participate in parenting groups.
- d. The FC program will provide advocacy and resource referrals for all families in order to tailor intervention to meet individualized needs.

A. The project will serve 100 families with children within the Baltimore's Westside Empowerment Zone.

Data Collection:

- Referral Sources
- Concerns and Risks Identified by Referral Sources at Intake
- Number of Families Enrolled Each Year

Method of Data Collection:

- Intake Referral Forms
- Family Connections MIS (Management Information System Database)

Sampling Procedure:

- None

Data Analysis:

- Descriptive data

The project was successful in meeting the goal of recruiting over 100 families (an average of 25 families per year). Over the four years of enrollment into the Family Connections program, we enrolled 154 families with a total of 473 children. Table 1 describes the number of referrals by categories of referral sources during the project demonstration. Table 2 describes the risks identified by referral sources at the time of referral. Table 3 is a list of the number of families enrolled into the project each year.

Table 1. Referral sources

| Referral Source | Number of Referrals | Percent of Referrals |
|------------------------|----------------------------|-----------------------------|
| Self (Caregiver) | 35 | 16.3 |
| School System | 64 | 29.8 |
| Health Care System | 44 | 20.5 |
| Public Social Service | 25 | 11.6 |
| Other | 47 | 21.8 |
| Total | 215 | 100% |

Table 2. Risks identified by referral sources at intake

| Concerns & Risks Identified at Intake | All Appropriate Referrals (n=216) | Percentage of all Referrals | Family Connections Clients (n=154) | Percentage of Clients |
|--|--|------------------------------------|---|------------------------------|
| Neglect Concerns | | | | |
| Inadequate/Delayed Health Care | 33 | 15.3% | 25 | 16.2% |
| Poor Personal Hygiene | 20 | 9.3% | 12 | 7.8% |
| Inadequate Nutrition | 19 | 8.8% | 14 | 9.1% |
| Unsafe Housing Conditions | 36 | 16.7% | 27 | 17.5% |
| Drug-exposed Newborn | 6 | 2.8% | 6 | 3.9% |
| Isolating | 12 | 5.6% | 9 | 5.8% |
| Permitting Drug Use | 6 | 2.8% | 4 | 2.6% |
| Delay in Obtaining Mental Health Care | 67 | 31.0% | 49 | 31.8% |
| Chronic Truancy | 23 | 10.6% | 18 | 11.7% |
| Inadequate Supervision | 47 | 21.8% | 34 | 22.1% |
| Inadequate Clothing | 18 | 8.3% | 13 | 8.4% |
| Unsanitary Household Conditions | 16 | 7.4% | 14 | 9.1% |
| Shuttling | 6 | 2.8% | 5 | 3.2% |
| Inappropriate Substitute Caregiver | 3 | 1.4% | 2 | 1.3% |
| Inadequate Nurturance | 20 | 9.3% | 16 | 10.4% |
| Witnessing Violence | 16 | 7.4% | 12 | 7.8% |
| Permitting Maladaptive Behavior | 41 | 19.0% | 33 | 21.4% |
| Unmet Special Education Needs | 26 | 12.0% | 21 | 13.6% |

| Concerns & Risks Identified at Intake | All Appropriate Referrals (n=216) | Percentage of all Referrals | Family Connections Clients (n=154) | Percentage of Clients |
|---|--|------------------------------------|---|------------------------------|
| Caregiver Risks | | | | |
| Employment | 154 | 71.3% | 109 | 70.8% |
| Mental health Problem | 51 | 23.6% | 41 | 26.6% |
| Alcohol/Drug Problem | 51 | 23.6% | 36 | 23.4% |
| Homelessness | 17 | 7.9% | 12 | 7.8% |
| Domestic Violence | 14 | 6.5% | 9 | 5.8% |
| Child Risks | | | | |
| Behavior Problems | 132 | 61.1% | 102 | 66.2% |
| Physical Disability | 10 | 4.6% | 8 | 5.2% |
| Developmental Disability | 22 | 10.2% | 17 | 11.0% |
| More than 3 children | 76 | 35.2% | 46 | 29.9% |
| Learning Disability | 42 | 19.2% | 31 | 20.1% |
| Note: Percentages total more than 100% because families typically present more than one risk. | | | | |

Table 3. Number of families enrolled per year

| Time Period of Enrollment | Number of Families |
|----------------------------------|---------------------------|
| October 1996 - September 1997 | 2 |
| October 1997 - September 1998 | 28 |
| October 1998 - September 1999 | 64 |
| October 1999 - September 2000 | 60 |
| Total | 154 |

B. Each family will receive at least one weekly home visit with a student intern during their enrollment in Family Connections.

Data Collection:

- Number of Face-to-Face Home visits per family (3 vs. 9 mos.)
- Number of Face-to-Face Agency visits per family (3 vs. 9 mos.)
- Number of Face-to-Face Other visits per family (3 vs. 9 mos.)
- Number of Direct Services provided to families (3 vs. 9 mos.)
- Number of Indirect Services provided (3 vs. 9 mos.)

Method of Data Collection:

- Family Connections MIS

Sampling Procedure:

- None

Data Analysis:

- Descriptive Data

Families received an average of 1.13 hours of direct services per week while they were opened for services in the program. (See Appendix H for a list of Staff and Social Work Interns). There were differences, however, in the average number of hours of services provided to intervention groups. On average, the three-month intervention group received 1.4 hours per week during the three-months they were provided services. In comparison, the nine-month group received on average, slightly less than one hour (.86 hours) of service per week over nine-months that they were provided services. Table 4 presents these data.

Table 4. Comparison of direct services between intervention groups

| Direct Service Type | 3-month intervention N=70 families | | | | 9-month intervention N=84 families | | | |
|----------------------------------|---------------------------------------|---|---------------------------|--------------------------------------|---------------------------------------|---|-----------------------------|--------------------------------------|
| | Total # of service episodes | Mean # (SD) of services across families | Total # of hrs of service | Mean # (SD) of hours across families | Total # of service episodes | Mean # (SD) of services across families | Total # of hours of service | Mean # (SD) of hours across families |
| Letters | 128 | 3.8 (3.4) | 26.6 | .86 (.95) | 333 | 4.8 (3.2) | 58.9 | .87 (.63) |
| Telephone Calls | 1162 | 18.2 (14.8) | 134.8 | 2.1 (2.0) | 2963 | 37.0 (27.8) | 282.2 | 3.5 (3.3) |
| Face-to-Face: Home | 848 | 12.5 (7.2) | 720.0 | 10.8 (7.0) | 1947 | 23.7 (13.6) | 1439.3 | 17.6 (12.4) |
| Face-to-Face: Family Connections | 63 | 3.0 (2.3) | 78.3 | 3.9 (3.9) | 109 | 3.3 (4.6) | 112.9 | 3.4 (5.2) |
| Face-to-Face: Agency | 139 | 4.1 (3.5) | 174.7 | 5.1 (4.7) | 404 | 6.3 (7.1) | 521.2 | 8.3 (10.0) |
| Face-to-Face: Other | 53 | 2.3 (3.0) | 59.3 | 2.6 (3.2) | 175 | 4.2 (4.4) | 166.8 | 4.0 (3.8) |
| Total | 2393 | --- | 1193.7 | --- | 5931 | --- | 2581.36 | --- |

Additional assistance was provided to families through indirect services (e.g., letters, phone calls to other agencies and advocacy assistance with collaborative partners, locating resources, testifying in court, etc.). An average of 3 and ½ total hours of indirect services (often in 5 and 10 minute blocks) were provided to families while Family Connections provided them services. The three-month group families received an average of 2 hours of indirect services in comparison to the nine-month families who received an average of 5 hours of indirect services. These indirect services are presented in Table 5.

Table 5. Comparison of indirect services between intervention groups

| Indirect Service Type | 3-month intervention N=70 | | | | 9-month intervention N=84 | | | |
|----------------------------------|------------------------------|---|---------------------------|--------------------------------------|------------------------------|---|-----------------------------|--------------------------------------|
| | Total # of service episodes | Mean # (SD) of services across families | Total # of hrs of service | Mean # (SD) of hours across families | Total # of service episodes | Mean # (SD) of services across families | Total # of hours of service | Mean # (SD) of hours across families |
| Letters | 32 | 1.9 | 6.98 | .41(.41) | 119 | 3.2 | 19.6 | .54(.56) |
| Telephone Calls | 807 | 13.2 | 94.83 | 1.58(1.56) | 1957 | 26.8 | 253.87 | 3.48(3.99) |
| Face-to-Face: Family Connections | 1 | 1 | .05 | --- | 18 | 1.4 | 81.78 | 1.99(1.97) |
| Face-to-Face: Off-site | 41 | 1.5 | 28.70 | 1.10(.92) | 139 | 3.4 | 25.75 | 1.98(5.80) |
| Clinical Notes | 126 | 11.5 | 17.30 | 6.44(5.46) | 80 | 6.7 | 46.62 | 3.88(2.95) |
| Total | 1007 | --- | 147.86 | | 2313 | --- | 427.62 | --- |

C. *The project will provide caregivers who have been assigned to group the opportunity to participant in parenting groups.*

Data Collection:

- Number of Families that were assigned to group (3 vs. 9 mths)
- Number of Families that received group

Method of Data Collection:

- Family Connections MIS
- Sign in sheets, case records

Sampling Procedure:

- Random sampling at intake into one of four groups (3 month without group, 3 month with group, 9 month without group, and 9 month with group)

Data Analysis:

- Descriptive Data

The Family Connections program had numerous difficulties in the implementation of group services as previously described. All fifty-seven caregivers who were randomly assigned to receive a parent group service were offered a group service. However, on average, less than 32% of the caregivers in these families attended any of the parent group services offered. The most frequent reasons for non-attendance included: family functioning issues in dealing with health and medical problems, substance abuse, and mental health difficulties of the caregiver and/or children. In addition, many of the families had very serious concrete needs, which made it difficult for them to commit to a parent group at the same time and place each week. See Table 6 for a comparison of group participation by intervention group.

Table 6. Participation in parent group services by families assigned to receive parent group services

| | Assigned to group | Attended some group | Percent that Attended Some Group |
|------------------|-------------------|---------------------|----------------------------------|
| 3 months N=70 | 23 | 11 | 47.82% |
| 9 months N=84 | 34 | 7 | 20.59% |
| Total | 57 | 18 | 31.58% |

D. The program staff will provide advocacy and resource referrals to all families to tailor intervention to meet individualized needs.

Data Collection:

- Number of Families that received direct service advocacy
- Number of Families that received indirect services advocacy

Method of Data Collection:

- Family Connections MIS – Direct Services – Purpose Advocacy
- Family Connections MIS – Indirect Services – Purpose Advocacy

Sampling Procedure:

- None

Data Analysis:

- Descriptive Data

Family Connections provided families with intensive family advocacy. Staff members and interns worked closely with community providers in order to best meet the individualized needs of families. Tables 7 and 8 demonstrate the significant level of effort to advocate for client families through direct and indirect services. Other purposes of contacts with and on behalf of clients are also depicted in these tables.

Table 7. Direct service type by service purpose

| | Letter | | Telephone Call | | Face-to-Face: Home | | Face-to-Face: Family Connections | | Face-to-Face: Other Agency | | Face-to-Face: Other | |
|-----------------------------|--------|------|----------------|------|--------------------|------|----------------------------------|------|----------------------------|------|---------------------|------|
| | # | % | # | % | # | % | # | % | # | % | # | % |
| Advocate | 6 | 1.3 | 79 | 2.0 | 43 | 1.5 | 0 | 0 | 84 | 15.5 | 15 | 6.6 |
| Assess | 12 | 2.6 | 189 | 4.6 | 606 | 21.7 | 15 | 8.7 | 55 | 10.1 | 41 | 18.0 |
| Support/ Counsel | 19 | 4.1 | 405 | 9.8 | 974 | 34.9 | 90 | 52.3 | 148 | 27.3 | 69 | 30.3 |
| Assist/ Provide | 28 | 6.1 | 343 | 8.3 | 452 | 16.2 | 25 | 14.5 | 98 | 18.0 | 31 | 13.6 |
| Plan | 39 | 8.5 | 385 | 9.3 | 319 | 11.4 | 6 | 3.5 | 24 | 4.4 | 7 | 3.1 |
| Refer | 27 | 5.8 | 87 | 2.1 | 56 | 2.0 | 3 | 1.8 | 14 | 2.6 | 4 | 1.8 |
| Role Play | 0 | 0 | 5 | .1 | 3 | .1 | 0 | 0 | 1 | .2 | 3 | 1.3 |
| Schedule | 329 | 71.4 | 2618 | 63.5 | 221 | 7.9 | 10 | 5.8 | 16 | 2.9 | 14 | 6.1 |
| Teach | 1 | .2 | 2 | .005 | 9 | .3 | 15 | 8.7 | 15 | 2.8 | 9 | 3.9 |
| Transport | 0 | 0 | 12 | .3 | 108 | 4.0 | 8 | 4.7 | 88 | 16.2 | 35 | 15.3 |
| Missing | -- | | -- | | 4 | | -- | | -- | | -- | |
| Total | 461 | 100 | 4125 | 100 | 2795 | 100 | 172 | 100 | 543 | 100 | 228 | 100 |

Table 8. Indirect service type by service purpose

| | Type of Service | | | | | | | | | |
|----------------------------|-----------------|------|----------------|------|----------------------------------|------|------------------------|------|----------------|------|
| | Letter | | Telephone Call | | Face-to-Face: Family Connections | | Face-to-Face: Off-site | | Clinical Notes | |
| Purpose | # | % | # | % | # | % | # | % | # | % |
| Advocate | 41 | 27.2 | 386 | 14.0 | 1 | 5.3 | 31 | 17.2 | 0 | 0 |
| Clinical Documentation | 5 | 3.3 | 23 | .8 | 1 | 5.3 | 3 | 1.7 | 198 | 96.1 |
| Non-clinical Documentation | 18 | 11.9 | 12 | .4 | 0 | 0 | 4 | 2.2 | 3 | 1.45 |
| Testify in Court | 0 | 0 | 0 | 0 | 0 | 0 | 1 | .6 | 0 | 0 |
| Consult/ Collaborate | 18 | 11.9 | 846 | 30.6 | 10 | 52.6 | 78 | 43.3 | 2 | 1.0 |
| Schedule | 36 | 23.8 | 329 | 11.9 | 1 | 5.3 | 11 | 6.1 | 0 | 0 |
| Locate Resources | 33 | 21.9 | 1166 | 42.2 | 6 | 31.5 | 52 | 28.9 | 3 | 1.45 |
| Missing | --- | --- | 2 | .1 | --- | --- | --- | --- | --- | --- |
| Total | 151 | 100 | 2764 | 100 | 19 | 100 | 180 | 100 | 206 | 100 |

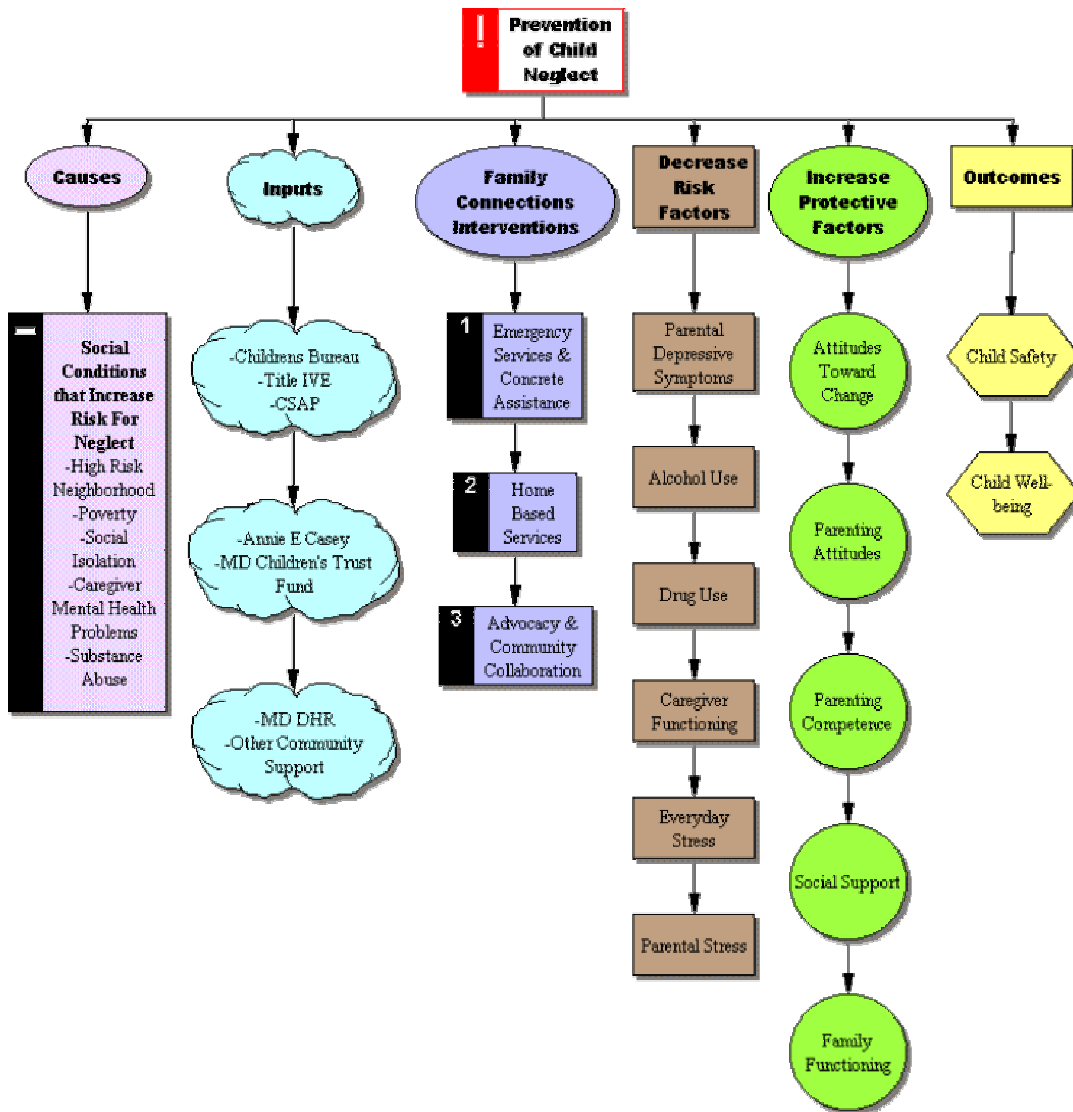
III. Outcome Evaluation

A. Proposed Outcome Objectives

The logic model that guided this evaluation suggests that locating in a high risk community; collaborating with formal and informal community organizations; attending to emergency and concrete needs; and providing individualized, strengths based intervention and social support will increase protective factors and decrease risk factors that will eventually lead to increased child safety and child well being. The model further identifies important sources of funding beginning with the original 1996 USDSS, Children's Bureau demonstration grant and supported over time with other federal, state,

and local resources. Currently the program is supported by the Maryland Department of Human Resources, the Title IVE Education for Child Welfare Program, the Annie E. Casey Foundation, and a variety of other community resources. See Figure 1. Specific objectives and hypotheses that elaborate on this model follow.

Figure 1. Family Connections logic model



A. Research Hypotheses

1) Decrease risk factors among families at risk for child neglect

Caregiver Depressive symptoms

Hypothesis 1a. Caregivers will report a statistically significant decrease in depressive symptoms as measured by the Center for Epidemiologic Studies Depressed Mood Scale (CES-D).

Hypothesis 1b. The level of depressive symptoms reported by caregivers will be statistically different between the 3-month and 9-month intervention groups.

Caregiver Alcohol use

Hypothesis 1c. Caregivers will report a statistically significant decrease in problematic alcohol use as measured by the CAGE.

Hypothesis 1d. The level of problematic alcohol use/abuse reported by caregivers will be statistically different between the 3-month and 9-month intervention groups.

Caregiver Drug use

Hypothesis 1e. Caregivers will report a statistically significant decrease in drug use/abuse as measured by the NIMH Diagnostic Interview Schedule – Version III – Revised (DIS-III-R).

Hypothesis 1f. The level of drug use/abuse reported by caregivers will be statistically different between the 3-month and 9-month intervention groups.

Hypothesis 1g. Social work interns will observe a statistically significant decrease in caregiver substance abuse as measured by the Substance Abuse subscale of the Family Risk Scales—Adult.

Hypothesis 1h. The level of improvement (reduction in substance abuse) observed by social work interns will be statistically different between the 3-month and 9-month intervention groups.

Caregiver functioning

Hypothesis 1i. Social work interns will observe a statistically significant improvement in caregiver functioning as measured by Family Risk Sub-Scales—Adult (physical health, mental health, adult relationships) and the Child Well Being- Parental Capacity for Child Care Sub-Scale.

Hypothesis 1j. The level of improved caregiver functioning observed by social work interns will be statistically different between the 3-month and 9-month intervention groups.

Everyday Stress

Hypothesis 1k. Caregivers will report a statistically significant decrease in life stress as measured by the Everyday Stressors Index.

Hypothesis 1l. The level of decrease in life stress reported by caregivers will be statistically different between the 3-month and 9-month intervention groups.

Parenting stress

Hypothesis 1m. Caregivers will report a statistically significant decrease in parental stress as measured by the Parenting Stress Index-Short Form.

Hypothesis 1n. The level of decrease in parental stress reported by caregivers will be statistically different between the 3-month and 9-month intervention groups.

2) Increase protective factors among families at risk for child neglect**Attitudes Toward Change**

Hypothesis 2a. Social work interns will observe a statistically significant improvement in attitudes toward change as measured by the Caregiver Recognition of Problems, Caregiver Motivation to Solve Problems, and Caregiver Cooperation with Case Planning/Services subscales of the Child Well-Being Scales.

Hypothesis 2b. The level of improved attitudes toward change observed by social work interns using the Caregiver Recognition of Problems, Caregiver Motivation to Solve Problems, and Caregiver Cooperation with Case Planning/Services subscales of the Child Well-Being Scales will be statistically different between the 3-month and 9-month intervention groups.

Parenting attitudes

Hypothesis 2c. Caregivers will report a statistically significant increase in appropriate parental attitudes as measured by the Adult-Adolescent Parenting Inventory.

Hypothesis 2d. The level of increase in appropriate parental attitudes reported by caregivers will be statistically different between the 3-month and 9-month intervention groups.

Parenting competence

Hypothesis 2e. Caregivers will report a statistically significant increase in parenting competence as measured by the Parenting Sense of Competence Scale.

Hypothesis 2f. The level of increase in parenting competence reported by caregivers will be statistically different between the 3-month and 9-month intervention groups.

Social support

Hypothesis 2g. Caregivers will report a statistically significant increase in social support as measured by the Social Provisions Scale.

Hypothesis 2h. The level of increased social support reported by caregivers will be statistically different between the 3-month and 9-month intervention groups.

Family Functioning

Hypothesis 2i. Caregivers will report a statistically significant improvement in family functioning as measured by the Self-Report Family Inventory.

Hypothesis 2j. The level of improved family functioning reported by caregivers will be statistically different between the 3-month and 9-month intervention groups.

Hypothesis 2k. Research staff will observe a statistically significant difference between the 3-month and 9-month intervention groups in the quality of family functioning (emotional and verbal responsibility, encouragement of maturity, emotional climate, growth fostering, active stimulation, family participation, and paternal involvement) as measured by the Home Observation for Measure of the Environment (HOME) six months following the close of intervention.

3) Increase child safety among families at risk of neglect.**Child maltreatment**

Hypothesis 3a. The number of reports to the Child Protective Services (CPS), including both indicated and unsubstantiated reports, will decrease among families in the program.

Hypothesis 3b. The number of reports to CPS will be statistically different between the 3-month and 9-month intervention groups.

Hypothesis 3c. The number of indicated reports to the Child Protective Services (CPS) will decrease among families in the Family Connections program.

Hypothesis 3d. The number of indicated reports to CPS will differ between the 3-month and 9-month intervention groups.

Meeting basic needs of children

Hypothesis 3e. Social work interns will observe a statistically significant increase in positive physical and psychological care to meet the basic needs of children as measured by the Child Well-Being Scales.

Hypothesis 3f. The level of increase in positive physical and psychological care to meet basic needs of children will be statistically different between the 3-month and 9-month intervention groups.

Physical Home environment

Hypothesis 3g. Research staff will observe a statistically significant difference between the 3-month and 9-month intervention groups in the quality of the physical home environment (overcrowding, noise level, residence structural soundness, and play area safety) as measured by the Home Observation for Measure of the Environment (HOME) six months following the close of intervention.

4) Improve well-being of children at risk of neglect**Child behavior**

Hypothesis 4a. Caregivers will report improved child behavior (internalizing and externalizing) as measured by the Child Behavior Checklist.

Hypothesis 4b. The level of improved child behavior (internalizing and externalizing) reported by caregivers will be statistically different between the 3-month and 9-month intervention groups.

Child functioning

Hypothesis 4c. Social work interns will observe improved child functioning as measured by five Family Risk Sub-Scales (physical health, mental health, home behavior, school adjustment, and delinquent behavior).

Hypothesis 4d. The level of improved child functioning observed by social work interns using five Family Risk Sub-Scales (physical health, mental health, home behavior, school adjustment, and delinquent behavior) will differ between the 3-month and 9-month intervention groups.

B. Questions Related to Outcome Objectives**1) Decrease risk factors among families at risk for child neglect****Caregiver Depressive Symptoms**

1a. How effective is the program in decreasing caregiver self-reports of depressive symptoms as measured by the Center for Epidemiologic Depressed Mood Scale at three time points (baseline, case closure, 6-month follow-up)?

1b. Is there a difference between families served in 3-months versus 9-months in caregiver self-reports of depressive symptoms as measured by the Center for Epidemiologic Depressed Mood Scale at three time points?

- i. **Expectations:** After participation in the Family Connections program, caregivers will report a statistically significant decrease in depressive

symptoms. The level of decrease in depressive symptoms will be statistically different between the 3-month and the 9-month intervention groups.

- ii. **Definitions:** Depressive symptoms are defined according to the dimensions of the Center for Epidemiologic Depressed Mood Scale. The scale measures the respondent's perception of depressed mood, feelings of guilt and worthlessness, feelings of helplessness and hopelessness, psychomotor retardation, loss of appetite, and sleep disturbance.

Caregiver Alcohol Use

1c. How effective is the program in decreasing caregiver self-reports of problematic alcohol use as measured by the CAGE at three time points (baseline, case closure, 6-month follow-up)?

1d. Is there a difference between families served in 3-months versus 9-months in the pattern of change in caregiver self-reports of problematic alcohol use as measured by the CAGE at three time points?

- i. **Expectations:** After participation in the Family Connections program, caregivers will report a statistically significant decrease in alcohol use/abuse. The level of decrease in alcohol abuse/use will be statistically different between the 3-month and the 9-month intervention groups.
- ii. **Definitions:** Alcohol use is defined according to the CAGE screening tool used to assess the respondent's risk of alcoholism. Higher scores indicate greater risk.

Caregiver Drug Use-Self Report

1e. How effective is the program in decreasing caregiver self-reports of drug use/abuse as measured by the DIS-III-R drug module at three time points (baseline, case closure, 6-month follow-up)?

1f. Is there a difference between families served in 3-months versus 9-months in the pattern of change in caregiver self-reports of drug use/abuse at three time points?

- i. **Expectation:** After participation in the Family Connections program, caregivers will report a statistically significant decrease in drug use/abuse. The level of decrease in drug use/abuse will be statistically different between the 3-month and the 9-month intervention groups.
- ii. **Definitions:** Drug use/abuse is defined according to the NIMH Diagnostic Interview Schedule-Version III-Revised (DIS-III-R) drug module.

Caregiver Substance Abuse - Observation

1g. How effective is the program in reducing caregiver drug abuse as measured by the Family Risk Scales—Adult, Substance Abuse Subscale at two time points (baseline, case closure)?

1h. Is there a difference between families served in 3-months versus 9-months in the reduction of substance abuse problems at two time points?

- i. **Expectations:** After participation in the Family Connections program, social work interns will observe a statistically significant decrease in caregiver substance abuse. The level of decrease in caregiver substance abuse will be statistically different between the 3-month and the 9-month intervention groups.
- ii. **Definitions:** Substance Abuse is defined based on the Family Risk Scales—Adult, Substance Abuse which assesses substance use and abuse on a 5 point scale from a rating of 5 – considerable substance abuse with severe consequences to a 1 indicating no abusive or socially unacceptable use of substances.

Caregiver Functioning

1i. How effective is the program in improving caregiver functioning as measured by the Family Risk Scales—Adult (physical health, mental health, adult relationships) and the Child Well Being Subscale-Parental Capacity for Child Care at two time points (baseline, case closure)?

lj. Is there a difference between families served in 3-months versus 9-months in the pattern of change in the improvement of the caregiver's functioning at two time points?

- i. **Expectations:** After participation in the Family Connections program, social work interns will observe a statistically significant increase in caregiver functioning. The level of increase in caregiver functioning will be statistically different between the 3-month and the 9-month intervention groups.
- ii. **Definitions:** Caregiver functioning is defined based on the Family Risk Scales—Adult, which assess physical health, mental health, and adult relationships. The Adult Relationships in Household subscale is rated on a four-point scale and Caregiver Physical Health and Mental Health are rated on five point scales. Higher scores indicate more serious problems. Caregiver functioning is also measured by the CWBS-Parental Capacity for Child Care subscale which is rated on a four-point scale and later converted to seriousness scores ranging from 100 (adequate functioning) to a 13 rating indicating severely inadequate functioning.

Everyday Stress

lk. How effective is the program in decreasing caregiver self-reports of life stress as measured by the Everyday Stressors Index at three time points (baseline, case closure, 6-month follow-up)?

ll. Is there a difference between families served in 3-months versus 9-months in the pattern of change in caregiver self-reports of life stress at three time points?

- i. **Expectations:** After participation in the Family Connections program, caregivers will report a statistically significant decrease in stress. The level of decrease in life stress will be statistically different between the 3-month and the 9-month intervention groups.

- ii. **Definitions:** Life stress is defined according to dimensions of the Everyday Stressors Index including: financial concerns, role overload, employment problems, interpersonal problems, and parental worries.

Parenting Stress

1m. How effective is the program in decreasing the caregiver self-reports of parental stress as measured by the Parenting Stress Index–Short Form at three time points (baseline, case closure, 6-month follow-up)?

1n. Is there a difference between families served in 3-months versus 9-months in the pattern of change in caregiver self-reports of parental stress at three time points?

2) Increasing protective factors among families at risk for child neglect

Attitudes Toward Change

2a. How effective is the program in improving attitudes toward change as measured by Caregiver Recognition of Problems, Caregiver Motivation to Solve Problems, and Caregiver Cooperation with Case Planning/Services subscales of the Child Well-Being Scales at two time points (baseline and closure)?

2b. Is there a difference between families served for 3-months versus 9-months in improving attitudes toward at two time points?

- i. **Expectations:** After participation in the Helping Families Prevent Child Neglect program, social work interns will observe a statistically significant improvement in attitudes toward change. The level of improvement in attitudes toward change will be statistically different between the 3-month and the 9-month intervention groups.
- ii. **Definitions:** Attitudes toward change are defined based on the Child Well-Being Scales—Adult, which assess caregiver recognition of needs, caregiver motivation to solve problems, and caregiver cooperation with case planning/services.

Parenting Attitudes

2c. How effective is the program in increasing appropriate parenting attitudes as measured by the Adult-Adolescent Parenting Inventory (AAPI) at three time points (baseline, case closure, 6-month follow-up)?

2d. Is there a difference between families served in 3-months versus 9-months in the pattern of change in caregiver self-reports of appropriate parenting attitudes at three time points?

- i. **Expectations:** After participation in the Family Connections program, caregivers will report a statistically significant increase in the appropriateness of parenting attitudes. The level of increase in appropriate parenting attitudes will be statistically different between the 3-month and the 9-month intervention groups.
- ii. **Definitions:** Appropriate parenting attitudes are defined based on the dimensions measured by the AAPI including: parental view of physical punishment, parental empathic awareness of children's needs, role reversal, and the appropriate expectations of child development.

Parenting Competence

2e. How effective is the program in increasing caregiver self-reports of parenting competence as measured by the Parenting Sense of Competence Scale at three time points (baseline, case closure, 6-month follow-up)?

2f. Is there a difference between families served in 3-months versus 9-months in the pattern of change in caregiver self-reports of parenting at three time points?

- i. **Expectations:** After participation in the Family Connections program, caregivers will report a statistically significant increase in parental competence. The level of increase in parental competence will be statistically different between the 3-month and the 9-month intervention groups.

- ii. **Definitions:** Parental competence is defined as the perceived level of parental efficacy and parental satisfaction as measured by the Parenting Sense of Competence Scale.

Social Support

2g. *How effective is the program in increasing caregiver self-reports of social support as measured by the Social Provisions Scale at three time points (baseline, case closure, 6-month follow-up)?*

2h. *Is there a difference between families served in 3-months versus 9-months in the pattern of change in caregiver self-reports of social support at three time points?*

- i. **Expectations:** After participation in the Family Connections program, caregivers will report a statistically significant increase in social support. The level of increase in social support will be statistically different between the 3-month and the 9-month intervention groups.
- ii. **Definitions:** Social support is defined according to the dimensions of support measured by the Social Provisions Scale. This scale measures the caregiver's perception of the availability of guidance/advice, opportunity for nurturance, social integration, attachment, reassurance of worth, and reliable alliance.

Family Functioning

2i. *How effective is the program in increasing caregiver self-report of improved family functioning as measured by the Self-Report Family Inventory at three time points (baseline, case closure, 6-month follow-up)?*

2j. *Is there a difference between families served in 3-months versus 9-months in the pattern of change in caregiver self-reports of improved family functioning at three time points?*

- i. **Expectations:** After participation in the Family Connections program, caregivers will report a statistically significant improvement in family functioning. The level of improvement in family functioning will be

statistically different between the 3-month and the 9-month intervention groups.

- ii. **Definitions:** Family functioning is defined according to the constructs of the Self-Report Family Inventory. This inventory measures the caregiver's perception of family health, expressiveness, leadership, conflict, and cohesion.

2o. Is there a difference between families served in 3-months versus 9-months in family functioning at the 6-month follow-up as measured by the Home Observation for Measure of the Environment (HOME)?

- i. **Expectations:** After participation in the Family Connections program, research staff will observe a statistical difference in family functioning between the 3-month and the 9-month intervention groups.
- ii. **Definitions:** Family functioning is defined according to the dimensions of the Home Observation for Measurement of the Environment (HOME) including: emotional and verbal responsibility, encouragement of maturity, emotional climate, growth fostering materials and experience, provision for active stimulation, family participation in developmentally stimulating experiences, and paternal involvement.

3) Increasing child safety among families at risk for child neglect

Child Maltreatment

3a. How effective is the program in reducing the number of both indicated and unsubstantiated CPS reports on families served by the program?

3b. Is there a difference between families served for 3-months versus 9-months in the number of both indicated and unsubstantiated CPS reports?

- i. **Expectations:** After participation in the Family Connections program, the number of both indicated and unsubstantiated CPS reports made will decrease.
The number of both indicated and unsubstantiated CPS reports made will be

statistically different between the 3-month and the 9-month intervention groups.

- ii. **Definitions:** A CPS report is defined by the Code Of Maryland Regulations (COMAR) as “an allegation of child abuse or neglect made or received under Family Law Article, Title 7, Subtitle 5, Annotated Code of Maryland”.

3c. How effective is the program in reducing the number of indicated CPS reports of abuse or neglect on families served by the program?

3d. Is there a difference between families served for 3 months versus 9 months in the number of indicated CPS reports on families served by the program?

- i. **Expectations:** After participation in the Family Connections program, the number of indicated CPS reports will decrease. The number of indicated CPS reports will differ between the 3-month and the 9-month intervention groups.
- ii. **Definitions:** An indicated CPS report is defined by the Code of Maryland Regulations (COMAR) as “a finding that there is credible evidence, which has not been satisfactorily refuted that abuse or neglect occurred”. An unsubstantiated CPS report is defined by COMAR as “a finding that there is insufficient evidence to support a finding of indicated or ruled out.”

Meeting Basic Needs of Children

3e. How effective is the program in improving the physical and psychological care of children to meet basic needs of children as measured by the Child Well-Being Scales at two time points (baseline, case closure)?

3f. Is there a difference between the 3-month group and the 9-month group in the physical and psychological care of children to meet basic needs of children at two points in time?

- i. **Expectations:** After participation in the Family Connections program, social work interns will observe a statistically significant improvement in physical and psychological care to meet the basic needs of children. The level of

improvement in the physical and psychological care of children to meet basic needs will be statistically different between the 3-month and the 9-month intervention groups.

- ii. **Definitions: Physical care to meet basic needs** is defined based on Subscales of the Child Well-Being Scales to assess: physical health care; nutrition/diet; clothing; personal hygiene; household furnishings; overcrowding; household sanitation; security of residence; availability of utilities; physical safety in the home; supervision of younger children; supervision of teenagers; and arrangements for substitute care. **Psychological care to meet basic needs** is defined based on Subscales of the Child Well-Being Scales to assess: mental health care; parental acceptance of/affection for children; parental approval of children; parental expectations of children; parental consistency of discipline; and parental teaching/stimulating of children. Subscales use between four and six point scales however the final ratings are computed using a severity score up to 100 (recognizing that some dimensions contribute more consequences to children than others). Higher severity scores indicate fewer concerns.

Physical Home Environment

3g. Is there a difference between the 3-month and 9-month intervention groups in the level of child safety as measured by the Home Observation for Measure of the Environment (HOME)?

- i. **Expectations:** After participation in the Family Connections program, research staff will observe a statistical difference between the 3-month and the 9-month intervention groups in the quality of the physical home environment.

- ii. **Definitions:** Physical home environment is defined according to the HOME Observation for Measurement of the Environment, which assesses aspects of the child's physical environment including overcrowding, noise level, residence structural soundness, and play area safety.

4) Increase child well-being among families at risk for child neglect

Child Behavior

4a. How effective is the program in improving the parental perception of externalizing and internalizing child behaviors as measured by the Child Behavior Checklist at three time points (baseline, case closure, 6-month follow-up)?

4b. Is there a difference between families served in 3-months versus 9-months in the pattern of change in the presentation of externalizing and internalizing child behaviors as at three time points?

- i. **Expectations:** After participation in the Family Connections program, caregivers will report a statistically significant decrease in child behavior problems. The level of decrease in child behavior problems will be statistically different between the 3-month and the 9-month intervention groups.
- ii. **Definitions:** Child behavior problems are defined according to the Child Behavior Checklist, which includes two domains of child behavior: internalizing behavior (somatic, withdrawn, anxious or depressive) and externalizing behavior (delinquent or aggressive).

Child Functioning

4c. How effective is the program in improving child functioning as measured by five subscales of the Family Risk Scales (physical health, mental health, home behavior, school adjustment, and delinquent behavior) at two time points (baseline, case closure)?

4d. Is there a difference between the 3-month group and the 9-month group in child functioning at two time points?

- i. **Expectations:** After participation in the Family Connections program, social work interns will observe a statistically significant improvement in child functioning. The level of improvement in child functioning will differ between the 3-month and the 9-month intervention groups.
- ii. **Definitions:** Child functioning is defined according to the Family Risk Scales—Child which assess the child’s physical health, mental health, home behavior, school adjustment, and delinquent behavior.

C. Method To Answer Outcome-Related Questions

1) Decrease risk factors among families at risk for child neglect

Caregiver Depressive Symptoms

1a. How effective is the program in decreasing caregiver self-reports of depressive symptoms as measured by the Center for Epidemiologic Depressed Mood Scale at three time points (baseline, case closure, 6-month follow-up)?

1b. Is there a difference between families served in 3-months versus 9-months in caregiver self-reports of depressive symptoms at three time points?

Method of assessment: A standardized measure of caregivers’ depressive symptoms was included in the computer-assisted self administered research protocol at baseline, case closure, and 6-month follow-up.

Data collected: The Center for Epidemiologic Studies-Depressed Mood Scale (CES-D) (Radloff, 1977) is a 20-item self-report scale consisting of six subscales 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).

Data analysis: Data analyses included descriptive statistics in addition to one repeated measures analysis, which was performed with CES-D total scores at baseline, case closure, and 6-month follow-up as the dependent variables. In the analysis there was one between subjects factor—treatment group (3 months v. 9 months)—and one within subject factor—administration time (baseline, case closure, and 6-month follow-up). The analysis simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time).

Discussion: There were no issues that affected the data collection or data analyses for this question.

Caregiver Alcohol Use

Ic. How effective is the program in decreasing caregiver self-reports of problematic alcohol use as measured by the CAGE at three time points (baseline, case closure, 6-month follow-up)?

Id. Is there a difference between families served in 3-months versus 9-months in the pattern of change in caregiver self-reports of problematic alcohol use at three points in time?

Method of assessment: A standardized measure of caregivers' alcohol use was included in the computer-assisted self-administered research protocol at baseline, case closure, and the 6-month follow-up.

Data collected: The CAGE (Ewing, 1984; Ewing & Rouse, 1970) is a four-item scale used to assess whether alcohol use is problematic. Higher CAGE total scores indicate a higher risk of alcoholism. The total score of 2 or higher indicates alcoholism or problem drinking (Mayfield, McLeod, & Hall, 1974).

Data analysis: Data analyses included descriptive statistics in addition to one repeated measures analysis, which was performed with CAGE total scores at baseline, case closure, and 6-month follow-up as the dependent variables. In the repeated

measures analysis there was one between subjects factor—treatment group (3 months v. 9 months)—and one within subject factor—administration time (baseline, case closure, and 6-month follow-up). The analysis simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time).

Discussion: Only those reporting ever using alcohol were asked CAGE questions resulting in a small sample at each time point.

Caregiver Drug Use – Self Report

1e. How effective is the program in decreasing caregiver self-reports of substance use/abuse as measured by the DIS-III-R drug module at three time points (baseline, case closure, 6-month follow-up)?

1f. Is there a difference between families served in 3-months versus 9-months in the pattern of change in caregiver self-reports of substance use/abuse at three time points?

Method of assessment: A standardized measure of caregivers' drug use/abuse was included in the computer-assisted self-administered research protocol at baseline, case closure, and 6-month follow-up.

Data collected: Questions from the NIMH Diagnostic Interview Schedule – Version III – Revised (DIS-III-R) (Robins, Helzer, Cottler, & Goldring, 1989; Zuravin & DePanfilis, 1996) on drug use were used.

Data analysis: Descriptive statistics for the DIS-III-R

Discussion: Only clients who self identified “ever using a drug to get high” were included in these analyses resulting in a small sample size at all three points in time.

Caregiver Substance Abuse - Observation

1g. How effective is the program in reducing caregiver substance abuse problems as measured by the Adult Substance Abuse Subscale of the Family Risk Scales at two time points (baseline, case closure)?

1h. Is there a difference between families served in 3-months versus 9-months in the reduction of caregiver substance abuse problems at two time points?

Method of assessment: A standardized measure of caregiver substance abuse was used for observational assessment by social work interns at baseline, every 3 months during the intervention, and at case closure.

Data collected: The Family Risk Scales (Magura, Moses, & Jones, 1987) are used to assess caregiver substance abuse. The measures are standardized and designed to measure a child's risk of entering foster care. The risk variables measured are those believed to contribute to or precipitate need for out-of-home placement" (Magura, Moses, & Jones, 1987). This scale was one of nine used by this study out of the twenty-six available Family Risk Scales. Each scale rates the adequacy of functioning (Magura, Moses, & Jones, 1987). Lower scores indicate higher levels of functioning.

Data analysis: Repeated measures analysis was performed with the Drug Abuse Subscale scores at baseline and case closure as the dependent variables. In this analysis, there was one between subjects factor—treatment group (3 months v. 9 months)—and one within subject factor—administration time (baseline and case closure). This analysis simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time).

Discussion: Missing data at both points in time affected the total number of families available for analysis on these dimensions.

Caregiver Functioning

li. How effective is the program in improving caregiver functioning as measured by three Family Risk Sub-Scales (physical health, mental health, and adult relationships) and the Child Well-Being Parental Capacity for Child Care Sub-Scale at two time points (baseline, case closure)?

lj. Is there a difference between families served in 3-months versus 9-months in the improvement of the caregiver's functioning at two time points?

Method of assessment: A standardized measure of caregiver functioning was used for observational assessment by social work interns at baseline, every 3 months during the intervention, and at case closure.

Data collected: Three Family Risk Scales (Magura, Moses, & Jones, 1987) and one Child Well Being Subscale (Magura and Moses, 1986) were used to assess caregiver functioning. The Family Risk Scale measures are standardized and designed to measure a child's risk of entering foster care. The risk variables measured are those believed to contribute to or precipitate need for out-of-home placement" (Magura, Moses, & Jones, 1987). Scores on three of the nine subscales used in this study were used to assess caregiver functioning in relation to caregiver physical health, mental health, and adult relationships in household. Each scale rates the adequacy of functioning (Magura, Moses, & Jones, 1987). Lower scores indicate higher levels of functioning. The Child Well Being Scales are similarly constructed however after initial ratings, scores are converted to seriousness scales so it is possible to compare ratings between subscales.

Data analysis: Repeated measures analyses were performed with one CWB subscale and three Family Risk subscale scores at baseline and case closure as the dependent variables. In all four analyses, there was one between subjects factor—treatment group (3 months v. 9 months)—and one within subject factor—administration time (baseline and case closure). These analyses simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time).

Discussion: Missing data at both points in time affected the total number of families available for analyses on these dimensions.

Everyday Stress

1k. How effective is the program in decreasing caregiver self-reports of life stress as measured by the Everyday Stressors Index at three time points (baseline, case closure, 6-month follow-up)?

1l. Is there a difference between families served in 3-months versus 9-months in the pattern of change in caregiver self-reports of life stress at three time points?

Method of assessment: A standardized measure of caregivers' perception of life stress was included in the computer-assisted self-administered research protocol at baseline, case closure, and 6-month follow-up.

Data collected: The Everyday Stressors Index (Hall, Williams, & Greenberg, 1985) is a 20-item scale used to assess common problems experienced on a daily basis reflected in five domains: financial concerns, role overload, employment problems, interpersonal problems, and parental worries. Higher total scores indicate a higher degree of perceived stress.

Data Analysis: One repeated measures analysis was performed with everyday stress total scores at baseline, case closure, and 6-month follow-up as the dependent variables. In the analysis there was one between subjects factor—treatment group (3 months v. 9 months)—and one within subject factor—administration time (baseline, case closure, and 6-month follow-up). The analysis simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time).

Discussion: There were no issues that affected the data collection or data analyses for this question.

Parenting Stress

1m. How effective is the program in decreasing the caregiver self-reports of parental stress as measured by the Parenting Stress Index at three time points (baseline, case closure, 6-month follow-up)?

In. Is there a difference between families served in 3-months versus 9-months in the pattern of change in caregiver self-reports of parental stress at three time points?

Method of assessment: A standardized measure of caregivers' perception of parenting stress was included in the computer-assisted self-administered research protocol at baseline, case closure, and 6-month follow-up.

Data collected: A total scale and three subscales (36-items) of the Parenting Stress Index- Short Form (PSI/SF) (Abidin, 1983) which measure stress related to the parent-child relationship, were administered to caregivers at baseline, case closure, and the 6-month follow-up. Higher scores for each subscale indicate higher degrees of perceived stress.

Data analysis: Repeated measures analyses were performed with the total score and three parenting stress subscale scores at baseline, case closure, and 6-month follow-up as the dependent variables. In all four analyses there was one between subjects factor—treatment group (3 months v. 9 months)—and one within subject factor – administration time (baseline, case closure, and 6-month follow-up). These analyses simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time).

Discussion: In this study, the Parenting Stress Index-Short Form was used to ask questions specific to an index child—the youngest child between the ages of 5 and 11 identified at the beginning of the study. In five families, the index child changed over the course of the study, and therefore the data was not included in the repeated measures analysis

2) Increase protective factors among families at risk for child neglect

Attitudes Toward Change

2a. How effective is the program in improving attitudes toward change as measured by three Child Well-Being Sub-Scales (Caregiver Recognition of Problems, Caregiver Motivation to Solve Problems, and Caregiver Cooperation with Case Planning/Services) at two time points (baseline and closure)?

2b. Is there a difference between families served for 3-months versus 9-months in attitudes toward change at two time points?

Method of assessment: A standardized measure of attitudes toward change was used for observational assessment by social work interns at baseline, every 3 months during the intervention, and at case closure.

Data collected: Child Well-Being Scales (CWBS) (Magura & Moses, 1986) are “designed to measure a family’s (or child’s) position on 43 separate dimensions using fully anchored rating scales completed by social workers. The dimensions cover four areas of parenting role performance, familial capacities, child role performance, and child capacities. Each scale measures a concept that is related to one or more physical, psychological, or social needs that all children have: degree to which this set of needs is met defines a child’s state of overall well being. Each scale has between 3 and 6 levels ranging from adequate to increasing degrees of inadequacy on a given dimension” (Magura & Moses, 1986).

This study used 27 of the 43 Child Well-Being Scales. Three of the twenty-seven scales assessed factors related to the caregiver’s attitude toward change (caregiver recognition of problems, caregiver motivation to solve problems, and caregiver cooperation with case planning/services). Each scale is comprised of ratings ranging from levels of adequate functioning to levels reflecting inadequate functioning (Magura & Moses, 1986).

Scores are converted to seriousness scores which “makes it possible to compare seriousness of situations harmful to children described on different scales” (Magura & Moses, 1986, p. 96). Higher scores suggest adequate situation or care provided for the well-being of the child. Scores range from 0 indicating most serious condition to 100 indicating adequate condition.

Data analysis: Repeated measures analyses were performed with three Child Well-Being subscale scores at baseline and case closure as the dependent variables. In all three analyses there was one between subjects factor—treatment group (3 months v. 9 months)—and one within subject factor—administration time (baseline and case closure). These analyses simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time).

Discussion: Incomplete data at the beginning or end of service reduced the overall number of families that could be included in this analysis.

Parenting Attitudes

2c. How effective is the program in increasing appropriate parenting attitudes as measured by the Adult-Adolescent Parenting Inventory at three time points (baseline, case closure, 6-month follow-up)?

2d. Is there a difference between families served in 3-months versus 9-months in the pattern of change in caregiver self-reports of appropriate parenting attitudes at three time points?

Method of assessment: A standardized measure of caregivers’ attitudes was included in the computer-assisted self-administered research protocol at baseline, case closure, and the 6-month follow-up.

Data collected: The Adult-Adolescent Parenting Inventory (AAPI) (Bavolek, 1984) is a self-report measure of parenting attitudes. The AAPI is comprised of 36 items representing 4 constructs including:

1. empathy towards children's needs
2. parent-child role reversal
3. parental expectations of the child's development
4. parental value of corporal punishment

Raw scores are converted to standardized scores called STEN scores. Based on normative data from non-abusive African American female adults (Bavolek, 1984, p. 67), higher STEN scores indicate less abusive or more nurturing attitudes.

Table 9. AAPI score interpretation

| STEN score | Score interpretation (Bavolek, 1984) |
|------------|--|
| 1-2 | High risk for abusive parent-child interactions |
| 3-4 | Low scores reflecting deficiencies in appropriate parenting behavior but do indicate some individual strengths |
| 5-6 | Norm |
| 7-10 | Exceed expectations |

Data analysis: Repeated measures analyses were performed with four parenting attitude subscale scores at baseline, case closure, and 6-month follow-up as the dependent variables. In all four analyses there was one between subjects factor—treatment group (3 months v. 9 months)—and one within subject factor—administration time (baseline, case closure, and 6-month follow-up). These analyses simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time).

Discussion: There were no issues that affected the data collection or data analyses for this question.

Parenting Competence

2e. How effective is the program in increasing caregiver self-reports of parenting competence as measured by the Parenting Sense of Competence Scale at three time points (baseline, case closure, 6-month follow-up)?

2f. Is there a difference between families served in 3-months versus 9-months in the pattern of change in caregiver self-reports of parenting competence at three time points?

Method of assessment: A standardized measure of caregivers' perception of parental competence was included in the computer-assisted self-administered research protocol at baseline, case closure, and the 6-month follow-up.

Data collected: The Parenting Sense of Competence Scale (PSOC) (Gibaud-Wallston & Wandersman, 1978) is a 17-item self-report measure designed to assess parent self-esteem. Johnston and Marsh (1989) conducted a study to provide psychometric and normative data for the PSOC and identified two factors of the PSOC: satisfaction and efficacy. They conceptualize satisfaction as "an affective dimension reflecting parent's frustration, anxiety and motivation" and efficacy as "an instrumental dimension reflecting competence, problem-solving ability, and capability to manage parenting role" (Johnston & Marsh, 1989, p. 167). Higher scores indicate the caregiver's perception of greater competence.

Data analysis: Repeated measures analyses were performed with parenting satisfaction subscale scores and parent efficacy subscale scores at baseline, case closure, and 6-month follow-up as the dependent variables. In both analyses there was one between subjects factor—treatment group (3 months v. 9 months), and one within subject factor—administration time (baseline, case closure, and 6-month follow-up). These analyses simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time).

Discussion: There were no issues that affected the data collection or data analyses for this question.

Social Support

2g. How effective is the program in increasing caregiver self-reports of social support as measured by the Social Provisions Scale at three time points (baseline, case closure, 6-month follow-up)?

2h. Is there a difference between families served in 3-months versus 9-months in the pattern of change in caregiver self-reports of social support at three time points?

Method of assessment: A standardized measure of caregivers' social support was included in the computer-assisted self-administered research protocol at baseline, case closure, and 6-month follow-up.

Data collected: The Social Provisions Scale (Russell & Cutrona, 1984) is comprised of 24 items used to measure six relational provisions:

1. **attachment**, provided by intimate relationships where the person receives a sense of security and safety
2. **social integration**, provided by a network of relationships in which individuals share interests and concerns
3. **opportunity for nurturance**, derived from relationships where the person is responsible for the well-being of another
4. **reassurance of worth**, provided by relationships where the person's skills and abilities are acknowledged
5. **reliable alliance**, derived from relationships where the person can count on others for assistance under any circumstances
6. **guidance** provided by relationships with trustworthy and authoritative individuals who can provide advice (Cutrona, 1984, p. 379).

High scores on the total scale and on each of the subscales indicate that caregivers were provided this support by his/her current social relationships.

Data analysis: Repeated measures analyses were performed with the total scale score and six social support subscale scores at baseline, case closure, and 6-month follow-up as the dependent variables. In all seven analyses there was one between subjects factor—treatment group (3 months v. 9 months)—and one within subject factor

–administration time (baseline, case closure, and 6-month follow-up). These analyses simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time).

Discussion: There were no issues that affected the data collection or data analyses for this question.

Family Functioning

2i. *How effective is the program in increasing caregiver self-report of improved family functioning as measured by the Self-Report Family Inventory at three time points (baseline, case closure, 6-month follow-up)?*

2j. *Is there a difference between families served in 3-months versus 9-months in the pattern of change in caregiver self-reports of improved family functioning at three time points?*

Method of assessment: A standardized measure of family functioning was included in the computer-assisted self-administered research protocol at baseline, case closure, and 6-month follow-up.

Data collected: The Self-Report Family Inventory (SFI) (Beavers, Hampson, & Hulgus, 1985) is a 36-item self-report measure of family functioning. Five subscales assess dimensions of family health, conflict, cohesion, leadership, and expressiveness. Lower scores indicate more competence on all of the SFI subscales.

Data analysis: Repeated measures analyses were performed with five family functioning scores at baseline, case closure, and 6-month follow-up as the dependent variables. In all five analyses there was one between subjects factor—treatment group (3 months v. 9 months)—and one within subject factor –administration time (baseline, case closure, and 6-month follow-up). These analyses simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time).

Discussion: There were no issues that affected the data collection or data analyses for this question.

2k. Is there a difference in family functioning at the 6-month follow-up between families served in 3-months versus 9-months as measured by the HOME Observation for Measure of the Environment?

Method of assessment: During the 6-month follow-up, research staff assessed family functioning using The Home Observation for Measure of the Environment (HOME) (Caldwell & Bradley, 1984).

Data collected: The HOME assesses the “quality and quantity of stimulation and support available to a child in the home environment” (Bradley, 1994, p. 242). The HOME Inventory for Families of Elementary Children is comprised of 59 items representing eight subscales. Seven of the subscales are used to assess family functioning:

1. Emotional and Verbal Responsibility
2. Encouragement of Maturity
3. Emotional Climate
4. Growth Fostering Materials and Experience
5. Provision for Active Stimulation
6. Family Participation in Developmentally Stimulating Experiences
7. Paternal Involvement

Research staff members were trained to rate each family based on standardized criteria. Each subscale was then scored. Higher scores indicate “more socially desired developmental outcomes” (Bradley, 1994, p. 243). According to Ozturk Ertem, Forsyth, Avni-Singer, & Damour (1997), “a score of 38 or more has been associated with a good developmental outcome and...a score less than 28 has been associated with a poor developmental outcome” (p. 324). In their sample of 73 high-risk families living in an impoverished urban environment, the mean score of the HOME was 31.7 (SD=6.0).

Data analysis: Descriptive statistics; A Multivariate Analysis of Variance (MANOVA) was performed with HOME subscales at the 6-month follow-up as the dependent variables (N=117). In the analysis there was one independent variable—treatment group (3 months v. 9 months)—and eight dependent variables—emotional and verbal responsibility score, encouragement of maturity score, emotional climate score, growth fostering materials score, active stimulation score, family participation score, paternal involvement score, and total scale score.

Discussion: There were no issues that affected the data collection or data analyses for this question.

3) Increase child safety among families at risk for child neglect

Child Maltreatment

3a. How effective is the program in reducing the number of both indicated and unsubstantiated Child Protective Service (CPS) reports made regarding families served by Family Connections?

3b. Is there a difference between families served for 3-months versus 9-months in the number of both indicated and unsubstantiated CPS reports on families served by Family Connections?

3c. How effective is the program in reducing the number of indicated CPS reports regarding families served by Family Connections?

3d. Is there a difference between families served for 3 months versus 9 months in the number of indicated CPS reports regarding families served by Family Connections?

Method of assessment: Upon the receipt of suspected child maltreatment referrals by telephone, in person, fax or mail, the Child Protective Service (CPS) determined the validity of the referral and assessed whether the reported information would meet the statutory and agency guidelines for child abuse and neglect. Then, the screening worker forwarded the referral to the appropriate unit for subsequent investigation. If child maltreatment were either indicated or unsubstantiated at the time of

investigation, the reports were entered to the Maryland Department of Human Resources (DHR) Client Information System (CIS) (<http://www.ocyf.state.md.us/2002BOOK.pdf>).

Data collected: From the DHR CIS database, both indicated and unsubstantiated CPS reports on caregivers served by this project between 1985 and March 31, 2001 were retrieved. The CPS data on each child and caregiver included beginning and ending dates, type of maltreatment, case status, and case closure reason for each CPS episode.

Data analysis: Descriptive statistics; Chi square test for categorical variables to compare status of both indicated and unsubstantiated child maltreatment reports with different treatment groups.

Discussion: The number of indicated CPS reports on child abuse and neglect during as well as 6-month follow up of intervention was small. Analyses such as logistic regression and repeated measures analysis of variance could not be performed to predict whether the intervention was effective in reducing the number of indicated CPS reports or to examine changes in the number of CPS reports across time due to the small number of CPS reports, particularly during follow-up.

Meeting Basic Needs of Children

3e. How effective is the program in improving the physical and psychological care of children to meet basic needs as measured by the Child Well-Being Scales at two time points (baseline, case closure)?

3f. Is there a difference between the 3-month group and the 9-month group in the physical and psychological care of children to meet basic at two points in time?

Method of assessment: Social work interns used a standardized measure of the care of children to meet basic needs for observational assessment at baseline, every 3 months during the intervention, and at case closure.

Data collected: Child Well-Being Scales (CWBS) (Magura & Moses, 1986) are “designed to measure a family’s (or child’s) position on 43 separate dimensions using fully anchored rating scales completed by social workers. The dimensions cover four areas of parenting role performance, familial capacities, child role performance, and child capacities. Each scale measures a concept that is related to one or more physical, psychological, or social needs that all children have: degree to which this set of needs is met defines a child’s state of overall well being. Each scale has between 3 and 6 levels ranging from adequate to increasing degrees of inadequacy on a given dimension” (Magura & Moses, 1986).

This study used 27 of the Child Well-Being Scales. Scales used in similar research were selected to represent physical and psychological care of children. Physical care to meet basic needs was represented by the following scales: physical health care; nutrition/diet; clothing; personal hygiene; household furnishings; overcrowding; household sanitation; security of residence; availability of utilities; physical safety in the home; supervision of younger children; supervision of teenagers; and arrangements for substitute care. Psychological care to meet basic needs was represented by the following scales: mental health care; parental acceptance of/affection for children; parental approval of children; parental expectations of children; parental consistency of discipline; and parental teaching/stimulating of children. Each scale is comprised of ratings ranging from levels of adequate functioning to levels reflecting inadequate functioning (Magura & Moses, 1986). Scales use between four and six point rankings however the final ratings are computed using a severity score up to 100 (recognizing that some dimensions

contribute more consequences to children than others). Higher severity scores indicate fewer concerns.

Data analysis: Repeated measures analyses were performed with Child Well-Being subscale scores at baseline and case closure as the dependent variables. In all analyses there was one between subjects factor—treatment group (3 months v. 9 months)—and one within subject factor—administration time (baseline and case closure). These analyses simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time).

Discussion: Missing data at baseline or closing limited the number of families available for analyses related to these subscales.

Physical Home Environment

3g. Is there a difference between the 3-month and 9-month intervention groups in the level of the physical home environment as measured by the Home Observation for Measure of the Environment (HOME) at the six month follow-up?

Method of assessment: During the 6-month follow-up, research staff assessed the physical home environment using The Home Observation for Measure of the Environment (HOME) (Caldwell & Bradley, 1984).

Data collected: The HOME assesses the “quality and quantity of stimulation and support available to a child in the home environment” (Bradley, 1994, p. 242). The HOME Inventory for Families of Elementary Children is comprised of 59 items representing eight subscales. One of the subscales called “Aspects of the Physical Environment” was used to assess the child’s physical home environment. Research staff members were trained to rate each family based on standardized criteria. Each subscale was then scored. Higher scores indicate “more socially desired developmental outcomes” (Bradley, 1994, p. 243).

According to Ozturk Ertem, Forsyth, Avni-Singer, & Damour (1997), “a score of 38 or more has been associated with a good developmental outcome and... a score less than 28 has been associated with a poor developmental outcome” (p. 324). In their sample of 73 high-risk families living in an impoverished urban environment, the mean score of the HOME was 31.7 (SD=6.0).

Data analysis: Descriptive statistics; A Multivariate Analysis of Variance (MANOVA) was performed with one HOME subscale at the 6-month follow-up as the dependent variables (N=117). In the analysis, there was one independent variable—treatment group (3 months v. 9 months)—and nine dependent variables—emotional and verbal responsibility score, encouragement of maturity score, emotional climate score, growth fostering materials score, active stimulation score, family participation score, paternal involvement score, physical environment score, and total scale score.

Discussion: There were no issues that affected the data collection or data analyses for this question.

4) Increase child well-being among families at risk for child neglect

Child Behavior

4a. How effective is the program in improving the parental perception of externalizing and internalizing child behaviors as measured by the Child Behavior Checklist at three time points (baseline, case closure, 6-month follow-up)?

4b. Is there a difference between families served in 3-months versus 9-months in the in the presentation of externalizing and internalizing child behaviors at three time points?

Method of assessment: A standardized measure of caregiver perception of child behavior was included in the computer-assisted self-administered research protocol at baseline, case closure, and 6-month follow-up.

Data collected: The Child Behavior Checklist (Achenbach, 1991) is a 112-item measure of children’s competencies and problems as reported by their caregivers. The CBCL represents two domains of behavior: internalizing behavior (somatic, withdrawn, anxious or depressive) and externalizing behavior (delinquent or aggressive). For clinical use, raw scores are converted to t scores that “facilitate comparisons of the degree of deviance indicated by children’s standing on different scales and different instruments (Achenbach, 1991, p. 189). For research purposes, raw scores are used.

Table 10. CBCL interpretation of T scores

| Interpretation (Achenbach, 1991) | CBCL T Score |
|---|---------------------|
| Normal | < 60 |
| Borderline | 60-63 |
| Clinical | > 63 |

Data analysis: Repeated measures analyses were performed with three child behavior raw scores at baseline, case closure, and 6-month follow-up as the dependent variables. In all three analyses there was one between subjects factor—treatment group (3 months v. 9 months)—and one within subject factor –administration time (baseline, case closure, and 6-month follow-up). These analyses simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time).

Discussion: This study used the Child Behavior Checklist to ask questions specific to an index child—the youngest child between 5 and 11 identified at the beginning of the study. In five families, the index child changed over the course of the study, and therefore their data was not included in the repeated measures analyses.

Child Functioning

4c. How effective is the program in improving child functioning as measured by five Family Risk Sub-Scales (child physical health, mental health, home behavior, school adjustment, and home behavior) at two points (baseline, case closure)?

4d. Is there a difference between the 3-month group and the 9-month group in child functioning at two time points?

Method of assessment: Social work interns used a standardized measure of child functioning for observational assessment at baseline, every 3 months during the intervention, and at case closure.

Data collected: The Family Risk Scales—Child (Magura, Moses, Jones, 1987) are used to assess child functioning. The scales are “designed as a standardized measure of a particular kind of risk—a child’s risk of entering foster care. The risk variables measured are those believed to contribute to or precipitate need for out-of-home placement” (Magura, Moses, & Jones, 1987).

This study used 9 of the 26 Family Risk Scales. Five of the nine scales assessed child physical health, mental health, home behavior, school adjustment, and delinquent behavior. Each scale is comprised of ratings ranging from levels of adequate functioning to levels reflecting inadequate functioning (Magura, Moses, & Jones, 1987). Lower scores indicate higher levels of functioning.

Data analysis: Repeated measures analyses were performed with five Family Risk Scales—Child subscale scores at baseline and case closure as the dependent variables. In all five analyses there was one between subjects factor—treatment group (3 months v. 9 months)—and one within subject factor—administration time (baseline and case closure). These analyses simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time).

Discussion: Missing data at baseline or case closure reduced the number of children available for these analyses.

D. Findings For Outcome-related Questions

Descriptive Results – Caregivers and Families:

The findings reported below are based on 154 caregivers and 473 children who participated in the Family Connections program 1997 and 2001. Of the 154 primary caregivers, the majority were female (98.1%), African American (86.4%), never married (65.0%) and unemployed (57.8%). The ages of primary caregivers ranged from 19 to 72 years ($M=36.87$, $SD=12.15$). The mean educational level was 10.78 years ($SD=2.21$) and the mean income level was \$9,571.34 ($SD=\$5,785.40$). There were no significant group differences between the 3 month intervention group and the 9 month intervention group in age ($t=.279$, $p=.781$), educational level ($t=.106$, $p=.915$), income ($t=-.833$, $p=.406$), or total number of children ($t= 1.566$, $p=.120$). See Table 11.

Table 11. Demographic characteristics of total sample and by intervention group

| Characteristic | Total | | 3 months | | 9 months | | Chi Square | Sig. |
|------------------|-------|------|----------|------|----------|------|------------|------|
| | N | % | N | % | N | % | | |
| Gender | | | | | | | .181 | .670 |
| Male | 3 | 1.9 | 1 | 1.4 | 2 | 2.4 | | |
| Female | 151 | 98.1 | 69 | 98.6 | 82 | 97.6 | | |
| Race | | | | | | | 4.515 | .341 |
| African American | 133 | 86.4 | 59 | 84.3 | 74 | 88.1 | | |
| Caucasian | 17 | 11.0 | 9 | 12.9 | 8 | 9.5 | | |
| Hispanic | 1 | .6 | 0 | 0 | 1 | 1.2 | | |
| Mixed Race | 2 | 1.3 | 2 | 2.9 | 0 | 0 | | |
| Other | 1 | .6 | 0 | 0 | 1 | 1.2 | | |

| Characteristic | Total | | 3 months | | 9 months | | Chi Square | Sig. |
|-----------------|-------|------|----------|------|----------|------|------------|------|
| | N | % | N | % | N | % | | |
| Marital Status | | | | | | | 2.700 | .609 |
| Never Married | 100 | 64.9 | 42 | 60.0 | 58 | 69.0 | | |
| Married | 8 | 5.2 | 3 | 4.3 | 5 | 6.0 | | |
| Separated | 20 | 13.0 | 11 | 15.7 | 9 | 10.7 | | |
| Divorced | 15 | | 9 | 12.9 | 6 | 7.1 | | |
| Widowed | 11 | 9.7 | 5 | 7.1 | 6 | 7.1 | | |
| | | 7.1 | | | | | | |
| Work Status | | | | | | | 6.418 | .170 |
| Full-time Job | 29 | 18.8 | 12 | 17.1 | 17 | 20.2 | | |
| Part-time Job | 13 | 8.4 | 4 | 5.7 | 9 | 10.7 | | |
| In | 16 | 10.4 | 6 | 8.6 | 10 | 11.9 | | |
| School/Training | 89 | 57.8 | 42 | 60.0 | 47 | 56.0 | | |
| Unemployed | 7 | 4.5 | 6 | 8.6 | 1 | 1.2 | | |
| Retired | | | | | | | | |

Descriptive Results - Child Characteristics

Of the 473 children served by the Family Connections program, the majority were African American (84.6%) and living with their mothers (77.8%). The age of children ranged from zero to twenty (Mean = 8.27, SD=4.01). The number of children per family ranged from one to nine (Mean= 3.07, SD=1.59). See Table 12 for additional information about the children's demographic information.

Table 12. Demographic characteristics of children

| Characteristics of Children | Total | |
|-----------------------------|-------|------|
| | N | % |
| Gender | | |
| Male | 241 | 51.0 |
| Female | 232 | 49.0 |
| Race | | |
| African American | 400 | 84.6 |
| Caucasian | 50 | 10.6 |
| Other | 23 | 4.8 |

| Characteristics of Children | Total | |
|-----------------------------------|-------|------|
| | N | % |
| Caregiver's Relationship to Child | | |
| Mother | 368 | 77.8 |
| Grandmother | 64 | 13.5 |
| Father | 4 | .9 |
| Other Relative | 33 | 6.9 |
| Non-relative | 4 | .9 |

Results Regarding Risk Factors

Results are presented with respect to each of the previously identified hypotheses and research questions. Risk factors that were the target of intervention included: caregiver depressive symptoms, caregiver use of alcohol, caregiver use of drugs, caregiver functioning, everyday stress, and parenting stress.

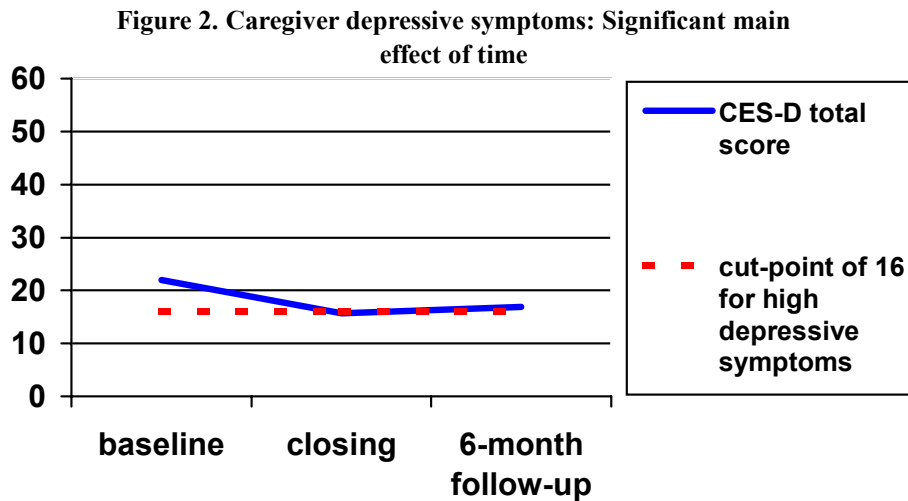
Caregiver Depressive Symptoms

1a. How effective is the program in decreasing caregiver self-reports of depressive symptoms as measured by the Center for Epidemiologic Depressed Mood Scale at three time points (baseline, case closure, 6-month follow-up)?

1b. Is there a difference between families served in 3-months versus 9-months in caregiver self-reports of depressive symptoms as measured by the Center for Epidemiologic Depressed Mood Scale at three time points?

Results related to Depressive Symptoms:

Descriptive results indicate that the number of families who scored at the clinical cut point decreased from baseline to closing and stayed relatively constant at the six-month follow-up. Specifically, 65.6% of 154 caregivers had a CES-D total score of 16 or higher at baseline. This decreased to 42.6% of 136 caregivers with a CES-D total score of 16 or higher at case closure, and 45.6% of 136 caregivers with a CES-D total score of 16 or higher at the six-month follow-up. See Figure 2.



A single group repeated measures analysis was used to assess change over time in the caregivers' depressive symptoms (N=125). **A statistically significant main effect of time was found ($F=18.239$, $p<.0005$). A statistically significant interaction between time and group was found ($F=3.185$, $p=.045$).** There was no statistically significant main effect of group ($p=.073$). However, from baseline to case closure, the 9-month intervention group shows more improvement than the 3-month intervention group and these differences are statistically significant (refer to Table 13). From case closure to the 6-month follow-up, scores of the 3-month intervention group remained fairly stable, while scores increased slightly for the 9-month group. At follow-up, the difference in scores for the two groups was similar to the difference at baseline.

Table. 13 Differences between groups in caregiver depressive symptoms.

| Treatment group | Mean | Standard Error |
|------------------------|-------------------|-----------------------|
| 3-month group | Baseline | 22.69 |
| | Case closure | 18.69 |
| | 6-month Follow-up | 17.77 |
| 9-month group | Baseline | 21.14 |
| | Case closure | 12.76 |
| | 6-month Follow-up | 15.92 |

Discussion of Results. These results suggest that Family Connections intervention may have been effective at helping caregivers reduce depressive symptoms. These results further suggest that longer intervention (nine-months) versus shorter intervention (three-months) is more effective at decreasing depressive symptoms among caregivers. Given that families served for longer periods of time were more likely to participate in change-oriented services, these results are supportive of the premise that it takes a longer period of time for enduring risk factors to be addressed.

Issues Relevant to Interpretation of Depressive Symptoms Results. These results need to be considered as exploratory as women with depressive symptoms are noted to go through cycles of higher levels of symptoms to lower levels of symptoms over the course of a year. It is also important to note that the time periods at which depressive symptoms were measured varied between groups because each were measured at the beginning, end, and six months following the closure of services. For the three-month group, the six-month period follow-up was nine months after beginning with Family Connections. The nine-month intervention group was not observed for the six month follow up until 15 months after beginning with Family Connections. Those differences alone make it more difficult to interpret these findings. A further question emerges about why for the nine-month group; the positive reduction of depressive symptoms does not endure at the six-month follow-up. However, it does need to be

noted that at the six month follow-up, the mean score for the nine-month intervention group is slightly less than the 16 cut point, while the mean score for the three-month group is still above the 16 cut point even though the differences between the groups at this point are no longer statistically significant.

Caregiver Alcohol Use/Abuse

1c. How effective is the program in decreasing caregiver self-reports of problematic alcohol use/abuse as measured by the CAGE at three time points (baseline, case closure, 6-month follow-up)?

1d. Is there a difference between families served in 3-months versus 9-months in the pattern of change in caregiver self-reports of problematic alcohol use/abuse as measured by the CAGE at three time points?

Results Related to Self-Report of Alcohol Use/Abuse:

At baseline, 102 caregivers (66.2%) reported that they now drink or have ever drunk alcohol beverages. The majority of caregivers, who reported that they drink alcohol, received a score of 0 or 1 at all three points in time. A total score of 2 or higher indicates alcoholism or problem drinking. Table 14 reports the percent of caregivers with CAGE Total Scores at each data collection point.

Table 14. Percent of caregivers with CAGE total scores

| CAGE Total Score | Baseline (N=102) | Case closure (N=69) | 6-Month Follow-up (N=68) |
|-------------------------|-------------------------|----------------------------|---------------------------------|
| 0-1 | 79.4% | 78.3% | 80.9% |
| 2-3 | 15.6% | 14.5% | 14.8% |
| 4 | 4.9% | 7.2% | 4.4% |

A two group repeated measures analysis was performed to assess change over time in the caregivers' alcohol use (N=46). The sample size for this analysis was reduced to 46 caregivers who answered consistently that they "ever used alcohol" at all three time

points. There was no statistically significant main effect of time ($p=.494$), main effect of group ($p=.226$) or group by time interaction ($p=.501$).

Discussion of Results. The results suggest that most caregivers did not report that they had alcohol related problems at the beginning of intervention. Fifty-two of the 154 caregivers reported that they didn't drink alcohol at all and another 80 caregivers scored a 0 or 1 on the CAGE. These results are consistent with other studies conducted by the Principal Investigator of high-risk families in Baltimore (Zuravin and DePanfilis, 1996). Of those who scored 2 or higher on the CAGE, there were only small, non-statistically significant changes over time.

Issues Relevant to the Interpretation of Alcohol Use Results. Only those reporting ever using alcohol at all three points in time were available for the repeated measures analysis resulting in a small sample ($N=44$). This may have affected the power to detect statistically significant findings.

Caregiver Substance Use/Abuse – Self Report

1e. How effective is the program in decreasing caregiver self-reports of substance use/abuse as measured by the DIS-III-R drug module at three time points (baseline, case closure, 6-month follow-up)?

1f. Is there a difference between families served in 3-months versus 9-months in the pattern of change in caregiver self-reports of substance use/abuse as measured by the DIS-III-R drug module at three time points?

Results Related to Substance Use/Abuse:

Of the 154 caregivers, 62 (40.3%) reported ever using at least one drug (not including alcohol) at baseline. Of these 62 caregivers, the mean age at initiation of drug use was 17.92 ($SD=5.47$). Marijuana, cocaine, crack and heroin were drugs that were used more than other drugs by caregivers who reported ever using at least one drug. Of the 62 caregivers who reported ever using drugs, 48 indicated that they had used drugs 5

or more times. The level of drug use self reported by these caregivers at baseline is described in Table 15.

Table 15. Self-report level of drug use/abuse at baseline by respondents reporting use of drugs five or more times

| Level of Drug Use | Number Responding Yes | Percent of Responses |
|---|-----------------------|----------------------|
| Reported using drugs almost everyday for 2 weeks or more (n=48) | 41 | 85.4% |
| Reported ever feeling dependent on any drugs or being unable to keep from using them (n=46) | 30 | 65.2% |
| Reported that drug use caused them considerable problems with their family, friends, on the job, at school, or with the police (n=46) | 31 | 67.4 |
| Reported that they have often been high on drugs or suffering their after-effects while working or taking care of their children (n=46) | 24 | 52.2 |
| Reported that they have spent time in a detoxification unit or hospital to get treatment for drug problems (n=46) | 16 | 34.8 |
| Reported that they have participated in an outpatient drug treatment program to get help with drug problems (n=46) | 22 | 47.8 |

At case closure, 50 respondents out of 136 (36.8%) reported ever using drugs, and at the six-month follow-up, 57 respondents out of 136 (41.9%) reported having ever used drugs. We were particularly interested in whether the percent of caregivers reporting recent drug use would decrease over time. Results presented in Table 16 indicate that at baseline approximately 25% of caregivers who ever reported using drugs also reported that they had used drugs for almost two weeks or more within the last two weeks prior to their baseline interview and that they stayed high on drugs for a whole day or more within the last two weeks before their interview. At case closure, only 16% indicated using drugs within the last two weeks and 12% indicated that they had stayed high for a day or more within the last two weeks. At the six-month follow-up, 14% of respondents

who ever used drugs suggested recent drug use in the last two weeks or being high for a whole day or more within the last two weeks.

Table 16. Caregivers' drug use within last 2 weeks of those reporting ever using drugs

| Questions | Baseline (N=62) | Case closure (N=50) | 6-Month Follow-up (N=57) |
|--|--------------------|---------------------------|-----------------------------|
| Used any drugs for almost 2 weeks or more within last 2 weeks | 16 (25.8%) | 8 (16.0%) | 8 (14.0%) |
| Stayed high on any drugs for a whole day or more within last 2 weeks | 15 (24.2%) | 6 (12.0%) | 8 (14.0%) |

Discussion of results. Review of descriptive data indicates a decrease in the number of caregivers reporting frequent use of drugs between baseline and case closure. In addition, there is not much change in percent reporting drug use from case closure to the 6-month follow-up. This may suggest that the self-reported decrease in drug use may have been sustained beyond the intervention.

Issues relevant to the interpretation of drug use self-report data. Because of the sensitivity of reporting drug use, it is assumed that some respondents who used drugs did not report their use. It may also be the case that they disclosed drug use at one point in time but did not disclose drug use at other points in time. Due to the challenges of interpreting drug use self-report data, we also used an observational measure of substance abuse.

It is also important to note that the Family Connections intervention protocol includes working with other treatment providers, particularly on issues that require the expertise of other providers, such as drug treatment. Anecdotal reports suggest that social work staff and interns were frequently frustrated due to difficulties in obtaining

quality substance abuse treatment in a timely manner. Even when caregivers planned strategies to arrange for care of their children so that they could enter in-patient treatment (when it was recommended), there were numerous examples of clients being put on waiting lists for extensive periods of time. These lengthy waits frequently reduced the likelihood that the caregiver would successfully engage in other aspects of Family Connections intervention.

Substance Abuse – Observation by Student Interns

1g. How effective is the program at decreasing caregiver substance use/abuse as measured by the Adult Substance Abuse Subscale of the Family Risk Scales at two time points (baseline, case closure)?

1h. Is there a difference between families served in 3-months versus 9-months in the decrease of caregivers' use/abuse of substances at two time points?

Results of Observation of Substance Abuse:

As part of the initial Family Assessment, student interns completed the Parent's Substance Abuse subscale of the Family Risk Scales on 107 caregivers. This scale is scored from 1 (representing no abusive or socially unacceptable use of alcohol and no use of other drugs) to a 5 (considerable substance abuse, with severe consequences). Twenty-three percent of these 107 caregivers were observed to have a substance abuse problem rated at a level of 3, 4, or 5 during the first thirty days of intervention. Table 17 presents these results.

Table 17. Observation of caregivers' substance abuse within 30 days of case opening (n=107)

| Rating | Frequency | Percent | Cumulative Percent |
|---|------------------|----------------|---------------------------|
| 1-No abusive or socially unacceptable use of alcohol; no use of other drugs | 81 | 75.7 | 75.7 |
| 2-Moderate use of marijuana, but no "hard drugs" | 1 | .9 | 76.6 |
| 3-Some substance abuse but no serious consequences yet | 6 | 5.6 | 82.2 |
| 4-Considerable substance abuse, with some serious consequences | 15 | 14.0 | 96.3 |
| 5-Considerable substance abuse, with severe consequences | 4 | 3.7 | 100.0 |
| Total | 107 | 100.0 | |

NOTE: Only partial definitions of ratings are included

At case closure, student interns rated 94 caregivers with respect to their use of substances. Of these, they observed only 13.85 % of caregivers with a substance abuse problem rated between a 3 and a 5 on the Caregiver Substance Abuse Subscale of the Family Risk Scales (compared to 23% at Intake). These results are depicted in Table 18.

Table 18. Observation of caregivers' substance abuse at case closure (n=94)

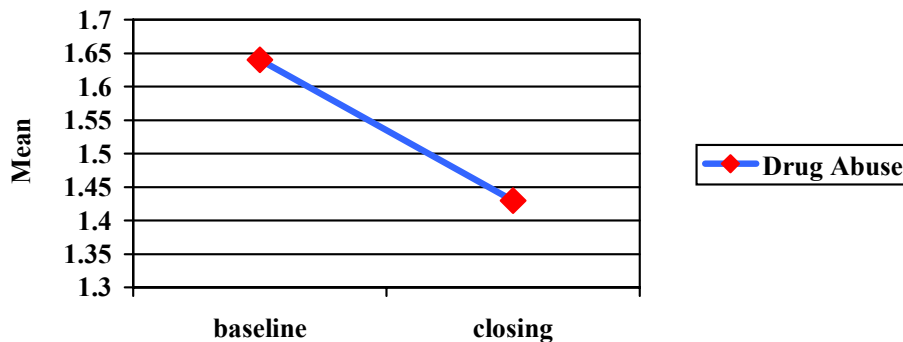
| Rating | Frequency | Percent | Cumulative Percent |
|---|------------------|----------------|---------------------------|
| 1-No abusive or socially unacceptable use of alcohol; no use of other drugs | 76 | 80.85 | 80.85 |
| 2-Moderate use of marijuana, but no "hard drugs" | 5 | 5.3 | 86.15 |
| 3-Some substance abuse but no serious consequences yet | 4 | 4.3 | 90.45 |
| 4-Considerable substance abuse, with some serious consequences | 8 | 8.5 | 98.95 |
| 5-Considerable substance abuse, with severe consequences | 1 | 1.05 | 100.0 |
| Total | 94 | 100 | |

NOTE: only partial descriptions of ratings are included.

In a repeated measures analysis with 71 caregivers where data was available at two points in time, the dependent variable was the Family Risk Scales—Adult drug abuse

subscale scores at baseline and case closure (N=71). Significant effects of time were found ($F = 4.935, p = .030$). **There was a statistically significant decrease in the drug abuse subscale scores from baseline (M=1.64, se=.14) to case closure (M=1.43, Se=.11, p=.030)**. There was no statistically significant main effect of group ($p = .077$) or interaction between group and time ($p = .448$). See Figure 3.

Figure 3. Observation of substance use/abuse between intake and case closure: Significant main effect of time



Discussion of Results. These results suggest that interns observed a reduction in the number of clients with a substance abuse problem from the beginning of intervention until the closure of intervention. A repeated measure analysis also found a statistically significant difference in the Substance Abuse Family Risk Subscale mean from the beginning of intervention until the end of intervention. No statistically significant differences in outcome were noted between families served for three months versus nine months.

Issues relevant to the interpretation of drug use observational data. Given the amount of missing data for this subscale, results need to be interpreted with caution.

The small number of cases could have especially made it difficult to determine differences between intervention groups. Furthermore, even though there was a statistically significant decrease in the drug abuse subscale scores for the 71 adult caregivers (out of 154 caregivers) who had both points in time assessed and recorded, the amount of missing data suggests the need to continue to analyze this dimension with other caregivers served in this program. However, given the direction of non-significant change using the DIS-R drug module and the findings from this observational measure, the results do suggest the need to further explore the connection between substance abuse and care of children and the degree to which this intervention may reduce the impact of substance abuse on the care of children.

Caregiver Functioning

Ig. How effective is the program in improving caregiver functioning as measured by the Family Risk Scales—Adult (FRS-A) and one CWB subscale at two time points (baseline, case closure)?

Ih. Is there a difference between families served in 3-months versus 9-months in the improvement of caregivers' functioning at two time points?

Results of Observation of Caregiver Functioning:

Student interns were asked to assess four dimensions of caregiver functioning as part of their family assessment, case evaluation every three months (for the nine month group), and again at case closure.

Physical Health. Physical health was assessed on five levels ranging from a rating of 1 (good physical health) to a 5 (seriously physically ill or impaired). At intake, 79.5% of 132 caregivers were assessed as in good health or generally healthy. This compares to 73.8% of 111 caregivers rated as in good health or generally healthy at closure. See Table 19

Table 19. Observation of caregivers' physical health at intake and case closing

| Physical Health Dimension-Family Risk Scale | Rating at Intake (n=132) | % of total at Intake | Rating at Closure (n=111) | % of total at Closure |
|---|--------------------------|----------------------|---------------------------|-----------------------|
| 1-Good physical health | 59 | 44.7 | 54 | 48.6 |
| 2-Generally healthy, but some threats to health exist | 46 | 34.8 | 28 | 25.2 |
| 3-Mildly physically ill or impaired – no or mild impact on ability to perform child caring role. | 17 | 12.9 | 16 | 14.4 |
| 4-Moderately physically ill or impaired – significant impact with ability to function but still able to perform some child care functions | 8 | 6.1 | 11 | 9.9 |
| 5-Seriously physically ill or impaired – significant impact on ability to perform in a child caring role | 2 | 1.5 | 2 | 1.8 |
| TOTAL | 132 | 100 | 111 | 99.9 |

NOTE: only partial descriptions of ratings are included.

For 105 caregivers where data at both points in time was available, a repeated measures analysis was conducted with a dependent variable using the Family Risk Scales—Adult physical health subscale scores at baseline and case closure (N=105). There was no statistically significant main effect of time ($p=.903$), main effect of group ($p=.867$) or interaction between group and time ($p = .903$).

Caregiver's Mental Health. The second dimension assessed by interns at intake and at case closure was the caregiver's mental health subscale of the Family Risk Scales. This scale ranges from a rating of 1 (adequate, no identifiable difficulties) to a rating of 5 (incapacitated due to mental illness). At Intake, interns assessed caregivers as adequate or generally mentally healthy 88.5% of the time. At case closure, with slightly fewer caregivers, they still assessed 87.8% as adequate or generally mentally healthy. See Table 20.

Table 20. Observation of caregivers' mental health at intake and case closure

| Mental Health Dimension-Family Risk Scale | Rating at Intake (n=130) | % of total at Intake | Rating at Closure (n=115) | % of total at Closure |
|---|--------------------------|----------------------|---------------------------|-----------------------|
| 1-Adequate, no identifiable difficulties | 62 | 47.7 | 57 | 49.6 |
| 2-Generally mentally healthy, but experiencing psychological distress reaction | 53 | 40.8 | 44 | 38.3 |
| 3-Moderate mental disturbance – due to mental disturbance, caregiver's functioning impaired in a number of life areas, including some impairment on ability to perform child caring role. | 14 | 10.8 | 13 | 11.3 |
| 4-Serious mental disturbance – unable to function in most life areas, including child caring role. | 1 | .8 | 1 | .9 |
| 5-Incapacitated due to mental illness – major mental illness, unable to function independently at all. | 0 | | 0 | |
| TOTAL | 130 | 100.1 | 115 | 100.1 |

NOTE: only partial descriptions of ratings are included.

The repeated measures analysis with the dependent variable –Family Risk Scale, Adult mental health subscale scores at baseline and case closure (N=108) revealed consistent results to descriptive data. There was no statistically significant main effect of time ($p=.559$), main effect of group ($p=.571$) or interaction between group and time ($p = .204$).

Caregiver Relationships with Adults. The third caregiver functioning dimension assessed by interns related to the caregiver's relationships with other adults in the household. When other adults were present in the household, this assessment scale was completed. This is a four-point scale ranging from a rating of 1 when adult relationships were viewed as good to a rating of 4 when severe discord, with physical injury was observed. At Intake, interns rated 53.5% of the adult relationships as good and at case closure, they rated 50.6% of the adult relationships as good. They also rated an increase

at case closure in the number of caregivers who were in adult relationships with some discord occurring. (a change from 26.7% to 36.1%). See Table 21.

Table 21. Observation of adult relationships in the household

| Adult Relationships Dimension-Family Risk Scale | Rating at Intake (n=86) | % of total at Intake | Rating at Closure (n=83) | % of total at Closure |
|---|-------------------------|----------------------|--------------------------|-----------------------|
| 1-Adult relationships are good; only infrequent, normal arguments occur. | 46 | 53.5 | 42 | 50.6 |
| 2-Some discord, adults have more than usual amount of arguments, children are sometimes drawn into arguments between adults | 23 | 26.7 | 30 | 36.1 |
| 3-Frequent or pervasive discord, children are often the focus of arguments and may be blamed for adult conflicts | 15 | 17.4 | 10 | 12 |
| 4-Severe discord, with physical injury resulting from violence | 2 | 2.3 | 1 | 1.2 |
| TOTAL | 86 | 99.9 | | 99.9 |

NOTE: only partial descriptions of ratings are included.

In a repeated measures analysis comparing the dependent variable- Family Risk Scales—Adult relationship subscale scores at baseline and case closure (N=66), there were no statistically significant differences in ratings. Specifically, there was no statistically significant main effect of time ($p=.981$), main effect of group ($p=.893$) or interaction between group and time ($p = .274$).

Caregiver Capacity for Child Care. The fourth caregiver functioning dimension assessed by student interns at intake and case closure was with the Caregiver Capacity for Child Care subscale of the Child Well Being Scales. This scale assesses the degree to which there are significant physical, mental-emotional, or behavioral limitations that interfere with the ability to care for children. The scale ranges from an initial rating of 1, representing adequate capacity to a rating of 4, representing severely inadequate capacity for childcare. These scores are converted to seriousness scores prior to analysis ranging

from a score of 100 to represent adequate capacity for childcare to a score of 13 representing severely inadequate capacity to care for children. Descriptive results suggest that both at Intake and Case Closure, more than 56% of caregivers were assessed with adequate capacity for childcare and approximately 31% were assessed with marginally adequate childcare capacity. See Table 22.

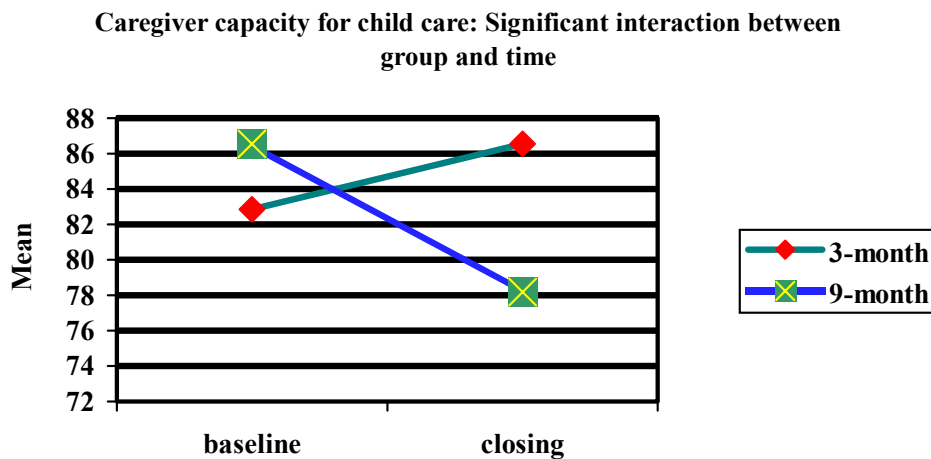
Table 22. Observation of caregiver capacity for child care at intake and case closure

| Caregiver Capacity for Child Care – Child Well Being Scale | Rating at Intake (n=130) | % of total at Intake | Rating at Closure (n=111) | % of total at Closure |
|---|--------------------------|----------------------|---------------------------|-----------------------|
| 100-Adequate; No significant physical, mental-emotional, or behavioral limitations that interfere with ability to care for children. | 74 | 56.9 | 65 | 58.6 |
| 63-Marginally adequate; caregiver has a physical, mental-emotional, or behavioral problem that threatens to intervene with child caring ability (e.g., chronic physical illness, disability, mental illness, substance abuse, criminal activity). | 42 | 32.3 | 35 | 31.5 |
| 48-Moderately inadequate; parent has a physical, mental-emotional, or behavioral problem that is of long duration that may have already or could in the future lead to out-of-home placement | 13 | 10 | 9 | 8.1 |
| 13-Severely inadequate; parent has no current capacity to care for children due to a physical, mental-emotional, or behavioral problem. | 1 | .8 | 2 | 1.8 |
| TOTAL | 130 | 100 | 111 | 100 |

One repeated measures analysis was performed with caregiver capacity for childcare scale scores at baseline and case closure as the dependent variables (N=102). In the analysis there was one between subjects factor—treatment group (3 months v. 9 months), and one within subject factor—administration time (baseline and case closure). The analysis simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time). **A significant interaction between group and time was**

found ($F=7.619$, $p=.007$). Whereas the three-month group started with a lower mean seriousness score (82.85), the mean score at closing increased to 86.56. In contrast, the nine-month group started with a higher mean score of 86.56 but was assessed with a mean seriousness score of 78.17 at closing. There was no statistically significant main effect of time ($p=.395$) or main effect of group ($p=.414$). See Figure 4.

Figure 4. Interaction between group and time in caregiver capacity for child care; non-significant main effect of group or time



Discussion of results. Both descriptive and repeated measures analyses did not identify any changes over time related to observation of the caregiver's physical health, mental health, adult relationships, or capacity for childcare (based on health, mental health, or behavioral issues). The physical health results are not surprising as most adults were rated as physically healthy when they began intervention. The mental health results however are a surprise given the high levels of depressive symptoms identified with the self-report CES-D at baseline and the reduction of depressive symptoms by the time

cases were closed. With respect to adult relationships, which are often difficult to assess at the beginning of intervention, descriptive results seem to indicate that more problematic relationships were observed at the closure of services than at the beginning of intervention. Since observation of this dimension is often based on what the caregiver will personally reveal, rather than observation of conflict between adults, the results are less surprising. Relationships between the intern and the primary caregiver may have been enhanced by the end of services thereby making it more likely that clients would reveal their circumstances more accurately. Finally, questions exist as to what might explain the fact that fewer nine-month clients were observed with adequate capacity for childcare at the end of services in comparison to the three-month clients. Since changes over time were not statistically significant, it is impossible to draw any conclusions that these differences were based on differences in the intervention.

Issues relevant to the interpretation of caregiver functioning observational data. Given the amount of missing data for these subscales, results need to be interpreted with caution. As has been previously noted, there were serious compliance problems during the first several years of intervention. Student interns did not routinely use these assessment instruments either to guide their intervention or to document progress in dimensions that may have been the focus of intervention. The findings pertaining to mental health functioning of the primary caregiver however do suggest the need for student interns to receive additional training on methods of understanding mental health challenges that may affect the day-to-day care of children.

Everyday Stress

Ig. How effective is the program in decreasing caregiver self-reports of life stress as measured by the Everyday Stressors Index at three time points (baseline, case closure, 6-month follow-up)?

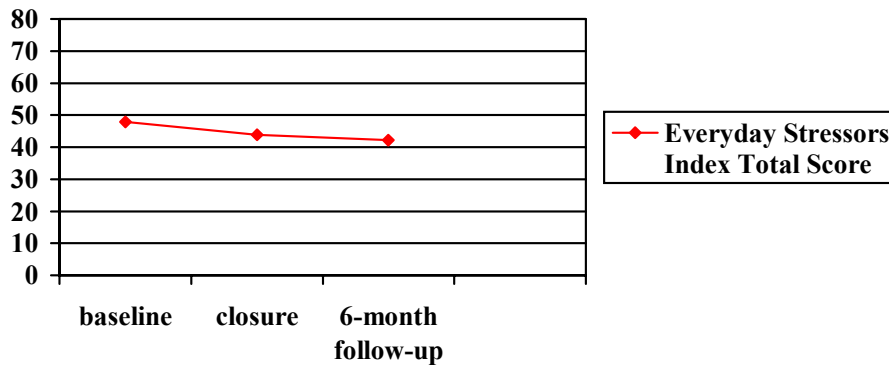
1h. Is there a difference between families served in 3-months versus 9-months in the pattern of change in caregiver self-reports of life stress at three time points?

Results Related to the Everyday Stress of Caregivers:

The Everyday Stressors Index (Hall, Williams, & Greenberg, 1985) is a 20-item scale used to assess common problems experienced on a daily basis reflected in five domains: financial concerns, role overload, employment problems, interpersonal problems, and parental worries. Higher total scores indicate a higher degree of perceived stress. Data was collected via computer assisted research protocols administered at baseline, case closure, and six months following intervention.

A two group repeated measures analysis was performed to assess change over time in the caregivers' life stress level (N=125). **A significant effect of time was found ($F = 18.377, p < .0005$). There was a statistically significant decrease in the stress total scores from baseline ($M=47.90, se=.91$) to case closure ($M=43.89, se=.95, p < .0005$) and from baseline to the 6-month follow-up ($M=42.24, se=1.01, p < .0005$).** There was no statistically significant change from case closure to 6-month follow-up ($p=.090$). There was no statistically significant main effect of group ($p=.165$) or interaction between group and time ($p=.948$). See Figure 5.

Discussion of results. The caregivers experienced a decrease in stress during the intervention, and this decrease was sustained beyond the intervention. There was no statistically significant difference between the two treatment groups over time.

Figure 5. Everyday stress: Significant main effect of time

Issues relevant to the interpretation of every day stress data. These results are consistent with the Family Connections model of intervention, which suggests that the first several months (for both the 3 month and 9 month group) focus on emergency and basic needs of families. Many families received assistance to attend to inadequacies in their households (food, utilities, furniture, etc.) and to their abilities to manage limited incomes to meet the basic needs of family members. Social work interns employ significant advocacy skills in the community to help families access community resources to attend to these needs. Seeing no difference in groups is therefore not a surprise as both groups received similar intervention that could serve to alleviate the everyday stress of caregivers.

Parenting Stress

1i. How effective is the program in decreasing the caregiver self-reports of parental stress as measured by the Parenting Stress Index (PSI/SF) at three time points (baseline, case closure, 6-month follow-up)?

1j. Is there a difference between families served in 3-months versus 9-months in the pattern of change in caregiver self-reports of parental at three time points?

Findings Related to Parenting Stress:

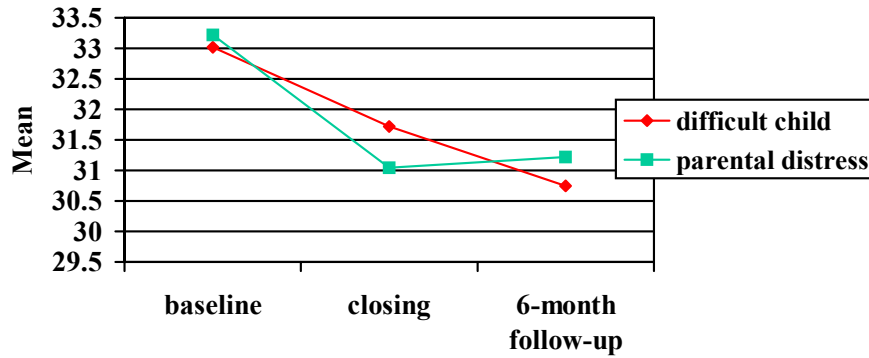
A total scale and three subscales (36-items) of the Parenting Stress Index-Short Form (PSI/SF) (Abidin, 1983) which measure stress related to the parent-child relationship, were administered to caregivers at baseline, case closure, and 6-month follow-up. Higher scores for each subscale indicate higher degree of perceived stress. Results for each subscale and then the total score are presented separately.

PSI/SF Difficult Child Subscale. In the first repeated measures analysis, the dependent variables were the PSI/SF difficult child subscale scores at baseline, case closure, and 6-month follow-up (N=120). **There was a significant main effect of time (F=7.020, p=.001). The difficult child subscale scores significantly decreased from baseline (M=33.02, se=.75) to case closure (M=31.72, se=.70, p=.021) and from baseline to the six-month follow-up (M=30.75, se=.72, p<.0005).** There was no statistically significant change from case closure to the six-month follow-up (p=.061). There was no statistically significant main effect of group (p=.400) or interaction between group and time (p=.130). See Figure 6.

PSI/SF Parental Distress subscale. In the second repeated measures analysis, the dependent variables were the PSI/SF parental distress subscale scores at baseline, case closure, and 6-month follow-up (N=120). **There was a significant main effect of time (F=7.865, p=.001). The parental distress subscale scores significantly decreased from baseline (M=33.22, se=.67) to case closure (M=31.04, se=.69, p<.0005) and from baseline to the 6-month follow-up (M=31.22, se=.69, p=.001).** There was no statistically significant change from case closure to the 6-month follow-up (p=.743). There was no statistically significant main effect of group (p=.282) or interaction

between group and time ($p=.954$). See Figure 6.

**Figure 6. PSI Difficult Child & Parental Distress subscales:
Significant main effects of time**



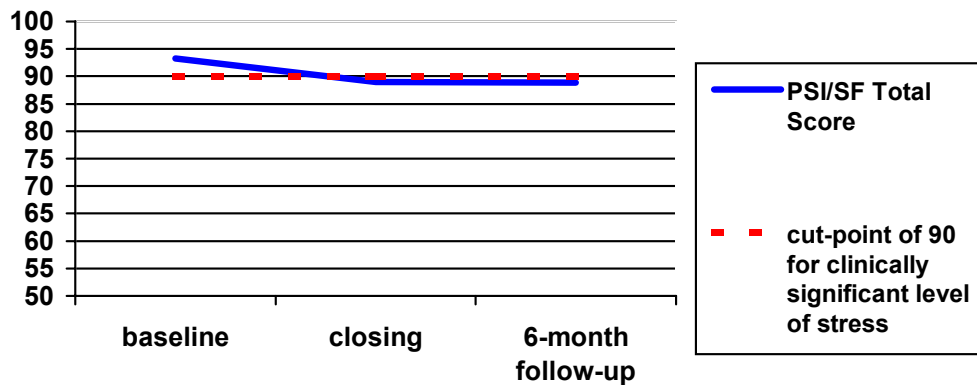
PSI/SF Parent-Child Dysfunctional Interaction subscale. In the third repeated measures analysis, the dependent variables were the PSI/SF parent-child dysfunctional interaction subscale scores at baseline, case closure, and 6-month follow-up ($N=120$). There was no statistically significant main effect of time ($p=.335$), of group ($p=.055$) or interaction between time and group ($p=.100$).

PSI/SF Short Form Total Score. In the fourth repeated measures analysis, the dependent variables were the PSI/SF short form total scores at baseline, case closure, and 6-month follow-up ($N=120$). **There was a significant main effect of time ($F=6.684$, $p=.002$). The total scores significantly decreased from baseline ($M=93.24$, $se=1.6$) to case closure ($M=88.99$, $se=1.63$, $p=.001$) and from baseline to the 6-month follow-up ($M=88.83$, $se=1.74$, $p=.002$).** There was no statistically significant change in total scores from case closure to the 6-month follow-up ($p=.900$). There was no statistically

significant main effect of group ($p=.141$) or interaction between group and time ($p=.157$).

See Figure 7.

Figure 7. Parenting stress total score: Significant main effects of time



Discussion of results: The results indicate that, for the group as a whole, the intervention may contribute to a decrease in parenting stress. The findings also indicate that over time, the caregivers perceived their children as less demanding and the decrease in stress seems to endure beyond the intervention to the 6-month follow-up. The differences between the 3 and 9-month intervention groups were not significant.

Issues relevant to the interpretation of parenting stress data. These results in combination with the everyday stress data suggest that Family Connections intervention may be effective in reducing the perceptions of caregivers about everyday stress and parenting stress. With respect to parenting stress, it was expected that families served for a longer time would have experienced greater reductions of perceived parental stress as there would have been greater opportunity to work with parents to enhance parent-child

relationships and reduce parent-child conflict. Further exploring these relationships will be important in future studies of the effectiveness of this intervention.

Results Regarding Protective Factors

Results are presented with respect to each of the previously identified hypotheses and research questions. Intervention focused on increasing the following protective factors: attitudes toward change; parenting attitudes; parenting sense of competence (PSOC); social support; and family functioning.

Attitudes Toward Change

2a. How effective is the program in improving attitudes toward change as measured by three Child Well-Being Sub-Scales (Caregiver Recognition of Problems; Caregiver Motivation to Solve Problems, and Caregiver Cooperation with Case Planning/Services) at two time points (baseline and closure)?

2b. Is there a difference between families served for 3-months versus 9-months in attitudes toward change at two time points?

This study used 27 of the 43 Child Well-Being Scales. Three of the twenty-seven scales assessed factors related to the caregiver's attitude toward change (caregiver recognition of problems, caregiver motivation to solve problems, and caregiver cooperation with case planning/services). Each scale is comprised of ratings ranging from levels of adequate functioning to levels reflecting inadequate functioning (Magura & Moses, 1986). Scores are converted to seriousness scores which "makes it possible to compare seriousness of situations harmful to children described on different scales" (Magura & Moses, 1986, p. 96). Higher scores suggest adequate situation or care provided for the well-being of the child. Scores range from 0 indicating most serious condition to 100 indicating adequate condition. Inclusion of these three subscales was important, as a core program philosophy is that families who are more successfully engaged in the change process will also be more successful at achieving outcomes.

Results Related to Attitudes Toward Change:

Student interns were asked to assess three aspects of a caregiver's attitude toward change as part of their family assessment, case evaluation every three months (for the nine month group), and again at case closure. Results for each of the three subscales will be presented separately (caregiver recognition of problems, caregiver motivation to solve problems, and caregiver cooperation with case planning/services).

Caregiver Recognition of Problems Subscale. The caregiver recognition of problems subscale was initially rated by interns on a three-point scale ranging from 1 (representing adequate) to a 3 (seriously inadequate). These individual ratings were then converted to seriousness scores ranging from a score of 100 to represent adequate and 43 to represent seriously inadequate. Interestingly, descriptive data suggests that both at Intake and at Case Closure, only slightly more than half of the caregivers were observed to have an adequate understanding of the problems facing the family. This is despite the fact that all families initially accepted services voluntarily. See Table 23.

Table 23. Observation of caregivers' recognition of problems at intake and case closure

| Caregiver Recognition of Problems | Rating at Intake (n=141) | % of total at Intake | Rating at Closure (n=113) | % of total at Closure |
|--|--------------------------|----------------------|---------------------------|-----------------------|
| 100-Adequate; good understanding and recognizes responsibility | 80 | 56.7 | 62 | 54.9 |
| 55-Moderately inadequate; partial understanding, recognizes only limited responsibility | 51 | 36.2 | 46 | 40.7 |
| 43-Seriously inadequate; recognizes no personal responsibility; accepts no responsibility for children's unmet needs | 10 | 7.1 | 5 | 4.4 |
| TOTAL | 141 | 100 | 113 | 100 |

NOTE: only partial descriptions of ratings are included.

One repeated measures analysis was performed with scores of caregiver recognition of problems scale seriousness scores at baseline and case closure as the dependent variables (N=107). In the analysis there was one between subjects factor—treatment group (3 months v. 9 months), and one within subject factor—administration time (baseline and case closure). The analysis simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time). There was no significant main effect of time ($p=.729$), main effect of group ($p=.132$), or interaction between group and time ($p=.142$).

Caregiver Motivation to Solve Problems. The caregiver motivation to solve problems subscale was initially rated by interns on a five-point scale ranging from 1 (representing adequate) to a 5 (seriously inadequate). These individual ratings were then converted to seriousness scores ranging from a score of 100 to represent adequate and 31 to represent seriously inadequate. Descriptive results are consistent with the previous subscale. Approximately half of the caregivers were observed to demonstrate adequate motivation to solve problems prior to service and slightly more than half were observed to be motivated to solve problems at the closure of services. See Table 24.

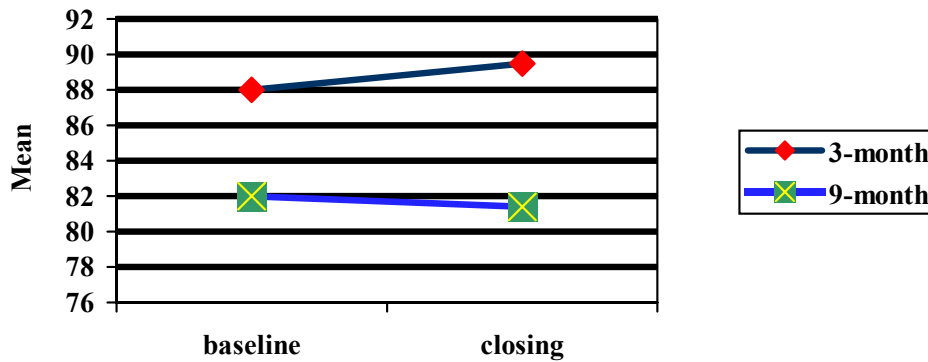
Table 24. Observation of caregivers' motivation to solve problems at intake and case closure

| Caregiver Motivation to Solve Problems | Rating at Intake (n=140) | % of total at Intake | Rating at Closure (n=118) | % of total at Closure |
|--|--------------------------|----------------------|---------------------------|-----------------------|
| 100-Adequate; shows concern and has realistic confidence. | 69 | 49.3 | 67 | 56.8 |
| 70-Marginally adequate; shows concern, lacks confidence that she can overcome problems | 54 | 38.6 | 31 | 26.3 |
| 62-Moderately inadequate: seems concerned, but carelessness leads to problems with meeting needs of children as a result | 14 | 10.0 | 18 | 15.3 |
| 50-Seriously inadequate; indifferent; apathetic; does not prioritize child over other temptations | 3 | 2.1 | 2 | 1.7 |
| 31-Severely inadequate; rejection of parental role | 0 | 0 | 0 | 0 |
| TOTAL | 140 | 100 | 118 | 100.1 |

NOTE: only partial descriptions of ratings are included.

One repeated measures analysis was performed with scores of caregiver motivation to solve problems seriousness scores at baseline and case closure as the dependent variables (N=114). In the analysis there was one between subjects factor—treatment group (3 months v. 9 months), and one within subject factor—administration time (baseline and case closure). The analysis simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time). **A significant main effect of group was found (F=8.088, p=.005). The three-month group was observed to be more motivated to solve problems at intake (88 mean rating) compared to a mean rating of 82 at Intake for the nine-month group. At closure, the Intake group was observed to be slightly more motivated than the initial mean score (89.5 mean rating) compared to a reduced rating of 81.4 mean rating at closure for the nine-month group.** There was no significant main effect of time (p=.826) or interaction between group and time (p=.543). See Figure 8.

Figure 8. Motivation to solve problems: Significant main effect of group, non-significant effect of time



Caregiver Cooperation with Case Planning and Services. The caregiver cooperation with case planning and services subscale was initially rated by interns on a four-point scale ranging from 1 (representing adequate) to a 4 (seriously inadequate). These individual ratings were then converted to seriousness scores ranging from a score of 100 to represent adequate and 46 to represent seriously inadequate. Descriptive results are consistent with the previous subscale. Approximately half of the caregivers were observed to cooperate adequately with services at the beginning of intervention and slightly more than half were observed to be cooperative with case planning and services at the closure of services. See Table 25.

Table 25. Observation of caregivers' cooperation with case planning at intake and case closure

| Caregiver Cooperation with Case Planning and Services | Rating at Intake (n=140) | % of total at Intake | Rating at Closure (n=118) | % of total at Closure |
|--|--------------------------|----------------------|---------------------------|-----------------------|
| 100-Adequate; parent is fully and actively involved in case planning and services, keeps appointments | 69 | 49.3 | 67 | 56.8 |
| 59-Mildly inadequate; parent is not fully involved in case planning and/or services; accepts services but doesn't always make the best use of them; makes appointments but often postpones them. | 54 | 38.6 | 31 | 26.3 |
| 54-Moderately inadequate: parent is only minimally involved with services; there is a pattern of passive resistance | 14 | 10.0 | 18 | 15.3 |
| 46-Seriously inadequate: actively resists any agency contact or involvement | 3 | 2.1 | 2 | 1.7 |
| TOTAL | 140 | 100 | 118 | 100.1 |

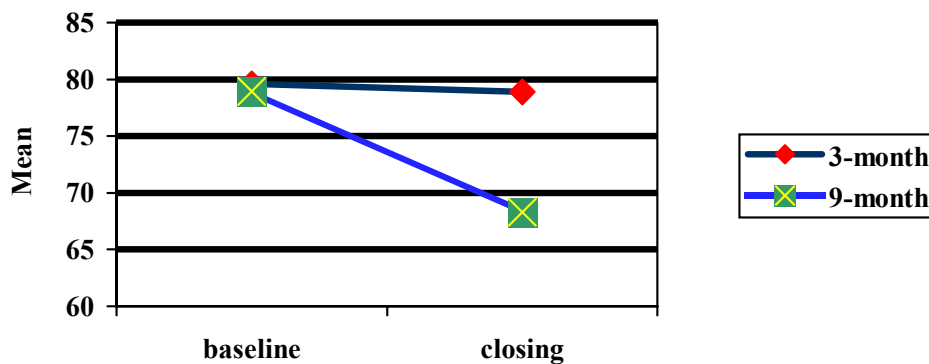
One repeated measures analysis was performed with scores of caregiver cooperation with case planning/services scale scores at baseline and case closure as the dependent variables (N=134). In the analysis there was one between subjects factor—treatment group (3 months v. 9 months), and one within subject factor—administration time (baseline and case closure). The analysis simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time).

A significant interaction between group and time was found (F=5.932, p=.016). The 9-month intervention group experienced a greater decrease in seriousness scores from baseline (M=78.96, se=2.65) to case closure (M=68.29, se=2.70) than the seriousness scores of the 3-month intervention group dropped only slightly between baseline (M=79.59, se=2.73) and case closure (M=78.91, se=2.78). This means that the nine-month group was much less cooperative at the end of

services than was the three-month group, which maintained a relatively high level of cooperation throughout the three months of intervention.

The main effect of time was significant ($F=7.648, p=.006$). For the group as a whole, the caregivers' cooperation with case planning/services scale scores decreased from baseline ($M=79.27, se=1.90$) to case closure ($M=73.60, se=1.94$). The main effect of group was non-significant ($p=.086$). See Figure 9.

Figure 9. Caregiver's cooperation with services: Significant main effect of time; Interaction between group and time



Discussion of results. These results suggest that families as a whole were not observed to increase their recognition of problems, motivation to solve problems, or their cooperation with services over time. The results do suggest though that both with motivation to solve problems and cooperation with services that the three-month group was observed to increase their engagement to more successfully use services than the nine-month group. At the end of services, their mean ratings either increased or stayed

relatively the same on the motivation to solve problems and cooperation with services subscales.

Issues relevant to the interpretation of attitudes toward change observational data. Given the amount of missing data for these subscales, results need to be interpreted with caution. Nevertheless, there are several possible explanations for the findings on these subscales. First, the three-month group knew from the beginning that they could only access services for three months, which may have had some effect on their interest to engage more quickly to work. Another factor that could have influenced their motivation could be related to the differences in the intensity of services that the three-month group may have received during their complete period of intervention. The process evaluation identified that the three month group received a significantly higher average number of hours of services, than did the nine-month group in either the first three months or over the duration of their respective intervention periods. It is assumed that student interns also may have been more motivated to invest time with clients who they knew they would have less time to accomplish outcomes. Finally, another possible explanation for the differences in findings by group could be that once the emergency needs were addressed, it takes a different level of motivation to engage in making changes that could be more long lasting, e.g., issues around nurturing children, relationships between family members, etc. and perhaps families assigned to receive nine-months of intervention were not ready to tackle the more challenging problems in their life. These findings definitely suggest the need to explore these issues further as length of service has important implications for the costs of intervention.

Parenting Attitudes-Self Report

2b. How effective is the program in increasing appropriate parenting attitudes as measured by the Adult-Adolescent Parenting Inventory (AAPI) at three time points (baseline, case closure, 6-month follow-up)?

2c. Is there a difference between families served in 3-months versus 9-months in caregiver self-reports of appropriate parenting attitudes at three time points?

Results Related to Self-Reports of Parenting Attitudes: The Adult-Adolescent Parenting Inventory (AAPI) (Bavolek, 1984) is a self-report measure of parenting attitudes that was administered at baseline, case closure, and six months following the closure of services. Results related to each subscale will be presented for 125 respondents (61 in the 3-month group and 62 in the 9-month group). Lower scores on each subscale indicate greater challenges in parenting ranging from a 1 or 2 which indicate high risk for abusive parent-child interaction, to a 3-4 indicating some deficiencies in appropriate parenting but also reflecting some strengths, to a 5-6 which is considered normative for African American caregivers, to a 7-10 which exceeds expectations.

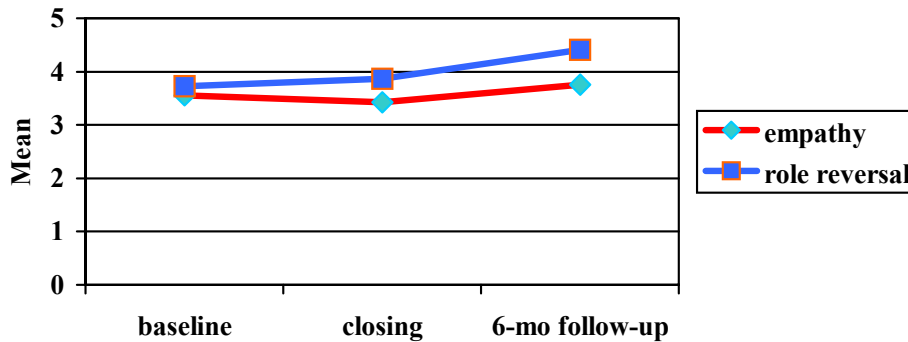
AAPI Empathy subscale. At baseline, the mean score for this subscale was 3.55 (3.52 for 3-month group, 3.59 for 9-month group). These means are in the low range reflecting deficiencies in appropriate parenting behavior but also indicating some individual strengths. These scores went down slightly by the closure of services but stayed in the same category (3.35 for the 3-month group and 3.49 for the 9-month group). At the six-month follow-up, scores increased with the 3-month group scoring a mean of 3.53 (almost the same as baseline) and the 9-month group scoring a mean of 3.98 (above the baseline score). In the first repeated measures analysis, the dependent variables were the AAPI empathy subscale STEN scores at baseline, case closure, and 6-month follow-

up (N=125). **A significant effect of time was found ($F = 3.563, p=.031$). There was a statistically significant increase in the empathy subscale scores from case closure ($M=3.42, se=.19$) to 6-month follow-up ($M=3.76, se=.19, p=.008$).** There was no statistically significant change from baseline ($M=3.55, se=.19$) to case closure ($p=.386$) or from baseline to the 6-month follow-up ($p=.217$). There was no statistically significant main effect of group ($p=.519$) or interaction between group and time ($p=.391$). See Figure 10.

AAPI Parent-Child Role Reversal subscale. At baseline, the mean score for this subscale was 3.72 (3.51 for 3-month group, 3.92 for 9-month group). These means were also in the low range reflecting deficiencies in appropriate parenting behavior but also indicating some individual strengths. The mean scores increased for both groups by the closure of services but still stayed in the same category (3.71 for 3-month group and 4.03 for the 9-month group). At the six-month follow-up, scores increased again with the 3-month group scoring a mean of 4.40 and the 9-month group scoring a mean of 4.41.

In the second repeated measures analysis, the dependent variables were the AAPI parent-child role reversal subscale STEN scores at baseline, case closure, and 6-month follow-up (N=125). **A significant effect of time was found ($F = 16.689, p<.0005$).** **There was a statistically significant increase in the parent-child role reversal subscale scores from baseline ($M=3.72, se=.18$) to 6-month follow-up ($M=4.41, se=.19, p<.0005$) and from case closure ($M=3.87, se=.18$) to 6-month follow-up ($p<.0005$).** There was no statistically significant change from baseline to case closure ($p=.325$). There was no statistically significant main effect of group ($p=.455$) or interaction between group and time ($p=.254$). See Figure 10.

**Figure 10. AAPI Empathy and Role Reversal subscales:
Significant main effect of time**



AAPI Parental Developmental Expectations subscale. At baseline, the mean score for this subscale was 5.14 (5.05 for the 3-month group, 4.92 for the 9-month group). Higher scores than on the previous two subscales, the overall mean was in the Normative Range for African American caregivers. The mean scores stayed relatively stable for both groups by the closure of services (5.13 for the 3-month group and 4.92 for the 9-month group). At the six-month follow-up, scores increased only slightly with the 3-month group scoring a mean of 5.35 and the 9-month group scoring a mean of 5.10.

In the third repeated measures analysis, the dependent variables were the AAPI parental developmental expectations subscale STEN scores at baseline, case closure, and 6-month follow-up (N=125). There was no statistically significant main effect of time ($p=.409$), main effect of group ($p=.703$) or group by time interaction ($p=.341$).

AAPI Parental Value of Corporal Punishment subscale. At baseline, the mean score for this subscale was 5.66 (5.65 for the 3-month group, 5.68 for the 9-month group). Similar to the previous subscale, the overall mean was in the Normative Range for African American caregivers. The mean scores increased slightly for both groups by

the closure of services (5.87 for the 3-month group and 5.89 for the 9-month group). At the six-month follow-up, scores increased slightly again with the 3-month group scoring a mean of 5.95 and the 9-month group scoring a mean of 5.92.

In the fourth repeated measures analysis, the dependent variables were the AAPI parental value of corporal punishment subscale STEN scores at baseline, case closure, and 6-month follow-up (N=125). There was no statistically significant main effect of time ($p=.156$), main effect of group ($p=.976$), or group by time interaction ($p=.969$).

Discussion of results: The results indicate that for the group as a whole, the intervention may contribute to an increase in appropriate parenting attitudes. Specifically, caregivers reported an increase in appropriate attitudes relating to parent and child roles. There was also a statistically significant increase in empathic awareness of their children's needs at the six-month follow-up. However, mean scores on these two subscales suggested some deficiencies in parenting at all three points in time. In contrast, mean scores on the developmental expectations and value of corporal punishment subscales started in the normative range and continued in the normative range at all three points in time.

Issues relevant to the interpretation of self-report data on parenting attitudes. Interpreting self-report data on parenting attitudes is complicated. Other studies have suggested that failure to detect changes over time may be related, in part, to a phenomenon that parents tend to rate themselves higher prior to an intervention. Following an intervention, when they "know more", they may sometimes rate themselves lower because they may be more honest about their strengths and limitations. It is unknown whether this phenomenon impacted these results.

The most concerning results are the low scores on the empathy subscale. Not uncommon in poor, overwhelmed families is the inability to individualize and view the world from the point of view of the children in the household. While some changes were detected between case closure and the six-month follow-up, there were no statistically significant changes between the baseline and closure of services.

Parenting Competence

2g. How effective is the program in increasing caregiver self-reports of parenting competence as measured by the Parenting Sense of Competence Scale (PSOC) at three time points (baseline, case closure, 6-month follow-up)?

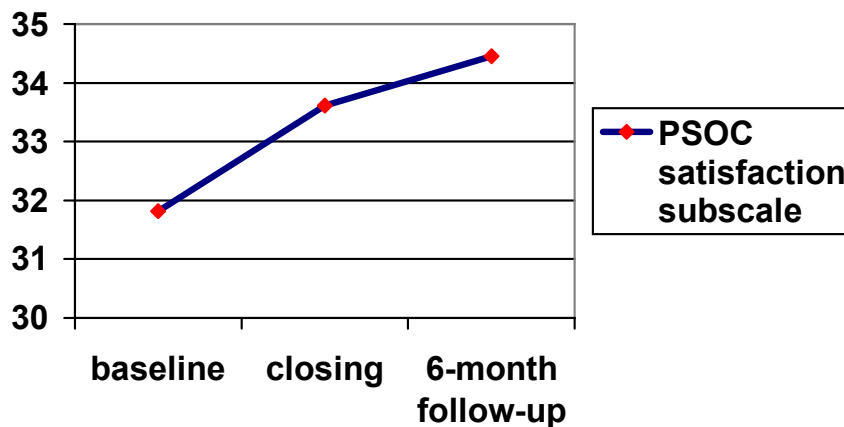
2h. Is there a difference between families served in 3-months versus 9-months in caregiver self-reports of parenting competence at three points?

The Parenting Sense of Competence Scale (PSOC) (Gibaud-Wallston & Wandersman, 1978) is a 17-item self-report measure designed to assess parenting self-esteem. Two subscales were administered as part of the computer assisted research protocol at Baseline, Case Closing, and the Six-Month Follow-up, (i.e., Parenting Satisfaction and Parenting Efficacy) Johnston and March (1989) conceptualize satisfaction as “an affective dimension reflecting parent’s frustration, anxiety and motivation” and efficacy as “an instrumental dimension reflecting competence, problem-solving ability, and capability to manage parenting role” (p. 167). Higher scores indicate the caregiver’s perception of greater competence. Results are presented separately for both sub-scales.

PSOC Satisfaction Subscale. In the first repeated measures analysis, the dependent variables were the PSOC satisfaction subscale scores at baseline, case closure, and 6-month follow-up (N=125). **A significant effect of time was found (F = 9.985, p<.0005). There was a statistically significant increase in the mean score of the**

satisfaction subscale from baseline ($M=31.82$, $se=.51$) to case closure ($M=33.61$, $se=.59$, $p=.001$) and from baseline to the 6-month follow-up ($M=34.45$, $se=.58$, $p<.0005$). There was no statistically significant difference between case closure and 6-month follow-up ($p=.146$). There was no statistically significant main effect of group ($p=.828$) or interaction between group by time interaction ($p=.927$). See Figure 11.

**Figure 11. PSOC Parenting Satisfaction subscale:
Significant main effect of time**



PSOC Efficacy Subscale. In the second repeated measures analysis, the dependent variables were the PSOC efficacy subscale scores at baseline, case closure, and 6-month follow-up ($N=125$). There was no statistically significant main effect of time ($p=.074$), main effect of group ($p=.409$), or interaction between time and group ($p=.803$).

Discussion of results: The results indicate that for the group as a whole, the intervention may contribute to the caregivers' perception of greater satisfaction with parenting. In addition, the increase in satisfaction is sustained beyond the end of the

intervention to the 6-month follow-up.

Issues relevant to the interpretation of expectations of children observational data. These results in combination with the results from the AAPI suggest that following intervention, caregivers may have increased positive attitudes about parent and child roles in the family and that they may feel more satisfied in their parenting role. The fact that there were no differences between groups in these outcomes continues to raise questions about the optimal length of service for this intervention.

Social Support

2i. How effective is the program in increasing caregiver self-reports of social support as measured by the Social Provisions Scale at three time points (baseline, case closure, 6-month follow-up)?

2j. Is there a difference between families served in 3-months versus 9-months in self-reports of social support at three points?

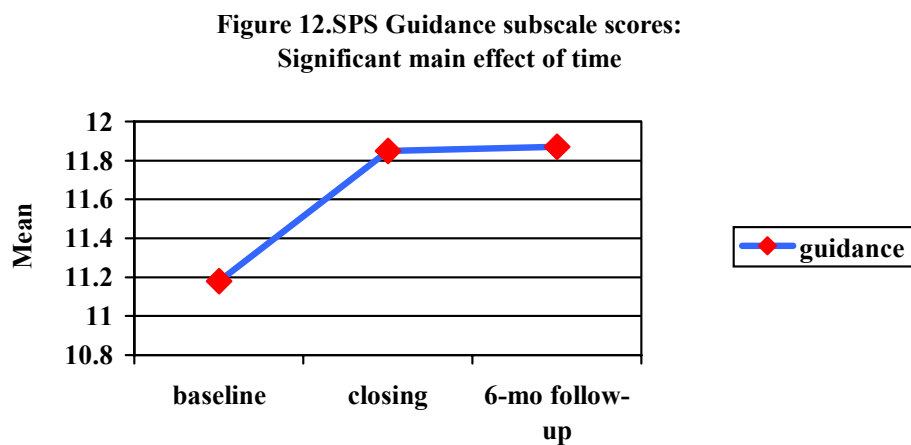
A standardized measure of caregivers' social support was included in the computer-assisted self-administered research protocol at baseline, case closure, and the 6-month follow-up. The Social Provisions Scale (Russell & Cutrona, 1984) is comprised of 24 items used to measure six relational provisions. High scores on the total scale and on each of the subscales indicate that caregivers were provided this support by his/her current social relationships.

Results Related to Social Support:

Results are presented for each of the six subscales (guidance, attachment, social integration, reliable alliance, reassurance of worth, and opportunity for nurturance), followed by results related to the total scale scores.

SPS Guidance subscale. In the first repeated measures analysis, the dependent variables were the SPS guidance subscale scores at baseline, case closure, and 6-month

follow-up (N=125). **Significant effects of time were found ($F = 5.924, p=.004$). There was a statistically significant increase in the guidance subscale scores from baseline ($M=11.18, se=.21$) to case closure ($M=11.85, Se=.18, p=.002$) and from baseline to the 6-month follow-up ($M=11.87, Se=.17, p=.003$). There was no statistically significant change from case closure to the 6-month follow-up ($p=.873$). There was no statistically significant main effect of group ($p=.234$) or interaction between group and time($p=.472$). See Figure 12.**

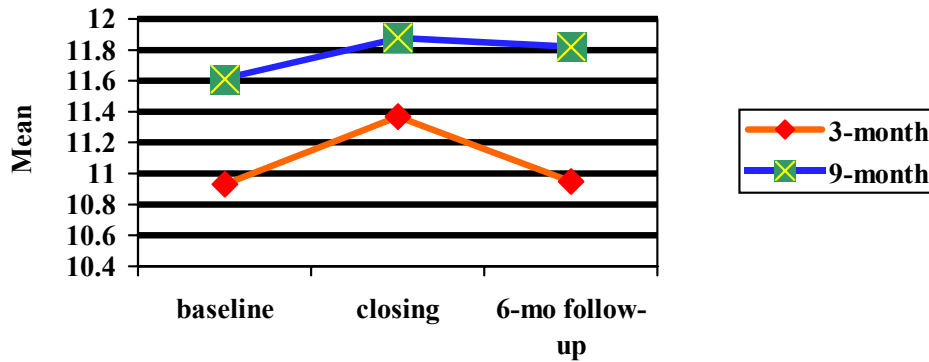


SPS Attachment subscale. In the second repeated measures analysis, the dependent variables were the SPS attachment subscale scores at baseline, case closure, and 6-month follow-up (N=125). **Significant effects of group were found ($F = 6.682, p=.011$). The 9-month intervention group had a significantly higher overall mean score ($M=11.78, se=.19$) than the 3-month intervention group ($M=11.09, Se=.19$).** These differences were evident at baseline ($M=10.93$ for the 3 month group, $M=11.61$ for the 9 month group); at case closure ($M=11.37$ for the three month group compared to $M=11.88$ for the nine month group), and at follow-up ($M=10.95$ for the three month

group compared to $M=11.82$ for the nine month group). There was no statistically significant main effect of time ($p=.091$) or interaction between group and time ($p=.577$).

See Figure 13.

Figure 13. SPS Attachment subscale scores: Significant main effect of group, non-significant effect of time



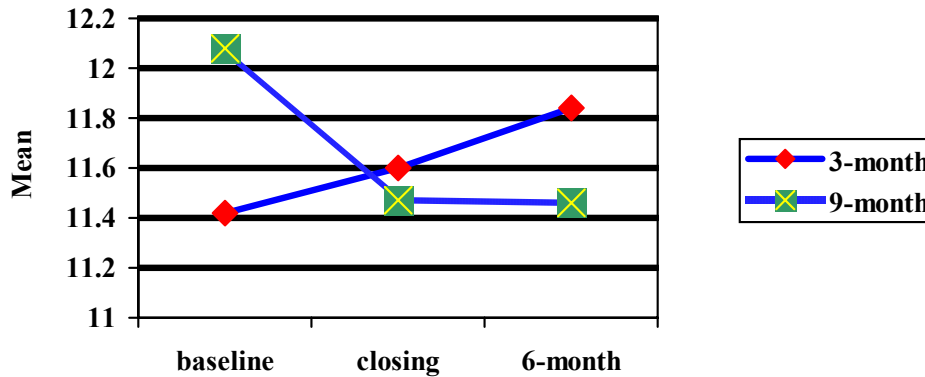
SPS Social Integration subscale. In the third repeated measures analysis, the dependent variables were the SPS social integration subscale scores at baseline, case closure, and 6-month follow-up ($N=125$). There was no statistically significant main effect of time ($p = .475$), main effect of group ($p = .355$), or group by time interaction ($p = .732$).

SPS Reliable Alliance subscale. In the fourth repeated measures analysis, the dependent variables were the SPS reliable alliance subscale scores at baseline, case closure, and 6-month follow-up ($N=125$). There was no statistically significant main effect of time ($p = .166$), main effect of group ($p = .132$), or group by time interaction ($p = .717$).

SPS Reassurance of Worth subscale. In the fifth repeated measures analysis, the dependent variables were the SPS reassurance of worth subscale scores at baseline, case closure, and 6-month follow-up (N=125). There was no statistically significant main effect of time ($p = .816$), main effect of group ($p = .298$), or group by time interaction ($p = .936$).

SPS Opportunity for Nurturance subscale. In the sixth repeated measures analysis, the dependent variables were the SPS opportunity for nurturance subscale scores at baseline, case closure, and 6-month follow-up (N=125). **A significant interaction between time and group was found ($F = 3.808, p=.025$).** The three-month group started out with a mean lower than the nine-month group ($M=11.42$ for the 3 month group versus $M=12.08$ for the 9 month group). By case closure, the 3-month mean increased to 11.60 in contrast to the mean for the 9-month group decreasing to 11.47. By the six month follow-up, the 3 month group increased slightly again with a mean of 11.84 in contrast to the nine-month group which decreased to 11.47. There was no statistically significant main effect of time ($p=.507$) or main effect of group ($p=.846$). See Figure 14.

Figure 14. SPS Opportunity for Nurturance: Significant interaction between group and time



SPS Total Scale Score. In the seventh repeated measures analysis, the dependent variables were the SPS total scale scores at baseline, case closure, and 6-month follow-up (N=125). There was no statistically significant interaction between group and time ($p=.504$), main effect of time ($p=.100$) or main effect of group ($p=.114$).

Discussion of results: The group as a whole reported a significant increase in perceived social support of trusting/authoritative figures in their lives (SPS Guidance subscale) following participation in the Family Connections program. The increase was sustained beyond the end of the intervention. There were differences between groups on the Attachment subscale but these differences cannot be attributed to the intervention. There was an interaction between group and time on the Opportunity for Nurturance subscale that also cannot be attributed to the intervention.

Issues Relevant to the Interpretation of Social Support data. The fact that there were changes in only one SPS subscale was a surprise, especially in view of the significant changes in reduced everyday stress and parenting stress. However, it is

important to note that these caregivers felt relatively supported in their social relationships at the beginning of intervention, which would make these findings more understandable. Interns also reported that caregivers felt supported in their social relationships as the mean ratings on the CWBS, Support for Principal Caregiver subscale were high at intake (92.36) and at case closure (93.56). This could be interpreted that most caregivers had one or more members of their immediate family and two or more friends or relations who could be called on to help as needed at the beginning and throughout the intervention.

Family Functioning

2k. How effective is the program in increasing caregiver self-report of improved family functioning as measured by the Self-Report Family Inventory (SFI) at three time points (baseline, case closure, 6-month follow-up)?

2l. Is there a difference between families served in 3-months versus 9-months in caregiver self-reports of improved family functioning at three time points?

A standardized measure of family functioning was included in the computer-assisted self-administered research protocol at baseline, case closure and 6-month follow-up. The Self-Report Family Inventory (SFI) (Beavers, Hampson, & Hulgus, 1985) is a 36-item self-report measure of family functioning. Five subscales assess dimensions of family health, conflict, cohesion, leadership, and expressiveness. Lower scores indicate more competence on all of the SFI subscales.

Results Related to Self-Report Family Functioning:

Results are presented separately for all SFI subscales: conflict, cohesion, leadership, expressiveness, and health. Lower scores indicate more competence on all of the SFI subscales.

SFI Conflict subscale. In the first repeated measures analysis, the dependent variables were the SFI conflict subscale scores at baseline, case closure, and 6-month follow-up (N=125). There was no statistically significant main effect of time ($p = .239$) or main effect of group ($p = .700$). The group by time interaction was non-significant ($p = .223$).

SFI Leadership subscale. In the second repeated measures analysis, the dependent variables were the SFI leadership subscale scores at baseline, case closure, and 6-month follow-up (N=125). There was no statistically significant main effect of time ($p = .998$) or main effect of group ($p = .384$). The group by time interaction was non-significant ($p = .097$).

SFI Expressiveness subscale. In the third repeated measures analysis, the dependent variables were the SFI expressiveness subscale scores at baseline, case closure, and 6-month follow-up (N=125). There was no statistically significant main effect of time ($p = .723$) or main effect of group ($p = .479$). The group by time interaction was non-significant ($p = .924$).

SFI Health subscale. In the fourth repeated measures analysis, the dependent variables were the SFI health subscale scores at baseline, case closure, and 6-month follow-up (N=125). There was no statistically significant main effect of time ($p = .166$) or main effect of group ($p = .559$). The group by time interaction was non-significant ($p = .717$).

SFI Cohesion subscale. In the fifth repeated measures analysis, the dependent variables were the SFI cohesion subscale scores at baseline, case closure, and 6-month

follow-up (N=125). There was no statistically significant main effect of time ($p = .248$) or main effect of group ($p = .315$). The group by time interaction was non-significant ($p = .232$).

Discussion of results. There were no significant findings with respect to improvement in family functioning as assessed by the self-report family inventory.

Family Functioning Observation –Six Month Follow-up

2k. Is there a difference between families served in 3-months versus 9-months in family functioning at the 6-month follow-up as measured by the HOME Observation for Measure of the Environment?

During the 6-month follow-up, research staff assessed family well-functioning using The Home Observation for Measure of the Environment (HOME) (Caldwell & Bradley, 1984). Seven of the subscales were used to assess family functioning: Emotional and Verbal Responsibility; Encouragement of Maturity; Emotional Climate; Growth Fostering Materials and Experience; Provision for Active Stimulation; Family Participation in Developmentally Stimulating Experiences; and Paternal Involvement. Higher scores indicate “more socially desired developmental outcomes” (Bradley, 1994, p. 243). According to Ozturk Ertem, Forsyth, Avni-Singer, & Damour (1997), “a score of 38 or more has been associated with a good developmental outcome and...a score less than 28 has been associated with a poor developmental outcome” (p. 324). In their sample of 73 high-risk families living in an impoverished urban environment, the mean score of the HOME was 31.7 (SD=6.0).

Results related to Family Functioning at the Six-Month Follow-Up. A

Multivariate Analysis of Variance (MANOVA) was performed with HOME subscales at the 6-month follow-up as the dependent variables (N=117). In the analysis there was one independent variable—treatment group (3 months v. 9 months)—and eight dependent

variables—emotional and verbal responsibility score, encouragement of maturity score, emotional climate score, growth fostering materials score, active stimulation score, family participation score, paternal involvement score, and total scale score. Results suggested that the main effect of group was non-significant ($p = .094$).

Other findings:

- Mean score of the HOME for 117 caregivers assessed was 34.75 (SD=8.83)
- 24 (20.5%) caregivers had a HOME score < 28 ¹
- 43 (36.8%) caregivers had a HOME score ≥ 38 ²

Discussion of results: Descriptive data indicates that, for the group as a whole, the mean score of family functioning approaches a score associated with a good developmental outcome. In addition, the mean score of this population ($M=34.75$, $SD=8.83$) is higher than that of a comparable sample of families ($M= 31.7$, $SD= 6.0$) in a study done by Ozturk and colleagues (1997).

Results Regarding Child Safety

Results are presented with respect to each of the previously identified hypotheses and research questions. Intervention focused on increasing protective factors and decreasing risk factors with an ultimate intended outcome to increase child safety and increase child well being (presented in the next section).

Child Abuse and Neglect

5a. How effective is the program in reducing the number of both indicated and unsubstantiated CPS reports made regarding any child in families served by Family Connections?

5b. Is there a difference between families served for 3-months versus 9-months in the number of both indicated and unsubstantiated CPS reports?

¹ HOME score <28 is associated with poor developmental outcome (Ozturk et al., 1997).

² HOME score ≥ 38 is associated with good developmental outcome (Ozturk et al., 1997).

5c. How effective is the program in reducing the number of indicated CPS reports of made regarding any child in families served by Family Connections?

5d. Is there a difference between families served for 3 months versus 9 months in the number of indicated CPS reports?

Findings Regarding Child Abuse and Neglect:

Comparisons were made between families served for 3 months and 9 months in the number of CPS reports made before Family Connections intervention, during intervention, and six months following the closure of intervention. Prior to Family Connections intervention, CPS had received 274 reports of child abuse or neglect related to 87 of the 154 caregivers (56.5%) in this sample. Fifty-nine (38.3%) of these reports were determined to be indicated. See Tables 26-27.

Table 26. Number of both indicated and unsubstantiated reports made to CPS before Family Connections Intervention. (N=154)

| Group | CPS report | |
|-----------------------------|------------|------------|
| | No | Yes |
| 3 months (N= 70) | 29 (41.4%) | 41 (58.6%) |
| 9 months (N= 84) | 38 (45.2%) | 46 (54.8%) |
| Total (N= 154) ³ | 67 (43.5%) | 87 (56.5%) |

(Treatment group difference: non-significant, chi square= .225, p=.635)

Table 27. Number of reports made to CPS that were indicated, prior to Family Connections Intervention. (N=154)

| Group | CPS indicated report | |
|-----------------------------|----------------------|------------|
| | No | Yes |
| 3 months (N= 70) | 42 (60.0%) | 28 (40.0%) |
| 9 months (N= 84) | 53 (63.1%) | 31 (36.9%) |
| Total (N= 154) ⁴ | 95 (61.7%) | 59 (38.3%) |

(Treatment group difference: non-significant, chi square=.155, p=.694)

³ NOTE: 274 CPS reports were made related to 87 caregivers prior to Family Connections intervention.

⁴ NOTE: 110 CPS reports were indicated on 59 caregivers prior to Family Connections intervention

While Family Connections was providing intervention, twenty-four CPS reports were made related to seventeen caregivers (11% of 154 families). Reports were determined by CPS to be indicated in 12 of these 17 situations.

In some cases, Family Connections personnel made the CPS report and in other situations, other community representatives initiated the report. In several instances, the Family Connections intern was in the home for the first time, and the CPS worker arrived in response to a report from someone else in the community. In those cases, Family Connections continued to provide services as long as the children were safe and the family was willing to receive services. There were no statistically significant differences in the number of CPS reports between intervention groups. See Tables 28-29.

Table 28. Number of both indicated and unsubstantiated reports made to CPS while Family Connections was providing services (N=154)

| Group | CPS report | |
|------------------|-------------|------------|
| | No | Yes |
| 3 months (N= 70) | 61 (87.1%) | 9 (12.9%) |
| 9 months (N= 84) | 76 (90.5%) | 8 (9.5%) |
| Total (N= 154) | 137 (89.0%) | 17 (11.0%) |

(Treatment group difference: non-significant, chi square=.432, p=.511)

Table 29. Number of CPS reports determined to be indicated while Family Connections was providing services. (N=154)

| Group | CPS indicated report | |
|-----------------------------|----------------------|-----------|
| | No | Yes |
| 3 months (N= 70) | 64 (91.4%) | 6 (8.6%) |
| 9 months (N= 84) | 78 (92.9%) | 6 (7.1%) |
| Total (N= 154) ⁵ | 142 (92.2%) | 12 (7.8%) |

(Treatment group difference: non-significant, chi square= .108, p=.742)

⁵ NOTE: 12 reports that were determined to be indicated were made related to 12 caregivers

Following the closure of Family Connections Intervention, searches on 139 families found that there had been 11 reports made to CPS related to 11 caregivers. (Fifteen families had less than six-months follow-up time and could not be included in the search). Five of these reports related to families who had been served for three months and six related to families in the nine-month group. Of these 11 reports, five of them were determined to be indicated (four from the three-month group and one from the nine-month group). See Tables 30-31.

Table 30. Number of both indicated and unsubstantiated CPS reports made within six months of the closure of Family Connections intervention. (N=139).

| Group | CPS report | |
|------------------|-------------|-----------|
| | No | Yes |
| 3 months (N= 70) | 65 (92.9%) | 5 (7.1%) |
| 9 months (N= 69) | 63 (91.3%) | 6 (8.7%) |
| Total (N= 139) | 128 (92.1%) | 11 (7.9%) |

(Treatment group difference: non-significant, chi square=.115, p=.735)

Table 37. Number of CPS reports determined to be indicated within the six-month follow-up after Family Connections case closure. (N=139)

| Group | CPS indicated report | |
|-----------------------------|----------------------|----------|
| | No | Yes |
| 3 months (N= 70) | 66 (94.3%) | 4 (5.7%) |
| 9 months (N= 69) | 68 (98.6%) | 1 (1.4%) |
| Total (N= 139) ⁶ | 134 (96.4%) | 5 (3.6%) |

(Treatment group difference: non-significant, chi square=1.823, p=.177)

Logistic regression analyses were run to see whether the length of time families were served predicted the status of CPS reports made during the follow-up and the final model was non-significant at p= .734. When logistic regression analyses were run to see

⁶ NOTE: The five indicated reports during the follow-up were related to five caregivers.

whether the length of time families were served predicted the status of substantiated CPS reports made during the follow-up, the final model was non-significant at $p = .163$.

Discussion of results: Descriptive data indicates that fewer CPS reports (both indicated and unsubstantiated reports) were made on the participants of Family Connections following intervention compared to prior to intervention.

Issues relevant to the interpretation of child maltreatment data. There are limitations with using CPS reports as measures of child maltreatment as they may under represent the actual number of children who may have been maltreated, both before, during, and after Family Connections intervention. Furthermore, the follow-up time of six months was relatively short. Following families for a longer period of time would provide a greater measure of the success of this program to prevent child maltreatment over time.

Meeting Basic Needs

3e. How effective is the program in improving physical and psychological care to meet basic needs of children as measured by the Child Well-Being Scales (CWBS) at two time points (baseline, case closure)?

3f. Is there a difference between the 3-month group and the 9-month group physical and psychological care to meet basic needs of children at two points in time?

Social work interns used a collection of Child Well Being subscales to assess the physical and psychological care provided to children to meet their basic needs. Areas of assessment for physical care included: physical health care, nutrition/diet, clothing, personal hygiene, household furnishings, overcrowding, household sanitation, security of residence, availability of utilities, physical safety in the home, supervision of younger children, supervision of teenage children, and arrangements for substitute child care. Areas of assessment for psychological care included: mental health care, parental

acceptance of/affection for children, parental approval of children, parental expectations of children, and parental teaching/stimulation of children.

Results related to the physical and psychological care of children to meet basic needs:

Descriptive and repeated measures results are presented separately for indicators of physical care and psychological care.

Physical care results:

Each CBW scale is comprised of ratings ranging from levels of adequate functioning to levels reflecting inadequate functioning (Magura & Moses, 1986). Ratings are then converted to seriousness scores. Higher seriousness scores indicate higher well-being and less concern that the basic needs of children are unmet. Findings at baseline indicate that families were assessed with seriousness scores in the 80s and 90s for all but one subscale, child safety. Means and standard deviations for these dimensions are presented in Table 31.

Table 31. CWBS seriousness scores for indicators of physical care at baseline

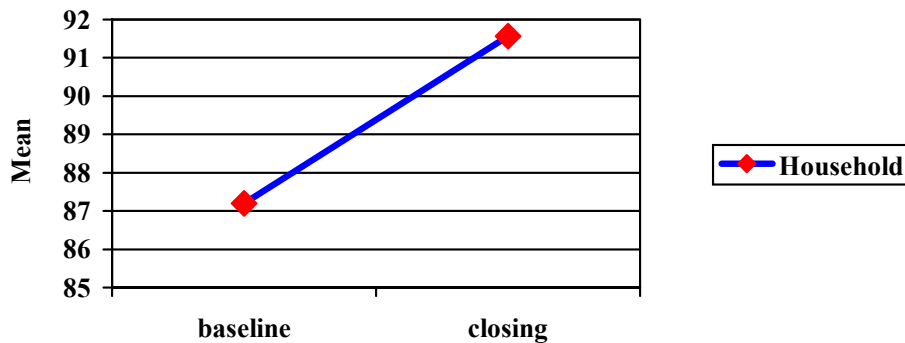
| Scale (CWBS Number) | Valid N | Minimum | Maximum | Mean | S.D. |
|---------------------------------------|---------|---------|---------|------|-------|
| Indicators of Physical Care | | | | | |
| Physical health (1) | 130 | 34 | 100 | 89.9 | 16.96 |
| Nutrition/diet (2) | 105 | 32 | 100 | 87.9 | 18.11 |
| Clothing (3) | 113 | 46 | 100 | 93.4 | 9.87 |
| Personal hygiene (4) | 108 | 53 | 100 | 94.5 | 11.53 |
| Household furnishings (5) | 124 | 54 | 100 | 87.2 | 15.40 |
| Overcrowded (6) | 133 | 51 | 100 | 86.0 | 17.10 |
| Household sanitation (7) | 123 | 21 | 100 | 80.5 | 23.47 |
| Security of residence (8) | 131 | 64 | 100 | 92.9 | 12.58 |
| Availability of utilities (9) | 127 | 53 | 100 | 93.2 | 12.6 |
| Physical safety in home (10) | 117 | 25 | 100 | 77.9 | 29.4 |
| Supervision of younger children (12) | 126 | 41 | 100 | 90.8 | 14.4 |
| Supervision of teenagers (13) | 54 | 39 | 100 | 84.9 | 18.1 |
| Arrangements for substitute care (14) | 112 | 33 | 100 | 92.5 | 14.0 |

Repeated measures analyses were performed for physical care seriousness scores at baseline and case closure as the dependent variables. In each analysis there was one between subjects factor—treatment group (3 months v. 9 months), and one within subject factor—administration time (baseline and case closure). These analyses simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time). Statistically significant changes in time were observed in three of the physical care subscales: household furnishings, overcrowding, and household sanitation.

CWBS Household Furnishings. One repeated measures analysis was performed with household furnishings scale seriousness scores at baseline and case closure as the dependent variables (N=100). In the analysis there was one between subjects factor—treatment group (3 months v. 9 months), and one within subject factor—administration time (baseline and case closure). These analyses simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time).

A significant main effect of time was found ($F = 8.314, p=.005$). There was a statistically significant increase in the household furnishings subscale seriousness scores from baseline ($M=87.20, se=1.58$) to case closure ($M=91.56, se=1.22$). There was no statistically significant main effect of group ($p=.714$) or interaction between group and time ($p=.390$). See Figure 15.

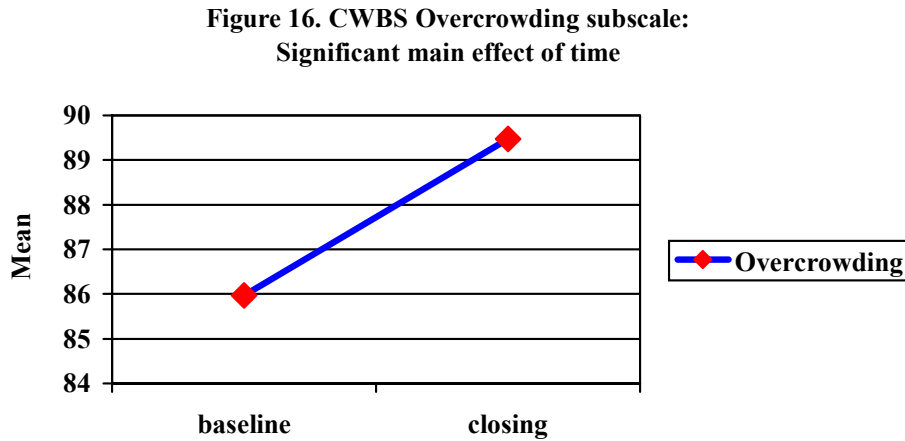
**Figure 15. CBWS Household Furnishings subscale:
Significant main effect of time**



CWBS Overcrowding. One repeated measures analysis was performed with overcrowding seriousness scores at baseline and case closure as the dependent variables ($N=105$). In the analysis there was one between subjects factor—treatment group (3 months v. 9 months), and one within subject factor—administration time (baseline and case closure). The analysis simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time).

A significant main effect of time was found ($F=4.980, p=.028$). There was a statistically significant increase in the overcrowding subscale seriousness scores from baseline ($M=85.97, se=1.67$) to case closure ($M=89.47, se=1.40$). There was no statistically significant main effect of group ($p=.784$) or interaction between group and

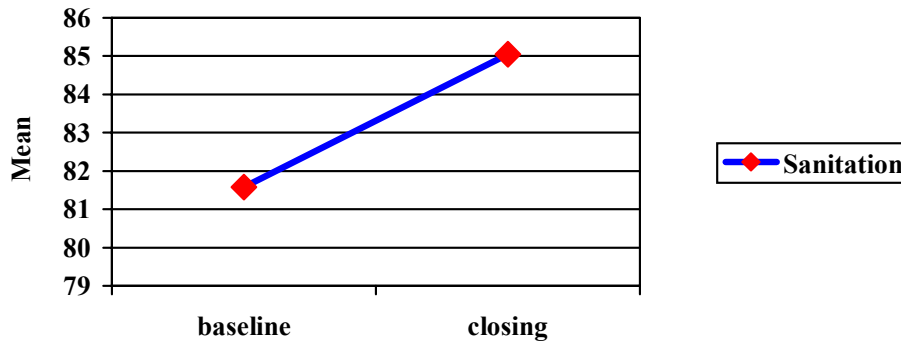
time ($p=.329$). See Figure 16.



CWBS Household Sanitation. One repeated measures analysis was performed with household sanitation seriousness scores at baseline and case closure as the dependent variables ($N=100$). In the analysis there was one between subjects factor—treatment group (3 months v. 9 months), and one within subject factor—administration time (baseline and case closure). The analysis simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time).

A significant main effect of time was found ($F = 4.406, p=.038$). There was a statistically significant increase in the household sanitation subscale seriousness scores from baseline ($M=81.57, se=2.30$) to case closure ($M=85.05, se=2.14, p=.038$) indicating improvement in child well-being. There was no statistically significant main effect of group ($p=.828$) or interaction between group and time ($p=.115$). See Figure 17.

**Figure 17. CWBS Household Sanitation subscale:
Significant main effect of time**



Psychological care results:

Each scale is comprised of ratings ranging from levels of adequate functioning to levels reflecting inadequate functioning (Magura & Moses, 1986). Ratings are then converted to seriousness scores. Higher seriousness scores indicate higher well-being and less concern that the basic needs of children are unmet. Findings at baseline indicate that families were assessed with seriousness scores in the 80s for all but one subscale, mental health care. Means and standard deviations for these dimensions are presented in Table 32.

Table 32. CWBS seriousness scores for indicators of psychological care at baseline

| Scale (CWBS Number) | N | Minimum | Maximum | Mean | Standard Deviation |
|--|-----|---------|---------|------|--------------------|
| Indicators of psychological care | | | | | |
| Mental health care (11) | 127 | 15 | 100 | 75.4 | 23.18 |
| Parental acceptance of/affection for children (24) | 108 | 35 | 100 | 84.6 | 17.30 |
| Parental approval of children (25) | 97 | 63 | 100 | 83.2 | 11.65 |
| Parental expectations of children (26) | 110 | 47 | 100 | 85.4 | 12.26 |
| Parental consistency of discipline (27) | 85 | 53 | 100 | 86.7 | 9.74 |
| Parental teaching/stimulation of children (28) | 87 | 41 | 100 | 86.3 | 12.43 |

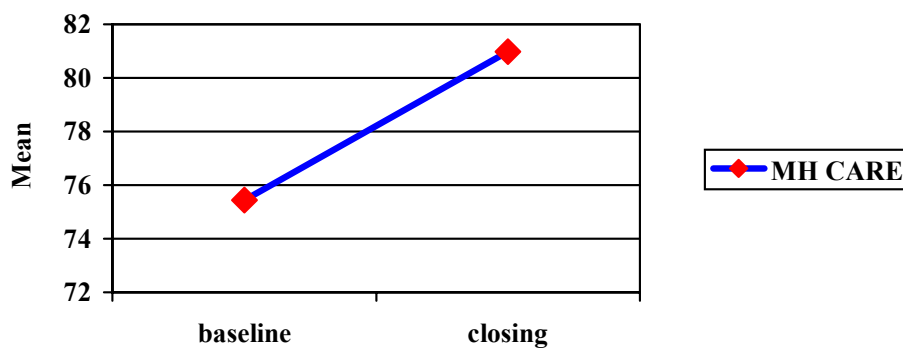
Repeated measures analyses were performed for psychological care seriousness scores at baseline and case closure as the dependent variables. In each analysis there was one between subjects factor—treatment group (3 months v. 9 months), and one within subject factor—administration time (baseline and case closure). These analyses simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time). Statistically significant changes were observed in two of the psychological care subscales: mental health care and caregiver teaching/stimulating of children.

CWBS Mental Health Care. One repeated measures analysis was performed with mental health care scale seriousness scores at baseline and case closure as the dependent variables (N=96). In the analysis there was one between subjects factor—treatment group (3 months v. 9 months), and one within subject factor—administration time (baseline and case closure). The analysis simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time).

A significant main effect of time was found ($F = 5.961, p=.016$). There was a

statistically significant increase in the mental health care subscale seriousness scores from baseline (M=75.44, se=2.38) to case closure (M=80.98, se=2.16). This increase indicates an improvement in the adequacy of mental health care provided to children who could benefit from professional treatment for a mental, emotional, or psychological problems. There was no statistically significant main effect of group ($p=.952$) or interaction between group and time ($p=.391$). See Figure 18.

**Figure 18. CWBS Mental Health Care subscale:
Significant main effect of time**

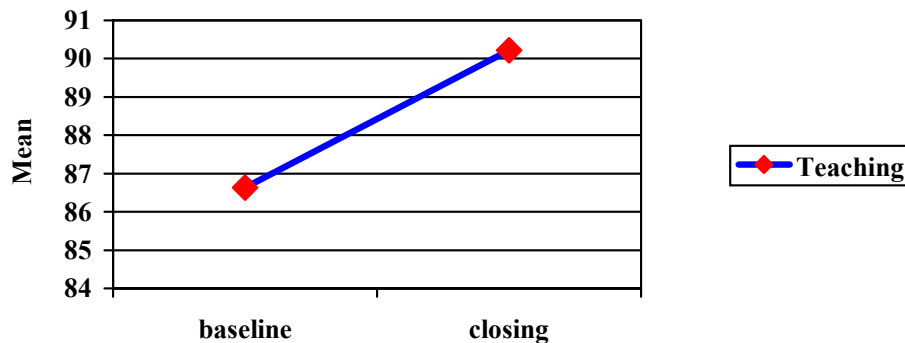


CWBS Caregiver Teaching/Stimulating of Children. One repeated measures analysis was performed with caregiver teaching/stimulating of children scale seriousness scores at baseline and case closure as the dependent variables ($N=60$). In the analysis there was one between subjects factor—treatment group (3 months v. 9 months), and one within subject factor—administration time (baseline and case closure). The analysis simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time).

Significant effects of time were found ($F = 9.008, p=.004$). There was a

statistically significant increase in the caregiver teaching/stimulating of children subscale seriousness scores from baseline (M=86.63, se=1.47) to case closure (M=90.21, se=1.19, p=.004). There was no statistically significant main effect of group (p=.352) or interaction between group and time (p=.132). See Figure 19.

**Figure 19. CWBS Caregiver Teaching subscale:
Significant main effect of time**



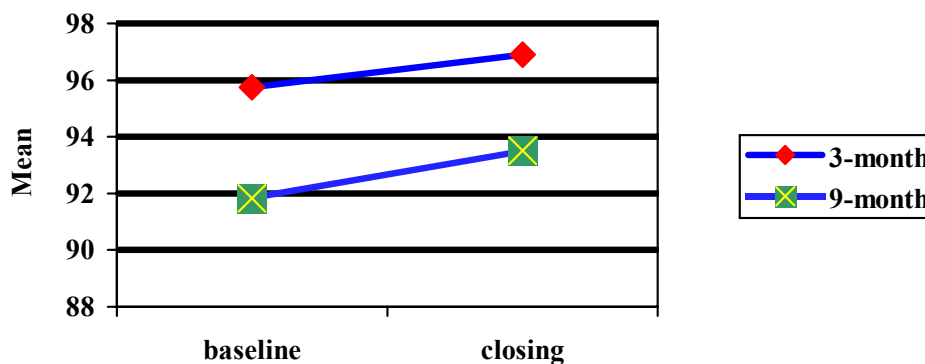
Other Findings related to Basic Needs:

Results of other repeated measures analysis related to the physical care or psychological care of children follow. There were significant effects of group related to adequacy of clothing, personal hygiene, supervision of young children, and caregiver approval of children. There was also a significant interaction between group and time related to the security of residence. These differences cannot be attributed to the intervention but are presented for a complete understanding of circumstances in these families. With the other subscales, there were no statistically significant effects of time, group, or interaction of group and time.

CWBS Clothing. One repeated measures analysis was performed with clothing

seriousness scores at baseline and case closure as the dependent variables (N=90). In the analysis there was one between subjects factor—treatment group (3 months v. 9 months), and one within subject factor—administration time (baseline and case closure). The analysis simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time). **A significant main effect of group was found (F=5.899, p=.017).** The nine-month group was assessed with slightly less adequate clothing for children both at Intake and Closing. **No significant differences between means at Intake (M=93.41) and Closing (95.38) were determined.** In sum, there was a significant effect of group, (F=5.899, p=.017) but no significant main effect of time (p=.101) or interaction between group and time (p=.756). See Figure 20.

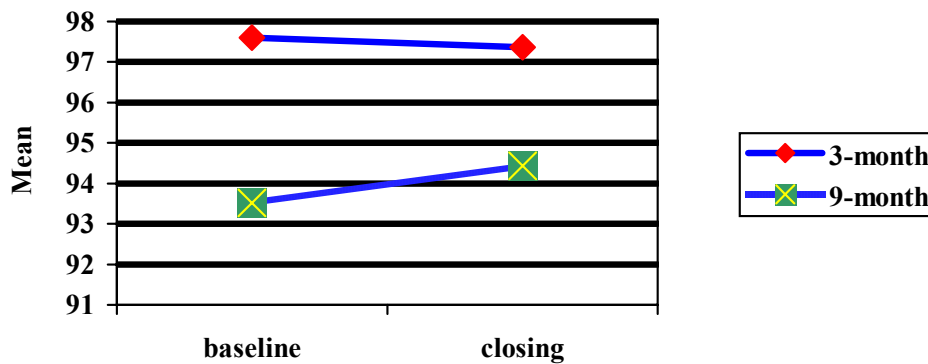
Figure 20. CWBS Adequacy of Clothing subscale: Significant main effect of group, non-significant effect of time



CWBS Personal Hygiene. One repeated measures analysis was performed with personal hygiene seriousness scores at baseline and case closure as the dependent variables (N=89). In the analysis there was one between subjects factor—treatment group (3 months v. 9 months), and one within subject factor—administration time

(baseline and case closure). The analysis simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time). A **significant main effect of group was found ($F=4.025$, $p=.048$)**. The three-month group was rated with higher levels of adequacy than the nine-month group at Intake and Case Closure. **There were no significant differences between mean seriousness scores at Intake ($M=94.49$) and Case Closure ($M=95.49$)**. In sum, there was a significant effect of group but no significant main effect of time ($p=.768$) or interaction between group and time ($p=.609$). See Figure 21.

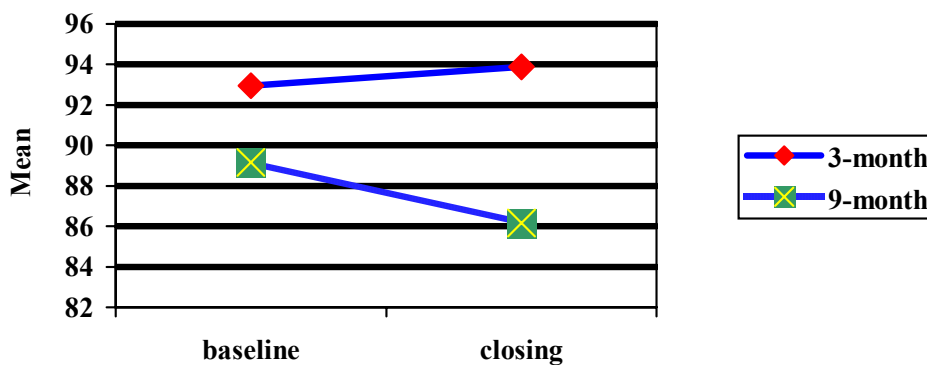
Figure 21. CWBS Personal Hygiene subscale: Significant main effect of group, non-significant effect of time



CWBS Supervision of Younger Children. One repeated measures analysis was performed with supervision of younger children scale seriousness scores at baseline and case closure as the dependent variables ($N=100$). In the analysis there was one between subjects factor—treatment group (3 months v. 9 months), and one within subject factor—administration time (baseline and case closure). The analysis simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time). **There**

was a significant main effect of group ($F=5.431$, $p=.022$). Whereas the three-month group was rated relatively high at Intake ($M=92.94$) and increased slightly at Case Closure ($M=93.89$), the nine-month group was rated lower at Intake ($M=89.15$) and decreased in adequacy of supervision of young children by Case Closure (86.15). Overall, there was no significant difference between mean scores at Intake ($M=90.79$) and Case Closure ($M=89.90$). In sum, there was a significant main effect of group but there was no significant main effect of time ($p=.482$) or interaction between group and time ($p=.179$). See Figure 22.

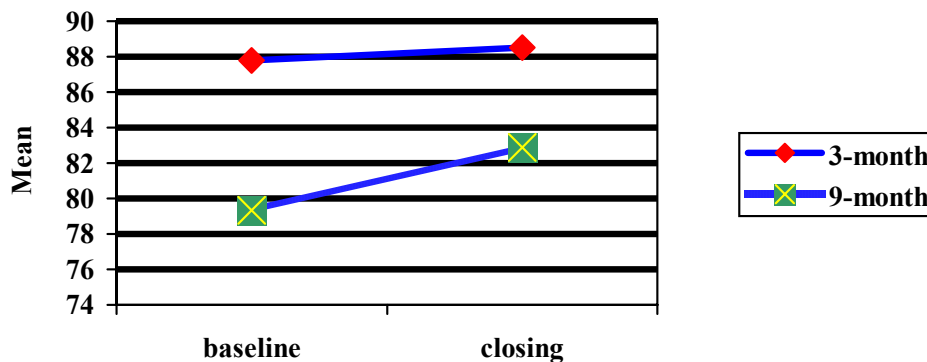
**Figure 22. CBS Supervision of Young Children subscale:
Significant main effect of group, non-significant effect of time**



Caregivers' Approval of Children. One repeated measures analysis was performed with caregiver approval of children scale seriousness scores at baseline and case closure as the dependent variables ($N=72$). In the analysis there was one between subjects factor—treatment group (3 months v. 9 months), and one within subject factor—administration time (baseline and case closure). The analysis simultaneously tested one

main effect of time, one main effect of group, and an interaction (group by time). A **significant main effect of group was found ($F= 8.170, p=006$)**. At Intake, the three-month group was rated ten points higher than the nine-month group (87.79 versus 79.32). Both groups increased mean scores at case closure but these increases were not statistically significant. **The difference in the mean seriousness scores between Intake ($M=83.16$) and Closure ($M=85.54$) was also non-significant**. There was no significant main effect of time ($p=.058$) or interaction between group and time ($p=.210$). See Figure

**Figure 23. CBS Caregiver Approval of Children subscale:
Significant main effect of group, non-significant effect of time**



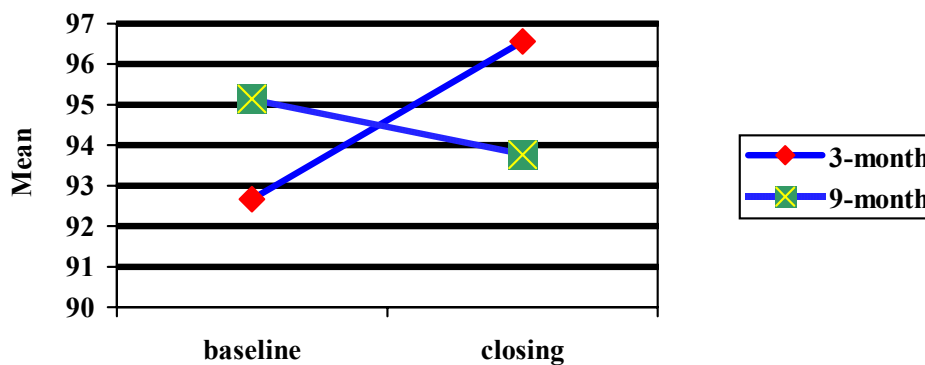
23.

CWBS Security of Residence. One repeated measures analysis was performed with security of residence seriousness scores at baseline and case closure as the dependent variables ($N=106$). In the analysis there was one between subjects factor—treatment group (3 months v. 9 months), and one within subject factor—administration time (baseline and case closure). The analysis simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time). A significant

interaction between group and time was found ($F=4.259$, $p=.042$). The mean seriousness scores for the three-month group increased from Intake ($M=92.67$) to Case Closure ($M=96.56$) while the mean seriousness scores for the nine-month group started higher than for the three-month group but decreased slightly from Intake ($M=95.14$) to Case Closure ($M=93.77$). **There were no significant differences overall between the mean seriousness scores at Intake ($M=92.86$) and Case Closure ($M=95.55$).** In sum, there was a significant interaction between group and time but the main effect of time was non-significant ($p=.326$) and the main effect of group was non-significant ($p=.920$).

See Figure 24.

Figure 24. CWBS Security of Residence subscale: Significant interaction between group and time



Formatted

CWBS Physical Health Care. One repeated measures analysis was performed with physical health care seriousness scores at baseline and case closure as the dependent variables ($N=103$). In the analysis there was one between subjects factor—treatment group (3 months v. 9 months), and one within subject factor—administration time (baseline and case closure). The analysis simultaneously tested one main effect of time,

one main effect of group, and an interaction (group by time). There was **no statistically significant increase in the mean physical health care seriousness scores from Intake (M= 89.88) to Case Closure (M=90.25)**. There was no significant main effect of time ($p=.780$), main effect of group ($p=.555$), or interaction between group and time ($p=.206$).

CWBS Nutrition/Diet. One repeated measures analysis was performed with nutrition/diet seriousness scores at baseline and case closure as the dependent variables ($N=83$). In the there was one between subjects factor—treatment group (3 months v. 9 months), and one within subject factor—administration time (baseline and case closure). The analysis simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time). There was **no significant difference between seriousness mean scores at Intake (M=87.91) and Case Closure (M=91.03)**. There was no significant main effect of time ($p=.130$), main effect of group ($p=.191$), or interaction between group and time ($p=.075$).

CWBS Availability of Utilities. One repeated measures analysis was performed with availability of utilities scale seriousness scores at baseline and case closure as the dependent variables ($N=95$). In the analysis there was one between subjects factor—treatment group (3 months v. 9 months), and one within subject factor—administration time (baseline and case closure). The analysis simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time). **There was no significant difference between seriousness mean scores at Intake (M=93.23) and Case Closure (M=95.88)**. There was no significant main effect of time ($p=.219$), main effect of group ($p=.471$), or interaction between group and time ($p=.271$).

CWBS Physical Safety in Home. One repeated measures analysis was

performed with scores of physical safety in home scale seriousness scores at baseline and case closure as the dependent variables (N=94). In the analysis there was one between subjects factor—treatment group (3 months v. 9 months), and one within subject factor—administration time (baseline and case closure). The analysis simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time). **There was no significant difference between seriousness mean scores at Intake (M=77.88) and Case Closure (M=81.71).** There was no significant main effect of time ($p=.378$), main effect of group ($p=.814$), or interaction between group and time ($p=.777$).

CWBS Supervision of Teenage Children

One repeated measures analysis was performed with supervision of teenage children scale seriousness scores at baseline and case closure as the dependent variables (N=29). In the analysis there was one between subjects factor—treatment group (3 months v. 9 months), and one within subject factor—administration time (baseline and case closure). The analysis simultaneously tested one main effect of time, main effect of group, and an interaction (group by time). **There was no significant difference between seriousness mean scores at Intake (M=84.93) and Case Closure (M=87.79).** In sum, there was no significant main effect of time ($p=.306$), main effect of group ($p=.154$), or interaction between group and time ($p=.306$).

CWBS Arrangements for Substitute Child Care. One repeated measures analysis was performed with arrangement for substitute child care scale seriousness scores at baseline and case closure as the dependent variables (N=86). In the analyses there was one between subjects factor—treatment group (3 months v. 9 months), and one within subject factor—administration time (baseline and case closure). The analysis

simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time). **There was no significant difference between mean seriousness scores at Intake (M=92.45) and Case Closure (M=94.32).** There was no significant main effect of time ($p=.257$), main effect of group ($p=.299$), or interaction between group and time ($p=.057$).

CWBS Caregiver Consistency of Discipline. One repeated measures analysis was performed with caregiver consistency of discipline scale seriousness scores at baseline and case closure as the dependent variables ($N=60$). In the analysis there was one between subjects factor—treatment group (3 months v. 9 months), and one within subject factor—administration time (baseline and case closure). The analysis simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time). **There was no significant difference in the mean seriousness scores at Intake (M=86.74) and Case Closure (M=88.40).** There was no significant main effect of time ($p=.106$), main effect of group ($p=.466$), or group by time interaction ($p=.774$).

CWBS Caregiver Acceptance of/Affection for Children. One repeated measures analysis was performed with caregiver acceptance of/affection for children scale seriousness scores at baseline and case closure as the dependent variables ($N=84$). In the analysis there was one between subjects factor—treatment group (3 months v. 9 months), and one within subject factor—administration time (baseline and case closure). The analysis simultaneously tested one main effect of time, one main effect of group, and an interaction (group by time). **There were no significant differences between mean seriousness scores at Intake (M=84.58) and Closure (M=84.02).** There was no

significant main effect of time ($p=.160$), main effect of group ($p=.055$), or interaction between group and time ($p=.582$).

Discussion of results: The results indicate that participation in the Family Connections program may contribute to enhanced physical and psychological care of children. Significant positive changes were observed in increases in seriousness scores (meaning more positive functioning) with respect to household furnishings, overcrowded household, and household sanitation. Improvements in psychological care were noted with respect to mental health care of children and teaching/stimulation of children by the caregiver.

Issues relevant to the interpretation of physical and psychological care to meet basic needs observational data. Given the amount of missing data for these subscales, results need to be interpreted with caution. As has been previously noted, there were serious compliance problems during the first several years of intervention. Student interns did not routinely use these assessment instruments either to guide their intervention or to document progress in dimensions that may have been the focus of intervention.

Another area for exploration is related to the differences that were noted in the three-month group and the nine month group both at Intake and Case Closure. While families were assigned to these intervention groups randomly, it did appear that interns observed more serious concerns about the nine-month group at Intake in a number of physical care areas. The possible effect of these group differences on the effectiveness of intervention should be explored in future analyses.

Home Environment

2g. Is there a difference between the 3-month and 9-month intervention groups in the level of child safety as measured by the Home Observation for Measure of the Environment (HOME)?

Results related to the home environment:

During the 6-month follow-up, research staff assessed the physical home environment using The Home Observation for Measure of the Environment (HOME) (Caldwell & Bradley, 1984). One of the reasons the study introduced this observation during the follow-up was because the intern driven observational assessments were only completed while intervention was provided.

One of the subscales called “Aspects of the Physical Environment” was used to assess the child’s physical home environment. Research staff members were trained to rate each family based on standardized criteria. Each subscale was then scored. Higher scores indicate “more socially desired developmental outcomes” (Bradley, 1994, p. 243).

A Multivariate Analysis of Variance (MANOVA) was performed with one HOME subscale at the 6-month follow-up as the dependent variables (N=117). In the analysis, there was one independent variable—treatment group (3 months v. 9 months)—and one dependent variable—aspects of the physical environment. **The main effect of group was non-significant (p = .094).**

Results Regarding Child Well Being:

Intervention was directed at increasing protective factors and decreasing risk factors with the ultimate purpose of achieving two outcomes: Child Safety (previously described) and Child Well Being (results presented here).

Child Behavior

4a. How effective is the program in improving the parental perception of externalizing and internalizing child behaviors as measured by the Child Behavior Checklist (CBCL) at three time points (baseline, case closure, 6-month follow-up)?

4b. Is there a difference between families served in 3-months versus 9-months in the caregiver report of externalizing and internalizing child behaviors) at three time points?

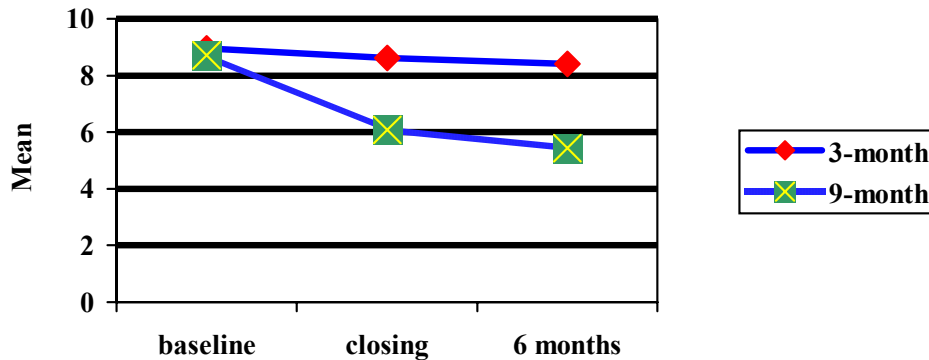
The Child Behavior Checklist, caregiver report was administered as part of the computer assisted self-administered research protocol at baseline, case closure, and six-month follow-up.

Child Behavior Related Results:

Results will be presented with respect to the CBCL Internalizing subscale, Externalizing subscale, and the total scale score.

Internalizing Raw Score Results. In the first repeated measures analysis, the dependent variables were the CBCL internalizing raw scores at baseline, case closure, and 6-month follow-up (N=111). A significant interaction between group and time was found ($F=3.105$, $p=.049$). Whereas the internalizing raw scores of the two groups are similar at baseline, the scores of the 9-month intervention group are lower at both case closure and 6-month follow-up than 3-month group. See Figure 25.

Figure 25. CBCL Internalizing Raw Score: Significant interaction between group and time



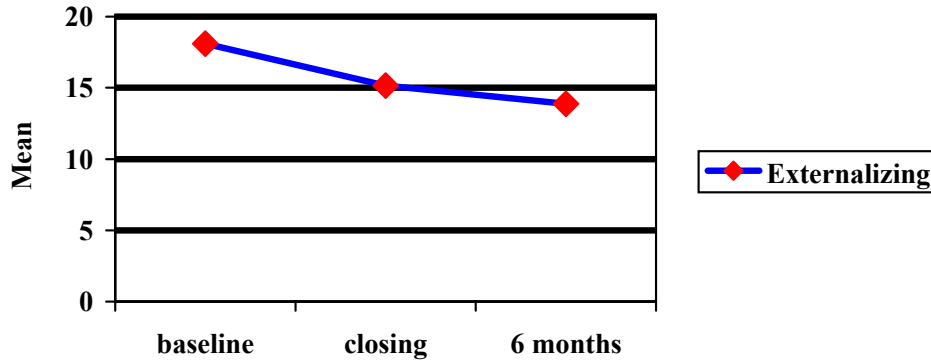
A significant main effect of time was also found ($F = 5.744, p = .004$). There was a statistically significant decrease in the internalizing raw scores from baseline ($M = 8.83, se = .784$) to case closure ($M = 7.34, se = .699, p = .007$), and from baseline to the 6-month follow-up ($M = 6.93, se = .694, p = .002$). However, due to the interaction between group and time, we cannot interpret this to mean that all families experienced a significant decrease in internalizing behaviors. The decrease from closing to the 6-month follow-up was non-significant ($p = .417$). There was no statistically significant main effect of group ($p = .147$).

CBCL Externalizing subscale. In the second repeated measures analysis, the dependent variables were the CBCL externalizing raw scores at baseline, case closure, and 6-month follow-up ($N = 111$). **A significant main effect of time was found ($F = 17.433, p < .0005$).** There was a statistically significant decrease in the externalizing raw scores from baseline ($M = 18.10, se = 1.15$) to case closure ($M = 15.16, se = 1.02, p < .0005$), from baseline to the 6-month follow-up ($M = 13.88, se = 1.00, p < .0005$), and

from case closure to the 6-month follow-up ($p=.022$). There was no statistically significant main effect of group ($p=.580$) or interaction between group and time ($p=.117$).

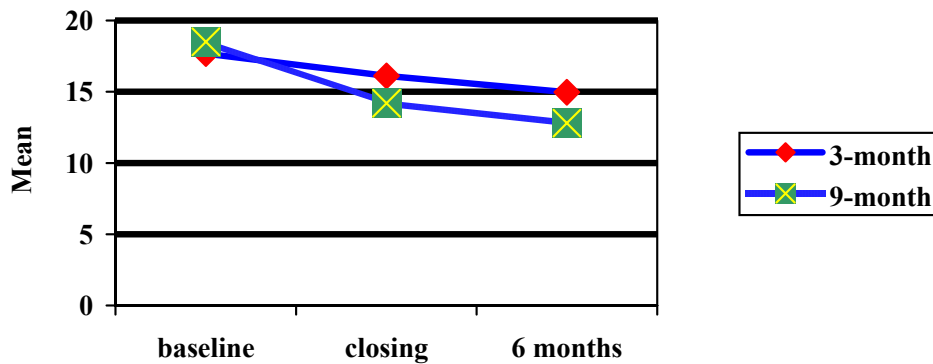
See Figure 26.

Figure 26. CBCL Externalizing Raw Score: Significant main effect of time



CBCL Total Problem Score. In the third repeated measures analysis, the dependent variables were the CBCL total raw scores at baseline, case closure, and 6-month follow-up ($N=111$). **A significant interaction between group and time was found ($F=3.546$, $p=.032$).** **The interaction between time and treatment group suggests that people who received nine months of intervention performed differently than those with three months of intervention.** The 9-month intervention group experienced a larger decrease in CBCL total problem scores from baseline to case closure and from case closure to 6-month follow-up than did the 3-month group. See Figure 27.

Figure 27. CBCL Total Raw Score: Significant interaction between group and time



Significant effects of time were also found ($F = 15.539, p < .0005$). There was a statistically significant decrease in the total raw scores from baseline ($M = 44.61, se = 2.96$) to case closure ($M = 36.80, se = 2.59, p < .0005$), from baseline to the 6-month follow-up ($M = 34.29, se = 2.56, p < .0005$). However, due to the significant interaction between group and time, we cannot interpret this to mean that the intervention contributed to a decrease in total raw score for the total sample. The decrease in total problem raw scores from case closure to the 6-month follow-up was non-significant ($p = .102$). There was no statistically significant main effect of group ($p = .465$).

Discussion of results: For the group as a whole, caregivers' perceptions of child behavior problems decreased. The decrease was sustained beyond the end of the intervention. Furthermore, there was a significant difference between the treatment groups with the 9-month group experiencing larger decreases in reported behavior problems than the 3-month group as measured by the CBCL externalizing behavior raw score and the CBCL total score

Child Functioning

4c. How effective is the program in improving the child functioning of children as measured by the Family Risk Scales-Child (FRS-C) at two time points (baseline, case closure)?

4d. Is there a difference between the 3-month group and the 9-month group in functioning of children at two time points?

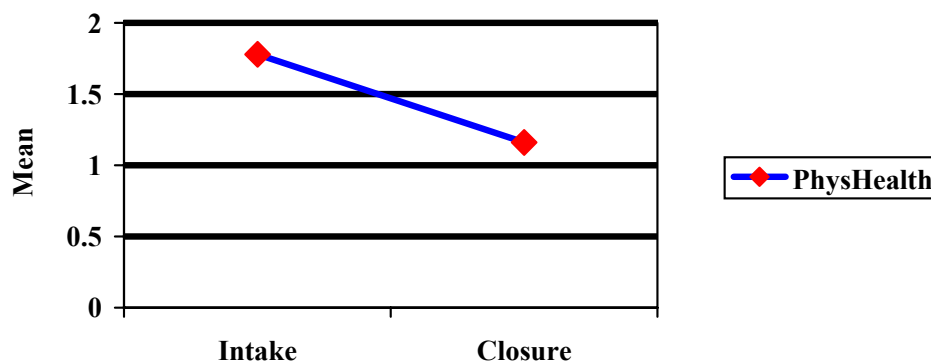
Results related to child functioning:

Social work interns used a standardized measure of child functioning for observational assessment at baseline, every 3 months during the intervention, and at case closure. The Family Risk Scales—Child (Magura, Moses, Jones, 1987) were used to assess child functioning. Five scales were used to measure child functioning: child physical health, mental health, home behavior, school adjustment, and delinquent behavior. Each scale is comprised of ratings ranging from levels of adequate functioning to levels reflecting inadequate functioning (Magura, Moses, & Jones, 1987). Lower scores indicate higher levels of functioning.

For each repeated measures analysis, the dependent variables were the Family Risk-Child subscale observational scores at intake and case closure. Of the five subscales, a significant main effect of time was found only related to physical health. The results of analyses for each subscale follows.

FRS-C Physical Health⁷. In the first repeated measures analysis, the dependent variables were the FRS-C physical health subscale scores at baseline and case closure (N=78). **A significant main effect of time was found (F=7.509, p=.008)**. There was a significant decrease in scores from baseline (M=1.71, se=.12) to case closure (M=1.48, se=.10, p=.008). There was no statistically significant main effect of group (p=.782) or interaction between group and time (p = .249). See Figure 28.

Figure 28. Family Risk Physical Health subscale: Significant main effect of time



FRS-C Mental Health. In the second first repeated measures analysis, the dependent variables were the FRS-C mental health subscale scores at baseline and case closure (N=74). There was no statistically significant main effect of time (p=.679), main effect of group (p=.486) or interaction between group and time (p = .098).

FRS-C Home Behavior. In the third first repeated measures analysis, the dependent variables were the FRS-C home behavior subscale scores at baseline and case

⁷ Lower scores indicate higher levels of functioning.

closure (N=68). There was no statistically significant main effect of time ($p=.368$), main effect of group ($p=.362$) or interaction between group and time ($p = .368$).

FRS-C Delinquent Behavior. In the fourth repeated measures analysis, the dependent variables were the FRS-C delinquent behavior subscale scores at baseline and case closure (N=65). There was no statistically significant main effect of time ($p=.091$), main effect of group ($p=.215$) or interaction between group and time ($p = .688$).

FRS-C School. In the fifth repeated measures analysis, the dependent variables were the FRS-C school subscale scores at baseline and case closure (N=64). **A significant interaction between time and group was found ($F=7.036, p=.010$).** The scores for the 3-month group decreased from baseline ($M=2.76, se=.25$) to case closure ($M=1.94, se=.20$) while the scores for the 9-month group remained relatively stable from baseline ($M=1.97, se=.26$) to case closure ($M=2.00, se=.21$). There was no significant main effect of group ($p=.201$).

Discussion of results: For the group as a whole, the physical health of children was observed by interns to improve over time.

IV. Relationships Between Program Implementation and Participant Outcome Evaluation Results

The process of developing and implementing a new outreach program in the West Baltimore Empowerment Zone brought with it many challenges, opportunities, and lessons. Some of the greatest challenges were overcome within the first two years (e.g., becoming known in the community as an important resource for families). Those types of challenges are not unlike the challenges that any new program has in its start up years.

And, while this program will always struggle to have sufficient funds to accomplish its mission, it is also clear that it now has a strong base of support and is to go out of business because of a lack of families who can benefit from what it has to offer.

On the other hand, one of the greatest opportunities this program had was to design a program with a threefold mission, i.e., to increase the safety and well-being for children, families, and communities by combining service to the community, education of graduate social work students, and research about what works. However, running a program that operates primarily with a constantly changing staff who are at the same time learning social work practice with families in neighborhoods will also probably be one of the program's greatest challenges over time. When considering the implications of this environment in the context of these results, numerous issues and questions emerge. Three are identified that have the most significant impact on the findings of this demonstration project.

1. Fidelity: Using clinical assessment instruments as part of practice

Anticipating the importance of maintaining consistency in the delivery of the intervention, the program team developed an Intervention Manual that outlines the philosophy, principles, and practice process for working with families to prevent child neglect. The program team implemented weekly seminars to reinforce these practice principles and procedures and each of the student interns received at least weekly individual supervision along with periodic group supervision. Part of the program model was to teach social work students the value of using standardized assessment instruments to understand the needs and strengths of families and to use these instruments to target outcomes, goals, case plans, and services. These

instruments also were intended to help practitioners assess change in families over time and were intended to be used as part of the process for evaluating the outcomes of the program. Despite these procedures, the results clearly indicate that some parts of the model were not implemented as intended. All students clearly did not use the assessment instruments as part of their practice and may not have understood the value of using them as part of their clinical practice with families. With respect to the research results, significant gaps of data from the observational assessments (i.e., Child Well Being Scales and Family Risk Scales) likely contributed to numbers too small to accurately assess outcome.

2. Fidelity: Level of service provided to the three month group versus the nine month group.

The process data suggests that the three-month group may have received more intensive services than the nine-month group received since families in the three-month group received an average of 1.4 hours of service per week in comparison to the average of .86 hour received by the nine-month group families. Since the intern's observation of family cooperation was also significantly different between the two intervention groups (nine-month families perceived to be less cooperative at case closure), many questions remain about whether each group received the intervention that was expected. It isn't know whether the interns were less intensely engaged with the nine-month families (possibly because they perceived they had a longer time to work with them), therefore more families declined services over time or whether the intensity of services provided to the three-month group families may have served to increase their positive

participation in the program. In any event, the fact that they may have been less active participation in services by the nine-month group over time, could contribute to why we saw fewer differences in outcomes between the groups over time.

3. Differences in Findings from Observational versus Self-Report Measures

There were several areas where self-report measures identified significant concerns that were not observed by the student interns. For example, a significant portion of caregivers was identified with depressive symptoms at Intake with the CES-D. In contrast, student interns assessed very few caregivers as having any mental health difficulties using the Family Risk Scale for Mental Health of Adults. This could be a problem with the measurement instrument but is probably also related to the lack of strong assessment skills on the part of some student interns. Similarly, the CBCL identified significant improvement externalizing and internalizing behavior of children but the observation by students related to the child's school behavior, home behavior, and mental health status did confirm these results. So, while one of the strengths of the design was the combination of self-report and observational instruments, it doesn't appear either that the observational instruments were uniformly used or if they were used, may not have been accurate appraisals of the circumstances.

V. Recommendations to Program Administrators or Funding Agencies regarding Future Program or Evaluation initiatives

This series of demonstration programs was a major investment of federal dollars on an issue that was long overdue. Even though various forms of neglect affect more children in this country than any other type of child maltreatment, we know less about how to prevent it or reduce the likelihood of it continuing, once identified. Despite this investment however, we still have only begun to develop models that may be promising. We still have a long way to go to refine these models and submit them to more rigorous evaluations. The following recommendations are offered as next steps in this process of understanding better what works and in what circumstances to increase the likelihood that the basic needs of children will be met.

1. Public policy must address the financial needs of families that lead some families to be at greater risk for neglect. The connection between poverty and neglect is clear. Any program that wants to prevent it, needs to recognize that it is much more difficult to meet the basic needs of your children when you don't have enough resources for the basic necessities of life. One of the greatest successes of Family Connections was the result of advocacy to help families make connections to community resources to deal with frequent income driven crises. The reductions in life stress are most likely related to these interventions. Yet, it shouldn't have to reach a crisis to recognize that it is hard to learn in school when you are hungry, that is hard to succeed in any positive social situation when you are tired because you have slept on the floor, and that before long our society pays by seeing behavior problems lead to criminal activity and other negative consequences.

2. Future demonstration projects need to more clearly document what they deliver and what their results are. And these initiatives need to be long term and lead to replications in other geographic sites. Ideally, we would see a national initiative that would be longitudinal and support the field-testing of interventions with rigorous evaluation designs. And if we wanted to dream, we would consider a multi-site national project which would implement these promising practices with a national evaluation of the results.
3. Given the large numbers of families with neglect in the public CPS system, and the fact that these families are much more likely have recurring problems, we need to carefully examine the feasibility of community based child protection initiatives to identify families early, provide supportive resources, with the goal of reducing the likelihood that we will need to rely on more costly and intrusive interventions over time.
4. Schools of Social Work and other professional institutions need to prepare future practitioners for working with families with multiple needs. The interrelationships between substance abuse, violence, poverty, and crime in neighborhoods increases the challenge to successfully increase positive outcomes for children.
5. Broader community organization initiatives set in neighborhoods need better testing in their connection to help families stay strong and meet the basic needs of their children. This is particularly true for urban environments.

6. All of us who have made a commitment to address the problem of neglect need to stay true to the challenge and share the incremental results of our work. Several such papers are underway as a result of this evaluation.