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Early Head Start - Child Welfare Services Initiative

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EXECUTIVE SUMMARY

Introduction and Background

The overall purpose of the Early Head Start/Child Welfare System (EHS/CWS) Initiative was to enhance and expand the service network for children and families involved in the child welfare system and to provide more intensive supplemental services in local communities that could benefit child welfare populations. The Initiative built upon an approach that assumed intensive collaboration and coordination between EHS agencies and local child welfare agencies would provide the most vulnerable children and families with access to child development, parenting, health, and family support services offered through EHS. These enhanced services were expected to result in improvements in safety, permanency, and well-being for CWS-involved infants and toddlers.

Over the course of the Initiative, local evaluation findings have shown the efforts of EHS/CWS projects to be successful in several areas. The specific areas in which a majority or certain subsets of grantees have experienced success include the following:

- Creating and maintaining safe and stimulating home environments for children;
- Improving families' access to basic medical and social services, particularly immunizations and well baby/well child visits;
- Reducing caregivers' stress levels by providing direct services or improving coping skills;
- Enhancing caregivers' skills and knowledge of positive parenting behaviors;
- Increasing the capacity of EHS staff to work with children and families involved in the child welfare system; and
- Promoting inter-organizational awareness and collaboration among EHS and local child welfare and/or other human service agencies.

The EHS/CWS Initiative is a joint effort established in 2002 by the Office of Head Start (formerly known as the Head Start Bureau) and the Children's Bureau, Administration on Children, Youth and Families (ACYF), Administration for Children and Families (ACF). To promote flexibility among the EHS/CWS grantees in experimenting with a variety of different service models, ACYF chose not to specify a particular program model under the Initiative. Rather, there was interest in permitting grantees to design their EHS/CWS programs so that a variety of models could be implemented to identify optimal strategies for engaging high-risk CWS families and to identify approaches that were associated with promising outcomes. As a result, each of the 24 funded grantees followed a unique theory of change that guided the services they provided to their target populations and the particular manner in which they structured their partnerships with CWS agencies.[1]

The program announcement defined the populations eligible for services under this Initiative to include (1) children in the CWS system who are living with their parents or other family

[1] Descriptions of the service models implemented by each of the EHS/CWS grantees and their site-specific evaluation findings are summarized in Volume II of this report.

members; (2) children in foster care settings; (3) children whose parents are incarcerated or in substance abuse recovery programs; and (4) other children from birth to age three who are in some way involved in CWS.

Local Evaluations

Each EHS/CWS grantee was required to conduct a local process and outcome evaluation. Overall, the primary emphasis of the local evaluations was on implementing strong process evaluations to promote improved services and program development and on increasing knowledge about building collaborative partnerships between local EHS and CWS agencies. In addition, it was expected that grantees would collect data to address the following cross-cutting questions:

- What are the factors that contribute to successful EHS/CWS partnerships?
- What challenges exist in bringing these two systems together?
- What program models work best to engage high-risk CWS children and families in EHS services?
- What services do these children and families utilize most often?
- What systems-level outcomes were achieved as a result of the projects?
- What participant-level outcomes are achieved, particularly in the areas of child and family safety, permanency, and well-being?[2]

To build evaluation capacity and ensure that local grantees received the knowledge and tools necessary to implement sound evaluations, James Bell Associates (JBA) was awarded a contract through the Children's Bureau (CB) to provide evaluation technical assistance (TA) to the EHS/CWS projects. JBA assisted grantees in building logic models, selecting appropriate research designs, establishing data collection plans, and scoring and interpreting data using both standardized and site-specific or "home grown" child, caregiver, and family assessment instruments.

Project Descriptions

Location of EHS/CWS Grantees

With the exception of ACF Region VIII[3], which had no funded EHS/CWS sites, the grantees were distributed across all ACF Regions in the United States. Almost half of the

[2] Although all grantees were required to conduct process and outcome evaluations, the flexibility given to grantees in designing their local projects and identifying optimal strategies to engage high-risk CWS families made it difficult to identify common outcome measures or impose uniform data collection and reporting standards across all sites.

[3] ACF's programmatic activities are implemented through 10 regional offices that serve States, territories, tribes, and grantees in their respective geographical areas. More information about ACF regional offices is available at http://www.acf.hhs.gov/programs/oro/index.html.

grantees were concentrated in the Midwestern United States (ACF Region V), with most grantees located in rural areas or small to midsize cities. Two grantees each were located in Regions I, III and X, while three were located in Region VI. Three grantees were situated in large metropolitan areas (Miami, New York City, and San Diego).

Prior Collaboration with CWS

Almost all EHS/CWS grantees had some prior history of collaboration with their local CWS agencies. In general, these collaborations were informal and based on experiences serving EHS children who subsequently became involved with CWS due to incidents of abuse or neglect. Half of the EHS/CWS grantees reported that they generally had limited contact with their CWS agencies and that any interactions or relationships prior to the Initiative were informal, unsystematic, and largely occurred on a case-by-case basis. Nine grantees reported that there had been prior collaboration and contacts established with a local CWS agency in the context of administrators or managers serving together on community advisory boards or steering committees.

Seven EHS grantees reported that their agencies had strong partnerships with CWS in the past and that their agencies had collaborated on previous community projects and initiatives. Three EHS/CWS grantees described their history with CWS as more formalized due to the EHS project's role as a CWS service provider. Four grantees reported that some EHS staff hired to work for their local EHS/CWS projects had previously worked in the CWS system. Hence, EHS/CWS grantees benefited from the experiences of staff who understood the inner workings of the CWS system and its policies and procedures.

Target Populations

Among the 24 EHS/CWS grantees, 21 targeted both foster care cases and in-home services cases. Among these 21 grantees, one (Waterville) specifically targeted pregnant women in the child welfare system; three grantees (Springfield, Tulsa, and San Diego) targeted children at risk for abuse or neglect (i.e., families with unsubstantiated maltreatment reports); and one grantee (Hillsboro) targeted parents with developmental delays. In addition, two grantees focused on drug-impacted populations (Allentown and New York). With a few minor exceptions and modifications, EHS/CWS grantees generally served the actual populations they targeted in their original grant applications.

Number of Funded Slots

The number of children that EHS/CWS grantees were funded to serve at any given time was relatively small. Seven grantees were funded to serve between four to eight children, three grantees were funded to serve 10 CWS children, 11 grantees were funded to serve between 15 and 20 children, and three grantees were funded to serve more than 20 children.[4] Grantees were expected to maintain their funded enrollment level and replace vacancies created when CWS children exited the project.

[4] Although grantees were expected to maintain enrollment at the number of children they were funded to serve, they could provide enhanced services to more than their funded allotment at any given time.

Service Models

Enhanced EHS/CWS services were delivered through one of four different program options: center-based models, home-based models, a mixed or "combination" models, and "locally designed" options. For the most part, the EHS/CWS grantees adhered to one of the first three of these program options:

- Home-based Models: Five EHS/CWS projects (Mentor, Wooster, Waterville, Sedalia, and Philipsburg) provided services through an exclusively home-based program option.

- Center-based Models: Seven EHS/CWS projects (Allentown, San Diego, Waterbury, Miami, Evanston, Springfield, and Hillsboro) were solely center-based, in which children were provided with developmentally appropriate childcare in addition to enhanced EHS services.

- Mixed or "Combination" Models: Ten grantees (Danville, Marion, Terre Haute, Tulsa, Monroe, Houghton, Greenville, Levelland, Moses Lake, and Madison) provided all enrolled children with a combination of both center-based services and home visits.

- The two remaining grantees—New York and Ironton—operated home- and center-based program options concurrently, with a certain number of slots allocated to each option.[5]

Overview of Core Services Provided by EHS/CWS Grantees

While varying in their frequency and intensity, all 23 grantees[6] described in this report provided all of the following core services:

- Development of Family Partnership Agreements (i.e., a set of goals based on the family's individual needs and abilities);
- Home visits;
- Center-based activities;
- Parent education and training activities;
- Socialization activities (i.e., semi-structured group activities for parents and their children);
- Client screenings and assessments (i.e., developmental, medical, and dental screenings, as well as services tailored to CWS-involved families such as home safety assessments);
- Medical care (e.g., pediatric exams, dental care, mental health services);
- Parent/child visitations (i.e., supervised visitations between parents and children when the parents do not have custody of their children); and
- Mental health treatment/counseling.

[5] More detailed information about each grantee's EHS/CWS project and its local evaluation findings is available in Volume II of this final report, entitled *Early Head Start-Child Welfare Initiative: Compendium of Grantee Grantee-Specific Findings.*
[6] Although 24 grantees were funded under this Initiative, one grantee did not submit a final evaluation report.

Overview of Distinctive Service Models

A small group of grantees implemented distinctive service models that differed from other EHS/CWS projects in terms of the array or types of services offered to enrolled families. The interventions provided through this subset of programs are unique to these particular grantees and are not common across the EHS/CWS projects.

Dyadic Therapy Model

Through a collaborative partnership among EHS, the Juvenile Court, the University of Miami, and the local CWS agency, the project in Miami implemented a dyadic therapy model.[7] CWS-involved toddlers in need of specialized mental health services were referred to the EHS/CWS program, in which they received center-based EHS services as well as dyadic therapy. Each toddler and his/her parent or guardian was assigned to a therapist from the University of Miami and was expected to complete 27 dyadic therapy intervention sessions.

Residential Mentor Couples

In Houghton, Michigan, the grantee served families through an intensive three-month live-in program with family "mentors" and a three-month follow-up home visiting program based in part on the Shared Family Care model used in California, Colorado, Minnesota, and Wisconsin. Families resided in a grantee-owned home and had their own living space. A mentor couple living in another section of the home modeled and taught effective parenting skills and linked families with area resources.

Residential Substance Abuse Treatment Model

The New York grantee partnered with the Palladia/Dreitzer Center for Women and Children, a local substance abuse treatment agency, to provide EHS services to infants and toddlers. Parents with infants younger than eight months were served through the home-based option, while those with children aged eight months and older were served through two EHS classrooms located at the Palladia Center. This program is unique in that it allows women to stay with their children while they undergo substance abuse treatment at the Palladia Center.

Emergency Shelter Cottages

The grantee in San Diego served EHS/CWS infants and toddlers that have been temporarily placed in out-of-home care at the Polinsky Children's Center, San Diego County's emergency shelter facility. A service co-location model was created by operating EHS classrooms on site at the emergency shelter. EHS staff worked to enhance and support the care that children received by providing ongoing training to the shelter's Residential Care Workers, who assumed the role of primary caregiver for each child in emergency placement. While at the

[7] Dyadic therapy is an approach to mental health treatment that differs from other developmental therapies in that the focus of treatment is less on the child than on the interpersonal dynamics and interplay between the parent and child (Maltese, 2005). Miami's dyadic therapy model involved videotaping play interactions to assess and improve children's cognitive development and parent-child attachment.

emergency shelter, children received medical assessments and treatment as well as developmental screenings and assessments.

Therapeutic Child Development Services for Drug-Impacted Children

In Allentown, Pennsylvania, the grantee served up to 15 drug-impacted children under three years of age in a full-year, full-day center environment offering therapeutic child development services, including specialized interventions such as play, speech, occupational, sensory, and physical therapies. Specialized techniques used by therapeutic teachers included "C position" holding (holding the baby firmly and curling the head and legs into a "C" shape); swinging/rocking in a rhythmic movement; placement and positioning; swaddling; bathing; massage; using weighted materials during play and sleep; use of comfort objects such as blankets, pacifiers, and heartbeat sounds; and low stimulation environments characterized by minimal light, noise, colors, and unnecessary visitors in the classrooms.

Key Implementation Findings

- The 23 EHS/CWS projects described in this report served a total of 1,303 CWS-involved children through 343 funded slots. Long-term slot vacancies were generally rare, with an average of 98 percent of all funded slots filled at any given time between December 2004 and June 2006. Some grantees attributed existing slot vacancies to a lack of referrals from their partnering CWS agencies. Of the 1,303 children enrolled in the projects, 336 (26 percent) were in out-of-home placement at some point during their participation.

- Participating children remained enrolled for an average of 327 days (nearly 11 months), a considerably shorter period than the average of 21 months observed among children enrolled in standard EHS programs. The substantially shorter average length of enrollment for children enrolled in EHS/CWS projects may be indicative of the special challenges faced in engaging and retaining CWS-involved families.

- Children participating in center-based EHS/CWS projects experienced longer average lengths of enrollment than children served through home-based or mixed model programs (490 days vs. 312 days and 256 days for home- and mixed-model programs, respectively). Center-based programs were also less likely to report barriers such as family resistance to receiving services, dropout following case closure by CWS, and parental mental health or substance abuse issues. Although the reasons for these enrollment disparities are not entirely clear, possible explanations include the greater social isolation experienced by families in home-based or mixed model programs (which in turn is correlated with issues such as mental illness and substance abuse) and the absence of coercion (whether perceived or real) to remain enrolled in EHS once CWS agency involvement ends. In addition, families enrolled in center-based programs have a very strong incentive to continue their involvement in the form of access to free high-quality child care.

- Individual grantees achieved varying levels of success in their ability to establish a firm and lasting collaborative relationship with their partnering CWS agency. However, nearly

all grantees (21 of 23) established an initial Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA) with their partnering agencies. Of these, more than half (12) reported at least one update to the MOU/MOA, which suggests a certain degree of commitment to reviewing and maintaining the partnership.

- Common barriers to more robust collaboration included a lack of communication between managerial and front-line staff from EHS and CWS agencies (which was exacerbated by the different professional vocabularies and organizational jargon) and philosophical differences in service orientation between EHS and CWS (e.g., EHS tends to focus more on building parental knowledge and capacity whereas CWS often stresses case plan compliance and child safety).

- Staff turnover or "burnout" was a frequent impediment to maintaining the quality and consistency of EHS/CWS services, with 11 grantees reporting this as a significant issue. In addition, 10 grantees reported turnover in a project director at some point during the five-year Initiative, which had deleterious effects on the capacity of some grantees to manage and coordinate services while providing the necessary level of leadership to sustain the impetus of their project.

- Contextual variables that had perceived negative effects on the EHS/CWS projects included economic and sociological factors (e.g., inadequate housing, joblessness, poor transportation infrastructure, endemic community drug use); a lack of local social and health resources; State and local budget cuts; and changes in the organization or leadership of State, local government, or community organizations (e.g., the breakup or consolidation of local child welfare agencies, the privatization of child welfare services).

Key Outcome Findings

The EHS/CWS grantees reported positive findings in multiple outcome areas, including child development and well-being; caregiver coping and parenting skills; organizational factors such as the enhancement of staff professional skills; and systemic factors such as inter-organizational awareness and communication and improved access to health and social services:

- In the domain of child well-being, the grantees demonstrated significant success in achieving certain health outcomes, specifically in the timely receipt of medical and developmental screenings, medical checkups, and immunizations. As a whole, EHS/CWS projects succeeded in screening virtually every enrolled child to ascertain its medical and/or development status. In addition, 87 percent of enrolled children across 17 reporting grantees were current on well-baby/well-child visits, while a nearly identical proportion of children across 18 grantees were current on all recommended immunizations at program exit. These statistics compare favorably with national immunization and well-child visit rates reported in the Center for Disease Control's 2006 *National Immunization Survey* and in the 2004 *National Health Interview Survey*.

- Some grantees reported lower levels of stress among caregivers struggling with the challenges of raising children while maintaining their households. Among five grantees

that systematically measured changes in stress using the *Parenting Stress Index* (PSI), average total caregiver stress scores decreased from the 73rd percentile at baseline to the 63rd percentile at follow-up. These results suggest that EHS/CWS supports and services may have some ameliorative effect on overall stress, thereby reducing the future risk of dysfunctional parenting behaviors.

- Findings from other grantees indicate moderate success in helping parents understand and value their children's needs and establish healthy and age-appropriate roles, expectations, and responsibilities among all family members. Five grantees that used the *Adult Adolescent Parenting Inventory* (AAPI-2) reported positive changes in parenting knowledge and skills as measured by the instrument's "Expectations", "Empathy", and "Role Reversal" subscales.

- Many grantees reported progress in improving the safety and quality of children's home environments. Four grantees reported improved home conditions (e.g., the presence of structure and organization in the environment, presence of appropriate play materials) using the *Home Observation and Measurement of the Environment* (HOME) *Inventory*, with average scores increasing from 31.28 at baseline to 35.53 at a follow-up administration. In addition, four other grantees reported slight to substantial improvements in the safety conditions found in enrolled families' homes as measured by locally designed home safety checklists.

- Programmatic and organizational improvements, as reflected in the increased knowledge and skills of EHS front-line staff to work effectively with CWS populations, were frequently attributed to expanded collaboration between EHS and CWS agencies. In addition, many grantees reported community or systems-level benefits as a result of the EHS/CWS projects, especially as evidenced by increased access by CWS-involved families to medical, developmental, and other human services.

Key long-term outcomes of interest on which the projects appeared to have more limited or uncertain effects include maltreatment recurrence and permanency:

- Among 19 grantees that collected and reported maltreatment data, the average maltreatment recurrence rate among enrolled families was approximately 11 percent. Although not strictly comparable, the national Child and Family Service Review (CFSR) maltreatment recurrence rate in Federal Fiscal Year 2006 was somewhat lower at 7.8 percent.[8] More frequent reports of maltreatment recurrence may be interpreted as a reflection of the greater concentration of services and professional contacts received by EHS/CWS families.

- Among the 13 grantees that reported comprehensive data on exits to reunification, adoption, or guardianship, the average net permanency rate for children who were in or

[8] CFSR is a monitoring and review system established in 2000 by the U.S. Department of Health and Human Services to assess conformity with certain Federal requirements for child protection, foster care, adoption, family preservation, family support, and independent living services. The Children's Bureau within HHS administers the CFSR review system. The relevance of CFSR to the EHS/CWS projects will be explored in more detail in the body of this report.

entered out-of-home placement at some point during their enrollment in an EHS/CWS project was 44 percent. Based on aggregated CFSR data, this figure is identical to the average 2003 permanency rate for the 17 States that hosted an EHS/CWS project site. At a minimum, these data suggest that children served through the EHS/CWS projects are at least as likely be reunified or otherwise achieve permanency as children in the general CWS population.

Sustainability of the EHS/CWS Initiative

Throughout this report and past synthesis reports, JBA adopted the conceptual model developed by Fixsen, Naoom, Blase, Friedman, and Wallace (2005) to frame our understanding of the program implementation process among EHS/CWS grantees. The last stage of this model— sustainability—represents the point at which the long-term operations and effectiveness of the projects are maintained within the context of a changing political, organizational, and funding environment. To assess the likelihood that EHS/CWS projects would be sustained following the formal end of the five-year project period, JBA queried project directors for the 23 EHS grantees described in this report regarding two primary questions: (1) whether they intended to continue using their additional funded slots to target services specifically at CWS-involved children and their families; and (2) whether they planned to sustain collaborative efforts with their partnering CWS agency at the same level and intensity as existed during the official five-year period of the EHS/CWS Initiative.

Sixteen of 23 project directors (almost two-thirds) responded to JBA's inquiry; of these, 13 project directors (about four-fifths) replied that they planned to reserve their additional funded slots exclusively for CWS-involved children. In addition, all 16 indicated an intention to maintain active collaboration and cooperation with their partnering CWS agency in identifying and serving families involved in the child welfare system. These answers suggest a strong commitment on the part of virtually all of the responding EHS agencies to maintain a special focus on addressing the safety and developmental needs of children deemed to be at greater risk of abuse and neglect, as well as on improving the capacity of parents to provide for their children's physical, emotional, and intellectual needs.

Key Lessons Learned

Several significant lessons, garnered through interviews with EHS project directors and reviews of their semi-annual and final reports, are summarized below according to their relevance to the key phases of the Fixsen implementation paradigm.

Program Exploration and Adoption

- Develop a thorough understanding of best practices and current research in the fields of early childhood development and child welfare prior to implementing a new program.

- Elucidate the specific problem(s) that the program seeks to address and carefully define the target population that will receive services.

- Before proceeding too far with program design and implementation, approach the leadership of the local CWS agency to assess its interest and commitment to partnering on a collaborative initiative to serve CWS-involved families.

Program Installation and Initial Implementation

- Develop clear and specific eligibility criteria for the target population.

- Involve front-line and managerial staff from the local CWS agency, as well as staff from other key social service agencies as appropriate, in the initial project planning and design phases.

- Hire key project staff (e.g., project directors and coordinators) before or during the very initial phases of program planning and startup.

- Recognize that high-risk families require long-term supports and services and that their cases may need to remain open longer than originally anticipated.

Full Operational Phase

- To reduce families' resistance to project participation, emphasize the role of front-line staff as advocates for the interests and needs of parents and their children rather than as monitors or enforcers of service plans and Family Partnership Agreements.

- To increase project referrals, explore strategies that foster the development of one-on-one professional relationships among EHS staff and CWS caseworkers.

- Seek to maintain families' enrollment for as long as possible to increase the likelihood of achieving positive changes in their capacities, behaviors, and status.

Program Innovation and Sustainability

- Encourage new collaborations with other child welfare service agencies and programs in the community to maintain support and enthusiasm for the project while increasing the range and intensity of services available to targeted families.

- Provide continual opportunities for program staff to enhance their knowledge and skills in working with CWS-involved children and families. Areas of focus should include education in working with drug-affected infants and toddlers, as well as children suffering from the psychological trauma of abuse, neglect, and separation from parents and siblings.

- Continually reassess the content and format of core project services (e.g., home visits) to ensure that they maintain high standards of quality and are responsive to the changing needs and circumstances of enrolled families.

Usefulness of Findings for the Children's Bureau, EHS Programs, and the Early Childhood Field

The experiences of the EHS/CWS grantees underscore the acquisition of valuable new knowledge that is relevant to the service and policy goals of the Children's Bureau, the Office of Head Start, and Early Head Start programs in general, as well as to the broader fields of early childhood education and child welfare. Specifically, the EHS/CWS Initiative has:

- Highlighted certain models and approaches to the provision of early childhood services that may be particularly effective in addressing the needs of children and families involved in the child welfare system.

- Confirmed the promise—and critical importance—of fostering partnerships between EHS programs and CWS agencies to effectively identify and serve families currently in the child welfare system or at future risk of maltreatment or out-of-home placement.

- Demonstrated the potential of collaborations with other community social and health service organizations to strengthen the nexus of supports and services available to special target populations (e.g., caregivers with mental health or substance use disorders).

- Revealed ongoing challenges to serving CWS-involved families and to building effective inter-organizational partnerships that must be addressed if similar early childhood initiatives are to achieve their full potential to promote the safety and well-being of infants and toddlers.

- Underscored the importance of building basic evaluation skills among EHS agencies as well as their capacity to sustain an evaluation infrastructure, which will allow them to track and analyze data regarding program operations and child and family outcomes in a manner that fosters ongoing program development and improvement.

The findings from this Initiative may be of particular interest to State-level child welfare departments that are seeking strategies and resources to improve the performance of local child welfare agencies on a range of outcomes addressed through the CFSRs. EHS programs and local CWS agencies, which often serve overlapping target populations but work in separate legal, professional, and philosophical spheres, have considerable potential to work in tandem to advance the common child welfare policy interests of both the States and the Federal government.

CHAPTER I
BACKGROUND AND OVERVIEW

A. Introduction

Young children in the child welfare system (CWS) are among the most vulnerable in the nation and are especially likely to be victimized by physical and emotional harm. Around the time the EHS/CWS Initiative was funded, the rate of victimization for children from birth to three years of age was 15.7 victims per 1,000 children—the highest for any age group of children (U.S. Dept. of Health and Human Services, 2002a). Each year, about 150,000 children under the age of five are placed in foster care; of these children, infants make up the largest and fastest growing group of children in out-of-home placement. These children often have physical and developmental conditions that complicate their care and increase the importance of providing them with the services available through EHS. For example, premature births, low birth weight, and positive drug toxicology have been found to range from 20 to 28 percent among 70,300 infants under one year of age involved in CWS during 1994. In addition, only slightly more than half of all children in CWS had a health screening, and only 32 percent had received a psychological assessment. When examining the presenting problems of primary caretakers in this same study, the most frequently noted problem was the lack of parenting skills (50 percent of primary caretakers). With respect to data on services offered and provided by CWS either directly or through referral, only 54 percent of parents with inadequate parenting skills were offered and received some form of parenting skills training (U.S. Dept. of Health and Human Services, 1997).

The Early Head Start/Child Welfare Services (EHS/CWS) Initiative offered an opportunity for CWS-involved infants and toddlers from 24 communities across the nation to receive an array of services that they typically would not receive through CWS, including health and developmental screenings through early intervention service providers.[9] The overall purpose of the EHS/CWS Initiative was to enhance and expand the service network for CWS-involved children and families and to provide more intensive supplemental services in local communities that could benefit child welfare populations. The Initiative was built on the assumption that intensive collaboration and coordination between EHS programs and local CWS agencies would provide some of the most vulnerable children and families with access to child development, parenting, health, and family support services available through EHS. These enhanced services were in turn expected to promote improvements in safety, permanency, and well-being among CWS-involved infants and toddlers.

The EHS/CWS Initiative is a joint effort established in 2002 by the Office of Head Start (formerly known as the Head Start Bureau) and the Children's Bureau (CB), Administration on Children, Youth and Families (ACYF). Funding was provided through title IV-B, subpart 2 of the Social Security Act—Promoting Safe and Stable Families (PSSF)—to enhance the capacity

[9]When the EHS/CWS projects were funded in the fall of 2002, the referral of infants and toddlers by CWS to early intervention services was not a routine practice. It was not until June 2003 that the Keeping Children and Families Safe Act was passed as a reauthorization of Child Abuse Prevention and Treatment Act, which included a new provision that requires States receiving CAPTA funds to develop and implement "provisions and procedures for referral of a child under the age of three who is involved in a substantiated case of child abuse or neglect to early intervention services funded under Part C of the Individuals with Disabilities Education Act."

of agencies to serve the needs of vulnerable infants and toddlers in the child welfare system by expanding service networks in local communities. PSSF provides formula grants to States to develop family support services, family preservation programs, time-limited reunification services, and adoption support programs. However, the resources available to CWS agencies have typically been insufficient to meet the needs of its youngest children unless combined and coordinated with other resources.

In 2002, ACYF made available approximately $72 million in financial assistance for the expansion of EHS services. Financial assistance was awarded competitively to local public and private not-for-profit and for-profit agencies. Agencies were expected to use the funds to provide child and family development services to low-income families with children under the age of three, as well as to pregnant women. Applicants were encouraged to apply for funding in one or more of the following three expansion categories: (1) current EHS grantees proposing to expand in their currently approved service areas; (2) new applicants and current EHS grantees proposing to establish projects in areas currently not served by an EHS program; or (3) New applicants and current EHS grantees proposing to serve children in an EHS program whose families are receiving support from CWS system (U.S. Dept. of Health and Human Services, 2002b).

According to the U.S. Department of Health and Human Services' (HHS) Program Announcement, existing EHS grantees were permitted to include a request to serve children involved with CWS as a second part of their application under Categories 1 or 2; or they were permitted to submit an application to only serve children involved with CWS as long as they continued to serve EHS children through their regular program. New EHS applicants were allowed to submit a request to serve children involved with CWS but could do so only if they were also requesting expansion funds under Category Two. EHS/CWS grantees funded under Category Three participated in a four-year demonstration that lasted from October 2002 through December 2006. Findings from the evaluation efforts of grantees in this final category are the focus of this report.

1. Program Eligibility and Families/Children Targeted

The Program Announcement for the EHS/CWS Services Initiative did not specify a target number of CWS-involved children that had to be served; this number was left to the discretion of each grantee. However, the Program Announcement cautioned applicants against proposing to serve disproportionately large numbers of CWS-involved children as compared to their total number of EHS slots, unless there was a compelling reason for doing so. In addition, the EHS requirement to serve low-income families or pregnant women who are at or below the poverty level was waived if the participating child was currently in foster care at the time of enrollment in the EHS/CWS project. Likewise, children in out-of-home placement were eligible for enrollment regardless of their foster family's income.

To promote flexibility among the EHS/CWS grantees in implementing their projects, ACYF intentionally chose not to specify a particular service model that grant recipients were required to follow. Rather, there was an interest in affording grantees the latitude to experiment with a variety of models in order to identify optimal strategies for engaging high-risk CWS

families and producing promising child welfare outcomes. As a result, each of the 24 funded grantees followed a unique theory of change that guided the services they provided to their target populations and the particular manner in which they structured their partnerships with CWS agencies.

The HHS Program Announcement defined the populations eligible for services under this initiative to include: (1) children in the CWS system who are living with their parents or other family members; (2) children in foster care settings; (3) children whose parents are incarcerated or in substance abuse recovery programs; and (4) other children from birth to age three who are in some way involved in CWS. EHS/CWS projects were not expected to develop new programs exclusively for CWS-involved families; rather, they were expected to expand—and when appropriate—modify their existing EHS programs to include CWS children and families.

2. Adherence to Performance Standards

The Head Start Program Performance Standards (hereinafter referred to as the Performance Standards)[10], which apply in general, to both Head Start (HS) programs and EHS programs, require that EHS programs engage in the following activities:

- *Find a medical home for children*— EHS programs are required to ensure that each child has a continuous source of accessible and coordinated health care.

- *Ensure that well child care, including immunizations and dental care, are up to date*—EHS programs are expected to collaborate with parents or other legal guardians to make arrangements for any necessary examinations and immunizations.

- *Conduct health and developmental screenings*—Within 45 days of entry into the program, EHS programs must screen children to identify concerns with respect to a child's developmental, visual, auditory, behavioral, motor, language, social, cognitive, perceptual, and emotional skills.

- *Track and maintain records*—Ensure that appointments are kept and that high-quality services are provided in a timely manner.

- *Identify nutritional needs and provide healthy meals and snacks*—EHS programs must design and implement a nutrition program that meets the nutritional and feeding requirements of each child.

- *Provide a clean and safe learning environment*—EHS programs are expected to provide a variety of toys and materials that promote active exploration and learning as well as emotional comfort and safety.

[10] Head Start Program Performance Standards and Other Regulations (45CFR Parts 1301-1311) are accessible online at http://www.acf.hhs.gov/programs/ohs/legislation/index.html.

- *Provide relationships that are consistent and secure*—EHS programs help infants and toddlers develop secure relationships by limiting teacher-child ratios in center-based settings to one teacher for every four children. Staff members are expected to support the social and emotional development of infants and toddlers using an approach to education that is individualized for each child and that focuses on self-awareness, autonomy, self-expression, and communication.

By adhering to the Performance Standards, EHS programs have the potential to dramatically affect the lives of many children and families by providing services and supports that address many of the concerns that brought them to the attention of CWS agencies in the first place.

3. Local Evaluations

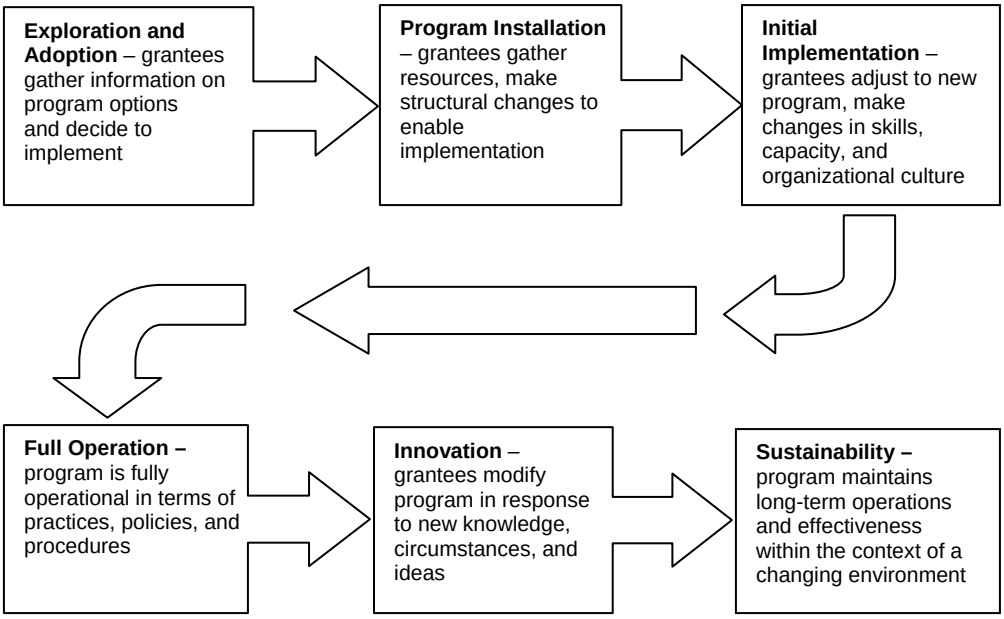
In addition to service delivery, each EHS/CWS grantee was required to conduct a local process and outcome evaluation.[11] To build evaluation capacity and to ensure that grantees received the knowledge and tools necessary to implement sound evaluations, James Bell Associates (JBA) was awarded a contract through the Children's Bureau (CB) to provide evaluation technical assistance (TA). JBA assisted grantees in building logic models, selecting appropriate research designs, developing data collection plans, and scoring and interpreting data collected using both standardized and site-specific or "homegrown" child, caregiver, and family assessment instruments. JBA provided TA through the following strategies:

- On-site meetings;
- Telephone consultations;
- Review of evaluation-related documents and materials, including evaluation plans, data collection instruments, and data analysis plans;
- Dissemination of relevant evaluation materials and models;
- Referrals to other grantees that were examining similar outcomes; and
- Group and individual meetings with grantees at Federal conferences.

JBA was also charged with preparing semi-annual synthesis reports that summarized the process and outcome findings reported by grantees through their local evaluations.[12] In examining the program implementation process across projects, JBA utilized the conceptual framework developed by Fixsen, Naoom, Blase, Friedman, and Wallace (2005), which describes program implementation as a process that unfolds in several discrete yet overlapping stages. As illustrated in **Exhibit I-1**, the continuum of implementation begins with "exploration and adoption" and ends with "sustainability." Through the synthesis reports, JBA articulated both site-specific and aggregate findings on projects as they moved through the stages of the Fixsen implementation paradigm. Although grantees progressed at different rates in implementing their projects, all grantees made gradual progress towards the final sustainability phase of the model.

[11] Additional funding was not made available to EHS agencies for conducting evaluations. Some sites used agency funding to hire outside evaluators while others used internal agency staff.
[12] Previous reports on the EHS/CWS Initiative can be obtained by request from JBA.

Exhibit I-1
Stages of the Program Implementation Process[13]



A prerequisite for participating in the EHS/CWS Initiative was to conduct a community needs assessment. As part of this assessment, each grantee gathered information about the needs and characteristics of its proposed target population that was then used to assist in selecting an appropriate program model and the types and range of services to be offered. Once grantees began providing services, they gathered resources and made structural adjustments that moved them into the "program installation" phase of the Fixsen paradigm.

During the "initial implementation" stage, some grantees were delayed as they adjusted to the new working relationships with their CWS partners. Issues that arose in this stage included disparate professional terminologies and jargon, sometimes clashing organizational cultures, and the need for CWS agencies to re-conceptualize EHS workers as true child development professionals and not simply daycare providers. Staff trainings, which were facilitated by the establishment of Memoranda of Understanding (MOU), helped CWS and EHS agencies gain a better understanding of one other's organizational cultures, professional language, and important contributions in improving permanency, safety, and well-being outcomes for children and families.

The establishment of MOUs and joint staff trainings helped many grantees achieve the "fully-operational" stage of the Fixsen model, in which they engaged in efforts to institutionalize practices, policies, and procedures improve service delivery for children and families. Grantees also started assessing their progress towards achievement of widely shared core outcomes,

[13] Adapted from Fixsen et al. (2005).

including improved safety conditions in the home, reduced parental stress, and improved parental knowledge and skills. In response to some of the initial process and outcome findings, grantees entered the "innovation" stage as they engaged in efforts to modify their programs in response to new knowledge and circumstances.

Many EHS/CWS grantees have currently reached the "sustainability" stage of Fixsen's framework. At this point, the implemented programs maintain long-term operations and effectiveness within the context of a changing organizational, financial, economic, and political environment. As detailed in the sections to follow, many grantees that reach the sustainability phase have updated their MOUs, institutionalized many new policies and procedures, and have included the special populations targeted through the Initiative in their regular service populations. These decisions signify the recognition by EHS and CWS agencies of the pivotal role that comprehensive child and family support services play in the lives of children and families involved in the CWS system.

Although Fixsen's framework is helpful in understanding the implementation stages of grantees projects, it is important to note that grantees reached the various stages of the framework at different times in the life cycle on the EHS/CWS Initiative. This was due to two significant factors: (1) the flexibility given to grantees to develop their own service models, which resulted in non-uniform progress through the implementation phases; and (2) the larger contextual environment in which individual grantees operated.[14] Factors such as geographic location, the characteristics of grantee communities, past history of collaboration with CWS, and the demographic characteristics of the target populations, served both as facilitators and inhibitors of project implementation.[15] The remainder of this chapter describes these and other factors that affected the scope and manner in which each project was implemented.

B. Project Descriptions

1. Location of EHS/CWS Grantees

With the exception of Region VIII, in which there were no funded EHS/CWS sites, the grantees were distributed across all ACF Regions in the United States.[16] As illustrated in **Exhibit 1-2**, almost half of the grantees were concentrated in the Midwestern United States (ACF Region V), with most grantees located in rural areas or small to midsize cities.[17] Two grantees were located in Regions I, III and X respectively, while three were located in Region VI. Three grantees were situated in large metropolitan areas (Miami, New York City, and San Diego).

[14] For more detailed information, see *Report on Planning and Start-Up of the Early Head Start/Child Welfare Services Initiative* (James Bell Associates, June 2004).
[15] For more detailed information see, *Implementation Activities and Reported Outcomes for the Early Head Start/Child Welfare Services (EHS/CWS) Projects* (James Bell Associates, September 2005).
[16] ACF's programmatic activities are implemented through 10 regional offices that serve States, territories, tribes, and grantees in their respective geographical areas. More information about ACF regional offices is available at http://www.acf.hhs.gov/programs/oro/index.html.
[17] Throughout this report, all EHS/CWS grantees will be identified by the city in which the grantee agency is located.

Exhibit I-2
Overview of EHS/CWS Programs

Grantee Name	Location	ACF Region	Funded Slots	EHS Program Model
B-H-K Child Development Board	Houghton, MI	V	16	Mixed
Carey Services, Inc.	Marion, IN	V	20	Mixed
Cen-Clear Child Services, Inc.	Phillipsburg, PA	III	20	Home-Based
Child Care Network of Evanston	Evanston, IL	V	4	Center-Based
Children's Therapy Center	Sedalia, MO	VII	5	Home-Based
Community Action of Wayne/Medina	Wooster, OH	V	10	Home-Based
Community Action Organization of Hillsboro	Hillsboro, OR	X	16	Center-Based
Community Action Project of Tulsa, Inc.	Tulsa, OK	VI	16	Mixed
Community Services for Children, Inc.	Allentown, PA	III	15	Center-Based
Crossroads: Lake County Adolescent Counseling Services	Mentor, OH	V	10	Home-Based
Dade County Board of Commissioners	Miami, FL	IV	24	Center-Based
Dane County Parent Council, Inc.	Madison, WI	V	10	Mixed
East Central Illinois Community Action Agency	Danville, IL	V	20	Mixed
EightCap, Inc.	Greenville, MI	V	16	Mixed
Family Services of Grant County	Moses Lake, WA	X	8	Mixed
Hamilton Center, Inc.	Terre Haute, IN	V	5	Mixed
Ironton-Lawrence County Community Action Organization	Ironton, OH	V	20	Mixed
Kennebec Valley Community Action Program	Waterville, ME	I	24	Home-Based
Miami Valley Child Development Center, Inc.	Springfield, OH	V	8	Center-Based
Neighborhood House Association	San Diego, CA	IX	32	Center-Based
New Opportunities, Inc.	Waterbury, CT	I	16	Center-Based
Northside Center for Child Development, Inc.	New York, NY	II	20	Mixed
South Plains Community Action Association	Levelland, TX	VI	8	Mixed
Volunteers of America of North Louisiana	Monroe, LA	VIII	8	Mixed

2. Characteristics of Grantee Communities

Although each grantee was unique in many respects, common themes emerged across many grantees in terms of the characteristics and challenges faced in their target communities. Many grantees noted increased drug use in their respective communities, in particular the rapid growth of methamphetamine use and its devastating impact on children and families. Methamphetamine was cited by many grantees as the single most important contributor to the rise in the number of children entering the CWS system. Other community factors described as contributing to increased CWS involvement include high unemployment rates; a paucity of substance abuse, mental health, and other social services; poor transportation infrastructures; social isolation; and high proportions of single-parent families.

3. Prior Collaboration with CWS

At the start of the Initiative, almost all EHS/CWS grantees had some prior history of collaboration with their local CWS agencies. In general, these collaborations were informal and based on experiences serving EHS children who subsequently entered CWS due to incidents of abuse and/or neglect. Interactions among EHS and CWS staff ranged from infrequent case-by-case communication to formalized partnership agreements established through MOUs or MOAs.

Half of the EHS/CWS grantees (Madison, Tulsa, New York, Levelland, Terre Haute, Marion, Greenville, Wooster, Ironton, Mentor, Dayton, and Danville) reported limited contact with their CWS agencies, with any interactions prior to the Initiative occurring on an informal case-by-case basis. Some grantees reported prior collaboration with a local CWS agency in the context of administrators or managers serving together on community advisory boards or steering committees (Houghton, Monroe, Ironton, Wooster, Dayton, Miami, Levelland, Waterville, and Madison).

Seven EHS grantees reported strong partnerships with CWS in the past and that their agencies have collaborated on previous community projects and initiatives (Miami, Waterbury, Philipsburg, Waterville, Moses Lake, Monroe, and San Diego). In Miami, EHS collaborated with the Juvenile Court and the University of Miami to operate the Miami Safe Start Initiative, in which CWS-involved toddlers were provided with EHS and specialized mental health services. The grantee in Waterville worked with the local CWS agency for four years on an initiative to promote child health and development and reduce child abuse. In Waterbury, the EHS grantee had established a prior agreement with the local CWS agency to hold cross-agency trainings to increase inter-organizational knowledge of the early childhood and child welfare service systems and to promote cross-agency communication. The grantee in San Diego already had an EHS classroom located at an emergency shelter operated by San Diego County where CWS-involved children could receive EHS services.

Three EHS/CWS grantees described their history with CWS as more formalized due to the EHS project's role as a CWS service provider. For example, the EHS/CWS grantee in Hillsboro had a prior contract with the Oregon Department of Social Services to provide EHS services for a limited number of children in State custody. The grantee in Evanston had been involved in processing child care subsidies for the Cook County Department of Children and Family Services. The EHS/CWS grantee in Sedalia serves as the early intervention and Part C provider for its area and consequently had been working with its local CWS agency for many years. Four grantees reported that some EHS staff had previously worked in the CWS system (Monroe, Sedalia, Wooster and Houghton). Hence, these grantees benefited from the experience of staff that understood the local CWS agency's policies and procedures and that had already established effective working relationships with CWS staff.

4. Number of Funded Slots

Grantees differed widely in the number of additional funded slots they received to serve CWS-involved children. Most grantees received funding to serve a relatively small number of children: 7 grantees were funded to serve between 4 and 8 children; 3 grantees were funded to serve 10 CWS children; 11 grantees were funded to serve between 15 and 20 children; and 3

grantees were funded to serve more than 20 children, with San Diego receiving by far the highest number of funded slots (32).[18] Overall, grantees received an average of 14.7 funded slots. Grantees were expected to maintain their funded enrollment levels and to fill vacancies when children exited their EHS/CWS projects. Therefore, the number of CWS children that a grantee served at any given time was expected to correspond to its funded enrollment level.

5. Data Availability and Comparability

Although all grantees were required to conduct local process and outcome evaluations, an important caveat involves the availability and consistency of data across grantees. Specifically, the flexibility given to grantees in designing their local projects and identifying optimal strategies to engage high-risk CWS families made it difficult to identify common outcome measures or to impose uniform data collection and reporting standards across all grantees. To facilitate data standardization, JBA created data reporting templates during the third year of the Initiative to encourage grantees with similar programs to collect and report data using common measures and definitions (see **Appendix B**). This effort was only partially successful, having been limited in part by staff turnover and the disparate capacities of grantees to collect, manage, analyze, and report evaluation data.

6. Organization of this Synthesis

The remainder of this synthesis is organized into several chapters that cover different categories of findings conveyed by grantees in their progress reports and final evaluation reports.[19] Chapter II reviews EHS/CWS program models, services, and distinctive service models, and includes an in-depth look at staffing structures, staff training, and core services provided to children and families. Chapter III reviews grantees' evaluation plans, including their research designs, process and outcome measures, and selected data collection tools and instruments. It concludes with a discussion of the challenges encountered by grantees in implementing their evaluations, as well as some of the solutions used to address them.

Chapter IV summarizes implementation findings across grantees—including client participation levels, service delivery and utilization, and project staffing and training—and concludes with a discussion of grantees' success in achieving their stated implementation objectives. Chapter V reports detailed findings on key child and caregiver outcomes, including home safety conditions, parental stress, and parenting knowledge and skills. In addition, findings on more distal child welfare outcomes, such as maltreatment recurrence and permanency, are reviewed, as well as broader organizational outcomes such as changes in caseworker knowledge and skills. Chapter VI concludes with a review of key findings and lessons learned, as well as a discussion of the long-term sustainability of the EHS/CWS projects and their implications for the advancement of State and Federal child welfare policy goals.

[18] Although grantees had to maintain enrollment of the number of children they were funded to serve, they could provide services to more than their funded number at any given time.

[19] Although 24 EHS/CWS grantees were funded in the fall of 2002, only 23 submitted a final report. The information contained in this synthesis report is based on the 23 grantees that submitted a final report.

CHAPTER II
EHS/CWS SERVICE MODELS

Each of the projects funded under the EHS/CWS Initiative provided services using a service model tailored to its unique service population. This chapter will briefly outline EHS/CWS program models; staffing and staff training; recruitment and eligibility; and the core set of services provided by grantees through their EHS/CWS projects. In addition, many grantees provided enhanced services tailored to serve CWS-involved families, which are discussed below. Finally, an overview of some distinctive and innovative EHS/CWS service models is presented.

A. Service Models

Although most grantees provided services tailored in some way to their unique target populations, all were required at a minimum to provide services that satisfy the Head Start and EHS Start Performance Standards including: (1) early childhood education, provided both in and out of the home; (2) home visits, especially for families with newborns and other infants; (3) parent education, including parent-child activities; (4) comprehensive health and mental health services, including services to support women during and after pregnancy; (5) nutrition services; and (6) ongoing support for parents through case management and peer support groups.

Like Head Start, EHS requires parent involvement and offers a variety of options for parents to become actively involved in the program, including the Policy Council, volunteer opportunities, and participation in their child's educational activities. Under the revised Performance Standards, individualized Family Partnership Agreements (FPAs) are to be developed with families that specify family goals, plans and timeframes for achieving these goals, and the roles and responsibilities of both staff and family members. Finally, all EHS grantees receive on-site monitoring reviews once every three years. During these reviews, program services are assessed using the Program Review Instrument for Systems Monitoring of Head Start and Early Head Start Grantees (PRISM) to determine whether the program has been implemented in compliance with the Performance Standards.

Enhanced EHS/CWS services were delivered through one of four program options: center-based models, home-based models, combination or "mixed" models, and "locally designed" options. For the most part, the EHS/CWS grantees adhered to one of the first three of these program options, as described in more detail below.

1. Home-Based Models

The home-based option consists of weekly 90-minute visits to families' homes to support the development of the parent-infant relationship (Jerald & Semlak, 2000). Parents whose children receive services through the home-based option are expected to participate in group socialization experiences, in which they learn about parenting and child development to enhance their skills and role as the child's primary teacher. The home-based model may be especially

convenient for families who have difficulty attending programs elsewhere due to a lack of transportation or problems with mental health or substance abuse. Altogether, five projects (Mentor, Wooster, Waterville, Sedalia, and Philipsburg) provided services through an exclusively home-based option.

2. Center-Based Models

Under center-based models, children are provided with developmentally appropriate childcare in addition to a range of enhanced EHS services. Seven EHS/CWS projects (Allentown, San Diego, Waterbury, Miami, Evanston, Springfield, and Hillsboro) operated solely center-based programs.

3. Combination or "Mixed" Models

Ten grantees (Danville, Marion, Terre Haute, Tulsa, Monroe, Houghton, Greenville, Levelland, Moses Lake, Madison) provided all enrolled children with a combination of both center-based services and home visits. For some projects, the combination model was specifically designed to provide enhanced EHS services to CWS-involved families. The remaining two grantees—New York and Ironton—operated home- and center-based program options concurrently, with a certain number of slots allocated to each option.

B. Staff Education and Staffing Ratios

Staff quality and skills have been given serious consideration in EHS programs. The revised Performance Standards require that EHS staff who work as teachers with infants and toddlers obtain a Child Development Associate (CDA) credential for infant and toddler caregivers, or an equivalent credential, within one year of hire. Furthermore, after September 30, 2003 at least 50 percent of all EHS teachers nationwide who work in center-based programs are required to have a college degree in early childhood education or a degree in a field related to early childhood education, combined with prior preschool teaching experience. The ratio of center-based child care staff to children among EHS/CWS grantees as a whole averaged approximately 5 to 1, while the average ratio of home visitors to families was 3.6 to 1.

C. Staff Training

All projects in the EHS/CWS Initiative provided special training for EHS staff. Special training topics included CWS policies and procedures, working with high-need families, and administering child and family assessment instruments. Grantees also held shared trainings with local CWS staff. Since front-line workers and managers from partnering CWS agencies were not always familiar with early childhood services, a common goal of many trainings was to educate local CWS staff about the goals, objectives, policies, and services offered by EHS programs.

D. Eligibility Criteria and Recruitment

In order to participate in the EHS/CWS Initiative, families first had to meet the general EHS eligibility requirements. Participants eligible for EHS include low-income pregnant women and families with children under the age of three. Families who have incomes at or below the poverty line, or who receive public assistance through Temporary Assistance for Needy Families (TANF) or through the Supplemental Security Income (SSI) program, meet the low-income requirement for eligibility. Although a child can be enrolled at any time from birth to age three, the intent of EHS is to intervene early and provide services during the entire first three years of a child's life (Jerald & Semlak, 2000).

In addition to the EHS eligibility requirements, each EHS/CWS project had its own specific requirements and priorities. Some grantees focused on children in foster care and family reunification, whereas others tailored their intervention to children remaining in the home. Most served children at various stages of their involvement with CWS (see **Exhibit II-1**). Eligibility was often determined by a grantee's unique theory of change and by the availability of community resources. For example, some required families to be receptive to change and non-hostile to EHS and CWS staff. Other grantees prioritized child maltreatment risk levels; for example, Monroe served families identified as at "high risk" for maltreatment, whereas Waterville only served low- to moderate-risk families. Some projects targeted more narrowly defined populations, such as caregivers and young children experiencing the effects of substance abuse (e.g., Monroe, Allentown, New York).

Most families were referred by CWS or community service providers. Only two grantees (Evanston and Marion) reported using outreach activities for recruitment. Memoranda of Understanding (MOUs) were important tools to guide the sharing of information across agencies that was necessary to generate referrals. For some projects, parents signed a blanket release of information form so that EHS workers could be informed of issues regarding a family's CWS case that were pertinent to the delivery of EHS services.

Participation in most projects was voluntary, although some families were court ordered to participate. It is possible that some CWS-involved families who participated "voluntarily" may have felt pressure from their CWS caseworkers to participate in an EHS/CWS project; this perceived or real coercive element may have been less pronounced when an EHS/CWS project was merely one of many possible service options offered to families. In situations in which families may have felt pressure to participate, EHS staff worked to build rapport with parents to ameliorate the negative effects of any perceived coercion. For example, the grantee in Springfield held a welcome event for families referred to its EHS/CWS project.

E. Overview of Core Services

While varying in their frequency and intensity, all EHS/CWS grantees provided a set of core services to all CWS-involved children and families. These core services reflect the minimum service standards for all EHS programs.

Exhibit II–1: EHS/CWS Eligibility Criteria and Referrals

Grantee	Eligibility Requirements					Referral Sources			
	Families with any level of CWS involvement (at risk or active)	Families with children in out-of-home placement	Families with active CWS cases only	Child age requirements	Other	CWS	Court Referral/ Order	Community Service Providers	Outreach Recruitment
Philipsburg, PA			●			●			
Miami, FL				●[20]			●		
Danville, IL		●			●[21]	●			
Evanston, IL		●			●[22]	●			●
Terre Haute, IN		●				●			
Marion, IN	●							●	●
Houghton, MI		●				●			
Greenville, MI	●					●	●	●	
Wooster, OH	●					●			
Ironton, OH	●					●	●		
Mentor, OH	●	●		●		●			
Tulsa, OK	●					●			
Monroe, LA	●[23]					●			
Madison, WI			●[24]			●			
Springfield, OH	●					●			
San Diego, CA		●[25]				●			
Hillsboro, OR	●					●			
Moses Lake, WA		●	●[26]			●			
Waterbury, CT	●					●			
Waterville, ME					●[27]	●		●	
New York, NY	●			●[28]	●[29]	●	●		
Sedalia, MO		●				●			
Allentown, PA		●			●[30]	●			

[20] Families with children aged 18 months and older.
[21] Intact families receiving family preservation services.
[22] Families with a substantiated report of child abuse.
[23] Priority given to the highest risk cases and those with substance use disorders.
[24] Priority given to infants and first-time mothers.
[25] Focused specifically on children in emergency shelter placements.
[26] Focus on active cases with very young children (< 1 year) with no domestic violence or sexual abuse issues.
[27] Intact families only with low to moderate child maltreatment risk.
[28] Children aged 8 months or younger at enrollment.
[29] Women enrolled in a substance-abuse treatment program.
[30] Substance-exposed newborns and toddlers.

1. Development of Family Partnership Agreements

An Individualized Family Service Plan (IFSP) is a cornerstone service provided by EHS programs. EHS staff work with the family to develop a set of desirable goals based on the family's individual needs and abilities. Once goals are established, a set of strategies to achieve those goals is developed. For several grantees, service plans were developed jointly with local CWS staff.

2. Home Visits

The EHS home visit, which is intended to be a vehicle for delivering comprehensive EHS services, makes use of everyday routines and household items to enhance parent and child learning (U.S. Dept. of Health and Human Services 2008). Five grantees operated exclusively home-based models, which generally involved the enhancement and augmentation of standard home-based EHS services. For example, Sedalia offered home visits twice per week to increase the number of contact hours with high-need CWS-involved families. A total of 12 grantees offered home visits in conjunction with or as an alternative to center-based services.

3. Center-Based Activities

As an alternative to home-based programs, EHS services may also be delivered at a centralized facility, such as an agency's Head Start childhood center. The benefits of a center-based service model include low staff-to-child ratios and the opportunity to work intensively with children on their developmental goals. Dependable, high-quality, and developmentally appropriate childcare is another important benefit of center-based models for parents that have work, school, or other commitments. In addition, some grantees used center-based services as an opportunity to promote the development of enrolled caregivers' parenting knowledge and skills.

4. Parent Education and Training Activities

All grantees offered some type of parent education through parent education classes, parent group meetings, and other parent training activities. These activities were separate from the regular educational curriculum incorporated into the projects' home- and center-based EHS programs. Some projects, such as Moses Lake, included informal learning through modeling appropriate caregiving behaviors.

5. Socialization Activities

Home-based and some combination-model programs provided semi-structured group activities for parents and their children to promote parent-child interaction and to model positive parenting behaviors. These socialization activities were distinct from formal parenting "classes" or workshops as well as from less formal recreational activities (e.g., Family Fun Nights).

6. Screenings and Assessments

As part of comprehensive EHS programming, all families received some type of developmental, medical, and dental screenings. In addition, some families were offered home safety assessments and psychological/mental health screenings.

7. Medical Care

A key objective of EHS is to provide children with a "medical home", which is defined by the American Academy of Pediatrics as "an approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective" (American Academy of Pediatrics, 2008). Basic medical services to which all enrolled children had access include pediatric examinations and dental care. In addition, some grantees offered therapeutic and counseling services with a more intensive focus on mental health issues.

8. Parent/Child Visitations

The EHS/CWS project as a whole served a total of 336 children in out-of-home placement. Some EHS grantees provided safe and neutral facilities for supervised visitations in cases that involved parents losing physical custody of their children. Given the large caseloads and limited resources of many CWS workers, the ability of some grantees to support supervised visitations served as a valuable resource to promote the child welfare goal of family reunification.

9. Mental Health Treatment and Counseling

Several grantees offered therapeutic and counseling services with a more intensive focus on mental health issues. The grantee in Miami, for instance, provided dyadic-therapy interventions through therapists from the University of Miami. The EHS project in Waterville focused on providing infant mental health supports. The project in Allentown served infants affected by substance abuse through specially designed therapeutic classrooms, while Wooster partnered with a mental health counseling center to provide mental health services to CWS-involved families.

F. Overview of Distinctive Service Models

In addition to standard EHS services, several grantees implemented distinctive program models that differed from other EHS/CWS projects in terms of the type, array, or scope of services offered. The interventions provided through this subset of grantees are unique and were not widely implemented across the EHS/CWS Initiative as a whole. This section briefly describes the core features of these distinctive service models.

1. Dyadic Therapy Model

Through a collaborative partnership established between EHS, the Juvenile Court, the University of Miami, and the local CWS agency, the project in Miami implemented a dyadic therapy model. Dyadic therapy is an approach to mental health treatment that differs from other developmental therapies in that the focus of treatment is less on the child (i.e., the "patient") than on the interpersonal dynamics and interplay between the parent and child (Maltese, 2005). The version of dyadic therapy implemented in Miami includes an in-depth interview with the mother and structured observation by a therapist of parent-child interactions at play. CWS-involved toddlers identified as needing specialized mental health services were referred to the EHS/CWS program, where they received standard center-based EHS services along with dyadic therapy. Each toddler and his/her parent or guardian was assigned to a therapist from the University of Miami and was expected to complete 27 dyadic therapy sessions. CWS case management goals were tracked along with the parents' and children's therapeutic goals, with progress in both of these domains presented at scheduled court hearings.

2. Residential Mentor Couples

Through Houghton's EHS/CWS project (known as Project New Start), families were served through an intensive three-month live-in program with family "mentors", followed by a three-month follow-up home visiting component modeled in part on the Shared Family Care program used in California, Colorado, Minnesota, and Wisconsin.[31] Families resided in a grantee-owned home and had their own living space, while a mentor couple living in another part of the home modeled effective parenting skills and linked families with area resources. At the end of three months, a new CWS family moved into the home. The same mentor family that provided live-in services also provided follow-up services for at least six hours a week.

3. Residential Substance Abuse Treatment

The New York grantee, the Northside Center for Child Development, partnered with the Palladia/Dreitzer Center for Women and Children to provide center-based EHS services in a residential substance abuse treatment setting. The Palladia Center is a residential substance abuse treatment facility that promotes drug-free lifestyles and positive mental health outcomes for mothers and pregnant women. The caregivers of children enrolled in a center-based slot participate in the Palladia Center's residential drug treatment program, which allows them to live with their children while they undergo treatment. Concurrently, their children receive center-based EHS services through two classrooms operating out of the Palladia Center that are staffed by EHS teachers from Northside Center. Parents with infants younger than eight months are served through the grantee's home-based EHS service option.

[31] Midway through the demonstration, Houghton changed to an "on-call" service model in which mentor couples are available to enrolled families on a 24/7 basis but no longer reside in the same home. This change occurred in part because of difficulties encountered with licensing the grantee's live-in facility as a foster care home.

4. Emergency Shelter Cottages

The grantee in San Diego served EHS/CWS infants and toddlers who were temporarily placed in out-of-home care at Polinsky Children's Center, San Diego County's emergency shelter facility. A co-location model was created by operating EHS classrooms on-site at the emergency shelter. EHS staff worked with shelter personnel, known as Residential Care Workers, who assumed the role of primary caregiver for each child in placement. EHS staff enhanced and supported the care that children received by providing ongoing training to all Residential Care Workers. Regular meetings were also held to address stress management and individual child cases. While at the emergency shelter, children received medical assessments and treatment as well as developmental screenings and assessments. Continuity of care was maintained after children left the emergency shelter through transitional services provided to the child's caregiver, custodial relative, or foster parent, as well as to other EHS centers and family service providers.

5. Therapeutic Child Development Services for Drug-Impacted Children

The grantee in Allentown served up to 15 drug-impacted children under three years of age through a full-day center-based program that involves specialized therapeutic child development services, including play, speech, occupational, sensory, and physical therapies. Particular attention was given to the physical environment of the center and to providing individualized and predictable patterns of care. Specialized techniques used by therapeutic teachers included "C position" holding[32]; swinging/rocking in rhythmic movements; swaddling; bathing; massage; using weighted materials during play and sleep; use of comfort objects such as blankets, pacifiers, and heartbeat sounds; and creating low stimulation environments through attention to minimal light, noise, colors, and unnecessary classroom visitors.

[32] "C position" holding is a therapeutic infant handling technique that increases an infant's sense of control and ability to relax (PICC, 2009). The technique involves holding a baby firmly and curling the head and legs into a "C" shape such that the baby's chin rests near his chest with the arms midline, while his back is slightly rounded with legs bent in an upright position.

CHAPTER III
OVERVIEW OF EVALUATION METHODOLOGIES

Each project in the EHS/CWS Initiative was responsible for designing and conducting a local evaluation. From the outset, many grantees lacked adequate resources to meet this challenge. Some grantees did not understand that they were expected to implement their own evaluations until after they were funded and therefore did not allocate money for evaluation activities. However, with the help of technical assistance from JBA, virtually all grantees succeeded in developing a theory of change and logic model to guide their evaluations; selecting and administering child and family assessment instruments; and collecting, storing, and analyzing the resulting data. Many grantees used creative strategies to secure resources for conducting evaluations, and all grantees demonstrably improved the research skills and capacity of their staff where few or none existed before. This chapter outlines the accomplishments of the EHS/CWS grantees in designing and implementing their evaluations, as well as the challenges and lessons learned along the way.

A. Cross-Site Evaluation Framework

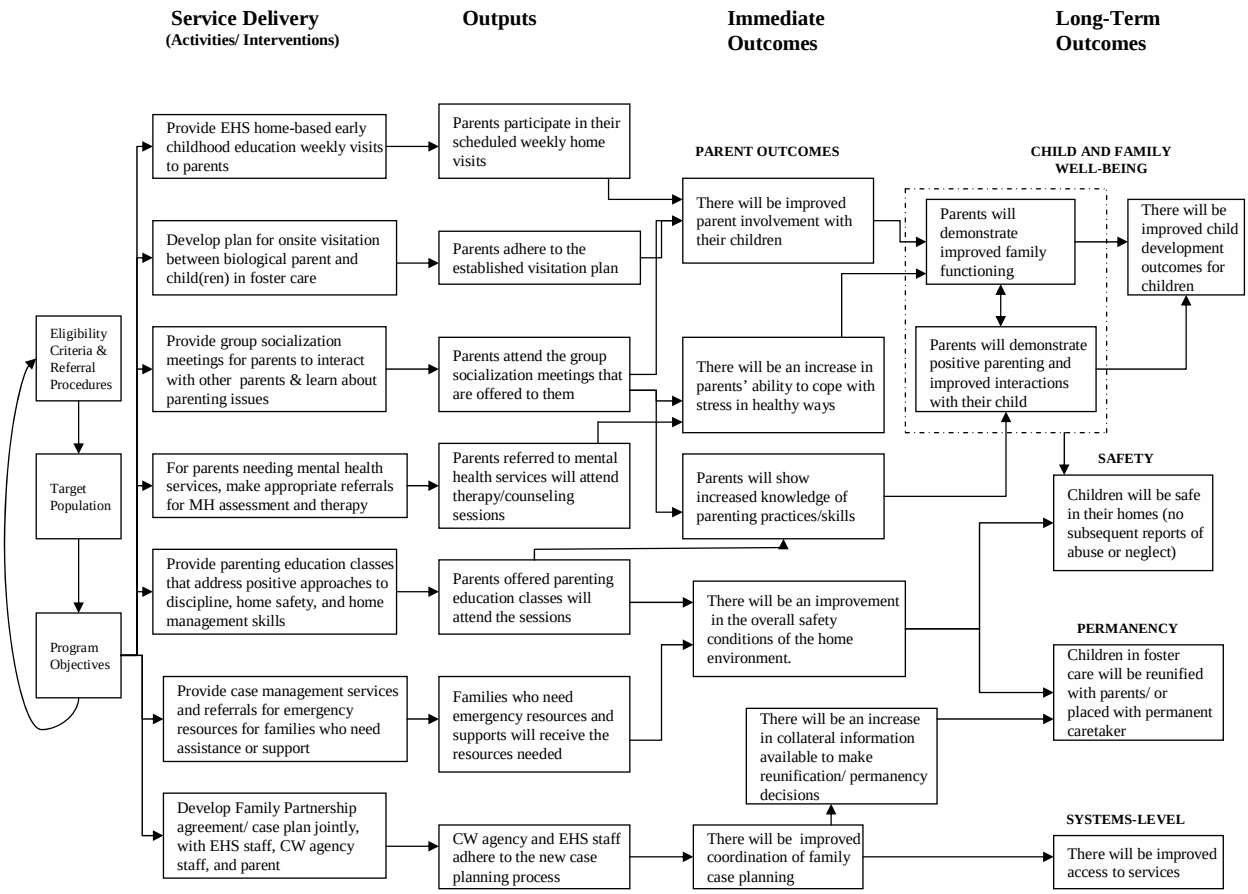
JBA provided syntheses of the grantees' progress throughout the course of the Initiative in the form of periodic reports and conference presentations. These syntheses supplied data regarding formative evaluation findings and heightened understanding of the accomplishments and lessons learned by grantees as a whole. JBA's work in this regard began with the development of a cross-site evaluation framework. Although each project followed a unique theory of change and addressed different site-specific outcomes, there were clusters of grantees that examined similar types of outcomes. During the first year of the EHS/CWS Initiative when most grantees were still in the planning and start-up phase, JBA developed a cross-site evaluation framework to help build consensus around common theories of change and to work toward identifying a limited number of outcomes relevant to multiple EHS/CWS projects (see **Exhibit III-1**). It is important to note that this cross-site evaluation framework does not imply the existence of a formal cross-site evaluation of the EHS/CWS projects. Not all grantees implemented all of the services or measured all of the outcomes depicted in the model; rather, the cross-site framework serves to provide a broad and inclusive overview of the full range of activities and outcomes addressed by the projects as a whole.

B. Overview of Local Research Methodologies

Each grantee implemented a research design that included both program outputs as well as short-term and longer-term outcomes; this research design was intended to reflect the grantee's specific theory of change and to be feasible in light of budgetary constraints on evaluation activities. All grantees eventually adopted pre-post test or longitudinal research designs, although each selected its own assessment instruments and developed site-specific data collection schedules. For example, although baseline data were collected from all participants, grantees varied in terms of the amount of time between subsequent measurement intervals (e.g.,

some grantees collected data every six months whereas others only collected data at program entry and exit).

Exhibit III - 1
EHS/CWS Cross-Site Evaluation Framework



In general, the grantees focused on implementing a strong process evaluation to gain knowledge on improving services and promoting program development, as well as increasing knowledge about building collaborative partnerships with local CWS agencies. In addition, it was expected that grantees would collect data to address the following cross-cutting questions:

- What are the factors that contribute to successful EHS/CWS partnerships?
- What challenges exist in bringing these two systems together?
- What program models work best to engage high-risk CWS children and families in EHS services?
- What services do these children and families utilize most often?

- What systems-level outcomes were achieved as a result of the projects?

- What participant-level outcomes are achieved, particularly in the areas of child and family safety, permanency, and well-being?

C. Process Evaluation

The grantees' process evaluations sought to accomplish two primary objectives: (1) tracking measures of service output and utilization to assess the extent to which each project achieved its "implementation objectives"[33]; and (2) collecting "formative" evaluation data to promote future program development and improvement. These aspects of grantees' process evaluations are discussed in more detail below.

1. Service Outputs and Utilization

Collecting service output and utilization data involves tracking the frequency, intensity, and degree of participation in services provided to enrolled children and families. Some programs were more successful than others in tracking and documenting these process measures. Given the considerable variation among projects in their capacity to collect and report process evaluation data, JBA developed an optional reporting template in the summer of 2005 that grantees could use as an addendum to their semi-annual progress reports to summarize service output and utilization data. The purpose of these optional reporting templates was to promote greater consistency across grantees in reporting process data by establishing similar definitions and standards for key process measures. The three broad categories of process measures tracked using the template include client enrollment; the number and types of services provided; and the number of children and caregivers who utilized each identified service. Although not mandatory, most grantees chose to use the data report template, which improved the overall reliability, accuracy, and consistency of basic service output and utilization data. An example of this template is included at the end of this report in Appendix B. For grantees that elected not to use the data reporting template, JBA conducted content analyses of these grantees' semi-annual reports to identify and report as much comparable data as possible on key process measures.

2. Formative Evaluation

Many grantees supplemented basic data on service outputs and utilization by collecting more in-depth "formative" data. Formative evaluations are designed to improve program performance by examining the service delivery process, the quality of program implementation, and the organizational context in which service delivery occurs. Of particular interest in a formative evaluation are the strengths and weaknesses of specific services, policies, and procedures; barriers to effective service delivery; and the identification of unexpected opportunities to achieve project goals. Such information is useful to program managers and staff

[33] "Implementation objectives" refer to the accomplishment of specific recruitment, enrollment, and service utilization goals. In other words, did a grantee serve its intended target population, enroll the number of children and families it intended serve, and provide the number and array of services it intended to offer? In addition, did children and families participate in program activities at the level and intensity desired?

as they consider whether services are reaching participants in the manner expected or if improvements and enhancements to their approach are necessary. Grantees collected formative evaluation data using a variety of methods, most notably focus groups and in-person interviews with CWS and EHS staff.

D. Outcome Evaluation

As noted earlier, the evaluations implemented by the EHS/CWS projects were tailored to the unique program model and theory of change of each grantee. However, as in the case of their process evaluations, most grantees tracked similar types of measures for their outcome evaluations, which were designed to assess the short- and longer-term effects of enhanced EHS/CWS services on the status and welfare of enrolled children and families. General outcome categories that were tracked by a majority of grantees included child-level outcomes, caregiver/family outcomes, and organizational/systems-level outcomes. Each of these major outcome categories is discussed in more detail below.

1. Child-Level Outcomes

Outcomes tracked on enrolled children fell into two subcategories: (1) child welfare outcomes and (2) child functioning and well-being. Child welfare outcomes, which reflect the focus of the EHS/CWS Initiative on families experience or at risk of abuse or neglect, centered largely on measures of child safety and permanency. For most grantees, child safety was operationalized in terms of maltreatment recurrence, i.e., the number of children who had a new maltreatment report (whether substantiated or unsubstantiated) following their enrollment in an EHS/CWS project. Likewise, permanency was generally defined in terms of the number of enrolled children ever in out-of-home placement who were reunified with their families of origin or otherwise achieved permanency through adoption or legal guardianship. For the most part, grantees relied on their CWS partners to supply data on maltreatment recurrence and permanency for their outcome evaluations. Altogether, 19 grantees were able to collect and report some on maltreatment recidivism, while 18 grantees tracked and reported some data on permanency outcomes. In addition, a smaller number of grantees examined placement prevention, generally operationalized as the number or proportion of children who avoided out-of-home placement following their enrollment in an EHS/CWS project.

Virtually all grantees tracked and reported data on one or more child development outcomes, which encompass changes in children's intellectual, communicative, social, and emotional functioning. Grantees used a variety of instruments to measure child development outcomes, many of which were already in use to assess children enrolled in standard EHS programs. The most common tool was the *Ages and Stages Questionnaire* (ASQ) (Bricker, Squires, & Twombly, 1995), which was used by 13 grantees to track changes in five key developmental areas: communication, gross motor skills, fine motor skills, problem-solving, and personal-social development. The second most common instrument, the *Denver Developmental Screening Test 2nd Edition* (Denver II) (Frankenburg, Dodds, Archer, et al., 1992), was used by seven grantees to track children's development in the functional areas of fine motor-adaptive skills, gross motor skills, personal-social development, and language skills. A complete list of

the instruments used by grantees to collect data on child development and functioning, including the number of grantees that used each tool, can be found in Chapter V of this report.

2. Parent/Caregiver Outcomes

Most grantees' theories of change incorporated the assumption that improved child welfare and developmental outcomes would arise from improvements in parental functioning and children's home environments. Specifically, many grantees examined outcomes related to changes in knowledge, skills, behavior, or status among caregivers or within the family unit as a whole, including:

- Caregivers' stress levels and ability to manage life, work, and family stress;
- Parenting knowledge and skills;
- Parent-child communication and interaction;
- Interpersonal dynamics and relationship among family members; and
- The safety and quality of the home environment, which is often regarded as a proxy measure for parental functioning, knowledge, and skill.

Grantees used a variety of methods to measure changes in these outcomes. For example, the grantee in Springfield used direct observation of parents to assess changes in parenting knowledge and skills, whereas other grantees used site-specific "home grown" checklists to measure improvements in home safety. In addition, most grantees used one or more standardized instruments that were administered at intake and at one or more subsequent measurement intervals. The most commonly used standardized instruments, along with a brief description of each, are listed below.

- **The Adult Adolescent Parenting Inventory (AAPI-2)** (Bavolek and Keene, 1999): The AAPI-2 is designed to assess the child-rearing attitudes of parents and caregivers. Constructs measured by this instrument include parents' expectations of children, parents' empathy toward children's needs, beliefs about and use of corporal punishment, parent-child roles and responsibilities, and the child's sense of power and independence.

- **The Parenting Stress Index (PSI)** (Abidin, 1995): The PSI is suggested to aid in the early identification of dysfunctional parent-child systems and in the assessment of family functioning, parenting skills, and child maltreatment risk. The tool consists of 13 sub-scales within 4 major domains: total stress, child domain, parent domain, and life stress. There are two versions of the PSI: A short form with 36 items and a long form with 101 items (the short form was preferred by most EHS/CWS grantees using the PSI).

- **Parent Behavior Checklist (PBC)** (Fox, 1998): The PBC measures the parenting practices of caregivers of children between the ages of one and five years. The scale

consists of 100 items that encompass three empirically derived subscales: Expectations, Discipline, and Nurturing.

- **Arnett Caregiver Interaction Scale** (Arnett, 1989): This instrument is designed to assess caregiver-child interactions in four sub-scales: degree of positive interaction (i.e., warm, enthusiastic, and developmentally appropriate behavior); punitiveness (i.e., hostility, harshness, and use of threat); detachment (i.e., lack of involvement and disinterest); and permissiveness.

- **Nursing Child Assessment Teaching Scale (NCATS)** (Nursing Child Assessment Satellite Training Parent-Child Interaction Program, 1995): The NCATS assesses the quality of caregiver interactions with children between birth and three years of age and is comprised of six subscales: (1) caregiver's sensitivity to cues; (2) caregiver's response to child's distress; (3) caregiver's fostering of social-emotional growth; (4) caregiver's fostering of cognitive growth; (5) clarity of child's cues; and (6) child's responsiveness to caregiver.

- **Maternal Behavior Rating Scale** (Mahoney et al., 1986): This is an observation-based tool used specifically for children with developmental problems. Mother-child dyads are instructed to play freely while their interactions are videotaped. A trained observer then rates 18 maternal behaviors on a Likert-type scale, including behaviors in the domains of child-orientation, quality of stimulus, and control.

- **Life Stress Questionnaire** (McWayne, 2005): This instrument measures self-reported stress as the result of a range of problems that include homelessness, physical illness, drug addiction, crime, unemployment, and CWS involvement.

- **Resilience Scale** (Wagnild & Young, 1993): This 25-item self-report scale measures a respondent's level of resilience, which is considered to be a positive personality characteristic that enhances individual adaptation to difficult situations. All items are scored on a seven-point scale, with 1 corresponding to "disagree" and 7 corresponding with "agree".

- **Crowell Parent-Child Relationship Procedure** (Crowell & Feldman, 1988): This instrument assesses caregiver-child interactions in an unstructured setting. The parent and child are observed and videotaped engaging in eight "episodes" including free-play, bubble blowing, clean up, four increasingly difficult problem-solving tasks, and a separation/reunion episode. The Crowell assesses the caregiver's limit setting, display of affect towards the child, and provision of emotional, instrumental, and behavioral support. In addition, it assesses the child's compliance with the caregiver's requests, display of affect toward the caregiver, aggression toward the caregiver, and task-oriented behaviors.

- **North Carolina Family Assessment Scale - Reunification (NCFAS-R)** (Kirk, 2000, 2001): The NCFAS-R is a modified version of the North Carolina Family Assessment Scale (NCFAS) (Kirk & Ashcraft, 1998) for use by family preservation service providers

working with foster care reunification cases. The scale's domains include environmental safety/stability, parental capabilities, quality of family interactions, family safety, child well-being, caregiver/child ambivalence regarding reunification, and family readiness for reunification.

- **Family Resource Scale** (Dunst & Leet, 1986): The Family Resource Scale is a self-report questionnaire that rates the adequacy of formal and informal sources of support for families with young children across 30 items, including such resources as food, shelter, financial resources, transportation, healthcare, time to be with family, child care, and time for self. The resources identified in the scale are generally organized from the most to the least essential.

- **Home Observation and Measurement of the Environment (HOME) Inventory** (Caldwell and Bradley, 2001): The HOME Inventory is designed to measure the safety, quality, and degree of stimulation in a child's home environment. The HOME includes six subscales: (1) responsiveness to parent, (2) avoidance of restriction and punishment, (3) organization of the environment, (4) appropriate play materials, (5) parental involvement, and (6) variety in daily stimulation.

- **Missouri Results Oriented Management and Accountability (ROMA) Family Self Sufficiency Scale** (Missouri Association for Community Action & Backs, 1999): The ROMA assists in assessing the progress of families in attaining economic, emotional, and social self-sufficiency. Designed for use in a semi-structured interview format, the ROMA measures a family's status on 12 factors that affect self-sufficiency, including educational attainment, academic skills, income, employment, access to health insurance, physical health, presence of mental health or substance abuse issues, adequacy of housing, adequacy of food resources, access to child care, transportation, and psychosocial and environmental stressors.

Among the range of instruments described above, three tools emerged during the course of the projects' evaluations as the most widely used: the AAPI-2, the PSI, and the HOME Inventory. Respectively, each of these instruments was suited to measure the short-term and intermediate caregiver outcomes of change in parenting knowledge and skill; parental stress levels; and the safety, quality, and stimulation of the home environment. Findings that emerged from the aggregation of data across sites that used these tools are discussed in more detail in Chapter V of this synthesis.

3. Organizational and System-Level Outcomes

"Organizational outcomes" refer to changes in the knowledge, skill, or behaviors of staff involved in implementing a program, as well as to changes in agency policies and practices. Changes in "systems-level" outcomes occur at the inter-agency and broader community level and refer to the nature and quality of relationships and communication across multiple organizations, as well as to the accessibility of high-quality services and resources for children and families.

Organizational outcomes of greatest interest to most EHS/CWS projects included EHS staff's capacity and skills to work with CWS populations; increased knowledge among EHS and CWS personnel of the laws, policies, and procedures governing their partnering organizations; and improved service delivery to CWS-involved families as measured by the number, variety, scope, and timeliness of services. At the systems level, the fundamental goals of many projects included the creation of lasting inter-organizational partnerships, improved inter-agency service coordination, and increased availability of quality health and human services in grantees' respective communities. By promoting positive change in broad system-level outcomes, grantees sought to enhance services for participating children and families and thereby improve their long-term safety and well-being. Common system-level outcomes examined by the EHS/CWS projects included improved family case coordination and data sharing, often evidenced though the establishment of Memoranda of Agreement or Understanding (MOA/MOUs); and the development or leveraging of other service collaboratives and initiatives in grantees' local communities. In most cases, grantees collected data on organizational and systems-level outcomes using meeting minutes, anecdotal reporting, and interviews with key front-line and managerial staff. These data sources were sometimes supplemented by data collected from written surveys of front-line staff.

E. Data Analysis and Reporting

EHS/CWS grantees were responsible for administering and scoring their selected assessment instruments, as well as for storing and analyzing the resultant data; most grantees relied on simple stand-alone databases and spreadsheet programs such as Microsoft Excel to accomplish these tasks. JBA provided technical assistance on these data collection and management tasks when necessary; in addition, JBA supported grantees in preparing their semi-annual progress reports and final reports by disseminating suggested report outlines, sample table shells, and data reporting templates for key service output and utilization data. Moreover, JBA supplied grantees with copies of its own semi-annual synthesis reports to inform them of how their site-specific findings were being synthesized and to provide examples of possible strategies for presenting and interpreting grantee-specific findings.

F. Evaluation Implementation: Challenges and Solutions

Grantees reported numerous challenges during all stages of their evaluation efforts; the most commonly experienced difficulties included low response rates to assessment instruments and other data collection modalities, along with a general paucity of resources to conduct evaluation activities. Grantees also reported problems with sharing or obtaining data from their CWS partners. These challenges, along with some solutions adopted by grantees in response, are discussed in more detail below.

1. Response Rates

Overall, grantees had difficulty collecting adequate levels of baseline and follow-up data. Three factors that contributed to low response rates include problems engaging families in

project services, low enrollment levels, and short enrollment timeframes. For some grantees, low enrollment was directly related to their small number of funded program slots, i.e., few slots restricted the amount of data that could be collected and the subsequent validity and generalizabiltiy of evaluation findings. Short enrollment periods resulted in families leaving an EHS/CWS project before follow-up data could be collected, a problem that is related to the broader implementation barriers of family engagement and retention. In addition to their negative effects on enrollment length, problems with family engagement often made it difficult to obtain even baseline data from some families, particularly when caregivers were resistant to participating in the project or to divulging sensitive personal information. The grantee in Moses Lake found that establishing trust and rapport between staff and program participants was essential to improving family retention levels and thereby enhancing the quantity and quality of evaluation data collected on caregivers and their children.

2. Lack of Resources

Many grantees lacked both qualified staff and funding to support their evaluation efforts. Without additional funds, EHS grantees had to implement their evaluation plans with existing financial resources and personnel. Key areas in which most grantees had to develop their evaluation capacity included the selection of an appropriate and feasible research design; identifying and administering assessment instruments that were appropriate for a project's objectives and target population; data collection; and data analysis and reporting. For many grantees, front-line staff assumed a critical role in the administration of assessment instruments and in the compilation and management of the resulting data. Not surprisingly, some project directors reported resistance from staff who felt burdened and overwhelmed by evaluation activities while simultaneously working to deliver quality services to children and families.

To address limitations in their evaluation capacity, some grantees found volunteer help through staff, faculty, and students from local universities and colleges. Because this assistance was provided on a voluntary basis, the amount of time and level of effort that these consultants could devote to evaluation activities was limited. Other ways in which grantees streamlined their evaluation efforts include adopting shorter assessment instruments, simplifying existing instruments, and limiting the number of instruments used for data collection.

3. Other Challenges

Partly as a result of their resource limitations, many grantees lacked an adequate research design and data collection plan when they began serving their first cohorts of CWS families. The delays experienced by some projects in establishing a viable data collection plan prior to implementation truncated the window for gathering reliable data on participant outcomes. This problem was often exacerbated by delays in establishing data sharing agreements between EHS and CWS, particularly with respect to the collection and reporting of child welfare data on maltreatment recidivism and exits to permanency. In some instances, problems with data sharing were addressed through MOUs/MOAs. In all cases, the challenges encountered by grantees in designing and implementing their evaluations placed limits on the quantity, quality, and comparability of evaluation findings, which will be explored in the following two chapters.

CHAPTER IV
IMPLEMENTATION OF THE EHS/CWS PROJECTS

This chapter presents findings from the implementation of the EHS/CWS projects. Specifically, the discussion will cover the topics of participant engagement and length of enrollment and retention, followed by a discussion of the lessons learned by grantees through implementing their projects. This strand of the discussion will cover the formation of EHS/CWS partnerships and the challenges faced in serving CWS-involved families. Finally, contextual factors that affected project implementation, including economic, sociological, environmental, and community-level conditions and events, are discussed. All of the findings presented in this chapter are based on data collected from grantees' semi-annual progress reports and final evaluation reports.

A. Client Participation and Enrollment

1. Enrollment Trends

Exhibit IV-1 indicates the number of funded slots received by each grantee and the total number of children enrolled from project inception through December 2006, as well as differences in enrollment over six-month intervals between December 2004 and June 2006. In total, EHS/CWS grantees reported serving 1,303 children and families from project inception through December 2006. Throughout the project, the aggregate number of funded slots (343) turned over almost 3.8 times. As is evident from the exhibit, some grantees served more CWS-involved children and families than others. Differences in enrollment levels were due to a variety of factors, the most obvious being variation in the number of funded slots, in addition to the disparate service models and goals of the projects. Some grantees focused upon helping families get back on track during periods of crisis, whereas others intended to work with children and families on a more extended basis. For example, the grantee in Evanston served the same four children and their families during the entire course of its project. In contrast, San Diego served a much larger number of children (176) through a crisis intervention model based at local emergency shelters.

Exhibit IV-1 suggests that sites experienced few long-term vacancies in program slots. Indeed, at times grantees enrolled more children than they were funded to serve. In June 2005, 92.7 percent of slots were filled; by December 2005 average enrollment exceeded 100 percent of funded slots (based on data from grantees that reported enrollment numbers), which meant that some grantees were relying on other resources—at least temporarily—to provide enhanced EHS/CWS services to certain families. When projects were not at full capacity, vacant slots were attributed to delays in referrals or in determining service eligibility. A few grantees ascribed difficulties with filling slots to a lack of referrals from their local CWS agency.

On average, families remained enrolled in an EHS/CWS project for 327 days, or nearly 11 months. This enrollment period is shorter than that expected of traditional EHS programs, which are intended to serve children from infancy until three years of age. A recent national evaluation of traditional EHS programs reported an average length of enrollment of 21 months (HHS, 2002c).

Exhibit IV–1
Program Enrollment and Vacancies over Time

Grantee	Funded Program Size (# of Children)	Total Number Served through 12/06	# of Children Enrolled at 6-month Intervals			
			12/04	6/05	12/05	6/06
Allentown, PA	15	29	15	14	16	NA[34]
Danville, IL	20	78	19	20	20	20
Evanston, IL	4	4	3	2	4	NA
Greenville, MI	16	66	20	20	20	20
Hillsboro, OR	16	57	16	16	17	10
Houghton, MI	16	84	13	10	16	18
Ironton, OH	20	101	20	20	NA	30
Madison, WI	10	34	10	11	NA	NA
Marion, IN	20	NA	20	17	21	NA
Mentor, OH	10	43	10	7	9	12
Miami, FL	24	86	23	24	NA	24
Monroe, LA	8	14	6	3	1	3
Moses Lake, WA	8	58	8	7	8	NA
New York, NY	20	83	15	17	20	18
Philipsburg, PA	20	82	NA	20	20	NA
San Diego, CA	32	176	NA	32	35	49
Sedalia, MO	5	37	5	8	7	7
Springfield, OH	8	17	8	8	10	NA
Terre Haute, IN	5	21	5	5	7	5
Tulsa, OK	16	68	16	12	16	9
Waterbury, CT	16	62	20	16	17	16
Waterville, ME	24	57	19	18	29	5
Wooster, OH	10	46	10	11	9	15
TOTALS	**343**	**1,303**	**281**	**318**	**302**	**261**
% of slots filled (of those reported)			**96.6%**	**92.7%**	**104%**	**98.9%**

[34] "NA" indicates that the grantee did provide enrollment data for the reporting period in question.

Factors that may have contributed to shorter lengths of enrollment in EHS/CWS projects include the following:

- *Age of the child at the time of enrollment*: Although data on the age of children entering EHS/CWS projects were not uniformly collected, anecdotal information reported by several grantees suggests that some children were on the older end of the EHS age eligibility continuum (e.g., over the age of two) by the time they enrolled. Projects enrolling disproportionate numbers of older children inevitably experienced shorter average lengths of enrollment.

- *Resistance to participation*: Eleven grantees reported a lack of motivation or outright resistance to participation on the part of enrolled families. A more detailed discussion of this and other implementation barriers is presented at the end of this chapter.

- *Service models focusing on crisis intervention*: As noted above, some grantees focused on serving families for a short period of time or only while they had an open CWS case. For example, most children served in the San Diego project were referred through San Diego County's emergency shelter system, during which time they remained in temporary CWS protective custody.

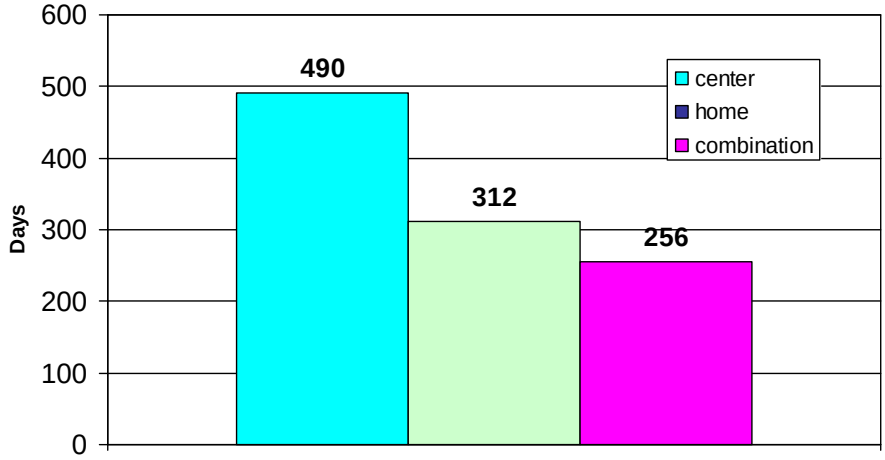
- *CWS case closure*: A decision by a partnering CWS agency to close a case appears to have encouraged some families to withdraw from their EHS/CWS projects. Indeed, nine grantees reported that families tended to drop out after CWS case closure. In addition, disruptions in EHS/CWS services were inevitable if a child was removed from the home, a termination of parental rights was issued, or if a child was adopted.

Whatever the most significant contributing factors may be, the relatively short average length of enrollment in EHS/CWS projects suggests that a comparatively narrow "window" exists for providing services to CWS-involved families, often less than one year. Grantees had to use this narrow timeframe effectively and efficiently to optimize positive outcomes for enrolled children and their caregivers.

2. Differences in Enrollment and Retention Patterns

Although no significant differences existed between EHS/CWS service models in terms of cumulative enrollment, **Exhibit IV–2** indicates that center-based programs were significantly more likely to have long enrollment periods ($p = .05$). This finding is unique to the EHS/CWS Initiative, with traditional EHS programs having similar lengths of enrollment across program types (U.S. Department of Health and Human Services, 2002c).

Exhibit IV–2
Average Length of Enrollment by Program Model



The specific reasons behind the longer average length of enrollment in center-based programs are unclear; however, certain known differences between projects operating center-based versus home-based service models may have some bearing on this finding. For example, grantees operating home-based models were more likely to report implementation barriers such as mental health and substance abuse in the target population, family resistance to participation, and dropout following CWS case closure. In addition, families enrolled in center-based programs had a strong incentive to remain involved because they benefited from access to free high-quality childcare. In combination, these factors may have improved enrollment lengths for center-based projects while driving down the average duration of enrollment in home-based projects.

B. Key Services Provided to CWS–Involved Families

EHS/CWS programs did not systematically report utilization data on all of the specific services provided. However, a significant number did report on three key services provided to CWS-involved families, which are described in detail below.

1. Home Visits

Grantees serving families through a home-based model scheduled an average of 4.6 home visits per month. This figure exceeds the standard of four monthly visits for traditional home-based EHS programs. Some grantees offered more frequent visits as part of an enhanced service plan for CWS-involved families. For example, the grantee in Sedalia offered eight visits per month as part of its intensive home-based service model based on the assumption that more frequent points of contact and lower family-to-staff ratios would enable staff to respond to crises and address the service needs of enrolled families more quickly.

2. Child Care

Between center-based and mixed programs, families were offered an average of 32.9 hours per week of free and developmentally appropriate childcare. The availability of childcare gave many parents the flexibility to work, seek employment, attend court hearings, and attend appointments for medical care, therapy, counseling, and other services.

3. Parent Education and Training Activities

Most grantees set out to provide some type of parent education and training, whether in the form of modeling appropriate behaviors, informal instruction, or formal educational programs. Fifteen grantees reported providing formal parenting classes, whose topics ranged from child development to car seat safety. The most common topics included general parenting knowledge and skills, child development, and fostering children's physical health and development, which were covered by 12 grantees. Other common topics included maintaining a safe home environment (reported by eight grantees) and stress management (reported by seven grantees).

C. Staff Training

Twenty-three grantees reported holding staff trainings. The three most common training topics (reported by nine grantees) included State/county CWS laws, policies, and procedures; EHS policies and infant/toddler development; and promoting learning readiness. Other popular topics included infant mental health (reported by eight grantees); conducting health and developmental screenings (eight grantees); family case planning and goal development (8 grantees); identifying signs of abuse and neglect (six grantees); and working with children experiencing abuse, neglect, or other trauma (six grantees).

D. Building EHS/CWS Partnerships

As discussed in Chapter I, only a handful of grantees had a prior working relationship with a CWS agency. Many forged relationships with their CWS partners specifically for the purpose of implementing an EHS/CWS project. Grantees achieved varying levels of success in cultivating these relationships. Some grantees reported regular and effective collaboration. For example, the grantee in Philipsburg reported regular weekly meetings between its EHS/CWS Liaison and CWS staff; the EHS/CWS Liaison also attended monthly court hearings for EHS/CWS families along with CWS staff. The grantee in Danville achieved an open line of communication with its partnering CWS agency through monthly meetings between CWS caseworkers and the EHS home-based teacher. Other grantees experienced more difficulty, with effective and open communication across agencies presenting an ongoing challenge. Evanston, for instance, reported that the Cook County CWS agency seemed to be unaware of the existence of its EHS/CWS project, which could have been due in part to the fact it was funded to serve only four children. The grantee in Ironton described a long period of resistance to participation

on the part of local CWS staff, who appeared to be waiting for a formal directive from CWS management to collaborate with EHS.

1. Establishment of MOUs/MOAs

Memoranda of Understanding (MOUs) or Memoranda of Agreement (MOAs) are documents that express a formal (although not necessarily legally binding) relationship between organizations and that describe the roles of the partnering organizations. In the EHS/CWS Initiative, MOUs were of key importance because the projects rested on the foundation of collaboration between CWS and EHS agencies. MOUs allowed partners to specify their respective responsibilities in the EHS/CWS project and determine policies and procedures for referrals, enrollment, and data sharing. MOUs also helped to protect the collaboration in the event of staff turnover, especially at the managerial level.

As **Exhibit IV–3** illustrates, almost all grantees were able to establish an initial MOU with their partnering agency. In addition, 12 grantees successfully updated their MOUs at least once, while six grantees updated their MOUs two or more times during the course of their projects. Two grantees were not able to establish an MOU with a partnering agency. For example, the grantee in Miami never established an MOU because of the recent privatization of Florida's child welfare system and the subsequent complexities that would have been involved in forming agreements with multiple private social service agencies. However, the grantee did foster a strong collaborative relationship with one private agency through cross-trainings and the development of a standardized referral process and screening protocol. In addition, the grantee established informal partnering relationships with the courts and had multiple service contracts with the University of Miami. As such, the lack of an MOU did not prevent the grantee from proceeding with the successful implementation of its EHS/CWS project.

Exhibit IV–3
Reported Establishment of MOUs

MOU Status	# of Programs (n=23)
Established initial MOU	21
Updated MOU at least once	12
Update MOU more than once	6

In Wooster, the grantee partnered with a mental health counseling center rather than the local CWS agency. The Wooster project originally planned to incorporate two county CWS agencies in its service model, whereby each county would hire a child welfare family advocate who would provide supplemental services to EHS/CWS families. However, due to insufficient funding, the CWS agencies were unable to hire these additional advocates. In light of this setback, the grantee instead negotiated with a new partner—a local mental health counseling center—that agreed to hire a family advocate to work with EHS/CWS families.

2. Partnership Activities

Collaborative relationships between EHS and CWS involved a range of activities, which are described in more detail below.

- *Joint Staffings, Case Planning, and Service Coordination*: All EHS/CWS projects involved some degree of joint case planning and service coordination with a local CWS agency or other partnering organization. In Allentown, for example, a multidisciplinary team of CWS caseworkers and supervisors, EHS managers, EHS staff, court-appointed child advocates, and a child psychologist met monthly to review and discuss EHS/CWS cases. In Marion, there was frequent communication between EHS and CWS at the frontline worker level, and joint case staffings were held on a monthly basis.

- *Shared Trainings*: Fourteen grantees reported holding shared trainings. For the most part, the topics of these trainings related to project-specific services and activities. Nine grantees held shared trainings on broader topics such as EHS policies, services, procedures, and performance standards, while six grantees held shared trainings on State or county CWS laws, policies, and procedures. Other shared trainings were held on topics similarly designed to strengthen the collaborative partnership, including the judicial system, court policies and procedures, and infant mental health.

- *Parent/Child Supervised Visits*: Fourteen grantees provided facilities for supervised visits between parents and their children in out-of-home placement. The number of visits depended in part on a grantee's particular service model. For example, families participating in Miami's dyadic therapy model had a minimum of one supervised visitation with the therapist. Waterbury reported the greatest average number of supervised visits, with an average of 10 per family. As a whole, these 14 grantees provided an average of 1.8 supervised visits per family. Some grantees did not target children in out-of-home placement and therefore did not participate in supervised visits.

- *Co-location*: Three grantees (Sedalia, Philipsburg and San Diego) adapted "co-location" models in which an EHS staff person was stationed at a CWS office or other facility. In Sedalia, the EHS Project Liaison was housed at the CWS agency headquarters and had direct access to CWS caseworkers and supervisors. The San Diego grantee operated an EHS classroom onsite at San Diego County's Polinsky Children's Center, an emergency shelter facility for children removed from the home. In Philipsburg, the local CWS agency provided office space for EHS staff, while CWS workers in turn had access to computers and telephones at the EHS office.

- *Shared Financial Resources*: Three EHS/CWS grantees (Dayton, Allentown, and Moses Lake) reported that their partnering CWS agencies contributed financial resources toward their EHS/CWS projects. In general, the CWS agencies paid a specified amount each year toward the cost of serving children in families with open CWS cases.

- *Cultivation of Professional Relationships*: Several grantees described other regular, albeit less formal contacts between EHS and CWS staff at both the front-line and managerial levels. The EHS/CWS projects in Moses Lake and Springfield reported that open and frequent communication occurred at all staff levels, while the CWS supervisor in Sedalia maintained an "open door" policy with EHS and CWS personnel to facilitate discussion regarding enrolled families on an informal, as-needed basis. These programs noted the positive effects of more frequent communication on inter-agency understanding and collaboration. Madison reported significant changes in personal relationships and levels of cooperation among EHS and CWS staff at both the direct service and administrative level; employees from both agencies gained a greater appreciation and respect for one another's work and contributions to the project. Similarly, Sedalia reported increased communication mutual understanding, cooperation, and respect among CWS and EHS staff.

E. Cross-Cutting Implementation Challenges

All grantees experienced some difficulties in implementing and realizing the objectives of their EHS/CWS projects. As discussed in the following section, these implementation challenges tended to involve issues with client engagement, staff retention and turnover, organizational barriers to effective service delivery, and broader contextual factors, such as the characteristics and resources available in grantees' communities.

1. Client Engagement and Retention

Client engagement and retention was a challenge reported by almost all grantees throughout the course of the EHS/CWS Initiative. As noted earlier, families remained enrolled in EHS/CWS projects for fewer than 11 months on average, far less time than the national average of 21 months in traditional EHS programs. This truncated enrollment is perhaps not surprising given the finding of the recent national EHS evaluation that programs experienced the greatest difficulty helping "high-risk" families, i.e., those with multiple risk factors such as substance abuse and low levels of education (HHS, 2002c). The target populations of the EHS/CWS Initiative by definition included high-risk families; some parents were dealing with substance abuse or metal health problems, others were incarcerated, and most experienced difficulty living up to accepted parenting norms. The most common barriers to family engagement and retention are noted below.

- *Mental Health/Substance Abuse*: Twelve grantees reported mental health and/or substance abuse as a barrier to engaging families in EHS/CWS services, particularly those programs implementing home-based service models. Indeed, all five home-based programs reported mental health and/or substance abuse as a major barrier to effective service delivery.

- *Family Resistance***:** Eleven grantees reported that families were reluctant to participate in EHS/CWS services. This resistance often resulted from a perception on the part of parents that EHS staff were actually CWS workers who were monitoring their behavior

to find reasons to take away their children. Some parents responded negatively to what they perceived as a lack of power in their relationship with EHS staff. In addition, some parents perceived subtle coercion from their CWS caseworkers to participate in an EHS/CWS project, or in the case of court-ordered enrollment, were actually required to participate. Perceived or real coercion to participate in an EHS/CWS project likely contributed to the resentment and resistance expressed by some enrolled families.

- *Transportation*: Ten grantees reported that a lack of reliable transportation limited the ability of some families to participate fully in project activities and services.

- *Dropout at CWS Case Closure*: Nine grantees reported that families tended to drop out of the EHS program once their CWS case was closed. This suggests a tendency of some families to "go along" with the program until they are no longer constrained by the legal mandates and authority of the CWS agency. In Sedalia, for example, family participation in home visits was far below the target number of visits; resistance to home visits in some cases resulted from parents getting past the "danger zone" of a possible out-of-home placement by meeting the requirements of a CWS case plan. Similarly, the grantee in Madison reported that families that enrolled because they believed CWS might remove their children were more likely to drop out early or fail to keep scheduled appointments once they perceived that this threat had passed.

- *Time Constraints*: Seven grantees identified the hectic schedules of enrolled families as an additional barrier to engagement. Between work, court appearances, mental health or substance abuse treatment, and other appointments and service commitments, many families faced serious time constraints to participate actively in EHS/CWS services.

- *High Family Mobility*: Six grantees reported that high levels of geographic mobility among enrolled families, often due to problems finding and maintaining employment and housing, contributed to high project dropout rates.

2. Staff Retention and Turnover

Staffing issues, particularly high turnover rates, created additional challenges for many EHS/CWS projects by disrupting service provision and slowing progress in establishing trusting relationships with enrolled families. Altogether, 11 grantees reported staff turnover as an implementation barrier. In addition, 10 grantees reported losing a director during the course of the EHS/CWS Initiative. Staff turnover often resulted from the high levels of stress associated with working with CWS-involved families, which in turn contributed to job "burnout" and dissatisfaction. For example, staff in Philipsburg's project found that working with its specific target population was extremely stressful because many families faced multiple complex and sometimes intractable challenges. In Terre Haute, staff faced the dual challenge of working within tight time constraints while trying to gain the trust of caregivers whose children were continually changing foster care placement settings. The grantee in Evanston reported that it had became a hub coordinator for Strengthening Families Illinois, a State-based initiative to prevent child abuse and neglect through partnerships among early childhood centers, parents, CWS agencies, and others social service providers. This new role limited the amount of services that

could be provided to EHS/CWS families as staff became burdened with their new roles and responsibilities.

Staff turnover contributed to the loss of seasoned employees' knowledge and experience, and sometimes disrupted the positive yet fragile relationships that had been cultivated with participating families. In San Diego, for example, staff turnover at the emergency shelter necessitated the use of substitute workers who were not always trained in early childhood services and appropriate teacher-child interactions. In addition, employee attrition drained projects' resources by compelling them to invest time and money to train new employees.

3. Organizational Barriers

Organizational barriers generally involved dynamics in the relationship between an EHS program and a CWS agency. As **Exhibit IV-4** indicates, nearly half of all grantees reported communication problems with their local CWS partner. These communication barriers sometimes resulted from infrastructure problems; for example, CWS workers in some communities lacked adequate access to information technology resources (e.g., voicemail and e-mail), which made it more difficult to contact and respond to EHS staff. Other problems emerged due to the different professional vocabularies and "jargon" of the child welfare and early childhood professions, which sometimes led to miscommunication and confusion regarding staff roles and responsibilities. Philosophical differences between EHS and CWS, which generally involved different professional perspectives on appropriate strategies and priorities for serving CWS-involved families, were reported by five grantees. Moses Lake, for instance, described EHS workers as having a service philosophy that emphasized client strengths, whereas CWS workers tended to stress case plan compliance and child safety. A few grantees described "turf" issues, i.e., mistrust or resistance due to a perceived violation of an agency or worker's traditional roles and responsibilities, as an additional organizational barrier. Some barriers were more systemic in nature in that they involved the actual staffing and organizational structures of the participating organizations. The grantee in Tulsa, for example, noted that the large caseloads of CWS workers limited their opportunities for daily interaction with enrolled families.

Exhibit IV-4
Common Organizational Barriers

Barrier	Number of Projects Reporting (n=23)
Communication problems between EHS and CWS	11
Philosophical differences between EHS and CWS	5
Lack of referrals from CWS	3
"Turf" issues between EHS and CWS	3

4. Contextual Factors

As summarized in **Exhibit IV-5**, grantees faced a range of contextual factors that often complicated their efforts to provide effective services. The most frequently reported contextual

issues include general economic and sociological factors, such as housing shortages, joblessness, poor transportation infrastructures, and endemic community drug abuse. The EHS/CWS project in New York described a steady increase in housing costs in the Harlem community, which forced many families who were otherwise eligible for EHS/CWS services to move to less expensive housing markets outside of the grantee's catchment area. Conversely, the project in Danville reported that the City of Chicago had recently closed many of its public housing projects; as a result, many former residents of these projects relocated to the grantee's community, which increased demand for public services, raised housing costs, and contributed to higher crime rates and larger caseloads for the local CWS agency. Seven grantees described a lack of local service resources as a significant barrier to effective project implementation. This paucity of resources was particularly acute in rural areas; indeed, five of seven grantees that reported resource problems are located in rural communities. In particular, mental health and substance abuse treatment resources were identified as in short supply.

Several grantees reported budget cuts at the State or local level that created constraints on the delivery of EHS/CWS services. In addition, changes in State or local government organization or leadership were identified by other grantees as an impediment to smooth project implementation. For example, Sedalia discussed the breakup of a local CWS department into two separate divisions, which disrupted the overall operations of the local CWS office and drew resources, time, and staff away from the EHS/CWS project. The grantee in Miami experienced difficulties in establishing a formal connection with its service partners while the child welfare system in Florida underwent a process of statewide privatization. One grantee reported delays in project implementation due to the impact of Federal policy priorities, particularly with respect to the staff time required at a local CWS agency to participate in a Federal Child and Family Service Review (CFSR).[35]

Exhibit IV–5
Contextual Factors Affecting Implementation

Barriers	Number of Project Reporting (n=23)
Economic and sociological factors	8
Lack of local service resources	7
State and local budget issues	5
Changes in the organization or leadership of State, local government, or community organizations	3
Impact of Federal laws and policies	1

[35] CFSR is a monitoring and review system established in 2000 by the U.S. Department of Health and Human Services to assess conformity with certain Federal requirements for child protection, foster care, adoption, family preservation, family support, and independent living services. The Children's Bureau within HHS administers the CFSR review system. See Chapter VI for a more detailed discussion of the relevance of CFSR to the EHS/CWS projects.

H. Summary

The analysis presented in this chapter suggests that despite numerous challenges, EHS/CWS grantees as a whole succeeded in meeting their most important implementation objectives, including the maintenance of funded enrollment levels and providing a range of specialized health and early childhood services. Key implementation findings are summarized below:

- Cumulative enrollment during the course of the EHS/CWS Initiative reached 1,303 CWS-involved families.

- Enrolled families were served for an average of 327 days, or nearly 11 months. This enrollment period is shorter than the average enrollment of 21 months observed among traditional EHS programs, which suggests that a relatively narrow "window" exists to provide effective interventions to CWS-involved families.

- Center-based programs had longer average lengths of enrollment (490 days, or slightly more than 16 months) than programs operating home-based or mixed models. Center-based projects also reported fewer implementation barriers, such as family resistance to service, dropout following CWS case closure, and mental health and substance abuse issues among enrolled caregivers.

- EHS/CWS projects serving children in out-of-home placement facilitated an average of 1.8 supervised visits between parents and their children in placement.

- Grantees achieved varying levels of success in establishing firm relationships with their CWS partners. However, nearly all established an initial MOU, many of which were renewed on a regular basis. Many projects held regular meetings and cross-agency trainings to promote joint case planning, service coordination, and improved knowledge and skills among front-line staff. In addition, a few grantees stationed staff at the offices of their partnering CWS agencies to increase project referrals and enhance communication between EHS and CWS staff.

- Common barriers to inter-organizational collaboration included communication problems between EHS and CWS workers; the disparate professional languages and "jargon" of EHS and CWS staff; philosophical differences between EHS and CWS with respect to priorities and appropriate strategies for serving CWS-involved families; and a lack of referrals from partnering CWS agencies.

- Factors that contributed to problems with client engagement and retention included resistance to participate in EHS/CWS services, sometimes due to mistrust and perceived or real coercion; dropout following CWS case closure; mental health and substance abuse issues among enrolled caregivers; limited transportation resources; and high levels of geographic mobility among enrolled families.

- Turnover in front-line staff and EHS project directors was identified as a significant implementation barrier by nearly half of all projects. Staff turnover often resulted from the high levels of stress associated with working with CWS-involved families, which in turn contributed to job "burnout" and dissatisfaction.

- Major contextual factors that affected implementation included sociological variables, such as unemployment, expensive housing markets, and endemic substance abuse; a lack of local service resources, particularly mental health and substance abuse services; State and local budget issues; and changes in the organization or leadership of State, local government, or community organizations.

CHAPTER V
OUTCOMES OF THE EHS/CWS PROJECTS

A. Introduction

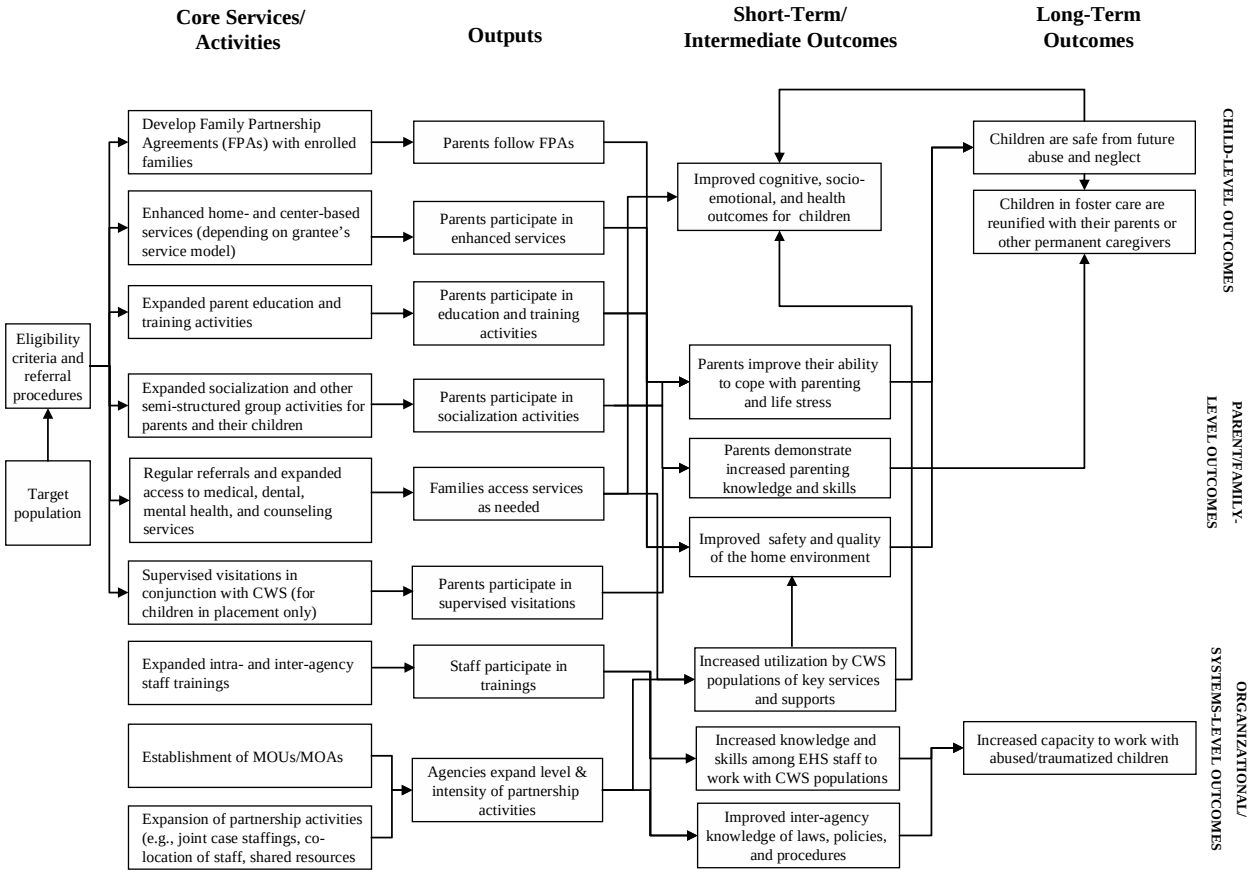
With the submission of their final evaluation reports in the spring of 2007, the EHS/CWS grantees have provided a cumulative picture of their success in improving key child, caregiver, and systems-level outcomes. Past synthesis reports prepared by JBA have primarily focused on short-term and intermediate participant-level outcomes that were identified as common to a majority of grantees, specifically in the domains of:

- Increased parenting knowledge and skills;
- Improved safety and environmental conditions in the home; and
- Reduced parental stress.

This chapter seeks to expand this discussion by synthesizing available findings across grantees on key child welfare outcomes of interest, including maltreatment recurrence and exits to permanency; child well-being outcomes, particularly timely and reliable access to medical care; and systemic or organizational outcomes that affect the grantees' long-term capacity to serve CWS populations. The discussion of outcomes is organized along three major dimensions: (1) child-level outcomes that relate to the safety, permanency, and well-being of CWS-involved children; (2) caregiver-level outcomes that pertain to parenting skills, parental functioning, and the ability of caregivers to maintain safe and stimulating home environments; (3) and "system-level" outcomes regarding changes in organizational capacity, collaboration with other organizations, and access to services. These three dimensions are also reflected in the revised cross-site evaluation framework depicted in **Exhibit V-1** below, which was developed after most projects had reached an advanced stage of implementation and more detailed evaluation findings had become available. The revised framework illustrates how the focus of the projects' service models and evaluations evolved from the original cross-site evaluation framework depicted in **Exhibit III-1**. Moreover, the presentation of child-level outcomes serves as the foundation for a broader discussion of the implications of the EHS/CWS Initiative for improving States' CFSR performance.[36]

[36] As noted in past synthesis reports, readers should exercise caution in drawing conclusions regarding the intensity or scale of positive outcomes described in this chapter, or in making comparisons across grantees about the relative effectiveness of their projects. A discussion of the most important caveats is included in Appendix A at the end of this report.

Exhibit V-1
Revised EHS/CWS Cross-Site Evaluation Framework



B. Child-level Outcomes

Although precise parallels cannot be drawn between the child-level data collected by the EHS/CWS grantees and CFSR safety and permanency measures, it is possible to operationalize two basic measures of safety and permanency across a majority of projects: (1) the number and proportion of children who experienced a subsequent maltreatment report (whether substantiated or unsubstantiated) following entry into the EHS/CWS project[37]; and (2) among children in out-of-home placement, the number and proportion that were reunified with their families of origin

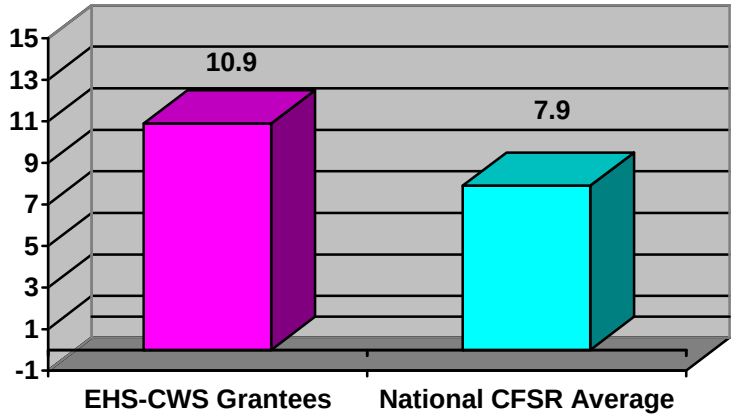
[37] The most comparable CFSR outcome measure is: "Of all children who were victims of a substantiated maltreatment allegation during the first six months of the year, what percent were not victims of another substantiated allegation within the next six-month period?"

or achieved permanency through adoption.[38] Findings with respect to these two measures are presented in the following sections.

1. Child Safety

Although grantees conceptualized child safety in numerous ways, a majority of grantees examined maltreatment recidivism, generally defined (as noted above) as the number and/or proportion of children that experienced a subsequent maltreatment report (whether substantiated or unsubstantiated) following entry into the EHS/CWS project. A total of 19 grantees (79 percent) reported some data on maltreatment recurrence; across these grantees, an average of 5.74 enrolled children had a maltreatment report following entry into the EHS/CWS project. With a total of 120 children associated with a subsequent report across these 19 grantees, and a total enrollment of 1,096 children[39], the average maltreatment recurrence rate is estimated to be nearly 11 percent (**Exhibit V-2**). Although not strictly comparable, the national CFSR maltreatment recurrence rate in Federal Fiscal Year 2006 was somewhat lower at 7.8 percent (U.S. Department of Health and Human Services, 2008).

Exhibit V-2
Comparison of Maltreatment Recurrence Rates



At first glance, these data suggest that children enrolled in the EHS/CWS projects are somewhat more likely to experience maltreatment recidivism than their peers in the general child welfare population. However, as is often the case with pilot projects that direct a range of intensive services on a vulnerable population, an apparent increase in a negative outcome may simply reflect the increased scrutiny experienced by enrolled families. Specifically, the heightened intensity of relationships between EHS/CWS program staff and program participants, combined with the greater number of service providers that are likely to interact with enrolled

[38] The most comparable CFSR outcome is: "Of all children entering foster care for the first time in the six-month period who remained in foster care for eight days or longer, what percent were discharged from foster care to reunification in less than 12 months from the date of latest removal from home?" There is also a corresponding CFSR outcome for exits to adoption.
[39] Note that the enrollment figure reported here (1,096 children) only includes data from the 19 grantees that also reported data on subsequent maltreatment reports. As discussed in Chapter IV, total cumulative enrollment across all 23 grantees comes to 1,303 children.

families, may reveal more concerns about child safety and well-being than would normally surface under more routine service conditions. In this sense, it is possible to interpret more frequent reports of maltreatment recurrence in a positive light as indicative of the greater concentration of services and professional contacts received by EHS/CWS families.

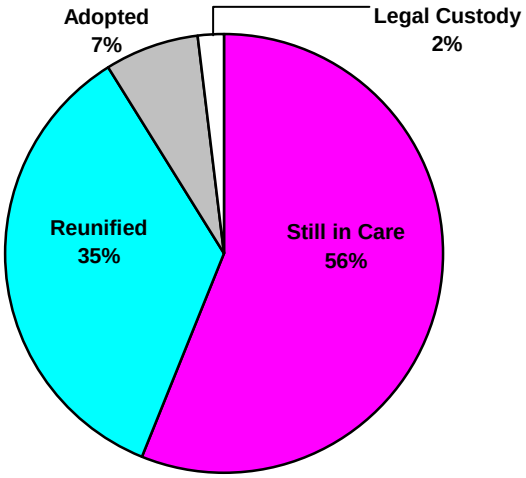
2. Exits to Permanency

A total of 18 grantees (75 percent) reported some data on placement rates, defined as the proportion of ever-enrolled children who were in or entered out-of-home placement at some point during their participation in an EHS/CWS project. Among these grantees, placement rates ranged from 20 percent to 100 percent, with almost half (48 percent) of all children having been in placement at some point during enrollment in their respective projects. Because these figures include children who were already in placement at the time of their enrollment in an EHS/CWS project as well as children who later entered placement, it is difficult to assess the overall effects of the grantees' projects in preventing out-of-home placement. Moreover, it is important to note that not all 24 grantees targeted or served children in out-of-home placement.

The same 18 grantees mentioned above also reported some data on exits to permanency; of these, 13 grantees (72 percent) reported findings in a format that allows for the cross-site summarization of permanency outcomes, defined as the proportion of children that exited to reunification, adoption, or permanent legal custody (i.e., guardianship). Of the 336 children ever in placement across these 13 grantees, 116 (35 percent) were reunified with their families of origin, 25 (7 percent) were adopted, and 8 (all reported by the grantee in Miami) exited to guardianship. The average net permanency rate (reunifications, adoptions, and guardianships combined) across these 18 grantees comes to 44 percent.

Net permanency rates ranged from a low of 12 percent to a high of 100 percent, with the grantees in Terre Haute, Springfield, and Madison reporting particularly high permanency rates of 76 percent, 100 percent, and 86 percent, respectively. However, direct comparisons among grantees in their permanency outcomes must be made with caution given the large disparities across sites in the number and proportion of children in out-of-home placement. For example, although the grantee in Springfield had a net permanency rate of 100 percent, it only had five children who were ever in out-of-home placement; this contrasts with grantees such as San Diego, Miami, and Moses Lake that have large out-of-home placement populations. **Exhibit V-3** provides another perspective on the permanency outcomes of the EHS/CWS projects by depicting the status of the 336 children ever in out-of-home placement as of December 2006.

Exhibit V-3
Permanency Status of EHS/CWS Children Ever in Placement
N=336



On balance, the net permanency rate observed within this population of CWS children is identical to the average 2003 permanency rate of 44 percent calculated using aggregated CFSR data from the 17 States that hosted a EHS/CWS project site (U.S. Department of Health and Human Services, 2006); these data suggest that children served through the EHS/CWS initiatives are at least as likely be reunified or otherwise achieve permanency as children in the general child welfare populations in these States. It is possible, however, that the permanency rates observed among these 13 grantees underestimate actual rates within the entire population of EHS/CWS families due to underreporting of permanency data by some grantees. Moreover, because no consistent data on length of time in out-of-home care were collected across all grantees, direct comparisons with the national CFSR permanency measures for reunification and adoption (which are benchmarked against timeframes of 12 and 24 months, respectively) are of limited validity.

3. Child Development and Well-Being

The EHS/CWS grantees examined multiple aspects of child well-being, including cognitive, communicative, and socio-emotional development; acquisition of early learning skills; and health and nutritional status. As indicated in their final evaluation reports, the grantees used a wide range of instruments to assess changes in children's developmental progress, which are summarized in **Exhibit V-4** in descending order of frequency.

Exhibit V-4
Summary of Child Development Screening and Assessment Instruments
N=23 Grantees

Instrument	# of Grantees
Ages and Stages Questionnaire (ASQ)	13
Denver Developmental Screening Test, 2nd Edition (DDST II)	7
Greenspan Socio-Emotional Growth Chart	3
Hawaii Early Learning Profile (HELP)	3
Creative Curriculum – Individualizing Goals and Objectives for Infants & Toddlers	2
Direct child observation (no specific instrument)	2
Early Learning Accomplishment Profile (ELAP)	2
Ounce of Prevention Scale	2
Battelle Developmental Inventory (BDI)	1
Bayley Scale for Infant Development	1
Brief Infant Toddler Socio-Emotional Assessment (BITSEA)	1
Child Well-Being Scales	1
Denver Articulation Screening Exam (DASE)	1
Devereux Early Childhood Assessment	1
Galileo Developmental Assessment	1
Greenspan Socio-Emotional Growth Chart	1
Infant and Toddler Development Assessment (IDA)	1
Macarthur Communicative Development Inventories (CDI)	1
Temperament and Atypical Behavior Scale	1
TRIAD Social Skills Assessment	1

Few screening and assessment instruments were used widely across the grantees, with only one tool (the ASQ) used by a slim majority, followed by the DDST II, which was used by almost a third of the grantees. The remaining instruments, which cover many different aspects of child development, are often used exclusively by just one grantee or at most two or three. Given the multitude of instruments used by the grantees to assess a wide spectrum of developmental constructs, generalizations regarding the overall progress of children enrolled in the EHS/CWS projects in many domains of child well-being are problematic. Moreover, some of these instruments—most notably the ASQ—are primarily designed to serve as screening tools to assess a child's current developmental status and needs and are not appropriate for measuring developmental changes over time. However, a review of results from different tools used by a range of grantees reflects a general trend toward improvement in multiple domains of children's cognitive and socio-emotional development:

- In Mentor, results from the *Greenspan Socio-Emotional Growth Chart* revealed that 90 percent of enrolled children were on target with respect to age-appropriate socio-emotional development and behaviors after participating in the project.

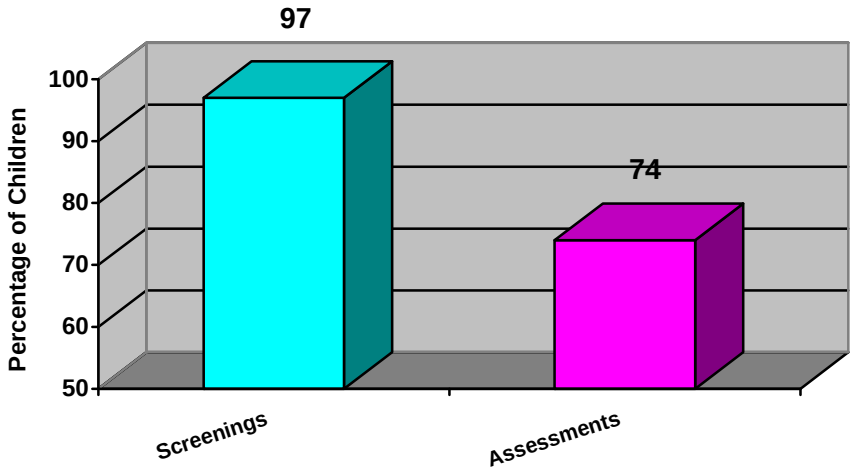
- Among children enrolled in Greenville's project, 71 percent of those who were not competent in all areas of the *Infant and Toddler Development Assessment* (IDA) at enrollment showed improvement in one or more developmental domains on a second administration.

- In a small sample of children (N=5) enrolled in Madison's project, all exhibited dramatic improvement in their language skills as measured by the *Macarthur Communicative Development Inventories* (CDI). For some children, percentile rankings increased about 50 percent in certain language domains.

- Ten percent of children enrolled in New York's project performed more than one standard deviation below national norms on the *Battelle Developmental Inventory* (BDI) at intake; by the time of a second test administration several months later, no children were performing more than one standard deviation below national norms.

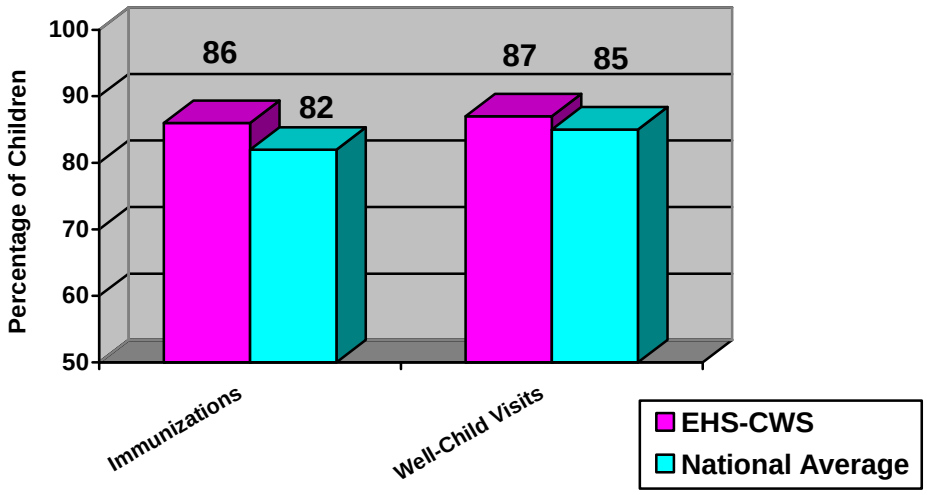
One aspect of child well-being that is more amenable to cross-site analysis involves certain health outcomes, specifically, whether children receive timely medical and developmental screenings and assessments, as well as appropriate medical checkups and immunizations. **Exhibit V-5** suggests that as a whole, the grantees have succeeded in screening virtually every enrolled child to ascertain its medical and/or development status. Twenty-one grantees reported some data on efforts to conduct medical or developmental screenings; among these grantees, a total of 1,075 children received a screening, which translates into 97 percent of all children enrolled in these projects. In addition, 20 grantees reported some data on subsequent efforts to conduct more in-depth assessments in cases in which developmental or medical issues were identified following an initial screening. Among these grantees, 745 children received a more in-depth medical or developmental assessment, which equates to 74 percent of all children enrolled in these projects. The lower number of completed assessments among these 20 grantees does not imply poorer performance; rather, as would be expected, these data suggest that fewer children had a potentially serious condition that required more in-depth testing and review.

Exhibit V-5
Receipt of Developmental/Medical Screenings and Assessments



A majority of EHS/CWS grantees supplied some information on well-baby/well-child visits (17 grantees) as well as immunizations (18 grantees), with aggregate data suggesting that they have generally performed well in both of these outcome areas. On average, 87 percent of enrolled children across 17 grantees (836 children in total) were current on well-baby/well-child visits at the time of their exit from the project, while a nearly identical proportion of children across 18 grantees (882 children in total) were current on immunizations at program exit.

Exhibit V-6
Receipt of Key Health Services at Program Exit



As **Exhibit V-6** illustrates, these statistics compare favorably with national immunization and well-child visit rates reported in the Center for Disease Control's 2006 *National Immunization Survey* (Centers for Disease Control, 2008) and the 2004 *National Health Interview Survey* (Child Trends, 2008). Moreover, given a lack of data or underreporting by some of the 24 grantees, these figures may represent underestimates of the actual number of children that achieved these well-being milestones.

C. Parent/Caregiver Outcomes

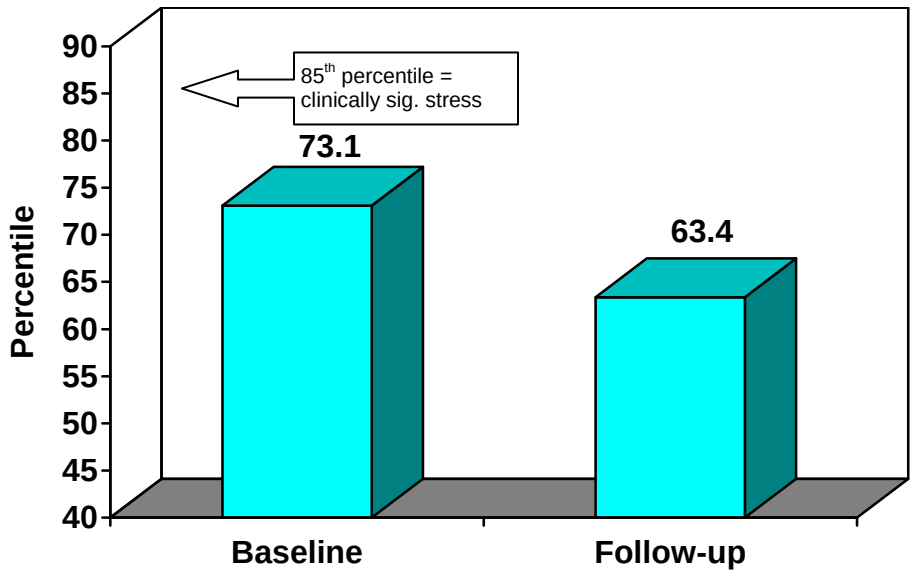
Almost all grantees sought to improve the ability of parents to cope with the challenges of childrearing, particularly when faced with the unique needs of infants and toddlers. Many grantees chose to conceptualize these impacts over time by measuring changes in parental stress levels; parenting knowledge, attitudes, and behaviors; and the quality and safety of the home environment.

1. Parental Stress

Stress levels can serve as a proxy measure for caregivers' capacity to cope with the challenges of raising children in difficult personal, economic, and social circumstances. The *Parenting Stress Index, 3rd Edition* (PSI), served as the most common standardized instrument used by grantees to measure caregiver stress levels. As described in Chapter III, the PSI is a self-report written questionnaire consisting of 13 sub-scales that calculates scores across four major domains: a "child" domain, a "parent" domain, life stressors, and a total stress score. Raw scores in each domain are converted to a normed percentile ranking for easier interpretation; a ranking in the 85th percentile or higher on the total stress score is interpreted to represent a clinically significant level of stress.

A total of eight grantees reported that they used the PSI in their final evaluation reports; of these, six provided data on one or more domains, including five grantees (Allentown, Sedalia, Terre Haute, Tulsa, and Wooster) that provided baseline and follow-up total stress scores. Altogether, these five grantees administered the PSI to a cumulative total of 122 caregivers at baseline and succeeded in re-assessing 77 (63 percent) during a follow-up administration. As illustrated in the **Exhibit V-7**, the average PSI total stress score for caregivers across the five sites decreased measurably from the 73rd percentile at baseline to the 63rd percentile at follow-up, a decline of 10 percent. Although the average baseline PSI score does not indicate clinically significant levels of stress among caregivers overall, the results do suggest that project services may further decrease the stress levels experienced by participating parents, thereby reducing the future risk of dysfunctional parenting behaviors. All grantees, with one exception, administered the PSI at 6-month intervals, which enhances the comparability of the cross-site findings.

Exhibit V-7
Average PSI Total Stress Scores at Baseline and First Follow-up
Baseline N = 122 Caregivers across 5 Grantees
Follow-up N = 77 Caregivers across 5 Grantees

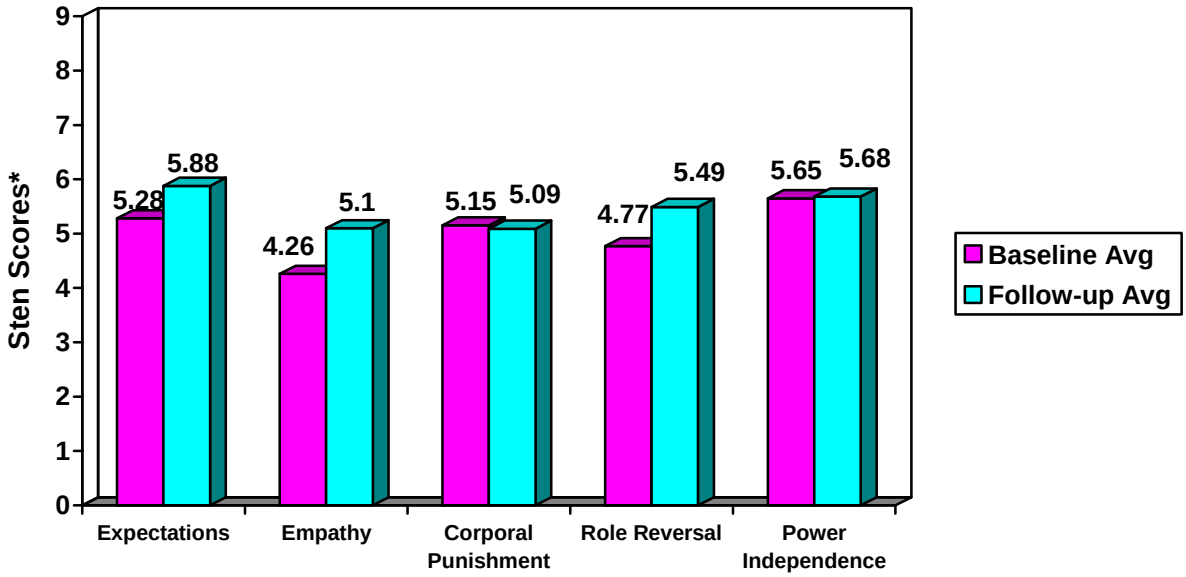


*A lower score means a better outcome (i.e., less stress).

2. Parenting Knowledge and Skills

In addition to caregivers' resilience in the face of life stressors, basic knowledge and skills regarding constructive parenting behaviors and practices constitute another important factor in promoting positive child outcomes. The *Adult-Adolescent Parenting Inventory*, 2nd Edition (AAPI-2) was used by several grantees to assess caregivers' parenting knowledge and skills. As described in Chapter III, the AAPI-2 measures change in five distinct sub-domains that include (1) parents' expectations of children; (2) empathy toward children's needs; (3) use of corporal punishment; (4) appropriateness of parent-child roles and responsibilities; and (5) the child's sense of power and independence. Raw scores are calculated for each sub-domain and are reported as "standard-ten" or "sten" scores, a standardized score with a distribution between 1 and 10. No total score is calculated for the AAPI-2. A total of five grantees—Greenville, Houghton, Ironton, Phillipsburg, and Tulsa—reported using the AAPI-2 at some point during their demonstrations, and all five reported comprehensive baseline and follow-up data in their final evaluation reports.

Exhibit V-8
Average Sten Scores by AAPI-2 Subscale at Baseline and Follow-up
Baseline N = 127 Caregivers across 5 Grantees
Follow-up N = 79 Caregivers across 5 Grantees



*A higher score indicates better outcomes.

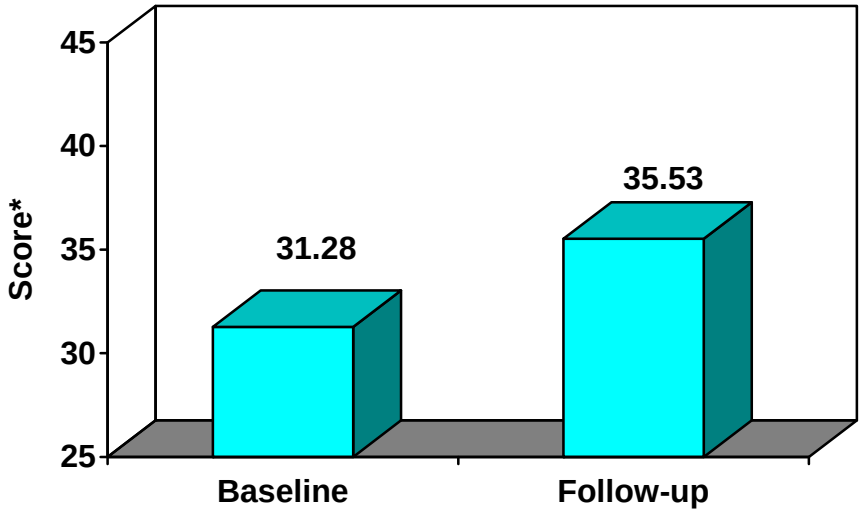
Exhibit V-8 indicates that these grantees administered the AAPI-2 to a combined total of 127 caregivers at baseline and succeeded in re-assessing 79 caregivers (62 percent) in a follow-up administration. The exhibit indicates that positive changes in parenting knowledge and skills were observed in the "Expectations", "Empathy", and "Role Reversal" subscales. Scores for the

"Corporal Punishment" and "Power/Independence" subscales remained essentially flat. These findings suggest that these five grantees collectively experienced moderate success in helping parents understand and value their children's needs and establish healthy and age-appropriate roles, expectations, and responsibilities among family members. However, the intervals between the first and second administrations of the AAPI-2 varied widely across grantees, with some employing a six-month interval, one a yearly interval, and another using the tool at case intake and closure regardless of the length of time between administrations. Although the lack of a common measurement interval limits the validity of aggregate findings, the observation of a general trend toward improvement in parenting knowledge and skills remains viable.

3. Safety and Quality of the Home Environment

The safety and quality of the home environment—generally conceptualized in terms of the physical conditions in the child's primary domicile and its social, emotional, creative, and intellectual milieu—serves as an indirect measure of parents' capacity to nurture the needs of their children for security and enriching life experiences. The data collection efforts of most grantees in measuring this construct involved site-specific safety checklists or standardized instruments like the *Home Observation and Measurement of the Environment* (HOME) *Inventory*. A review of grantees' final evaluation reports reveals that seven grantees reported using the HOME Inventory at some point during their projects, whereas five grantees reported on safety outcomes using a site-specific checklist or inventory. The HOME Inventory is designed to measure the quality of a child's home environment across six distinct domains: (1) responsiveness of the parent to the child's needs and interests; (2) avoidance of restriction and punishment; (3) presence of structure and organization in the environment; (4) presence of appropriate play materials; (5) degree of parental involvement in the child's play and activities; and (6) variety in the child's activities and interactions with other adult family members. The HOME calculates separate scores for each of these six subscales as a well as a total score, with higher scores indicative of improved environmental conditions. Four grantees—Wooster, Ironton, Greenville, and Madison—reported baseline and follow-up HOME data in their final evaluation reports. Altogether, these grantees administered the HOME to a cumulative total of 149 caregivers at baseline and succeeded in re-assessing over half (80 caregivers, or 54 percent) during a follow-up administration. Aggregate findings reported in **Exhibit V-9** below suggest that these four grantees experienced moderate success in improving the home environments of enrolled children, with average total HOME scores across all four sites increasing from 31.28 at baseline to 35.53 at a follow-up administration.

Exhibit V-9
Average HOME Scores at Baseline and Follow-up
Baseline N = 149 Caregivers across 4 Grantees
Follow-up N = 80 Caregivers across 4 Grantees



*A higher score means better outcomes (i.e., better home environment).

The use of different measurement intervals by the grantees to some extent limits the validity of aggregated HOME Inventory findings. Specifically, whereas Wooster and Madison administered the HOME at intake and case closure (a time period that can vary greatly in length), Ironton and Greenville administered the HOME at regular six-month intervals. The lack of a common measurement interval for the administration of the HOME complicates the accurate interpretation of aggregate longitudinal findings because program participants were exposed to the "treatment" of enhanced EHS/CWS services for varying lengths of time. However, a general observation of improvement in the quality of children's home environments over time among these grantees remains viable.

Although the HOME Inventory is the most common standardized instrument used by grantees to assess environmental conditions in the home, several grantees used locally developed home safety checklists. Unlike the HOME—which produces a more global assessment of a child's home environment by addressing issues such as child-caregiver interactions and the presence of stimulating toys and activities—the checklists tend to focus on concrete physical factors such as the presence of safety hazards. Six grantees reported collecting data using a safety checklist in their final evaluation reports, of which four provided quantitative findings. Because these checklists are developed by grantees specifically for use with their local service populations and are therefore not standardized, it is not possible to aggregate safety checklist data across multiple grantees. However, all four grantees that included checklist data in their final reports indicated slight to substantial improvements in the safety conditions found in enrolled families' homes:

- In Mentor, the average number of safety risk factors identified in families' homes declined from 3.8 to 1.4 six months following enrollment.

- In Danville, the proportion of enrolled families with a known safety issue in the home declined from 23 percent at enrollment to 0 percent at program exit.

- In Allentown, only 8 of 29 enrolled families (28%) had a known home safety issue at case closure.

- Average safety checklist scores for families enrolled in Ironton's program (measured as the proportion of home safety issues that were successfully addressed) improved slightly, increasing from 91.2 to 92.8 between intake and a six-month follow-up.

D. Organizational and Systems-Level Outcomes

"Organizational outcomes" refer to changes in the knowledge, skill, or behaviors of staff involved in implementing a program, as well as to changes in agency policies and practices. "Systems-level" outcomes occur at the inter-agency and broader community level and refer to changes in the nature or quality of relationships and communication across multiple organizations, as well as to the variety, scale, and accessibility of services and resources for children and families. By promoting positive change in these outcome areas, EHS/CWS grantees ultimately seek to improve the long-term safety and well-being of vulnerable children. Through a review of grantees' final evaluation reports, supplemented by a series of telephone interviews with EHS project directors, JBA identified two major organizational outcomes of interest across the EHS/CWS projects:

- Increased knowledge and skills of EHS staff to work effectively with CWS-involved families; and

- Increased capacity of EHS staff to work with abused and traumatized children.

In turn, systems-level outcomes of interest identified by JBA include:

- Improved inter-agency knowledge of the laws and policies governing child welfare and early childhood services, as well as increased knowledge among EHS and CWS staff regarding the types of services available through their respective agencies;

- Increased access to services and supports by CWS populations (e.g., medical and dental services; therapeutic services; financial, housing, education, and employment assistance); and

- The development and/or leveraging of new programs, services, or initiatives as a result of the EHS/CWS project.

Among these, the areas in which grantees perceived the most significant improvements include (1) the organizational outcome of increased knowledge and skills to work effectively with CWS populations; (2) the systemic outcome of improved inter-organizational knowledge; and (3) the systemic outcome of increased access by CWS-involved families to medical, developmental, and other human services. Several specific examples highlighted in grantees' final reports are noted below.

1. **Working with CWS Populations**

   - Based on scores on the Infant/Toddler Environmental Rating Scale (ITERS), staff from all four family shelters participating in San Diego's program exhibited consistent improvement in their capacity to provide a developmentally appropriate physical and psychological environment for enrolled children.

   - A self-report survey administered by the evaluators of Miami-Dade's project revealed a statistically significant increase in EHS workers' self-perceived knowledge of the characteristics, circumstances, and needs of CWS populations.

2. **Inter-Organizational Knowledge and Awareness**

   - In focus groups conducted as part of the evaluation of Dayton's project, CWS workers reported that they no longer regarded EHS as merely "daycare" and had come to appreciate the critical role that EHS programming plays in fostering positive cognitive and socio-emotional outcomes for children and in promoting greater parental involvement in their children's development.

   - The grantee in Mentor documented a total of 38 joint case review meetings between CWS and EHS staff. As a result of these meetings, EHS home visitors learned more about the development of CWS case plans and the laws governing the child welfare and foster care systems. CWS workers, in turn, learned about parent-child attachment and the mental health needs and issues faced by many infants and parents.

3. **Service Access**

   - In Monroe, 11 of 14 enrolled families reported that participation in the EHS/CWS project had increased their access to medical and human services, including referrals to primary care physicians; food, housing, and child care assistance; employment training and referral services; domestic violence counseling; and enrollment in Louisiana's Child Insurance Program (LaCHIP).

   - Families enrolled in Houghton's project received an average of 42 different medical, developmental, educational, and other social services.

On balance, a majority of grantees perceived their EHS/CWS projects as having positive effects on certain aspects of staff knowledge and skills while improving families' access to a

wider range of supports and services. It is less certain whether the projects improved staff's specific clinical skills in working with abused or traumatized children or served as a springboard for launching new or expanded child welfare or early childhood service initiatives. As in the case of other self-report data presented in this chapter, a lack of data or underreporting by some grantees may actually underestimate changes in one or more of these key organizational and systems-level outcomes.

Another important systems-level outcome involves the extent to which the EHS/CWS projects, along with improving inter-organizational awareness and knowledge, promoted greater collaboration and cooperation among EHS grantees and their partner organizations. As discussed in Chapter IV, an important proxy measure of organizational collaboration is reflected in the existence and renewal of Memoranda of Understanding or Agreements (MOUs/MOAs). Altogether, 86 percent of grantees that submitted a final report indicated that they had an existing or had established a new MOU/MOA with a partnering CWS agency or another social service organization.

E. Discussion and Conclusions

The submission of final evaluation reports by the EHS/CWS grantees highlights the progress made by many projects in multiple outcome areas, including child development and well-being; caregiver coping and parenting skills; and systems-level outcomes such as the enhancement of staff work skills, inter-organizational awareness and communication, and improved access to health and social services. Specific areas in which a majority, or certain subsets, of grantees experienced success include the following:

- Creating and maintaining safe and stimulating home environments for children;
- Improving families' access to basic medical and social services, particularly immunizations and well baby/well child visits;
- Reducing caregivers' stress levels by providing direct services or improving coping skills;
- Enhancing caregivers' skills and knowledge of positive parenting behaviors;
- Increasing the capacity of EHS staff to work with CWS-involved children and families; and
- Promoting inter-organizational awareness and collaboration among EHS and local CWS and/or other human service agencies.

Key outcomes on which the grantees' projects appeared to have more limited effects, or on which the long-term impact of the projects remains uncertain, include:

- The prevention of child maltreatment recurrence; and

- Exits to permanency, particularly reunification.

In highlighting areas in which program successes have been less clear, it is important to note the distal nature of many measures of safety and permanency, the small size of most grantees' target populations, and the limited timeframe available to many grantees for the systematic collection of child welfare data. Chapter VI will explore the implications of EHS/CWS project outcomes in more detail, particularly with respect to the Federal CFSR process. In addition, this final chapter will discuss the long-term sustainability of the EHS/CWS projects and the lessons learned by grantees in the course of planning, implementing, and maintaining their projects.

CHAPTER VI
SUMMARY AND IMPLICATIONS

A. Highlights of Major Implementation and Outcome Findings

This synthesis has provided a detailed review of findings and lessons learned reported by the EHS/CWS grantees over the course of the five-year EHS/CWS Initiative. To the extent possible, it has also sought to aggregate and summarize findings across multiple grantees to the extent that they shared common definitions of key implementation and outcome measures. The following section recaps some of the most significant cross-cutting results of the Initiative.

1. Major Implementation Findings

Despite numerous challenges, EHS/CWS grantees as a whole succeeded in meeting their most important implementation objectives, including the maintenance of funded enrollment levels and providing a range of specialized health and early childhood services. Key implementation findings are summarized below:

- The 23 EHS/CWS projects described in this report served a total of 1,303 CWS-involved children through a total of 343 funded slots. Long-term slot vacancies were generally rare, with an average of 98 percent of all funded slots filled at any given time between December 2004 and June 2006. Some grantees attributed slot vacancies to a lack of referrals from their partnering CWS agencies.

- Participating children remained enrolled for an average of 327 days (nearly 11 months), a considerably shorter period than the average of 21 months observed among children enrolled in standard EHS programs. The substantially shorter average length of enrollment for children enrolled in an EHS/CWS project may be indicative of the special challenges faced in engaging and retaining CWS-involved families.

- Children participating in center-based EHS/CWS projects experienced longer average lengths of enrollment than children served through home-based or mixed model programs (490 days vs. 312 days and 256 days, respectively). Center-based programs were also less likely to report barriers such as family resistance to receiving services, dropout following case closure by CWS, and parental mental health or substance abuse issues. Although the reasons for these enrollment disparities are not entirely clear, possible explanations include the greater social isolation experienced by families in home-based or mixed model programs (which in turn is correlated with issues such as mental illness and substance abuse) and the absence of coercion (whether perceived or real) to remain involved in EHS once CWS agency involvement ends. In addition, families enrolled in center-based programs had a strong incentive to continue their involvement because of the availability of free high-quality child care.

- Individual grantees achieved varying levels of success in their ability to establish a firm and lasting collaborative relationship with their partnering agency. However, nearly all grantees (21 of 23 reporting) established an initial MOU or MOA with their partnering agency. Of these, more than half (12) reported at least one update to the MOU/MOA, which suggests a certain degree of commitment to reviewing and maintaining the partnership.

- Common barriers to more robust collaboration included a lack of communication between managerial and front-line staff from EHS and CWS agencies, which was exacerbated by the different professional vocabularies and jargon of staff from each organization; and philosophical differences in service orientation between EHS and CWS (e.g., EHS tends to focus more on building parental knowledge and capacity whereas CWS often stresses case plan compliance and child safety).

- Staff turnover or "burnout" was a frequent impediment to maintaining the quality and consistency of EHS/CWS services, with 11 grantees reporting this as a significant issue. In addition, 10 grantees reported turnover in an EHS/CWS project director at some point during the five-year course of the Initiative, which had deleterious effects on the capacity of some grantees to manage and coordinate services while providing the necessary level of leadership to sustain the impetus of the EHS/CWS project.

- Contextual variables reported by grantees that had perceived negative effects on the EHS/CWS projects included economic and sociological factors (e.g., inadequate housing, joblessness, poor transportation infrastructure, endemic community drug use); a general lack of local social and health resources in the target communities; State and local budget cuts; and changes in the organization or leadership of State, local government, or community organizations (e.g., the breakup or consolidation of local child welfare agencies, the privatization of child welfare services).

2. Major Outcome Findings

The EHS/CWS grantees reported positive findings in multiple outcome areas, including child development and well-being; caregiver coping and parenting skills; organizational factors such as the enhancement of staff professional skills; and systemic factors such as inter-organizational awareness and improved access to health and social services. Specific examples of promising outcome findings include the following:

- In the domain of child well-being, the grantees demonstrated significant success in achieving certain health outcomes, specifically in the timely receipt of medical and developmental screenings, medical checkups, and immunizations. As a whole, EHS/CWS projects succeeded in screening virtually every enrolled child to ascertain its medical and/or development status. In addition, 87 percent of enrolled children across 17 reporting grantees were current on well-baby/well-child visits, while a nearly identical proportion of children across 18 grantees were current on all recommended immunizations at program exit. These statistics compare favorably with national immunization and well-child visit rates reported in the Center for

Disease Control's 2006 *National Immunization Survey* and in the 2004 *National Health Interview Survey*.

- Some grantees reported lower levels of stress among caregivers struggling with the challenges of raising children and maintaining their households. Among five grantees that systematically measured changes in stress using the *Parenting Stress Index* (PSI), average total caregiver stress scores decreased from the 73rd percentile at baseline to the 63rd percentile at follow-up. These results suggest that EHS/CWS supports and services may have some ameliorative effect on overall stress, thereby reducing the future risk of dysfunctional parenting behaviors.

- Findings from other grantees indicate moderate success in helping parents understand and value their children's needs and establish healthy and age-appropriate roles, expectations, and responsibilities among all family members. Five grantees that used the *Adult Adolescent Parenting Inventory* (AAPI-2) reported positive changes in parenting knowledge and skills in the test domains of "Expectations", "Empathy", and "Role Reversal".

- Many grantees reported progress in improving the safety and quality of children's home environments. Four grantees reported improved home conditions (e.g., the presence of structure and organization in the environment, presence of appropriate play materials) using the *Home Observation and Measurement of the Environment* (HOME) *Inventory*, with average scores increasing from 31.28 at baseline to 35.53 at a follow-up administration. In addition, four other grantees reported slight to substantial improvements in the physical safety conditions found in enrolled families' homes as measured by locally designed home safety checklists.

- Programmatic and organizational improvements, particularly reflected in the increased knowledge and skills of EHS front-line staff to work effectively with CWS populations, were frequently attributed to expanded collaboration between EHS and CWS agencies. In addition, many grantees reported community or "systems" level benefits as a result of the EHS/CWS projects, especially as evidenced by increased access among CWS-involved families to medical, developmental, and other human services.

Key long-term outcomes of interest on which the projects appeared to have more limited or uncertain effects include maltreatment recurrence and permanency:

- Among 19 grantees that collected and reported maltreatment data, the average maltreatment recurrence rate was approximately 11 percent. Although not strictly comparable, the national CFSR maltreatment recurrence rate in Federal Fiscal Year 2006 was somewhat lower at 7.8 percent. More frequent reports of maltreatment recurrence may be interpreted as a reflection of the greater concentration of services and professional contacts received by EHS/CWS families.

- Among grantees that reported data on exits to reunification, adoption, or guardianship, the average net permanency rate for children who were in or entered out-of-home placement came to 44 percent. Based on aggregated CFSR data, this figure is identical to the average 2003 permanency rate for the 17 States that hosted an EHS/CWS project site. At a minimum, these data suggest that children served through the EHS/CWS projects are at least as likely be reunified or otherwise achieve permanency as children in the general CWS population.

As described in more detail in Appendix A of this report, readers should exercise caution in drawing conclusions about the intensity or scale of positive outcomes reported by the EHS/CWS grantees, or in making comparisons across grantees regarding the relative effectiveness of their programs. These caveats are particularly true when assessing the impact of the projects on more distal outcomes like maltreatment recidivism and the achievement of permanency.

B. Sustainability of the EHS/CWS Initiative

Throughout this report and past synthesis reports, we have adopted the conceptual model developed by Fixsen et al. (2005) to frame our understanding of the program implementation process of the EHS/CWS grantees. The last stage of this model— sustainability—represents the point at which the long-term operations and effectiveness of the projects are maintained within the context of a changing political, organizational, and funding environment. Although sustainability in theory represents the final developmental phase of this conceptual framework, the question naturally arises whether the EHS/CWS projects in practice will be sustained beyond the original five-year period of the Federal initiative. The funding for the additional child slots received by the 24 EHS grantees is permanent; however, will the agencies continue to focus special attention on the needs of children involved in the child welfare system and maintain their collaborative partnerships with local CWS agencies?

To assess the likelihood that EHS/CWS projects would be sustained following the formal end of the five-year project period, JBA queried the project directors for the 23 EHS/CWS projects described in this report regarding two primary issues:

- Whether they intended to continue using their additional funded slots to target services specifically at CWS-involved children and their families; and

- Whether they planned to sustain collaborative efforts with their partnering CWS agency at the same level and intensity as existed during the official five-year period of the EHS/CWS Initiative.

Sixteen of 23 project directors (almost two-thirds) responded to JBA's query; of these, 13 project directors (about four-fifths) replied that they planned to reserve their additional funded slots exclusively for CWS-involved children. In addition, all 16 indicated an intention to maintain active collaboration and cooperation with their partnering CWS agency in identifying and

serving families involved in the child welfare system.[40] Although this informal approach to obtaining information about sustainability plans is not a substitute for a more systematic analysis of grantees' activities following the end of the five-year EHS/CWS Initiative, these answers suggest a strong commitment on the part of most EHS agencies to maintain a special focus on addressing the safety and developmental needs of children deemed to be at greater risk of abuse and neglect, as well as on improving the capacity of parents to provide for these children's physical, emotional, and intellectual needs.

C. Key Lessons Learned

As grantees proceed with plans to maintain their EHS/CWS projects, they will likely draw on many insights gleaned during five years of planning, establishing, and sustaining the operation of their programs. As they move through the stage of Fixsen et al.'s implementation framework, the EHS/CWS grantees have collectively identified many valuable lessons that are critical to ensuring the successful planning and execution of early childhood programs that target CWS-involved families. Several of these most significant lessons, garnered through interviews with EHS project directors and reviews of grantees' semi-annual progress reports and final evaluation reports, are summarized below according to their relevance to the key phases of the Fixsen implementation paradigm.

1. Program Exploration and Adoption

- Develop a thorough understanding of best practices and current research in the fields of early childhood development and child welfare prior to implementing a new program.

- Elucidate the specific problem(s) that the program seeks to address, and carefully define the target population that will receive services.

- Before proceeding too far with program design and implementation, approach the leadership of the local CWS agency to assess its interest and commitment to partnering on a collaborative initiative to serve CWS-involved children and families.

2. Program Installation and Initial Implementation

- Develop clear and specific eligibility criteria for the target population.

- Involve front-line and managerial staff from the local CWS agency, as well as staff from other key social service agencies as appropriate, in the initial project planning and design phases.

[40] As noted in past synthesis reports, one grantee (New York) is partnering with a residential substance abuse treatment provider rather than with a municipal child welfare/child protective services agency.

- Hire key project staff (e.g., project directors and coordinators) before or during the very initial phases of program planning and startup.

3. Full Operational Phase

- Recognize that high-risk families require long-term supports and services and that their cases may need to remain open longer than originally anticipated.

- To reduce families' resistance to project participation, emphasize the role of front-line staff as advocates for the interests and needs of parents and their children rather than as monitors or enforcers of service plans and Family Partnership Agreements.

- To increase project referrals, explore strategies that foster the development of one-on-one professional relationships between EHS staff and CWS caseworkers.

- Seek to maintain families' enrollment for as long as possible to increase the likelihood of achieving positive changes in their capacities, behaviors, and status.

4. Program Innovation and Sustainability

- Encourage new collaborations with other child welfare service agencies and programs in the community to maintain support and enthusiasm for the project while increasing the range and intensity of services available to targeted families.

- Provide continual opportunities for program staff to enhance their knowledge and skills in working with CWS-involved children and families. Areas of particular focus should include training in working with drug-affected infants and toddlers, as well as children suffering from the psychological trauma of abuse, neglect, and separation from parents and siblings.

- Continually reassess the content and format of core project services (e.g., home visits) to ensure that they maintain high standards of quality and are responsive to the changing needs and circumstances of enrolled families.

D. Implications for Building Evaluation Skills and Capacity

The long-term sustainability of the EHS/CWS projects will rest in part on maintaining and strengthening the evaluation capacity of the EHS agencies, particularly with respect to collecting and reporting data on valid and reliable process and outcome measures on a consistent basis. In this regard, a secondary outcome of the EHS/CWS Initiative has been the development of grantees' knowledge and skills in program evaluation and performance measurement. Prior to the Initiative, a majority of grantees had inadequate capacity to design and implement a systematic and robust program evaluation; these limitations were compounded by the fact that most grantees had few or no internal staff with training or education in evaluation and data

collection. Whereas some grantees had funds to retain third-party professionals to conduct program evaluations (usually faculty from local academic institutions), others had to rely solely on in-house personnel or in some cases on time and expertise provided on a voluntary basis by faculty and graduate students from local colleges and universities. A review of grantees' semi-annual progress reports and final reports, however, reveals the significant progress made by EHS programs in strengthening the key ingredients of a sustainable evaluation infrastructure. Specifically, almost all 23 grantees described in this report have:

- Developed a basic logic model to articulate the underlying program theory of their EHS/CWS projects and to guide the formulation of concrete outputs and outcomes;

- Identified and operationalized one or more process measures to track the provision of key project services (e.g., number of children enrolled, average length of enrollment, number of home visits);

- Identified and operationalized one or more outcome measures to evaluate the success of their projects in achieving positive changes in the knowledge, attitudes, skills, behaviors, or status of enrolled children and caregivers (e.g., average change in scores on a standardized instrument, proportion of Family Partnership Agreement [FPA] goals achieved);

- Selected or expanded the use of one or more standardized child or family assessment instruments; and

- Developed new or enhanced existing data collection systems, often in the form of stand-alone Excel spreadsheets. In some instances, grantees have modified Web-based or networked information management systems by adding new variables to accommodate the collection of a broader array of data on services received and outcomes achieved by enrolled children and families.

Although the quality and sophistication of these activities tended to be uneven across the grantees, they nonetheless provide evidence of overall improvement in the evaluation capacity of many EHS agencies that they will hopefully sustain and carry over into other aspects of their programming and operations. The experience of grantees in designing and implementing their evaluations also speaks to the general importance of ensuring that Federal grantees have access to the supports and resources necessary to collect and report high-quality information in a rigorous and systematic manner.

E. Implications for Child and Family Service Reviews

The impetus behind the promotion of systematic collaborations between EHS programs and CWS agencies lies in the interest of HHS in achieving better well-being, safety, and permanency outcomes for children at risk of or experiencing abuse, neglect, or out-of-home placement. As such, the goals of the EHS/CWS Initiative broadly parallel the objectives of the

Federal government in improving States' performance on a range of child welfare outcomes. In light of the convergence of the goals of this Initiative and Federal child welfare policy, the question arises as to the potential of EHS/CWS service collaboratives to enhance States' performance on key CFSR outcomes. In short, could similar initiatives of sufficient scope, intensity, and scale have an observable positive impact in a given State on CFSR outcomes?

A brief review of the outcomes summarized in this chapter hints at the potential of similar initiatives to exert positive effects on certain categories or subcategories of CFSR outcomes, particularly with respect to the range and quality of human services available to CWS-involved families and professional development opportunities for child welfare workers. Outcomes on which the EHS/CWS projects appear to have the most potential to exert positive effects include those aligned with the CFSR domains of child/family well-being and systemic/organizational change:

- CFSR Well-Being Outcome: Children receive adequate services to meet physical and mental health needs.

- CFSR Well-Being Outcome: Families have enhanced capacity to provide for children's needs.

- CFSR Systemic Factor: Ongoing training for staff that addresses the skills and knowledge base for services included in Child and Family Service Plans.

- CFSR Systemic Factor: Array of services to assess and address the needs of families and individual children.

Ultimately, the assumption is that better service delivery systems will improve States' performance on key CFSR safety and permanency outcomes. Outcomes in these areas that roughly parallel the long-term outcomes tracked by the EHS/CWS partnerships include the following:

- CFSR Safety Outcome: How effective is the agency in reducing the recurrence of maltreatment in children?

- CFSR Permanency Outcome: How effective is the agency in helping children in foster care return safely to their families when appropriate?

Although the effectiveness of the EHS/CWS projects in preventing maltreatment recurrence and promoting permanency remains uncertain, the outcomes discussed in this report as a whole have implications for State child welfare agencies to the extent that they are in alignment with the CFSR outcomes for which States are held accountable. The immediate goals of the EHS/CWS Initiative were confined to demonstrating the feasibility of establishing collaborative relationships among professionals from local EHS and CWS agencies to improve the well-being, safety, and stability of a limited pool of children and families. However, the success of the EHS/CWS projects in certain areas hint at the broader potential of similar

initiatives, if implemented at a sufficient scale and intensity, to serve as a resource to States in improving their performance on a range of CFSR outcomes, particularly those that pertain to improved staff training and expanded service arrays.

F. Usefulness of Findings for the Children's Bureau, Early Head Start Programs, and the Early Childhood Field

The experiences of the 23 EHS/CWS grantees described in this report underscore the acquisition of valuable new knowledge that is relevant to the service and policy goals of the Children's Bureau, the Office of Head Start, and Early Head Start programs in general, as well as to the broader fields of early childhood education and child welfare. Specifically, the EHS/CWS Initiative has:

- Highlighted certain models and approaches to the provision of early childhood services and supports that may be particularly effective in addressing the needs of children and families involved in the child welfare system.

- Confirmed the promise—and critical importance—of fostering partnerships between EHS programs and CWS agencies to effectively identify and serve families currently in the child welfare system or at future risk of maltreatment or out-of-home placement.

- Demonstrated the potential of collaborations with other social and health service organizations—such a residential substance abuse treatment centers and mental health clinics—to strengthen the nexus of supports and services available to special target populations (e.g., caregivers with substance use disorders) that will further reduce the exposure of vulnerable children to abuse, neglect, and family disruption.

- Revealed ongoing challenges to serving CWS-involved families and to building effective inter-organizational partnerships that must be addressed if similar early childhood initiatives are to achieve their full potential to promote the safety and well-being of infants and toddlers.

- Underscored the importance of building basic evaluation skills and resources among EHS programs that will allow them to track and analyze data regarding program operations and outcomes in a manner that fosters ongoing program development and improvement.

As discussed above, the findings from this Initiative may be of particular interest to State child welfare departments that seek strategies and resources to improve the performance of local CWS agencies on a range of outcomes addressed in the CFSRs. EHS programs and local CWS agencies, which often serve overlapping target populations but work in separate legal, professional, and philosophical spheres, have considerable potential to work in tandem to advance the common child welfare policy interests of States and the Federal government.

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APPENDICES

APPENDIX A
CAVEATS IN THE INTERPRETATION OF EVALUATION FINDINGS FROM EHS GRANTEES

- Preliminary nature of findings. The data reported by grantees are preliminary in nature and usually cover a narrow time frame of three to six-months, too little time to draw definitive conclusions about the effects of enhanced services on targeted outcomes.

- Small sample sizes. Most grantees have a small number of slots funded for enhanced EHS/CWS services and therefore reported baseline and follow-up data on a limited sample of children and families. Only a few grantees collected baseline data on more than two dozen families and many grantees collected baseline data on fewer than a dozen families. The numbers for follow-up data collection are often even smaller. Small samples place limits on the ability of grantees to discern significant trends in targeted outcomes or to generalize findings beyond the narrow scope of their respective EHS/CWS projects.

- Choice of evaluation designs. Most grantees' evaluations involve pre-post tests or time series analyses, designs that compare changes in participant outcomes at different points in time. These methodological approaches lack the statistical rigor of experimental designs that use random assignment or even of comparison group designs, making it more difficult to attribute observed changes in participants to the effects of enhanced EHS/CWS services.

- Different service models. Although grantees share many goals in fostering the safety and well-being of children and families, service models and interventions vary greatly across grantees. For example, some sites have chosen to implement home-based programs, whereas others have implemented center-based or mixed programs with both home- and center-based components. In addition, whereas some grantees have used their funding to provide a wide range of services and supports to families, other grantees have restricted their interventions to a more limited set of services.

- Different definitions of outcomes. Grantees that included similar outcomes in their logic models may define these outcomes in different ways, especially with respect to global outcomes with broad meanings. For example, some grantees defined an open-ended outcome like "family functioning" in terms of a family's economic well-being by examining variables such as parental employment, public assistance participation, and access to adequate housing. In contrast, other grantees defined family functioning in terms of psychological well-being by focusing on parent-child or spousal interactions and mental health.

- Different evaluation instruments. Even when grantees share a common definition of the same outcome, they may use different data collection tools to track changes in that outcome. When evaluating the outcome of "improved safety conditions in the home," for example, some grantees used a standardized instrument like the *Home Observation for Measurement of the Environment* (HOME) *Inventory*, whereas other grantees relied on locally developed, non-standardized "safety checklists." Because these tools vary greatly in their length, complexity, choice of items, scoring procedures, and statistical properties, they also differ in their sensitivity to changes in EHS/CWS families and their environments.

- Different time intervals to measure change. Along with diverse data collection instruments, grantees may collect data on outcomes at different time intervals. Although some standardized tools come with recommended guidelines for administration intervals (e.g., 3 months, 6 months), grantees' choice of intervals may be influenced by factors such as participant availability and turnover, time constraints to conduct the evaluation, or grantees' assessments of the amount of time necessary to detect changes in targeted outcomes. A grantee's choice of the interval between data collection points will affect the probability of detecting measurable changes as well as the intensity or scale of any observed changes.

- No tests of statistical significance. When tracking outcomes across time or groups, grantees have generally not conducted statistical tests (e.g., t-tests, ANOVA) to determine whether observed differences are attributable to effects beyond random chance. In many cases, the use of statistical tests would be inappropriate due to the small sample sizes available for most grantees' evaluations. As such, any observed changes in outcomes must be regarded at most as indicative of possible trends and not as definitive evidence of program impacts.

Appendix B
Sample Grantee Data Reporting Template

Process Measures	During Reporting Period	Cumulative
Number of children referred		
Number of children enrolled		
Number of new enrollees (children)		
Average length of enrollment for children (days)		
Average number of home visits per family		
Additional activity#1 provided (please specify activity)		
Number of clients participated in additional activity # 1		
Additional activity # 2 provided (please specify activity)		
Number of clients participated in additional activity # 2		
Additional activity#3 provided (please specify activity)		
Number of clients participated in additional activity # 3		
Additional activity # 4 provided (please specify activity)		
Number of clients participated in additional activity #4		
Immediate Outcomes		
EHS Staff develop improved knowledge, skills, attitudes and relationships		
Data Source (specify the instrument, measures or other means of collecting data)		
Baseline		
Follow-up #1		
Follow-up #2		
Follow-up #3		
Staff from both programs have supports and resources necessary to work collaboratively		
Data Source (specify the instrument, measures or other means of collecting data)		
Baseline		
Follow-up #1		
Follow-up #2		
Follow-up #3		
Staff express comfort in communicating with staff from the other partnering agency when jointly serving a family		
Data Source (specify the instrument, measures or other means of collecting data)		
Baseline		
Follow-up #1		
Follow-up #2		
Follow-up #3		
Parents are aware of the developmental strengths and needs of their children		
Data Source (specify the instrument, measures or other means of collecting data)		
Number of clients with this outcome as a goal		
Number of clients with baseline assessment completed		
Number of clients with first follow-up completed		
Number of clients with subsequent follow-ups completed		

Parents demonstrate increased ability to engage in activities and interactions that promote their child's development		
Data Source (specify the instrument, measures or other means of collecting data)		
Number of clients with this outcome as a goal		
Number of clients with baseline assessment completed		
Number of clients with first follow-up completed		
Number of clients with subsequent follow-ups completed		
Parents demonstrate positive guidance and discipline skills		
Data Source (specify the instrument, measures or other means of collecting data)		
Number of clients with this outcome as a goal		
Number of clients with baseline assessment completed		
Number of clients with first follow-up completed		
Number of clients with subsequent follow-ups completed		
Parents demonstrate improved skills in providing a safe and nurturing environment for their child		
Data Source (specify the instrument, measures or other means of collecting data)		
Number of clients with this outcome as a goal		
Number of clients with baseline assessment completed		
Number of clients with first follow-up completed		
Parents will demonstrate increased knowledge and skills in coping with stress		
Data Source (specify the instrument, measures or other means of collecting data)		
Number of clients with this outcome as a goal		
Number of clients with baseline assessment completed		
Number of clients with first follow-up completed		
Parents and child demonstrate improved attachment/interactions		
Data Source (specify the instrument, measures or other means of collecting data)		
Number of clients with this outcome as a goal		
Number of clients with baseline assessment completed		
Number of clients with first follow-up completed		
Intermediate Outcomes		
EHS staff have adequate levels of administrative support for providing services to targeted families		
Data Source (specify the instrument, measures or other means of collecting data)		
Number of clients with this outcome as a goal		
Number of clients with baseline assessment completed		
Number of clients with first follow-up completed		
Number of clients with subsequent follow-ups completed		
EHS staff demonstrate professional skills and capacities to provide services to families in the CWS system		
Data Source (specify the instrument, measures or other means of collecting data)		
Baseline		
Follow-up #1		
Follow-up #2		
Follow-up #3		
Children demonstrate developmental capacities within the normal range for their age		
Data Source (specify the instrument, measures or other means of collecting data)		
Number of clients with this outcome as a goal		
Number of clients with baseline assessment completed		
Number of clients with first follow-up completed		
Number of clients with subsequent follow-ups completed		

Children have less stress and develop appropriate coping strategies		
Data Source (specify the instrument, measures or other means of collecting data)		
Number of clients with this outcome as a goal		
Number of clients with baseline assessment completed		
Number of clients with first follow-up completed		
Number of clients with subsequent follow-ups completed		
Children are safe in their homes (i.e., no subsequent reports of abuse of neglect)		
Data Source (specify the instrument, measures or other means of collecting data)		
Number of clients with this outcome as a goal		
Number of clients with baseline assessment completed		
Number of clients with first follow-up completed		
Number of clients with subsequent follow-ups completed		
Long-Term Outcomes		
Improved developmental outcomes for children		
Data Source (specify the instrument, measures or other means of collecting data)		
Number of clients with this outcome as a goal		
Number of clients with baseline assessment completed		
Number of clients with first follow-up completed		
Number of clients with subsequent follow-ups completed		
Parents demonstrate enhanced parenting and personal functioning skills		
Data Source (specify the instrument, measures or other means of collecting data)		
Number of clients with this outcome as a goal		
Number of clients with baseline assessment completed		
Number of clients with first follow-up completed		
Number of clients with subsequent follow-ups completed		
System-Level Outcomes		
Staff from both programs have supports and resources necessary to work collaboratively		
Data Source (specify the instrument, measures or other means of collecting data)		
Baseline		
Follow-up # 1		
Follow-up #2		
Staff effectively collaborate in providing services to individual families in the CW system		
Data Source (specify the instrument, measures or other means of collecting data)		
Baseline		
Follow-up # 1		
Follow-up #2		
Follow-up #3		
Staff from both programs serving the same families have consistent and intentional interactions to ensure effective collaboration		
Data Source (specify the instrument, measures or other means of collecting data)		
Baseline		
Follow-up # 1		
Follow-up #2		
Follow-up #3		

Increased access to services for families	
Data Source (specify the instrument, measures or other means of collecting data)	
Baseline	
Follow-up # 1	
Follow-up #2	
Follow-up #3	
EHS and DCHS have effectively functioning working relationships and systems to support collaborative service delivery	
Data Source (specify the instrument, measures or other means of collecting data)	
Baseline	
Follow-up # 1	
Follow-up #2	
Follow-up #3	
EHS has the necessary system capacities to effectively work with children and families involved in the CWS system	
Data Source (specify the instrument, measures or other means of collecting data)	
Baseline	
Follow-up # 1	
Follow-up #2	
Follow-up #3	