In This Issue

Foreword

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Sonia C. Velázquez is vice president of the Children's Division at American Humane, where she provides program leadership and oversees professionals working in research and evaluation, systems improvement and practice advancement, child welfare training, policy and communications, and child abuse prevention and community support programs.

American Humane is honored to present this special issue of *Protecting Children*, dedicated to the national replication of the Family Connections Program.

Part of the mission of the Children's Division of American Humane is to enhance the ability of both local organizations and public agencies to respond effectively to the needs of vulnerable children and families, and to work with child protection professionals and agencies to improve their systems. This helps ensure that greater emphasis is placed on processes and results that focus on the best interests of children and their families.

The Family Connections Program is a strong example of how supporting and meeting the needs of the family can help prevent child maltreatment, measurably improve outcomes for children, and in many cases, prevent families from needing to become more deeply involved in the child welfare system.

According to the Ruth H. Young Center for Families and Children, "The original [Family Connections] Program, based at the University of Maryland in Baltimore, was the only program in the nation designated as 'demonstrated effective' in showing positive outcomes in the prevention of child abuse and neglect, in the 2003 report *Emerging Practices in the Prevention of Child Abuse and Neglect*."[1] Having participated as a panel member in the Emerging Practices effort in 2003, it is my distinct pleasure to support the dissemination of the Family Connections field implementation projects.

American Humane would like to recognize the tireless work of Diane DePanfilis and her colleagues from the University of Maryland, and Jill Filene for her project direction and research in conducting a national replication program that enlightens the field on the complexities of community-based services that prevent and address child abuse and neglect. American Humane also applauds the leadership and vision shown by Melissa Brodowski and her colleagues from the Office on Child Abuse and Neglect of the Children's Bureau, Administration for Children and Families, Department of Health and Human Services.

We are pleased to share the successes and lessons learned from this program with our readership, and look forward to the continued positive results of future replications of Family Connections.

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[1] The Ruth H. Young Center for Families and *Children. Family Connections – National program replication project.* Retrieved August 18, 2009, from http://www.family.umaryland.edu/ryc_best_practice_services/family_connections_replication.htm

Introduction to Family Connections and the National Replication Effort

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Dr. DePanfilis is a professor and associate dean for research at the University of Maryland School of Social Work. She is also director of the Ruth H. Young Center for Families and Children, a research center designed to promote the safety, permanency and stability, and well-being of children, families, and communities through education and training, research and evaluation, and best-practice service programs. She serves as the principal investigator of research for Family Connections. Dr. DePanfilis is also the principal investigator for the Atlantic Coast Child Welfare Implementation Center, which partners with state and tribal child welfare agencies to implement systems change that will improve the safety, permanency, and well-being of children, youth, and families.

Ms. Filene is a senior research associate at James Bell Associates. She received her master's in public health from the University of North Carolina at Chapel Hill. She has more than a decade of experience in applied research, program evaluation, and technical assistance. Her work has focused on replication studies and evaluations of parent training and child maltreatment prevention programs. Ms. Filene currently directs the National Cross-Site Evaluation of the Replication of Demonstrated Effective Prevention Programs (Family Connections). Prior to joining James Bell Associates, Ms. Filene worked as a

research fellow for the Centers for Disease Control and Prevention.

Ms. Brodowski has over 17 years of experience working in the field of child welfare and social services. She is the prevention specialist at the Office on Child Abuse and Neglect at the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services, where she manages a range of grant programs and contracts. She also worked at a county child welfare agency to develop new programs, manage interagency agreements, and implement various special projects. She completed her master's degree in social welfare and public health from the University of California at Berkeley in 1997. She is currently a part-time social work doctoral student at the University of Maryland, Baltimore, School of Social Work.

The purpose of this special issue of *Protecting Children* is to profile lessons learned and "tell the story" of the national replication of Family Connections (FC), a multi-faceted community-based service program that works with families in their homes, in the context of their neighborhoods, to help them meet the basic needs of their children and prevent child maltreatment. Based on promising results from the initial pilot program, FC was recognized in 2003 by the Office on Child Abuse and Neglect (OCAN), U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau as an effective program for

preventing child maltreatment in the report *Emerging Practices in the Prevention of Child Abuse and Neglect* (Thomas, Leicht, Hughes, Madigan, & Dowell, 2003). In following up on the report, the Children's Bureau awarded eight 5-year cooperative agreements, as well as a national cross-site evaluation to examine whether the grantees could replicate FC with fidelity in other settings with different target populations.

The FC Program was originally developed in 1996 through partial support from OCAN. The study design for the initial demonstration involved randomly assigning families that met risk inclusion criteria, but were not currently involved with child protective services (CPS), to receive FC services for either a 3- or 9-month period. Results of this study indicated changes for both groups, including positive changes over time in protective factors (parenting attitudes, parenting competence, social support); diminished risk factors (parental depressive symptoms, parenting stress, life stress); and improved child safety (physical and psychological care of children) and child behavior. Results further reflected that families served for 9 months reported greater improvements in the behavior of their children than families served for 3 months (DePanfilis & Dubowitz, 2005). These initial results are graphically depicted in Figure 1. Later analysis determined that the 3-month intervention was more cost effective than the 9-month intervention for all outcome domains except child behavior (DePanfilis, Dubowitz, & Kunz, 2008).

This introduction to the special issue briefly describes the history of the development of FC and the national replication effort, provides an overview of the program and fidelity criteria, identifies the replicating sites, and shares information about the national cross-site evaluation. Finally, it introduces the reader to each of the articles in this issue.

Description of FC

The FC Program operates from an ecological developmental framework using Bronfenbrenner's (1979) theory of social ecology as the primary theoretical foundation. Developed primarily to prevent child neglect, the program conceptualizes the problem as evolving when risk factors related to the child, caregivers, family system, and the environment challenge the capacity of caregivers and broader systems to meet the basic needs of children. FC uses a home-based, family-centered model of practice consistent with other home-based, tailored intervention approaches (Dunst, Trivette, & Deal, 1988; Kinney, Strand, Hagerup, & Bruner, 1994).

> FC uses a home-based, family-centered model of practice consistent with other home-based, tailored intervention approaches.

Nine practice principles guide FC interventions: community outreach, individualized family assessment, tailored interventions, helping alliances, empowerment approaches, a strengths-based perspective, cultural competence, developmental appropriateness, and outcome-driven service plans (DePanfilis, Glazer-Semmell, Farr, & Ferretto, 1999). Individualized intervention is designed to increase protective factors (e.g., social support) and decrease risk factors (e.g., parental depressive symptoms) associated with child maltreatment.

The core components of the FC Demonstration Program included: (1) Emergency assistance; (2) home-visiting family intervention (family assessments, outcome-driven service plans, individual and family counseling); (3) advocacy

and service coordination with referrals targeted toward risk and protective factors; and (4) multi-family supportive and recreational activities. Because the authors were interested in understanding whether shorter- versus longer-term services were more effective in supporting families to achieve positive outcomes, families were assigned to receive the same core services, but for different lengths of time (3 versus 9 months). Clinical self-report and observational measures (DePanfilis et al., 1999) were integrated into each family assessment, and service plans were developed accordingly. Similar to other home-based interventions (Lutzker & Rice, 1987), FC combined the education of graduate students with service to the community. First- and second-year social work interns completed the objectives of field placement courses by providing most of the services delivered for either 3 or 9 months. These services were provided under the close supervision of a faculty member. Interns received weekly individual supervision and clinical seminars, and they followed a detailed intervention manual (DePanfilis et al., 1999). The program was based in the community and most services were provided in participants' homes.

Background

In federal fiscal year 2001, the Children's Bureau initiated the Emerging Practices in the Prevention of Child Abuse and Neglect Project to harvest new information on child maltreatment prevention programs and initiatives operating around the country, and to disseminate that information to the professional community. The project involved scanning the environment for current information on prevention and seeking input directly from child maltreatment prevention programs. Under the guidance of an advisory group of experts in the field of child maltreatment prevention, including both practitioners and researchers, OCAN developed and implemented a program nomination strategy to learn more about current effective and innovative prevention

programs. Through this effort, FC was highlighted as an effective program in the *Emerging Practices* report that was released in federal fiscal year 2003 (Thomas et al., 2003).

The Children's Bureau planned to support future work based on the findings of this report that would contribute to advancing theory, policy, and evidence-based practice in child maltreatment prevention. In fiscal year 2003, the organization issued a funding announcement, *Replications of Demonstrated Effective Programs in the Prevention of Child Abuse and Neglect* (*Program Announcement No. CB-2003-01.D1*). The overall purpose was to provide financial support to replicate and evaluate critical components of programs that had demonstrated success in preventing or reducing the risk of child maltreatment by testing their effectiveness in other settings. Applicants could choose to replicate the demonstrated effective program identified in the Emerging Practices report (i.e., FC) or another program of equal merit. The projects funded under this priority area would incorporate features and components that held promise for contributing to the knowledge base about effective strategies in child maltreatment prevention.

The eight highest-scoring applications selected for funding all proposed to replicate the key components of the FC Program. Each of the projects planned to test the effectiveness of the program with a variety of different populations and geographic areas. Grantees were required to conduct rigorous local evaluations that included process, outcome, and cost components. The Children's Bureau also funded a national cross-site evaluation to examine whether the FC Program could be implemented with fidelity in other settings. The national evaluation is examining any adaptations that were made to the original model by the replicating sites and the impact of such changes that were made to meet the needs of each site's target population.

The study is also evaluating the effect of the replication projects on reducing risk factors, increasing protective factors, and preventing child maltreatment for families served. Finally, the national evaluation includes a comprehensive cost analysis that incorporates aggregate and case-level costs that were collected across all the replication sites.

The FC replication sites differed in a variety of ways, including their target populations (e.g., age and race/ethnicity), target community (e.g., large city or rural), program staff background (e.g., intern or clinician with a master's in social work), experience with federal grants, and experience with program evaluation and research (Filene, Kass, Smith, Hafford, & Bell, 2009). The eight replication sites were:

- **Asian Pacific Counseling and Treatment Center (APCTC)**. Located in Los Angeles, California, APCTC was established in 1977 to provide mental health services targeting Asian Pacific groups: Chinese, Filipino, Japanese, Korean, Vietnamese, Cambodian, Lao, and Thai individuals and families. APCTC is one of the oldest and largest mental health centers serving the Asian Pacific community throughout Los Angeles County. The APCTC Project proposed to reach out to Korean and Cambodian immigrant families that were living in Los Angeles County, met risk criteria for neglect, and were not receiving services from the public child welfare agency. These families were encouraged to participate in FC services for 3 or 6 months.

- **Black Family Development, Inc. (BFDI).** BFDI is a private, nonprofit, comprehensive family counseling agency that was created in 1978 by the Detroit Chapter of the National Association of Black Social Workers. Since that time, BFDI has grown to accommodate the increased demand for specialized, family-

focused counseling and advocacy services in the community. The BFDI Project proposed to serve families that were living in two high-risk communities in Wayne County (Detroit and Highland Park), met risk criteria for neglect, and were not receiving services from the public child welfare agency. The families could participate in FC services for 3 or 6 months.

- **Child and Family Tennessee (CFT).** Located in Knoxville, Tennessee, CFT is a private not-for-profit corporation that was founded in 1929. Since then, CFT has been a prominent service provider dedicated to helping children and families in East Tennessee by providing prevention, treatment, and advocacy services. The CFT Project proposed to reach out to families that were living in the Knoxville Empowerment Zone (a federally designated neighborhood with high rates of poverty and violence), met risk criteria for child abuse and neglect, and were not receiving services from the public child welfare agency. These families could participate in one of four different versions of the FC intervention: (1) FC for 3 months; (2) FC for 3 months, enhanced with parent education groups; (3) FC for 9 months; or (4) FC for 9 months, enhanced with parent education groups.

- **Children's Institute Inc. (CII).** CII is a private, nonprofit, multi-service agency located in Los Angeles, California, that is active in child welfare policy development, professional practice, and research and evaluation. Founded in 1906, CII has a long history and extensive experience in developing and implementing both child maltreatment prevention programs and home visitation programs. The CII Project proposed to reach out to families with young children (birth to 3 ½) that were living in high-risk neighborhoods in South Central Los Angeles, met risk criteria for neglect, and were not

receiving services from the public child welfare agency. They could participate in one of two different interventions: (1) FC for 9 months; or (2) Project Stable Home (a locally developed family preservation program) for 9 months. However, due to funding changes for Project Stable Home, CII stopped assigning families to Project Stable Home and added an individualized information and referral services group to its design.

- **DePelchin Children's Center (DCC).** DCC is a private, nonsectarian United Way agency that has served the greater Houston area for more than 110 years. The agency runs over 30 programs dedicated to adoption, foster care, counseling services, prevention services, residential services, and other service areas. The DCC Project proposed to reach out to families whose children were attending schools in the high-risk neighborhoods in Dickinson, Texas, that met risk criteria for neglect, and that were not receiving services from the public child welfare agency. These families could participate in one of four different versions of the FC intervention: (1) FC for 3 months; (2) FC for 3 months, enhanced with Just for Me Time (parental self-nurturing activities); (3) FC for 6 months; or (4) FC for 6 months, enhanced with Just for Me Time.

- **Respite Care of San Antonio ("Together in Strength" or TIS).** TIS is a collaborative effort formed by two separate agencies: Respite Care of San Antonio (RCSA) and Any Baby Can San Antonio (ABC). RCSA provides relief services to families struggling with the day-to-day challenges of caring for and raising children with developmental disabilities. ABC serves families with children facing serious health or developmental challenges. The TIS Project proposed to reach out to families with children between the ages of birth and 17 who had developmental disabilities

or chronic health conditions, were living in one of two Texas counties (San Antonio or Bexar), met risk criteria for neglect, and were not receiving services from the public child welfare agency. These families could participate in one of three different groups: (1) Services as usual; (2) FC for 6 months; or (3) FC for 12 months. TIS implemented a step-down service model that consisted of a gradual decrease in the intensity of services over a period of time, starting with weekly visits that tapered to monthly contacts and phone calls toward the end of the program.

- **University of Maryland, Baltimore Grandparent Family Connections (UMB-GFC).** UMB-GFC implemented the Grandparent FC Project through the UMB Center for Families (now reconstituted as the Ruth H. Young Center for Families and Children). The mission of the Center for Families was to promote the safety, health, and well-being of children, families, and communities through community and clinical services, research, education, and advocacy. The UMB Project proposed to reach out to grandparent families that were living in high-risk neighborhoods, met risk criteria for neglect, and were not receiving services from the public child welfare agency. These families could participate in one of three different versions of the FC intervention: (1) FC for 3 months; (2) FC for 6 months; or (3) FC for 6 months, enhanced with health and legal services. In addition, a fourth group was randomly assigned to receive no FC services.

- **Youth Health Service, Inc. (YHS).** YHS was created in 1978 to provide health, education, and social benefits to youths and their families residing in Barbour and Randolph counties, a rural, low-income region of north central West Virginia. The agency offers an array of behavioral health services. The YHS Project proposed to

> Cross-site outcome measures were chosen based on evidence of acceptable reliability and validity of the measures in previous research.

reach out to families that were living in the aforementioned counties, met risk criteria for neglect, and were not receiving services from the public child welfare agency. They could participate in one of four different versions of the FC intervention: (1) FC for 6 months; (2) FC for 6 months, enhanced with a motivational interviewing intervention; (3) FC for 12 months; or (4) FC for 12 months, enhanced with a motivational interviewing intervention. YHS also implemented a step-down service model. Families assigned to receive 6 months of services received weekly visits during the first 3 months, bimonthly visits for the next 3 months, and then an additional 3 months of monthly visits if they chose to participate in an optional booster period.

'Fidelity Criteria' for Replicating FC

During the first year of replication, the eight sites and the UMB Center for Families agreed on a set of "fidelity criteria," and each program developed an implementation manual that set forth its plans to replicate FC. These fidelity criteria (see Table 1) specified a set of nine philosophical principles, 14 criteria related to program structure, five criteria related to administrative activities, five criteria related to professional development activities, and six criteria related to research activities. The methods used to assess cross-site fidelity to the FC Program rely on an examination of the program staff's verbal and written reports of implementation, including archival data abstraction, semi-structured interviews, case record review, and focus group discussion.

National Cross-Site Outcome Measures

Cross-site outcome measures were chosen based on evidence of acceptable reliability and validity of the measures in previous research. Three measures were selected to assess the following protective factors:

- Parenting attitudes: *Adult-Adolescent Parenting Inventory (AAPI-2)* (Bavolek & Keene, 1999)

- Social support: *Support Functions Scale* (Dunst, Trivette, & Deal, 1988)

- Family functioning: *Family Assessment Form* (Children's Bureau of Southern California, 1997)

Two measures were selected to assess the following risk factors:

- Parental depressive symptoms: *Center for Epidemiologic Studies, Depressed Mood Scale* (Radloff, 1977)

- Parenting stress: *Parenting Stress Index, Short Form* (Abidin, 1995)

One additional measure was selected to assess child well-being: *Child Behavior Checklist* (Achenbach, 1991). Beyond the cross-site outcome measures, each site administered a variety of site-specific measures.

Articles in This Issue

In the first article, Sheila Tsai Wu, Akiko Mimura-Lazare, Carrie J. Petrucci, Naomi Kageyama, and Chong Suh describe three culturally competent practices that were

Figure 1. FC Logic Model
Assumptions: Home-based services focused on reducing risk factors and strengthening protective factors will result in increased safety and improved child behavior.
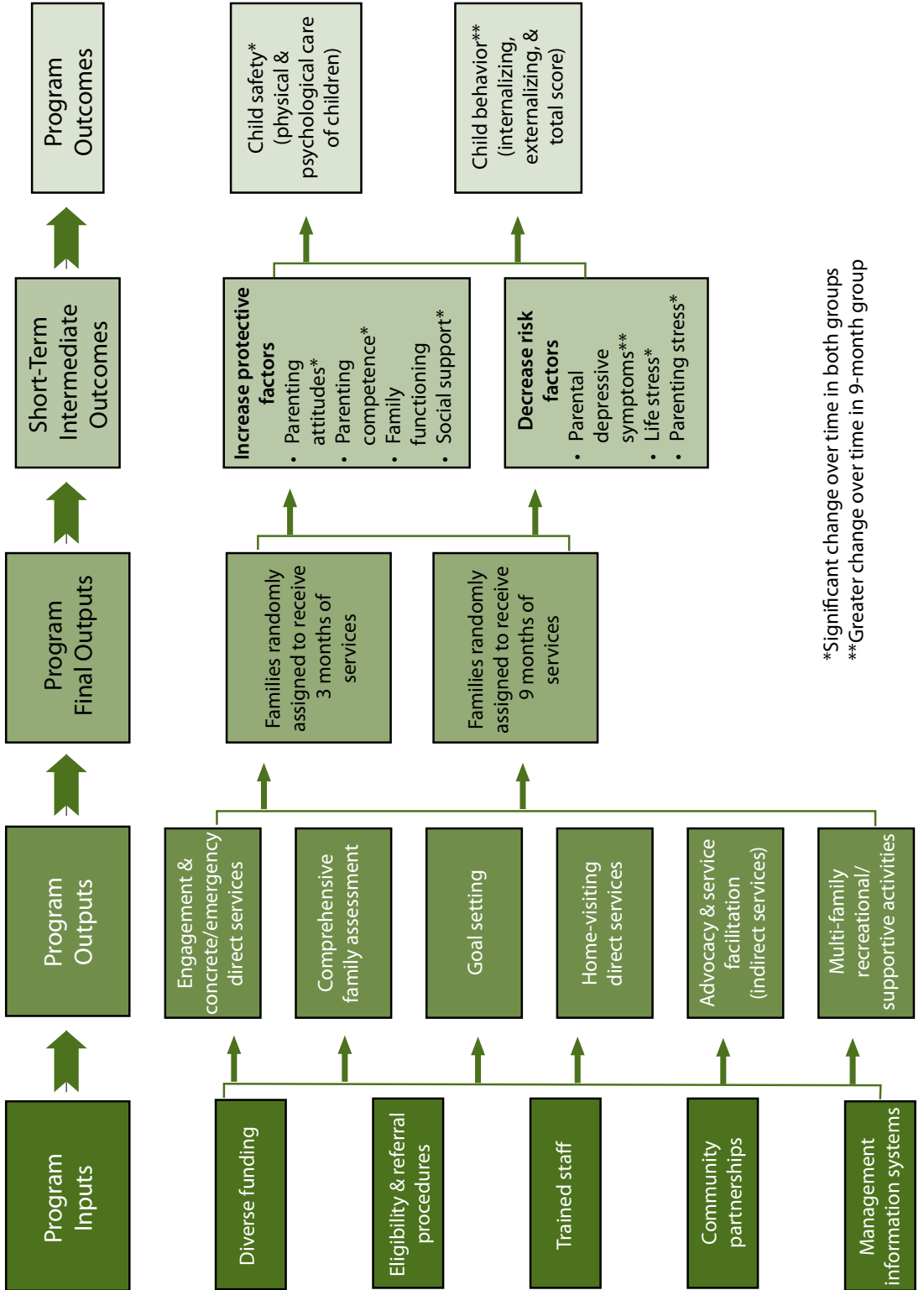
*Significant change over time in both groups
**Greater change over time in 9-month group

implemented in APCTC's replication of FC with Cambodian and Korean families: (1) "Buy-in" from the target population; (2) tailored service delivery protocols; and (3) cultural adaptations to FC for Cambodian refugee and Korean immigrant population groups.

The second article, by Kenyatta Stephens, Crystal Mills, Cynthia Williams, Tana Bridge, and Enos Massie, provides an example of the development of a helping alliance between a consumer and a counselor in BFDI's replication of FC. The article presents a case illustration of the clinical and programmatic processes associated with a helping alliance that were used by BFDI counselors to achieve a high level of engagement and successful outcomes with one high-risk family.

In the third article, Matthew T. Theriot, Kathryn R. O'Day, and Kathy Hatfield investigate client characteristics and service use measures predicting successful completion of CFT's replication of FC. Findings suggest that families served for 3 months were more likely to complete services than families served for 9 months. Further findings indicate that families receiving more comprehensive direct services were more likely to successfully complete the program, whereas families with housing problems, more children living in the home, and that received a greater number of different referral services were more likely to drop out of the program.

The fourth article, by Susan Zaid, Charity Eames, Demori Driver, and Adrienne LeGendre, describes DCC's implementation of Therapeutic Assessment (TA) as a therapeutic technique to help high-risk families and as an avenue to collect data on program performance in a community-based mental health setting. TA was used to enhance the implementation of the core components of FC, with specific emphasis on integrating research and practice.

The fifth article, by Tanya L. Sharpe, Diane DePanfilis, Frederick Strieder, and Gillian K. Gregory, describes modifications made to FC to address the needs of grandparent families. It also describes the perspectives of grandparents after their participation in UMB's Grandparent FC services. Qualitative findings revealed that the impact of the program fell into three domains: (1) Supports and services; (2) skill building; and (3) affect and behavioral changes.

The sixth article, by Melissa Lim Brodowski and Jill H. Filene, discusses the importance of involving and engaging program staff, including direct practice staff, in cost analyses. The article describes how program staff were engaged in the process of conducting an economic evaluation of the replications of FC and the lessons learned in conducting a comprehensive cross-site cost analysis. The paper concludes with key recommendations for practice and offers insight into how the process of conducting an economic evaluation can be used to facilitate ongoing learning and reflection regarding program practice, implementation, and research.

The seventh article, by Phaedra Corso and Jill H. Filene, consists of a description of the methods for conducting rigorous programmatic cost analyses, presenting cross-site cost analysis of the replications of FC as an example. The article includes the average programmatic costs of replicating FC across all eight sites.

Over the 5-year grant period, each of the FC replication projects was able to implement and rigorously evaluate the FC Program with varying levels of success. The articles in this special issue offer a rich opportunity to delve deeper into the unique aspects and lessons learned from five of the eight grantee projects. In addition, the two cost analysis articles provide sorely needed information to the field regarding the importance and relevance of economic evaluation. There are no short cuts to offer when attempting to

implement and rigorously evaluate a program proven to be effective in some instances in other jurisdictions and with entirely different target populations. Nonetheless, everyone involved with the projects is committed to ensuring that research informs future practice. This commitment is infused in all seven articles available in this issue of *Protecting Children*.

References

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

Achenbach, T. M. (1991). *Manual for the child behavior checklist: 4-18 and 1991 profile.* Burlington, VT: University of Vermont Department of Psychiatry.

Bavolek, S., & Keene, R. (1999). *Adult-adolescent parenting inventory.* Park City, UT: Family Development Resources.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by design and nature.* Cambridge, MA: Harvard University Press.

Children's Bureau of Southern California. (1997). *Family assessment form: A practice based approach to assessing family functioning.* Washington, DC: Child Welfare League of America.

DePanfilis, D., & Dubowitz, H. (2005). Family Connections: A program for preventing child neglect. *Child Maltreatment, 10,* 108-123.

DePanfilis, D., Dubowitz, H., & Kunz, J. (2008). Assessing the cost-effectiveness of Family Connections. *Child Abuse & Neglect, 32,* 335-351.

DePanfilis, D., Glazer-Semmell, E., Farr, M., & Ferretto, G. (1999). *Family Connections intervention manual.* Baltimore, MD: University of Maryland, Baltimore.

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

Filene, J. H., Kass, L., Smith, E. G., Hafford, C., & Bell, J. (2009). *National cross-site evaluation of the replication of demonstrated effective prevention programs (Family Connections): Interim evaluation report.* Arlington, VA: James Bell Associates.

Kinney, J., Strand, K., Hagerup, M., & Bruner, C. (1994). *Beyond the buzzwords: Key principles in effective frontline practice.* Falls Church, VA: National Center for Safety Initiatives Information Clearinghouse.

Lutzker, J. R., & Rice, J. M. (1987). Using recidivism data to evaluate Project 12-Ways: An ecobehavioral approach to the treatment and prevention of child abuse and neglect. *Journal of Family Violence, 2,* 283-290.

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

Thomas, D., Leicht, C., Hughes, C., Madigan, A., & Dowell, K. (2003). *Emerging practices in the prevention of child maltreatment.* Washington, DC: Office on Child Abuse and Neglect.

Appendix: FC Fidelity Criteria
Agreed to on January 13, 2004, by all replicating programs

The table presented below specifies the conditions necessary to replicate the FC Program. Each replicating program will develop an implementation plan that verifies how it will assure that the program is implemented with integrity.

FIDELITY CRITERIA
Philosophical Principles
Uses FC philosophical principles in the delivery of services: 　　1. community outreach 　　2. family assessment 　　3. individualized, tailored intervention 　　4. helping alliance 　　5. empowerment approaches 　　6. strengths perspective 　　7. cultural competence 　　8. developmental appropriateness 　　9. outcome-driven service plans
Program Structure
Uses, at a minimum, the original FC screening criteria (with the exception of geographical requirements and age limitations) as clear inclusion criteria for targeting and screening program clients
After clients are assigned to the FC intervention, an FC practitioner assigned to work with the family on an ongoing basis initiates the therapeutic alliance through face-to-face contact with the client within 1 business day of acceptance at intake
Provides at least 1 hour of face-to-face FC services to families at least once per week for at least 3 months
Provides most services in the community, meeting families where they live
Uses clinical assessment instruments to guide the identification of risk and protective factors associated with child neglect (or maltreatment) as part of the comprehensive family assessment
Develops and implements marketing and recruitment procedures targeted toward potential program clients
Establishes and manages referral procedures for actively reaching out to eligible families with offers of service
Forms and utilizes a community advisory panel that incorporates consumer input
Provides emergency services to address initial concrete needs and on an ongoing basis as needed
Conducts comprehensive family assessments to guide the service delivery process
Develops outcome-driven service plans geared to decrease risk and increase protective factors associated with child maltreatment
Delivers tailored, direct therapeutic services to help clients reduce risks, maximize protective factors, and achieve service outcomes and goals
Advocates on behalf of clients in the community and facilitates services provision by other organizations/individuals
Implements process for evaluation of client change over time and at case closing

Administrative Activities
Establishes safety policies for practitioners related to their work in the community
Develops, implements, and manages continuous methods for assessing quality assurance
Develops, implements, and manages risk management procedures (e.g., child abuse and neglect reporting, self-injurious behavior)
Tracks time units of service by type of services delivered
Tracks costs of all service units
Professional Development Activities
Recruits and supports a professional workforce (social work education or equivalent)
Provides initial training and orientation to all staff and provides all staff members with the FC intervention manual as revised by each program
Provides at least weekly clinical supervision to FC service providers
Fosters an organizational culture that reinforces the FC philosophical principles, intervention methods, and procedures via weekly clinical seminars or team meetings, and interpersonal interactions
Provides opportunities for staff to participate in seminars, conferences, and/or other training to support their continuous professional development in FC-related social work practice methods
Research Activities
Uses a logic model to specify the connections between outputs and outcomes
Uses an experimental research design with random assignment to at least two alternate treatment conditions or alternate interventions, or random assignment to treatment and control conditions
Measures change over time in risk factors, protective factors, and child safety and well-being outcomes, including at least a 6-month follow-up (after services end) measurement interval
Implements strategies that document the process of implementation and the service delivery process, and records time units of services
Uses a combination of self-report and observational standardized measures and collects data on official child abuse and neglect reports to assess change over time
Uses specific core measures as agreed on with other FC replication grantees

Culturally Competent Practice With Cambodian and Korean Families in Los Angeles: Results From a 5-Year Replication Project of Family Connections

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Dr. Wu is the assistant director of Asian Pacific Counseling and Treatment Centers (APCTC) in Los Angeles and a licensed psychologist in California. She has been with APCTC since 1992 after completing her National Institute of Mental Health post-doctoral fellowship at the Neuro-Psychiatric Institute, University of California, Los Angeles. Her areas of expertise include culturally and linguistically competent mental health treatment modalities for members of Asian and Pacific Islander communities, including children, youths, adults, and older adults. She was the principal investigator of the Family Connections replication study.

Ms. Mimura-Lazare is a licensed clinical social worker. She obtained her graduate degree in social work from the University of California, Los Angeles. She is a bilingual psychotherapist and clinical supervisor for APCTC in Los Angeles, specializing in children and transitional-age youth. She was the program coordinator for the Family Connections replication study.

Dr. Petrucci is a senior research associate at EMT Associates, Inc., an evaluation firm in Encino, California. She is also a field instructor at the School of Social Work, California State University, Los Angeles. She has conducted evaluation projects with public and private agencies in child abuse, substance abuse, HIV, and specialized courts. Prior to working in evaluation, she was a children's social worker at the Los Angeles County Department of Children and Family Services. She was the external program evaluator for the Family Connections replication study.

Ms. Kageyama is the director of program development for Special Service for Groups (SSG), a private, nonprofit human services organization based in Los Angeles. Her areas of expertise include program planning and implementation, strategic planning, program management, and program development. She has been with SSG since 1989 and in her current position since 1994.

Dr. Suh is the director of APCTC in Los Angeles and has been a licensed psychologist in California since 1984. She has been the director since 1988. Her professional experience includes teaching, research, clinical practice, and supervision. Her publication and presentation topics include psychotherapy research, police anti-corruption research, the psychological impact of the Los Angeles riots on Korean victims, cultural issues, and the psychosocial rehabilitation of Asian clients. She is also a board member for the National Asian American Pacific Islander Mental Health Association.

Introduction

Asian Pacific Counseling and Treatment Centers (APCTC)[1] is the oldest (established in 1977) and largest operator of mental health centers serving the Asian and Pacific Islander (API) communities in Los Angeles (LA) County, providing high quality, culturally competent mental health services to children, adolescents, adults and senior adults, and families. With multi-disciplinary teams, APCTC functions as a multilingual, multicultural provider with a full range of mental health programs and services. Implementing the Family Connections (FC) Program within this established mental health service delivery system was deemed an appropriate fit — one that would improve understanding of how to prevent child maltreatment within Asian communities. Of particular interest was the opportunity to implement culturally appropriate interventions for Cambodian families, a Southeast Asian sub-group, and Korean families, an East Asian sub-group.

FC was selected for several reasons to advance the prevention of child maltreatment within two very different Asian sub-groups. Most important was the flexibility of the nine practice principles (see page 5). In addition, the intensive staff training and cultural competency values were felt to be beneficial for the target populations.

The purpose of this article is to present three culturally competent practices specific to Cambodian and Korean sub-groups in the context of implementing FC: (1) "Buy-in" from the target population; (2) tailored service delivery protocols; and (3) cultural adaptations to FC for Cambodian refugee and Korean immigrant population groups. This discussion is presented to build on the utility of FC among culturally diverse populations.

Background: Cambodian and Korean Family Characteristics

Cambodian refugee and Korean immigrant families vary greatly in terms of immigration history, traditions, and current status in the United States. Members of the Cambodian population were refugees in this country, fleeing the brutal Pol Pot regime starting in 1975 (Chang, Rhee, & Berthold, 2008). The Korean population started immigrating to this country in the 1960s and more heavily in the 1980s (Kim & Cain, 2008). Their main incentive for immigration was economic opportunities (Shin & Shin, 1999). These immigration patterns have led to very different family issues and service needs.

LA County is home to 11% of all API children (Children Now, 2001), and California is home to 37% of all child maltreatment cases nationwide for children who are Asian (not Pacific Islander) (U.S. Department of Health & Human Services, 2009). Experts believe that the numbers are significantly underreported due to family loyalty and filial piety, and also the shared cultural values among the people who have contacts with these families. Many API groups find it shameful to talk about or share problems with those outside the family, and believe that they should solve problems by themselves. Close-knit ethnic enclaves reinforce these customs. Currently, 840 children who have ethnicity listed as Asian or Pacific Islander are receiving services from the LA County Department of Children and Family Services (DCFS). Interestingly, over 40.4% (twice the general population average of 20.8%) of these services are voluntary or non-court-mandated (Nguyen, 2008), possibly indicating a small crack in the community's historic "wall of silence." The growing understanding of maltreated children who are API provides compelling evidence supporting the need for child welfare prevention and intervention programs in this geographic area and other such growing communities nationwide.

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[1]APCTC is a division of Special Service for Groups, a private, nonprofit human services provider in California.

Cambodian Families

In LA County, the Cambodian population numbers 28,226 persons or 2.5% of the total Asian population. Significantly, however, 31% of child maltreatment cases investigated by the Asian Pacific Unit of DCFS involve Cambodian families (Nguyen, 2008). Treatment need among the Cambodian community is especially urgent as a result of the trauma many refugees endured in their home country under the Pol Pot Khmer Rouge regime (1975-1979), during which 1 to 3 million people died of starvation, disease, or mass executions. Many Cambodian refugees remain traumatized; more than 62% of the community suffers from post-traumatic stress disorder, and 51% have a major depressive disorder (Marshall, Schell, Elliott, Berthold, & Chun, 2005). Such staggering numbers indicate a great need for intervention.

However, there are multiple obstacles to serving this group. Cambodian families have a very high rate of linguistic isolation; 57% of all Cambodian households in LA County are without a person 14 or older who is able to speak English "very well" (APALC, 2004). The high rate of language isolation could be a result of a considerably low level of educational attainment; 56% of Cambodian adults aged 25 and older have not completed high school (APALC, 2004). In addition, Cambodians have a remarkably high poverty rate, with 68% below 200% of the federal poverty line (APALC, 2004). Poverty is well established as a risk factor for child maltreatment and overall child well-being (Thomas, Leicht, Hughes, Madigan, & Dowell, 2003; Sedlak & Broadhurst, 1996; Slack, Holl, McDaniel, Yoo, & Bolger, 2004).

> Treatment need among the Cambodian community is especially urgent as a result of the trauma many refugees endured in their home country under the Pol Pot Khmer Rouge regime.

Korean Families

The Korean population in LA County has grown by 28% from 1990 to 2000, representing 16.4% of LA County's Asian population (APALC, 2004; U.S. Census Bureau, 2000). Currently, 14.9% of the API child maltreatment cases investigated by the county are Korean (Nguyen, 2008). In LA County, 59% of Korean households are linguistically isolated (APALC, 2004). While Asians are more likely to be foreign-born (66%) than other ethnic groups (APALC, 2004), at 77%, Koreans are almost double the norm (U.S. Census Bureau, 2000). Such a rapidly expanding immigrant community typically experiences a high need for services and resources — but faces significant barriers to accessing them.

More than one third (36%) of Koreans in LA County live below 200% of the poverty level (APALC, 2004), even though there is a well-accepted stereotype of business proliferation and growth. There have been increasing reports of Korean domestic violence in the media, especially in the wake of a series of high-profile deadly family rampages in 2006 (Gable, 2006; Hayasaki, 2006) and the Virginia Tech massacre perpetrated by a disturbed Korean student in 2007. A report by the Asian and Pacific Islander Institute on Domestic Violence (2005) indicated that 30% of Koreans surveyed reported witnessing their fathers regularly hit their mothers, while 80% reported being hit regularly as children. These and other indicators showcase a growing risk for child well-being in this rapidly growing immigrant group.

Needs at Intake for Families Served

To implement FC with the target population, 74 Cambodian and Korean families were recruited to receive services. Descriptive information about these families that was collected during the intake process is presented. All families met the eligibility criteria for enrollment, which included: living in LA County; the parent or caregiver was a recent Cambodian or Korean immigrant; the family in need of services had at least one child who was between 5 and 11 and lived in the home; the family was stable and willing to accept services; and there was no current DCFS

Table 1. Demographic Characteristics for Cambodian and Korean Families at Intake (N = 74).

Demographic Characteristic	Cambodian Families (n = 39)	Korean Families (n = 35)
Parent/caregiver average age	41.7 yrs (standard deviation or sd =8.4)	41.6 yrs (sd=7.9)
Target child average age	8.2 yrs (sd=2.1)	8.5 yrs (sd=1.9)
Parent/Caregiver gender Female Male	 92.3% (36) 7.7% (3)	 100% (35) --
Target child gender Female Male	 35.9% (14) 64.1% (25)	 40.0% (14) 60.0% (21)
Parent/Caregiver marital status Married (living together) Separated/divorced/widowed Never married	 38.5% (15) 46.1% (18) 15.4% (6)	 82.4% (28) 17.6% (6) --
Parent/Caregiver employment Unemployed Part-time employment Full-time employment	 84.6% (33) 10.3% (4) 5.1% (2)	 58.8% (20) 11.8% (4) 29.4% (10)
Parent/Caregiver highest education completed Less than high school High school Some college/graduated Some graduate school/graduated	 69.2% (27) 17.9% (7) 10.3% (4) 2.6% (1)	 -- 11.8% (4) 76.4% (26) 11.7% (4)
Living arrangements House/Apt. owned House/Apt. rented Public housing/Section 8 Share house/apt. w/friend, relative	 2.6% (1) 69.2% (27) 17.9% (7) 10.2% (4)	 32.4% (11) 64.7% (22) 2.9% (1) --
Family annual income $9,999 and less $10,000 - $19,999 $20,000 - $29,999 $30,000 - $39,999 $40,000 - $49,999 $50,000 or more	 18.9% (7) 54.0% (20) 13.5% (5) 8.1% (3) -- 5.4% (2)	 11.8% (4) 17.6% (6) 32.3% (11) 5.9% (2) 14.7% (5) 17.6% (6)

involvement. Just over half of families were Cambodian (52.7%) and just under half were Korean (47.3%). Demographics for the Cambodian and Korean families are shown in Table 1.

For Cambodian families, almost all caregivers were female (92.3%). The average age of the caregiver was 42 years old, and the average age of the child was 8 years old. About two thirds of Cambodian families included a boy who was the identified child (64.1%). The largest percentage of Cambodian caregivers represented those who were separated, divorced, or widowed (46.1%), followed by those who were married (38.5%). More than two thirds of caregivers were unemployed (84.6%). A significant portion of Cambodian caregivers had less than a high school education (69.2%). More than two thirds lived in a rented house or apartment (69.2%). The most common income group was $10,000 to $19,999 per year (54.0%).

For Korean families, all caregivers were female, with an average age of 42 years old. The average

Table 2. Rank Ordering by Percent of Cambodian and Korean Families Receiving Public Assistance/ Participating in Social Welfare Programs at Intake ($N = 74$).

Cambodian Families ($n = 39$)		Korean Families ($n = 35$)	
% (n)	Rank ordering	% (n)	Rank ordering
59.0 (23)	(1) Food Stamps	17.1 (6)	(1) Medicaid
43.6 (17)	(2) Temporary Assistance for Needy Families (TANF)	5.7 (2)	(2) Food Stamps
33.3 (13)	(3) Medicaid	5.7 (2)	(2) Social Security
23.1 (9)	(4) Supplemental Security Income (SSI)	5.7 (2)	(2) SSI
12.8 (5)	(5) Women, Infants and Children (WIC)	2.9 (1)	(3) TANF
2.6 (1)	(6) Social Security	2.9 (1)	(3) WIC
--	(7) Unemployment	--	(4) Unemployment
--	(7) General assistance	--	(4) General assistance

Table 3. Rank Ordering of Risk Factors Experienced by 30% or More of Cambodian and Korean Families at Intake ($N = 74$).

Cambodian Families ($n = 39$)		Korean Families ($n = 35$)	
% (n)	Rank ordering	% (n)	Rank ordering
100 (39)	(1) Over-employed/newly employed/unemployed	82.9 (29)	(1) Over-employed/newly employed/unemployed
76.9 (30)	(2) Caregiver mental health problem	82.9 (29)	(1) Child behavior/mental health problem
48.7 (19)	(3) Isolation	40.0 (14)	(2) Inadequate nurturing
38.5 (15)	(4) Inadequate nutrition	37.1 (13)	(3) Permitting other maladaptive behavior
35.9 (14)	(5) Inadequate nurturing	31.4 (11)	(4) Delay in obtaining mental health care
33.3 (13)	(6) More than 3 children in the home		

age of the child was 8 years old. Boys were the identified child for 60% of families. Almost all caregivers were married (82.4%). About two thirds were unemployed (58.8%), with about one third employed full-time (29.4%). Most Korean caregivers had gone to college or graduated from college (76.4%) or attended or graduated from graduate school (11.7%). About two thirds lived in a rented house or apartment (64.7%). The most common income group was $20,000 to $29,999 per year (32.3%).

Table 2 presents data on the percentage of families that reported receiving public assistance and social welfare programs at intake. A rank ordering is also presented based on the total percentage of families receiving each benefit. Of immediate note is that in the case of Cambodian families, almost two thirds reported receiving Food Stamps (59% or 23 families), with almost half receiving Temporary Assistance for Needy Families (TANF) (43.6% or 17 families), and one third receiving Medicaid (33.3% or 13 families). Only a small number of Korean families reported receiving any of these types of government assistance, with the largest percentage reporting receipt of Medicaid (17.1% or 6 families). For the remainder of the assistance categories, only one or two Korean families reported receiving these at intake.

Table 3 presents the most prevalent risk factors that were experienced by 30% or more of Cambodian or Korean families. Over-employment (working excess hours), being newly employed, and unemployment were the most common risk factors for both Cambodian (100%) and Korean (82.9%) families. For Cambodian families, risk factors were caregiver-focused (caregiver mental health problems, isolation, and inadequate nurturing), related to basic needs (inadequate nutrition), and family-focused (more than three children in the home). For Korean families, risk factors were child-focused (e.g., child behavior/mental health problems, permitting maladaptive behaviors, delay in obtaining mental health care) and caregiver-focused (inadequate nurturing).

Table 4 presents the average scores for the standardized assessments conducted at intake. A general indicator of need is suggested when the average scores are in a problem or clinical range. For Cambodian families, areas of need were indicated for caregivers in several areas, including social support, depression, post-traumatic stress disorder (PTSD) symptoms, parenting skills (including inappropriate development expectations, lack of empathy, corporal punishment, role reversal, and power independence), parenting stress, and interactions between caregivers. No problems with children were in the clinical range. For Korean families, caregiver needs were also indicated in several areas, including social support, depression, PTSD symptoms, parenting (including empathy skills, use of corporal punishment, role reversal, and power independence), parenting stress, and caregiver/child interactions. Korean parents scored their children in the borderline problem range on the Child Behavior Checklist (CBCL).

Lessons Learned: Implications for Practice

In this section, we present the lessons learned in three main practice areas significant to culturally competent practice — "buy in" of Cambodian and Korean families, service delivery protocols, and cultural adaptations of FC — as well as the implications for frontline social workers, supervisors, and administrators.

'Buy-in' of Cambodian and Korean Families

Implications for Children's Social Workers, Supervisors, and Administrators
Community-based recruitment strategies. At the outset of FC implementation, outreach and participant recruitment took longer than expected, necessitating staff to intensify outreach efforts. For Cambodian families, one productive recruitment strategy included outreach to

Table 4. Areas of Need as Indicated by Mental Health Assessment Average Scores at Intake for Cambodian and Korean Families (*N* = 74).

Assessment	Cambodian Families (*n* = 39)		Korean Families (*n* = 35)	
Support Function Scales	Mean (M)=46.2 (standard deviation or sd = 13.6)	Moderate need	M=46.8 (sd=15.8)	Moderate need
Center for Epidemiologic Studies Depression Scale (CES-D)	24.6 (sd=10.7)	Clinical range >16	M=20.6 (sd=11.2)	Clinical range >16
Post-Traumatic Stress Disorder Symptom Checklist – Civilian Version (PCL-C)	M=44.1 (sd=16.2)	Clinical range >28 to 50	M=38.6 (sd=15.1)	Clinical range >28 to 50
Adult-Adolescent Parenting Inventory II (AAPI), Form A sten scores				
Inappropriate developmental expectations	M=2.6 (sd=1.1)	High risk	M=5.0 (sd=2.0)	Normal
Lack of empathy	M=1.3 (sd=.65)	High risk	M=2.8 (sd=1.5)	High risk
Corporal punishment	M=3.0 (sd=1.1)	High risk	M=3.6 (sd=1.3)	High risk
Role reversal	M=1.6 (sd=1.2)	High risk	M=2.8 (sd=1.5)	High risk
Power independence	M=1.6 (sd=1.2)	High risk	M=2.8 (sd=1.5)	High risk
Parenting Stress Index (PSI) – Short Form				
Total stress percentile	M=91.4 (sd=9.9)	Clinical range >90	M=96.8 (sd=4.1)	Clinical range >90
Child Behavior Checklist (CBCL) (1991) for Ages 4 to 18				
Internalizing behaviors	M=55.4(sd=8.4)	Normal <60	M=58.1 (sd=10.0)	Normal <60
Externalizing behaviors	M=49.8 (sd=7.6)	Normal <60	M=54.8 (sd=10.7)	Normal <60
Total problems	M=54.3 (sd=8.9)	Normal <60	M=61.3 (sd=10.9)	Borderline 60-63
Family Assessment Form (FAF)				
Section A: living conditions	M=2.7 (sd=.53)	Adequate	M=1.9 (sd=.48)	Adequate
Section B: financial	M=2.7 (sd=.59)	Adequate	M=1.9 (sd=.49)	Adequate
Section C: supports to caregivers	M=2.6 (sd=.64)	Adequate	M=2.3 (sd=.65)	Adequate
Section D: caregiver/child interactions	M=2.5 (sd=.64)	Adequate	M=3.0 (sd=.77)	Problems
Section E: developmental stimulation	M=2.9 (sd=.62)	Adequate	M=2.5 (sd=.71)	Adequate
Section F: interactions between caregivers	M=3.1 (sd=1.2)	Problems	M=2.7 (sd=1.0)	Adequate
Section G: caregiver history	M=2.7 (sd=.87)	Adequate	M=2.1 (sd=.59)	Adequate
Section H: caregiver personal characteristics	M=2.4 (sd=.50)	Adequate	M=2.1 (sd=.48)	Adequate

well-known community-based organizations. Once recruited, the provision of assistance with basic needs (food, employment, and housing), as supplied through the case management portion of FC, was identified as a compelling draw for most Cambodian families. For Korean families, a similar strategy of partnering with local community-based organizations or faith-based networks did not draw in families as hoped. Maximizing children's educational attainment was identified as the major draw to many of the Korean families whose members agreed to participate in FC. The most common source of referrals for both groups was self-referrals (46.2% of Cambodian referrals and 28.6% of Korean referrals), which often followed small group community presentations.

Staff "matching" by language/culture. While APCTC staff were extensively trained to provide culturally appropriate services, specific client "matching by ethnic sub-group" was not always possible. The main reason was a shortage of Cambodian professionals (i.e., therapists) both regionally and nationally — likely a direct result of their refugee history, which included the near-termination of almost all educated professionals and paraprofessionals during the Khmer Rouge regime in the late 1970s. As a result of this shortage, Korean therapists were used for Cambodian families, but worked in close collaboration with Cambodian outreach workers/ case managers who were able to build trusting relationships with Cambodian families. To have at least one member of the FC team "match" the client appeared to facilitate the provision of case management services, but may not have been sufficient to address more substantive emotional and psychological issues such as depression and

PTSD. All bilingual and bicultural staff were either immigrants themselves or had parents who were immigrants or refugees.

> Maximizing children's educational attainment was identified as the major draw to many of the Korean families whose members agreed to participate in FC.

Outreach and engagement. As noted, outreach and participant recruitment took longer than anticipated. Based on existing research and staff feedback, several factors were probably at work. First, child maltreatment is considered shameful behavior. As such, a broad community-based outreach approach (e.g., one that relied on churches) did not necessarily lead to community buy-in. Smaller parent (peer-based) groups were more receptive, as these groups were more willing to acknowledge problems (or potential problems) among peers. Different API sub-groups have different priorities, as evidenced by the clear differences between Cambodian and Korean groups. It behooves other providers looking to implement FC to use not only existing community-based organization networks and linkages, but create avenues for smaller, more intimate settings such as parent groups and neighborhood associations.

Service Delivery Protocols

Implications for Child Welfare Workers

The individualized approach of FC allowed for the incorporation of cultural nuances and styles by trained staff.

Greeting style. Bowing is the act of lowering the torso and head as a social gesture in direction to acknowledge another person. For many Southeast Asian groups, including Cambodians, pressing the hands together similar to a prayer may be done at the same time as bowing without any physical contact. However, depending on different emotions, including humility, sincerity, or

deference, physical contact (hand or arm shaking) may also accompany bowing. Respectfully nodding the head is acceptable — especially if familiarity has already been established. Bowing as part of the general greeting was uniformly observed by all staff throughout the project.

Use of culturally appropriate title. Bilingual staff commonly used culturally appropriate titles loosely translated as "uncle" or "aunt" for all Cambodian adult household members. This denoted respect and acceptance. With Cambodian families, men were greeted as "bong-pros" (uncle) and the women as "bong-srey" (aunt). Staff reported that over time, the use of titles became more informal and at times playful. Staff often reported that they felt fully accepted by the families and were treated as if they were part of extended family networks. For English-speaking staff who interacted with Cambodian parents, use of "Mr." or "Mrs." was appropriate initially, but as rapport developed, the English-speaking workers shifted to using "Uncle [First Name]" or "Aunt [First Name]." For Korean parents, greetings were more formal. "Mr." and "Mrs." were appropriate throughout service provision. Use of "Mom" and "Dad" as a third-person reference (i.e., when talking with a child) was also acceptable for both ethnicities in the context of parenting issues, but the more formal "Mother" and "Father" were often more comfortable for Korean families.

Food or other tokens of hospitality. Food is used within all Asian (and other) cultures in very specific ways. It is a token of respect and good manners to bring food or snacks. Arriving empty-handed would not have been commented upon, but would have been noticed. Promotional items (e.g., mugs) were also much appreciated. Providing staff a flexible budget to pick and choose the most appropriate items seemed to increase harmony among staff and clients.

Client choice for service delivery. The location of FC services was based on client choice, but most were provided in clients' homes. Services were sometimes provided at one of the APCTC clinics located throughout LA County. Repeated visits to a family's home firmly established the helping alliance, a core component of FC (see the Introduction in this issue). Overall, families appreciated the opportunity to decide where services would be provided.

Implications for Child Welfare Supervisors and Administrators

Staff cultural competency. As noted, Korean therapists worked with Cambodian families, but in close collaboration with Cambodian outreach workers/case managers who were able to build trusting relationships with the families. Under these circumstances, it was important that the supervisor encouraged the necessary teamwork by providing ongoing opportunities for the two staff to regularly communicate about the family. While staff-client "matching" is ideal, sharing a language with at least one team member was adequate. The integration of cultural norms (titles of respect for elders and adults, bowing, food, and tokens of appreciation) increased trust-building between all staff and families. Further, the use of cultural norms and establishment of the helping attitude among staff (another training requirement of FC) were welcomed and successful. Cultural competence, one of the nine FC practice principles, was reviewed throughout the project. Direct service staff reported that they accepted and respected cultural differences between the families and themselves by using empathy, by noticing the differences, and by noting the uniqueness of each family. They also reported that they engaged in ongoing cultural self-assessment by being positive about their own cultures and interested in other cultures, and by engaging in conversations on cultural issues outside of work with friends and colleagues. The

project supervisor used weekly team meetings, individual supervision sessions, and chart reviews to encourage the development of cultural competence.

Goal-setting differences between ethnic groups. As noticed throughout the project and discussed in staff focus groups, the targeted outcomes of service plan goals were very different for Cambodian and Korean families. Cambodian families identified goals that focused strongly on short-term, basic needs, including housing and food. It is reasonable to assume that Cambodians remain particularly impacted by their refugee experiences and therefore prioritize basic needs (food, shelter) over any other considerations. This is also in keeping with lower socio-economic status and high poverty levels among Cambodian families participating in the study — for families facing these challenges, basic needs take center stage. Korean families were more likely to identify educational and career goals for children, and seek long-term economic family and community stability. Children's educational attainment was consistently highlighted as a primary concern. While sample sizes were too small for comparison, these significant differences raise the question of how refugee versus immigrant status impacted various levels of family and community dynamics.

Cultural Adaptations of FC

Implications for Child Welfare Supervisors and Administrators

Translation of "Family Connections." Language nuances and translatability vary from culture to culture. The initial interpretation of a program name is important to potential clients, so considerable time was spent to assure that an appropriate translation was used. While the word "connections" is easily recognized as a term denoting familial and social networks, it does not translate well into either Cambodian or Korean languages. A process similar to a back-translation was used to assure that the program name was translated well. Staff who were fluent in each language, who were also fluent in English, and who understood FC came up with these translations. The translations were then shared with other staff who were fluent in both English and either Khmer (the language spoken in Cambodia) or Korean. Once it was decided that the translation worked in Khmer or Korean, the phrase was translated back to English. After much discussion, the name Caring for Our Families (CFOF) was selected to better represent the philosophical principles of FC.

Empowerment and strengths-based approaches. Empowerment and strengths-based approaches are integral to FC and contributed to its selection for implementation. However, based on staff observation, these are not always familiar or comfortable concepts to Asian communities and, in particular, to refugee sub-groups. Even with repeated discussions and sessions, families struggled with these concepts. As opposed to embracing a family-driven process, most Cambodian families preferred for staff to define and identify goals (short- and long-term) as well as the methods and activities required to accomplish those goals.

Many families appeared to be confused or embarrassed by staff's efforts to empower them to do things on their own rather than relying on staff to do things for them. This appears to be in keeping with the Cambodian refugee experience and common anomie — a state of hopelessness, helplessness, and feeling disconnected from society (Mozingo, 2009). In particular, for Cambodian refugees, staff felt 3 or 6 months of services (the two experimental groups) was too short to significantly empower families. Staff reported a lesser degree of resistance to empowerment and strengths-based approaches from Korean families, but still recognized the need to continually reinforce and reassure

families that their choices were "not wrong." It was typical that Korean families were very reticent during the initial trust-building phase and tried to pinpoint staff recommendations rather than their own. Once trust was established, however, Korean families were much more willing to self-identify goals, needs, and approaches, especially within the context of their children's educational attainment. As part of procedure, staff maintained both a respectful and deferential demeanor. Staff reported that the tendency for both groups to try to avoid taking the lead in service planning was not a dichotomy in the staff-client relationship, but more of a culture-influenced response to avoid appearing "demanding" or "needy."

Integration of FC within a traditional mental health agency. For a traditional mental health agency whose priority is to stabilize and provide intensive treatment to severely mentally ill clients, a comprehensive prevention strategy targeting at-risk families may seem out of keeping with the agency's primary intervention and stabilization mission. Further, a comprehensive prevention model such as FC (while service-rich) comes with a correspondingly high per-client cost. This is a difficult program design to maintain, especially during leaner economic times and/or when treatment dollars are more restrictive (both of these situations are currently the norm).

Also, a mental health provider may have more difficulty in outreach and recruitment than a traditional community-based organization. Negative stereotypes relating to mental illness remain an unfortunate part of our society, necessitating additional effort to recruit clients into a prevention program such as FC. Staff unanimously agreed that FC could be a tremendous asset for a family with one or more members already receiving mental health services.

Conclusions and Discussion

This FC replication study provided valuable evidence that sub-populations within the broader "Asian" category are distinct and unique,

requiring careful review and assessment of outreach or "buy-in" strategies, service delivery protocols, and cultural adaptations of the underlying philosophy and theories guiding practice. Understanding and navigating the "community" face as well as the "private" face for both Cambodian and Korean families was key to successful outreach, especially as it relates to sensitive topics such as child maltreatment and mental health. Partnering with community-based classes was found to be an effective outreach strategy for both Cambodian and Korean families, along with hiring staff whose language and culture matched those of the families.

While our sample sizes for Korean and Cambodian families are not large enough to make broad generalizations, staff's collective observations and anecdotal evidence revealed the critical need for culturally and linguistically appropriate service delivery models that consider greeting style, use of appropriate titles, consideration of how to handle tokens of hospitality, and client choice for the location of service delivery. Examination of goal-setting activities highlighted that Cambodian families exhibited very different demographic characteristics related to poverty and child risk than Korean families, and this impacted the goals they wished to pursue. As stated by Chang, Rhee, and Berthold (2008): "Unlike other Asian groups (e.g., Chinese, Filipino, Korean) who voluntarily immigrated to the United States with the aims of economic success…many Cambodians were forced to leave their homeland…to avoid war, executions, or labor camps under the Khmer Rouge regime" (p. 142). Some of the differences observed in this replication project may be related to refugee versus immigrant status, and are cause for thought regarding the ongoing impact of refugee experiences on future generations. For Korean families, the increasing incidence of violence, especially among Korean American youth, and strong parental expectations, must be taken into consideration for any practical application of prevention modalities (Kim & Cain, 2008; Ngo & Le, 2007).

Cultural adaptations specifically related to the underlying philosophy of FC were also considered. Adaptations to implementing an empowerment and strengths-based approach were important to consider in the context of Cambodian refugee and Korean immigrant populations. More work needs to be done to determine whether such practice theories are appropriate for these populations. The organizational context of implementing FC within an existing mental health program was also considered, with the competing interests of prevention versus intervention services brought to the forefront. Finally, cost and available resources must be taken into consideration for broad implementation of FC, especially for API populations still struggling with the "model minority" myth (the assumption of success despite marginalization) and corresponding shortages of prevention, treatment, and intervention practices and funding.

References

Asian and Pacific Islander Institute on Domestic Violence. (2005). *Fact sheet: Domestic violence in Asian communities.* San Francisco, CA: Author.

Asian Pacific American Legal Center (APALC). (2004). *The diverse face of Asians and Pacific Islanders in Los Angeles County 2004.* Los Angeles, CA: United Way of Greater Los Angeles.

Chang, J., Rhee, S., & Berthold, M. (2008). Child abuse and neglect in Cambodian refugee families: Characteristics and implications for practice. *Child Welfare, 87*(1), 141-160.

Children Now. (2001). *After school care for children: Challenges for California.* Los Angeles, CA: Author.

Gable, M. (2006, October 29). The fathers. *Los Angeles Times Magazine.* Retrieved August 28, 2009, from http://articles.latimes.com/2006/oct/29/magazine/tm-koreans44

Hayasaki, E. (2006, October 29). The daughter. *Los Angeles Times Magazine.* Retrieved August 28, 2009, from http://articles.latimes.com/2006/oct/29/magazine/tm-binna44

Kim, E., & Cain, K. (2008). Korean American adolescent depression and parenting. Journal of *Child and Adolescent Psychiatric Nursing, 21*(2), 105-115.

Marshall, G. N., Schell, T. L., Elliott, M. N., Berthold, S. M., & Chun, C. A. (2005). Mental health of Cambodian refugees 2 decades after resettlement in the United States. *Journal of the American Medical Association, 294*(5), 571-579.

Mozingo, J. (2009, April 12). Khmer Rouge survivors give voice to their 'silent suffering.' *Los Angeles Times* Retrieved August 28, 2009, from http://articles.latimes.com/2009/apr/12/local/me-khmer12

Ngo, H., & Le, T. (2007). Stressful life events, culture and violence. *Journal of Immigrant and Minority Health, 9*(2), 75-84.

Nguyen, L. H. (2008). *Child abuse and neglect among Asians in Los Angeles County.* Paper presented at Holiday Town Hall, Asian and Pacific Islander (API) Children, Youth and Family Council, Los Angeles, California.

Sedlak, A., & Broadhurst, D. (1996). *Third national incidence study of child abuse and neglect: Final report.* Washington, DC: U.S. Government Printing Office.

Shin, K., & Shin, C. (1999). The lived experience of Korean immigrant women acculturating into the United States. *Health Care for Women International, 20*, 603-617.

Slack, K. S., Holl, J. L., McDaniel, M., Yoo, J., & Bolger, K. (2004). Understanding the risks of child neglect: An exploration of poverty and parenting characteristics. *Child Maltreatment, 9*, 395-408.

Thomas, D., Leicht, C., Hughes, C., Madigan, A., & Dowell, K. (2003). *Emerging practices in the prevention of child abuse and neglect.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, & Families, Children's Bureau, Office on Child Abuse and Neglect.

U.S. Census Bureau. (2001). *American factfinder fact sheet for race, ethnic, or ancestry group.* Summary File 2 (SF 2) and Summary File 4(SF 4). Retrieved April 17, 2009, from http://factfinder.census.gov/

U.S. Department of Health and Human Services, Administration on Children, Youth and Families. (2009). *Child maltreatment 2007.* Washington, DC: U.S. Government Printing Office.

Maximizing the Therapeutic Helping Alliance With High-Risk Families

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The 'Helping Alliance'

To be an effective helper you must be able to picture yourself as the recipient of another's help. You must envision yourself as a recipient of child protective services; or perhaps homeless; or in some other way subject to conditions outside of your own control. Such imagery helps you get in touch with your own humanity and feel what it is like to be vulnerable. When we as practitioners are brave enough to allow such vulnerability, the importance of the helping alliance takes on new significance. We understand the importance of positive engagement with our consumers — the type of alliance we would desire should the tables be reversed.

In social work literature, the "helping alliance" often describes the worker-client relationship or partnership (Cournoyer, 2005). The strength of the helping alliance is developed and supported by empathy, respect, and authenticity. When consistently demonstrated, these qualities aid in the development and maintenance of rapport with consumers, which eventually leads to the formation of a solid helping alliance — an essential first step when intervening in any consumer system (Dore & Alexander, 1996).

Consumer perceptions of the counselor's skills influence perceptions of, and engagement in, the helping alliance (Dinger, Strack, Leichsenring, Wilmers, & Schauenburg, 2008). If the counselor is perceived to be skilled, the consumer is more likely to engage; and positive engagement improves treatment outcomes (Shirk & Karver, 2003). While other factors, such as readiness to change, motivation, and consumer compliance also influence treatment outcomes, the literature consistently shows that when the counselor and consumer agree on treatment goals and work collaboratively, outcomes are improved (Reid, 1996; Shirk & Karver, 2003; Cunningham, Duffee, Huang, Steinke, & Naccarto, 2008).

Valuing the Impacts of Community to Maximize the Helping Alliance

The formation of a strong helping alliance may be compromised by consumer experiences and behaviors. Deprivation and resource-poor environments increase risks to families and concomitantly increase the likelihood that families will have experiences with formal investigative and enforcement agencies. Unfortunately, these experiences are not often positive. Many consumers have described interactions with child protective services (CPS) as humiliating and aggressively intrusive. Consumers who have had negative experiences with providers are often labeled as "hostile," and tend to be more difficult to engage in a helping alliance (Puschner, Bauer, Horowitz, & Kordy, 2005). Dore and Alexander (1996) discuss the difficulty of engaging high-risk families, and emphasize the need for specialized knowledge and skills to assist in contextualizing approaches to support the formation of a positive helping alliance. Accordingly, contextualization of strategies and approaches in support of a positive helping alliance requires more than just an assessment and understanding of a consumer's

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situation. The counselor must actively work to develop trust, allay fears and suspicions, demonstrate acceptance and empathy, and affirm consumer competencies (Dore & Alexander, 1996). Taking the time to understand the consumer's perspective and connect with the consumer on an emotional level is the foundation of a solid helping alliance.

The development of a strong helping alliance is also influenced by the consumer's impressions. At initial contact, the consumer forms an impression that determines his or her level of willingness to enter into a trusting working relationship with the counselor. The initial impression, the perception of the agency's and/or therapist's reputation, and cognitions about level of need come together to shape perceptions relative to the value and potential outcomes of the alliance (De Weert-Van Oene, 2006). In the culture of urban communities with predominantly African American citizenry, consumer impressions of the value of entering into a helping alliance are often shaped by social-historical issues related to race: "The role of mistrust is one important aspect in the African American experience of…care. The cumulative effect of many negative clinical and clinical research experiences…continues to foster distrust of… providers…within the African American community" (Steinecke, Beaudreau, Bletzinger, & Terrell, 2007, p. 177). Consumers who have experienced racial discrimination tend to have greater personal discomfort with helping professionals, feel that they are not getting the best health care, and have more difficulty in achieving their mental health goals (Gee, Ryan, Laflamme, & Holt, 2006).

The true source of a counselor's power to forge a helping alliance with high-risk consumers lies — first and foremost — in the ability to harness understanding and compassion. Counselor contextual acumen, cultural responsiveness, and engagement skills are of critical importance in the development of a strong helping alliance.

When the counselor takes the time to actively engage consumers in the therapeutic process, establish emotional connections with consumers, ensure safety (trust) within the relationships, and develop a shared sense of purpose and goals, consumers are more likely to partner in the helping alliance (Friedlander, Lambert, Escudero, & Cragun, 2008). A last, but no less significant factor for maximizing counselor engagement, is the recognition that the consumer must set the agenda. Using this approach alters the nature of the working relationship such that the counselor is able to effectively interact with the consumer to mobilize resources and supports for change.

The Helping Alliance in Action

An understanding of the importance of the helping alliance and the ability to influence alliance formation were invaluable attributes possessed by the counselors in the Black Family Development, Inc. – Family Connections Program (BFDI-FC). In working with high-risk families, BFDI-FC counselors attended to relationships first. Much of the clinical activity in the initial sessions was designed to develop and further the therapeutic helping alliance, a Family Connections (FC) core philosophical principle. The counselors demonstrated acceptance and concern for consumers, and actively worked on developing trust and allaying fears. Guided by the agency's philosophy of care, BFDI-FC counselors were able to balance the science of helping with humanity, and effectively maximized the development of helping alliances with high-risk families that received services during the 5-year replication of FC in Detroit, Michigan.

Over 60% of families referred to the BFDI-FC Program had experienced prior CPS investigations. The majority of these families had multiple and serious problems, and had exhausted their personal array of resources in their attempts to ameliorate these problems. In many cases, because of past experiences with professional

helpers, engagement was neither simple nor straightforward. Therefore, BFDI-FC counselors contextualized strategies and approaches, and were successful in developing therapeutic and collaborative alliances with families that, because of the number and complexity of their struggles, were facing active crises and were difficult to engage (Dore & Alexander, 1996). BFDI-FC counselors cultivated helping alliances to support and strengthen family functioning. Within the context of a strong, therapeutic helping alliance, the counselors worked in partnership with each consumer family to identify strengths and needs, and to mobilize resources and supports to effect positive change. This paper presents a case illustration of the clinical and programmatic processes used by BFDI-FC counselors to achieve a high level of engagement and successful outcomes with one high-risk family.

The Case Family

The following case provides an example of the development of a strong helping alliance between a consumer and a BFDI-FC counselor. It shows how the counselor was able to initiate a therapeutic helping alliance in 1 business day, and harness the power of the alliance to enhance treatment outcomes. Throughout each treatment phase, BFDI-FC staff were determined to capitalize on consumer and family strengths to leverage change. Within the context of a strong helping alliance, positive outcomes were increased and the risk of harmful outcomes was decreased.

> One of the greatest assets a counselor can bring to the helping alliance is the ability to assess for risk factors while simultaneously capitalizing on, and further developing, protective factors in the family.

A Focus on Strengths

Ms. H is a 28-year-old woman who has overcome her own developmental delays to obtain and maintain part-time employment at a neighborhood restaurant. She is a single head of household raising a 6-year-old son who was diagnosed with autism, and also cares for her elderly mother and an infirm uncle. Despite living below the poverty level, she has successfully managed to furnish her home and feed her family. Daily, she prioritizes efforts to ensure her son's safety. Ms. H spends quality time with her son when she is not working. She takes him to school and occasionally takes him to the movies or to dinner.

The Basis for Referral

Ms. H was referred to the BFDI-FC Program by CPS as a result of a complaint filed by her son's school alleging that Ms. H was sending her son to school "inappropriately dressed" and that his hygiene was poor. An investigation was conducted and the CPS report noted additional risks for child neglect, including unsanitary environmental conditions. The report also noted that the son's autism presented a variety of challenges that potentially increased risks (Myers et al., 2002).

The Helping Alliance — Preparatory Review

The BFDI-FC counselor set the stage for the development of a helping alliance before the first meeting with the consumer by conducting a preparatory review of available consumer information. This review helped the counselor develop preliminary strategies to facilitate understanding and empathy upon initial contact

with the consumer (Cournoyer, 2005). During the preliminary review of case notes from previous workers, the BFDI-FC counselor assessed that the family's risks factors warranted concrete services and linkages into risk-reducing, accessible community resources. The counselor also used the case information to identify individual and family strengths, and was able to discern that the consumer had long-term resiliency skills despite present challenges.

One of the greatest assets a counselor can bring to the helping alliance is the ability to assess for risk factors while simultaneously capitalizing on, and further developing, protective factors in the family. This can best be achieved if the counselor has access to case information and is fully aware of the risk factors that may have been identified by other workers. However, it is also important for counselors to be aware of the potential biases that may be inherent in case records. The BFDI-FC counselor was fully aware of this possibility, and to address it, with the support of her supervisor, the counselor reflected on her thoughts and feelings about Ms. H and her family in an attempt to recognize biases and set them aside.

The process of counselor self-reflection is called "centering." Centering occurs when the worker deliberately organizes personal thoughts, feelings, and physical sensations conjured by the family contact or conditions. When centering, the counselor honestly acknowledges his or her own humanity, while ensuring that personal reactions do not block the ability to empathize and genuinely engage with the individual and/ or family with whom he or she seeks to develop a helping alliance. Centering can maximize a counselor's performance of professional

> All too often professional helpers are guilty of consciously or unconsciously seeing families through the mirror of their own circumstances.

obligations and delivery of social services (Cournoyer, 2005). Centering is most valuable when preparing to provide services to high-risk families whose strengths often go unnoticed over the course of their human service histories.

Using a strengths-based perspective is one of the philosophical principles of FC. The importance of focusing on strengths cannot be overemphasized. All too often professional helpers are guilty of consciously or unconsciously seeing families through the mirror of their own circumstances, and the deficit-based context of the conditions within and outside of their control. Strengths are vital levers to maximize positive outcomes.

In consultation with her supervisor, the BFDI-FC counselor reviewed the family strengths, personal biases, and responses, as well as potential evidence-based interventions to maximize the helping alliance. Critical consumer strengths that sustain resiliency were recognized and strategies were developed to mobilize these strengths to support the mental, emotional, and physical well-being of Ms. H's young son and family.

The Helping Alliance — Initial Contact

The helping alliance takes form at first contact with the consumer. Whether the first contact is with an agency receptionist or a helping professional, that contact shapes the consumer's perceptions and sets an initial course for the helping alliance. At the initial contact, the consumer forms an impression that determines his/her level of willingness to enter into a trusting working relationship with the helper

(De Weert-Van Oene, 2006). In accordance with FC fidelity criteria, BFDI-FC staff were prepared to initiate face-to-face contact within 1 business day. Ms. H did not have a telephone so the BFDI-FC counselor's first contact occurred by way of a home visit. Due to safety concerns and the need to complete a protocol-driven supervisory pre-screening, the BFDI-FC program supervisor accompanied the counselor to Ms. H's home.

The Social-Ecological Context

At the point of intake into the BFDI-FC Program, Ms. H and her family lived in a quaint home on the northeast side of Detroit. Most of the homes in the area were dilapidated. Her community was surrounded by small factories that had been closed, and the buildings remained unoccupied. Located on Ms. H's street were several burned and abandoned homes.

Outside the home, the counselor noted a number of environmental challenges. Garbage and other debris were on the porch and in the front yard. There was a smell of urine emanating from the home. After several knocks on the front door, Ms. H reluctantly appeared. The BFDI-FC counselor and supervisor identified themselves to her, and Ms. H hesitantly allowed them inside.

Once inside, the BFDI-FC counselor noticed an older African American male, identified as Ms. H's maternal uncle, lying on a broken sofa in the living room, covered by a blanket. This uncle had hygiene challenges and what appeared to be a foot condition that affected the appearance and odor of his uncovered feet. In the living room were four television sets that did not appear to be working. In the dining room was a full-size bed. Sitting on the side of the bed was an older African American woman, who was identified as Ms. H's mother. A television was sitting on a chair near the bed. Debris was on the floor throughout the room.

The BFDI-FC counselor and supervisor followed Ms. H into the kitchen where she invited them to have a seat. The kitchen was in need of cleaning. Ms. H proceeded to the refrigerator to show the counselor that she had food for her family. Ms. H revealed that she was doing the best she could, but she had limited income and often ran out of food. Ms. H indicated that she had previously received Food Stamps, but her case had been closed by the Department of Human Services (DHS). During this initial interaction, Ms. H shared that her mother and uncle lived with her, and that she was their caretaker. Ms. H stated that her mother provided child care for her son when she was at work and when she needed to run errands. Ms. H stated that she had a sister, who lived nearby, who also helped occasionally with child care. She proceeded to describe a consistent support network that included family, co-workers, and members of her faith.

Ms. H stated that when her son was 2 years old, the doctors at Children's Hospital told her that he was autistic, but did not explain what it meant. Children were often mean to her son, because he was different. In an attempt to protect her son, she isolated herself and him, and did not allow him to participate in key programs like Early-On or Head Start. Though her son now attends school, she described her relationship with her son's school as stressful, as the few times she had gone to the school, she had been made to feel unwelcome.

Consistent with the social-ecological model, the risk factors in this family were part of a system of risks that were interrelated and interdependent. The serious nature of the risks for child neglect were multi-determined — influenced by the interplay of economic pressures, limited supports/resources, parental coping skills, family relations, family support networks, and medical and environmental concerns.

Ms. H disclosed her anger at the threat posed by CPS involvement with her family. She told the counselor, "If the CPS worker or anyone else thinks they are going to take my son it's going to be a problem even if they come with the police." Anger is common among consumers who have services forced upon them. If not acknowledged, understood, and addressed, consumer anger has the potential to undermine the establishment of an effective helping alliance, and challenges a counselor's ability to maintain composure, professionalism, and empathy (Lown, 2007).

The BFDI-FC counselor anticipated Ms. H's anger and responded in an empathic and straightforward manner. The counselor described the program and reassured Ms. H that they were there to assist her and help her continue to care for her son at home. The counselor proceeded to coach Ms. H, indicating that a combative posture might not be appropriate at this point. She focused on developing trust and allaying fears and suspicions by listening to Ms. H's concerns and responding in ways that assured Ms. H that she understood her protective anger about the fear of removal of her child. In an attempt to engage Ms. H in the therapeutic process, the counselor suggested that CPS intervention may have been a blessing because it opened the door for the family to receive BFDI-FC services. The counselor acknowledged Ms. H's competencies and emphasized that she also wanted what was best for Ms. H's son; and that by working together, they might be able to resolve the issues that had brought her family to the attention of CPS.

At this point in the relationship, Ms. H was opening up to the counselor. It was discovered during the course of the conversation that the "inappropriateness of dress" allegation related to the fact that Ms. H's son was going to school without underwear and socks. Ms. H disclosed that she had been trying to wash her son's underwear and socks by hand because her washing machine was not working and she was unable to get to the laundromat. Her son had frequent toileting accidents and because she was unable to get some of his underwear clean after laundering them by hand, she had thrown them away. Since she was unable to purchase more, he was virtually without underwear and socks. Ms. H's body language and facial expressions indicated that she was very embarrassed. The counselor understood that Ms. H had suffered dehumanizing experiences with CPS and other formal "helping" systems and viewed the disclosure as a pivotal moment in developing the helping alliance. The counselor affirmed Ms. H, stating that she understood the dilemma, and would purchase underwear and socks of Ms. H's preference for her son. The items were purchased and taken to Ms. H the next day.

The development of a solid helping alliance is facilitated when the counselor is able to demonstrate usefulness in a tangible way (Cunningham et al., 2009; Montoya, 2006; Roberts, Grusky, & Swanson, 2008). A focus on understanding, and not judgment, with the intent of immediately resolving some of Ms. H's most pressing concerns was critical for the development of a helping alliance in this case (Marts, Lee, McRoy, & McCroskey, 2008). Ms. H began to trust that she would receive the help her family needed, and was more open to engaging in a helping alliance with the counselor.

The Helping Alliance — Stage-Matched Interventions

The "Stages of Change Model" provides a theoretical framework from which to understand levels of consumer engagement in the development of a helping alliance. The model was originally developed in the late 1970s and early 1980s by Prochaska and DiClemente while studying smoking cessation, and has since been recognized as having general application for behavior change (Kern, 2008). The idea behind the model is that behavior change does not happen in one step. Rather, people tend to progress

through different stages on their way to successful change — each progressing through the stages at his or her own rate. The stages of change are: (1) Pre-contemplation; (2) Contemplation; (3) Preparation; (4) Action; and (5) Maintenance (Kern, 2008).

When Ms. H first opened the door to the BFDI-FC staff, she was at the Pre-contemplation Stage, not interested in the help the counselor had to offer. As the BFDI-FC counselor affirmed Ms. H's strengths and demonstrated acceptance and empathy, Ms. H began to move into the Contemplation Stage. She considered the possibility of availing her family to services and revealed some of her family's needs to the counselor. The counselor's response to the disclosure about Ms. H's son's need for underwear and socks reinforced Ms. H's engagement. Ms. H began to have positive expectations of benefits for her family, which directly impacted the development of the helping alliance (Constantino, Arnow, Blasey, & Agras, 2005; Castonguay et al., 2004).

At the second interview with Ms. H, the BFDI-FC counselor continued to present as authentic, genuinely empathic, and personal. Consumers prefer to talk to someone who will listen with great interest, and try to understand the situation or problem. The counselor not only listened, but heard the needs and responded with solutions. Progressively, Ms. H stated that she felt really comfortable with the counselor, and found it easy to talk to the counselor because she did not feel judged. This deliberate style of professional engagement emphasized compassion and the counselor's use of referent power: the ability to attract others and build loyalty, acceptance, and

endorsement (French & Raven, 1960). The nature of the relationship with the counselor translated into positive expectations and helped move Ms. H from the Contemplation Stage to the Preparation Stage. Ms. H made a commitment to work with the counselor on ways to improve the situation for her family.

The counselor sealed the helping alliance with Ms. H by giving her confidence to move from Preparation to Action in supporting change for her family. Ms. H believed she had the ability to change her behavior and was actively involved in taking steps to effect positive change — using a variety of recommended and modeled techniques. At this stage, the helping relationship was built upon trust and mutual respect and directly promoted positive therapeutic outcomes (Shin et al., 2005).

> With the family stable in the new home, and the helping alliance well established, the counselor turned to issues that would secure the safety and well-being of Ms. H's son.

The counselor partnered with Ms. H to address the environmental conditions that placed Ms. H's son at risk (Wintersteen, Mensinger, & Diamond, 2005). The counselor did not disparage Ms. H's housecleaning behaviors; instead, she focused on the safety risks in the home — something Ms. H and the counselor could work together to resolve. A housing safety check was conducted and revealed that the home had structural damage. At this point, the nature of the relationship was positive and collaborative. Ms. H and the counselor were mutually engaged in therapeutic, solution-focused actions. They agreed that an important goal for the working relationship would be to secure safe housing for the family. The counselor and Ms. H worked together on locating different housing. The counselor provided Ms. H with a list of available housing for rent. Ms. H also began to look for alternative housing closer

to her sister, who was one of her primary family supports. While seeking alternative housing, Ms. H was evicted from her home upon discovering that her landlord had lost the home to foreclosure. Ms. H, her son, and her mother temporarily moved in with her sister, and saved money for the first month's rent and security deposit. After a few weeks, Ms. H located suitable housing and moved into the family's new home. The counselor assisted with the move by purchasing a stove and beds for Ms. H and her son. In addition, the counselor accompanied Ms. H to the DHS office to assist her in completing paperwork to reopen her financial assistance case.

During the housing search and family move, the counselor demonstrated that she was trustworthy (Campbell & Alexander, 2002; Stuart, 2004; Thompson, Brazile, & Akbar, 2004). She was non-judgmental, supportive, and dependable. Ms. H perceived the counselor as helpful, warm, and trustworthy — and the service outcomes were very positive (Bachelor, 1991). The school crisis had been effectively resolved in that Ms. H's son now had underwear and socks, and the environmental crisis had been addressed through the family move. With the family stable in the new home, and the helping alliance well established, the counselor turned to issues that would secure the safety and well-being of Ms. H's son. The counselor focused on basic cleaning skills with Ms. H., and introduced a "chore chart" to help Ms. H establish a cleaning routine and understand the importance of maintaining an environmentally safe home for her son. Additionally, the counselor worked with Ms. H on self-care to address her own personal hygiene regimen.

The counselor also began educating Ms. H about her son's diagnosis of autism spectrum disorder and what the long-term implications were for the family. The counselor found a support group for parents of children with autism and attended the first meeting with Ms. H. The counselor accompanied Ms. H to her son's

Individual Education Plan (IEP) hearing, where Ms. H was able to express the many challenges she had faced and also express the fact that she had felt unwelcome in the past when she attempted to engage with school staff. At the end of service provision, Ms. H had attended parent meetings at her son's school and accompanied him on field trips.

Ms. H and the BFDI-FC counselor successfully broached the Maintenance Stage with a solid therapeutic helping alliance. At the end of service provision, Ms. H had maximized the strengths she presented at the beginning of treatment, and had overcome the tremendous environmental, behavioral, and emotional barriers that had kept her from implementing the changes she had been aspiring to make on her own.

Case Outcome

Given the multi-determined nature of the family's challenges, clinical efforts were focused across the family's social ecology. Initial interventions were designed to reduce environmental stressors on the family and, concomitantly, enhance the family's ability to successfully navigate the environment by developing indigenous resources. The BFDI-FC counselor was not beleaguered by an overwhelming case. The counselor used discretion, was non-judgmental, and used the strength of the helping alliance to systematically address the enormity of the situation.

To decrease the risk of child abuse and neglect, the BFDI-FC counselor helped Ms. H learn to effectively manage multiple stresses and conditions within the family and neighborhood. Ms. H was empowered to address the family's problems. In this case, empowerment was derived from an effective helping alliance between the BFDI-FC counselor and the consumer, and resulted in the development and use of the capacities and resources of all involved parties

to address the needs of the family. The role of the BFDI-FC counselor was one of partner, guide, mediator, advocate, coach, and supporter.

Ms. H and her son are stable in their new home and have not experienced further CPS involvement. Ms. H has attended several BFDI-FC multi-family activities since the case closed. At the second follow–up contact, Ms. H was still using her chore chart to maintain an environmentally safe home. The helping alliance and the strengths perspective were vital for the development of the relationship between Ms. H and the BFDI-FC counselor, which, in turn, enabled Ms. H's positive behavior changes.

References

Bachelor, A. (1991). Comparison and relationship to outcome of diverse dimensions of the helping alliance as seen by client and therapist. *Psychotherapy, 28*, 534-549.

Campbell, C., & Alexander, J. (2002). Culturally competent treatment practices and ancillary service use in the outpatient substance abuse treatment. *Journal of Substance Abuse Treatment, 22*, 109-119.

Castonguay, L., Schut, A., Aikins, D., Constantino, M., Laurenceau, J., Bologh, L., et al. (2004). Repairing alliance ruptures in cognitive therapy: A preliminary investigation of an integrative therapy for depression. *Journal of Psychotherapy Integration, 14*, 4-20.

Constantino, M., Arnow, B., Blasey, C., & Agras, S. (2005). The association between patient characteristics and the therapeutic alliance in cognitive-behavioral and interpersonal therapy for bulimia nervosa. *Journal of Consulting and Clinical Psychology, 73*, 203-211.

Cunningham, S., Duffee, D., Huang, Y., Steinke, C., & Naccarto, T. (2009). On the meaning and measurement of engagement in youth residential treatment centers. R*esearch on Social Work Practice, 19*, 63-76.

Dinger, U., Strack, M., Leichsenring, F., Wilmers, F., & Schauenburg, H. (2008). Therapist effects on outcome and alliance in inpatient psychotherapy. *Journal of Clinical Psychology, 4*, 344-354.

Dore, M. M., & Alexander, L. B. (1996). Preserving families at risk of child abuse and neglect: the role of the helping alliance. *Child Abuse and Neglect, 20*, 349-361.

Friedlander, M., Lambert, J., Escudero, V., & Cragun, C. (2008). How do therapists enhance family alliances? Sequential analyses of therapist-client behavior in two contrasting cases. *Psychotherapy: Theory, Research, and Practice, 45*, 75-87.

Gee, G. C., Ryan, A., Laflamme, D. J., & Holt, J. (2006). The association between self-reported discrimination and mental health status among African descendants, Mexican Americans, and other Latinos in the New Hampshire REACH 2010 Initiative: The added dimension of immigration. *American Journal of Public Health, 96*, 1821-1828.

Kern, M. F. (2008). *Stage of change model.* Retrieved March 27, 2009, from http://www.addictioninfo.org/articles

Lown, B. (2007). Difficult conversations: Anger in the clinician-patient family relationship. *Southern Medical Journal, 100*, 34-40.

Marts, E., Lee, E., McRoy, R., & McCroskey, J. (2008). Point of engagement: Reducing disproportionality and improving child and family outcomes. *Child Welfare, 87*, 335-360.

Montoya, I. (2006). Treatment compliance in patients with co-occurring mental illness and substance abuse. *Psychiatric Times, 23*, 23-25.

Myers, J. E., Berliner, L., Briere, J. N., Hendrix, C. T., Reid, T. A., & Jenny, C. A. (2002). *The APSAC handbook on child maltreatment* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Puschner, B., Bauer, S., Horowitz, L., & Kordy, H. (2005). The relationship between interpersonal problems and the helping alliance. *Journal of Clinical Psychology, 61*, 415-429.

Reid, W. (1996). Task-centered social work. In F. J. Turner (Ed.), *Social work treatment: Interlocking theoretical approaches,* (pp. 617-640). New York: Simon & Schuster.

Roberts, K., Grusky, O., & Swanson, A. (2008). Client encounters in alternative HIV testing sites: Counselors' perceptions and experiences. *Behavioral Medicine, 34*, 11-19.

Shin, S., Chow, C., Camacho-Gonsalves, T., Levy, R., Allen, E., & Leff, H. (2005). A meta-analytic review of racial-ethnic matching for African American and Caucasian American clients and clinicians. *Journal of Counseling Psychology, 53*, 45-56.

Shirk, S., & Karver, M. (2003). Prediction of treatment outcome from relationship variables in child and adolescent therapy: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 71*, 452-464.

Steinecke, A., Beaudreau, J., Bletzinger, R. B., & Terrell, C. (2007). Race-neutral admission approaches: Challenges and opportunities for medical schools. *Academic Medicine, 82*, 117-126.

Stuart, R. (2004). Twelve practical suggestions for achieving multicultural competence. *Professional Psychology: Research and Practice, 35*, 3-9.

Thompson, V., Bazile, A., & Akbar, M. (2004). African Americans' perceptions of psychotherapy and psychotherapists. *Professional Psychology: Research and Practice, 35*, 19–26.

Wintersteen, B., Mensinger, J., and Diamond, G. (2005). Do gender and racial differences between patient and therapist affect therapeutic alliance and treatment retention in adolescents? *Professional Psychology: Research and Practice, 36*, 400-408.

Client and Service Use Predictors of Successfully Completing a Child Maltreatment Prevention Program

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Introduction

While previous research on child maltreatment prevention programs has linked a variety of different factors to positive outcomes, better client participation in services and successful program completion have emerged as critical contributors to improved family functioning and reduced child maltreatment (Bagdasaryan, 2005; Girvin, DePanfilis, & Daining, 2007; Littell & Tajima, 2000). Recent years have seen an increase in the attention paid to evaluating these factors and they are now correctly viewed as key measures of program quality and effectiveness. Moreover, for programs showing promising or mixed results, research focus has shifted to consider matters of service use and delivery, client participation, and predictors of successful program completion as mechanisms for contextualizing these results and even improving outcomes (Girvin et al., 2007).

Family Connections (FC) is one example of an emerging program with demonstrated effectiveness (DePanfilis & Dubowitz, 2005). To better understand client experiences in the

program and its effectiveness, Girvin, DePanfilis, and Daining (2007) examined factors predicting successful completion of FC. Among a list of demographic and descriptive characteristics, service satisfaction measures, and helping relationship indicators, the authors found that clients who successfully completed FC had higher depressive symptoms, more positive relationships with their caseworkers, and had participated in a 3-month treatment group compared to a 9-month group. Such findings have significant implications for program and service delivery, especially regarding efforts to develop and improve worker-client relationships. Nonetheless, the authors identify several limitations of their study, including the omission of additional variables that might be related to program completion.

Recognizing these limitations and in an attempt to build on this previous study, the present research extends Girvin, DePanfilis, and Daining's analysis to consider several other factors that have been linked in previous studies to facilitating or hindering child welfare program involvement and completion. Using data from Bridging the Gap, a federally-funded replication of FC located in Knoxville, Tennessee, the relationship of variables affecting successful program completion are examined, such as caregivers' ethnicity, housing status, number of children living in the home, history of domestic violence, relationship status, and comprehensive service use. This latter factor might be particularly important to child welfare professionals since it has implications for the scope and range of services needed to yield more positive family outcomes. More research, however, is needed to better understand this relationship. While several researchers have suggested that effective family support programs must provide a holistic and comprehensive array of services that address issues ranging from housing to job training to education (Trask, Taliaferro, Wilder, & Jabbar-Bey, 2005), other recent research suggests that

complementary services are not effective (Centers for Disease Control and Prevention, 2009) .

Among the other variables under consideration, ethnicity (especially African American) has consistently emerged as a significant variable in child welfare research. For example, national data have indicated that child victimization rates are higher for African Americans than for other racial groups (Lau et al., 2003; U.S. Department of Health & Human Services, 2009). African American children are disproportionately overrepresented in child protective services (CPS) (Ards, Myers, Chung, Malkis, & Hagerty, 2003) and placed in foster care at higher rates than other groups (Rivaux et al., 2008). More broadly, African American families often face higher levels of poverty, inadequate or unstable housing, and neighborhood violence than Caucasian families. These factors have been linked to more CPS involvement (Ernst, 2001; Rivaux et al., 2008). Research also has found that African American families sometimes are provided fewer services to prevent a child's removal from the home than other groups (Marts, Lee, McRoy, & McCroskey, 2008; Rivaux et al., 2008). Ethnicity was not included as an independent variable in Girvin et al.'s (2007) evaluation of factors predicting FC Program completion, presumably because their sample was overwhelmingly African American (87.5%).

Similarly, Courtney, McMurtry, and Zinn (2004) and Staerkel and Spieker (2006) found that housing problems were related to less participation in child welfare services and poorer long-term outcomes. Housing problems include being homeless (living on the streets or in a car) and unstable housing (e.g., living in a shelter or staying at a family member's, friend's, or stranger's home). Families in these situations also tend to have high residential mobility resulting from the strains of sharing housing and moving to find employment, among other issues (Courtney

et al., 2004). This too can contribute to more negative program outcomes. In a study of women attending a substance abuse treatment program, Kelly, Blacksin, and Mason (2001) found that women with fewer children, less CPS involvement, and fewer problems with homelessness, domestic violence, and psychiatric problems were more likely to successfully complete the program. Littell and Tajima (2000) similarly found that parental substance abuse, psychiatric problems, minority status, and lack of family support predicted lower levels of participation in intensive family preservation services. Given the myriad of factors associated with program completion, research that considers a variety of factors together has the potential to strengthen FC by identifying key characteristics that should be noted at intake since they might predict a family's likelihood of successfully (or unsuccessfully) finishing the program. This has clear practice implications as well since such information will highlight family needs and inform directed service delivery.

Methods

Sample and Study Site

Among 105 families participating in the Bridging the Gap Program between 2004 and 2008, 94 caregivers (89.5%) completed both the intake (baseline) and termination interviews. To be eligible for services, families had to be expecting a baby or have at least one child living in the home, and were identified as high-risk for child maltreatment by local schools, social service agencies, the court system, or medical settings. The first 64 families that were referred for services were randomly assigned to receive 3- or 9-month interventions. Families referred for services after the completion of random assignment received services for an indeterminate length of time. In the present study, this latter group is the reference group. Families in all three groups received the same model of care, including the same level of

contact with case managers and program staff, as well as identical data collection protocols. All clients were eligible to receive the same direct services and referrals for service.

At termination, 69 families (73%) had successfully completed the program. For the 3-month and 9-month treatment groups, this was defined as completing all services as planned for the duration of program involvement. For the reference group, program completion was defined as completing the services and treatment goals outlined in each family's service plan. Though not formally linked to a specific time interval, termination for the reference effort was targeted for 6 months after beginning the program. Accordingly, the average length of program involvement for this group was 194 days (or approximately 6 months). For those 25 caregivers who did not successfully complete the program, reasons given for not completing the program ranged from refusing further services, being unavailable for services, or family members leaving the service area.

Bridging the Gap replicated FC with a population very similar to the one served by the original FC Program in Baltimore. Clients served by Bridging the Gap were from federally defined empowerment zones, or areas recognized for high levels of poverty, unemployment, and economic hardship, located in Knoxville, Tennessee. In these areas, 40% of residents live below the poverty level, 60% receive some form of public assistance, and 25% do not have a high school diploma (Knoxville-Knox County, Tennessee Metropolitan Planning Commission, 2008). With the goals of increasing a family's protective factors and reducing risk factors for child maltreatment and child welfare services involvement, Bridging the Gap provided a comprehensive and holistic intervention to at-risk families that included services pertaining to alcohol and drug abuse treatment, mental and

physical health services, and parenting training classes, among other services and activities.

Measurement and Data Collection

Data were collected by trained program staff using standardized intake and termination questionnaires. Variables analyzed in this study are primarily from the intake (or baseline) interview and focus on target caregiver characteristics. These variables were selected because of their explicit or hypothesized relationship to program completion in other studies. From the baseline interview, variables include the target caregiver's ethnicity (African American = 1; Caucasian = 0), age in years, relationship status (married or serious relationship = 1), number of children aged 17 years or younger living in the household, personal history of domestic violence or abuse in adulthood (coded as 1; no abuse = 0), personal history of prior drug or alcohol abuse (coded as 1), and housing status. For this latter variable, if the target caregiver reported being homeless (e.g., living in a car or on the streets) or in unstable housing (e.g., presently staying at a relative, friend, or stranger's home) this was coded as 1 while stable housing (e.g., owning or renting own home or apartment) was coded as 0. Additionally, dummy variables were included to represent whether the caregiver was assigned to the 3-month, 9-month, or reference (indeterminate length) treatment group.

As part of the baseline interview, the target caregiver also completed several standardized measures. For each measure, internal consistency was assessed using Cronbach's Alpha (α). Completed measures include the Center for Epidemiologic Studies — Depression Scale (CES-D; Radloff, 1977). This is a 20-question measure with scores ranging from 0-60 and higher scores equaling greater depression (α = .92). Second, the Pearlin Mastery Scale (Pearlin &

Schooler, 1978) is a 7-item questionnaire yielding scores ranging from 7 to 28 with higher scores equaling a greater sense of personal control in one's life (α = .68). The Everyday Stressors Index (ESI; Hall, Williams, & Greenberg, 1985) is a 20-item scale measuring problems experienced on a daily basis (e.g., financial and employment problems, role overload). Higher scores equal more perceived stress (α = .78). The Support Functions Scale (SFS; Dunst, Trivette, & Deal, 1988) is a 20-item scale measuring a parent's personal need for different types of social support. Higher scores equal a perceived need for more support (α = .80). Finally, the CAGE (concerned, annoyed, guilty, eye-opener) Questionnaire Adapted to Include Drugs (CAGE-AID; Brown & Rounds, 1995) is a questionnaire asking four "yes or no" questions about respondents' attitudes and use of alcohol and drugs. Affirmative responses are scored as "1" and all questions are summed to create a 4-point scale wherein scores of 1 or higher indicate possible alcohol and drug problems. In this study, this measure was coded as a dichotomous variable (0 = no affirmative responses, 1 = 1 or more "yes" responses).

Variables derived from the termination interview include the number of different direct services provided in the program and the number of different referral services provided in the program. To create these variables, caregivers were asked about 49 different services that might have been provided as part of the program and to indicate if they or someone in their family received the service directly from the program or a referral to receive that service from an outside agency. Service categories included family support services (13 different services such as childcare and housing assistance), emergency assistance services (7 services including emergency assistance with clothing or food), advocacy services (5 services such as advocacy on the client's behalf in court or at child's school), vocational services (4 services including

job skills training and employment-search assistance), financial management/assistance services (3 services such as assistance in applying for benefits), case management services (4 services including crisis intervention and case management), mental health/counseling services (8 services such as alcohol and drug treatment and family counseling), and health or health promotion services (5 services including dental care and nutritional guidance). All affirmative responses were summed to create two indices of comprehensive service use with scores ranging from 0 to 49 (for direct services, mean = 11.9 and standard deviation = 5.8; for referral services, mean = 7.6 and standard deviation = 5.7). It is important to note that these are not measures of how often services were received or how often referrals were made; instead they represent how many different types of services were provided to families in the program. Such a measure of comprehensive service use has been used successfully in existing studies to highlight differences in service use by ethnicity and homelessness, among other characteristics (e.g., Theriot, Segal, & Cowsert, 2003).

Data Analysis

Data are presented in three tables. Table 1 and Table 2 show sample characteristics using the means (± standard deviations) for continuous variables and frequencies (plus percentages) for categorical variables. Table 1 compares characteristics across the three treatment groups (3-month, 9-month, and reference groups) while Table 2 compares characteristics by successful program completion or not. An analysis of variance (ANOVA) test with a Bonferroni adjustment for multiple comparisons was done to assess differences in standardized measures and program variables on Table 1 while chi-square and an ANOVA test with a Bonferroni adjustment compared the two groups shown in Table 2. Finally, Table 3 presents the results of

three multivariate logistic regression models. The dependent variable in all of these models is successful completion of the program (coded as 1; not successfully completing the program = 0). The study's sample size means that it was not possible to enter all independent variables into a single regression model. Such action would overload the model and possibly yield inaccurate results. Therefore, the independent variables described above were entered in three separate models. The first model included demographic and descriptive characteristics while the second model included the various standardized measures and the third model included the treatment group and service use indices. Prior to any analysis, all variables were tested for normality and all yielded acceptable skewness and kurtosis values for inclusion in the regression analyses (George & Mallery, 2001).

Results

Independent variables are compared by treatment group in Table 1. Among the various demographic and descriptive characteristics, the percentages and means are similar for the three groups with the exception of relationship status. For this variable, the percentage of target caregivers in the 3-month treatment group who are married or in a serious relationship (19%) is smaller than in the other two groups (44% and 53%, respectively). Based on results of the ANOVA comparisons, target caregivers in the 9-month and reference treatment groups had a greater sense of personal control in their lives. Average scores on the Pearlin Mastery Scale were 1 to 2 points higher for these groups (mean = 19.4 for the 9-month group and 20.8 for the reference group) than for the 3-month treatment group (mean = 18.5). There were no differences in the number of different direct services and referrals for services received across the three groups.

Table 1. Independent Variables by Program Participation (*N* = 94)

Independent Variables	3-Month Treatment Group (*n* = 32)		9-Month Treatment Group (*n* = 32)		Reference Group (*n* = 30)	
	Mean ± Standard Deviation (SD)	n (%)	Mean ± SD	n (%)	Mean ± SD	n (%)
Caregivers' Demographic and Descriptive Characteristics						
African American		17 (53)		21 (66)		18 (60)
Age in years	33.9 ± 13.3		30.5 ± 7.0		33.7 ± 9.5	
Number of children in household	2.8 ± 1.6		2.9 ± 1.6		2.8 ± 1.5	
Married or serious relationship		6 (19)		14 (44)		16 (53)
Currently working for pay		9 (28)		9 (28)		11 (21)
Homeless or unstable housing		4 (13)		4 (13)		4 (13)
Personal history of domestic violence or abuse in adulthood		21 (66)		21 (66)		23 (77)
Personal history of drug and/or alcohol abuse		9 (28)		7 (22)		10 (30)
Standardized Measures						
Support Functions Scale	59.8 ± 12.6		55.5 ± 8.3		59.3 ± 8.9	
CES-D	22.2 ± 13.9		24.9 ± 11.7		20.2 ± 14.1	
Everyday Stressors Index	46.0 ± 10.9		48.0 ± 8.8		43.8 ± 8.9	
CAGE-AID		4 (13)		3 (9)		7 (23)
Pearlin Mastery Scale*	18.5 ± 2.7		19.4 ± 3.1		20.8 ± 3.0	
Program and Service Variables						
Number of different direct services	12.4 ± 5.8		12.8 ± 7.2		10.3 ± 3.7	
Number of different referrals for services	7.6 ± 4.6		8.9 ± 6.6		6.3 ± 5.7	

*$F_{(2,93)} = 4.94$; p = .009

Table 2 shows the results of comparisons made between program completers and non-completers. Statistical analyses revealed few significant differences, including no differences in ethnicity, employment, relationship status, and history of domestic violence or substance abuse. Among the limited differences, a larger percentage of clients who did not successfully complete the program reported being homeless or in unstable housing at the intake interview (28%) compared to clients who did complete the program (7%). Non-completers also had more children on average than program completers. Moreover, a large percentage of participants in

Table 2. Independent Variables by Program Completion Status ($N = 94$)

Independent Variables	Completed Program ($N = 69$)		Did Not Complete Program ($N = 25$)	
Caregivers' Demographic and Descriptive Characteristics	Mean ± Standard Deviation (SD)	n (%)	Mean ± SD	n (%)
African American		35 (51)		16 (64)
Age in years	33.7 ± 11		29.9 ± 7	
Number of children in household*	2.6 ± 1		3.6 ± 2	
Married or serious relationship		25 (36)		11 (44)
Currently working for pay		22 (32)		7 (28)
Homeless or unstable housing**		5 (7)		7 (28)
Personal history of domestic violence or abuse in adulthood		47 (68)		18 (72)
Personal history of drug and/or alcohol abuse		18 (26)		8 (32)
Standardized Measures				
Support Functions Scale	57.4 ± 10		60.4 ± 9	
CES-D	21.1 ± 13		26.3 ± 12	
Everyday Stressors Index	45.1 ± 10		48.0 ± 8	
CAGE-AID		9 (13)		5 (20)
Pearlin Mastery Scale	19.3 ± 3		20.2 ± 3	
Program and Service Variables				
3-month treatment group***		30 (44)		2 (8)
9-month treatment group***		21 (30)		11 (44)
Indeterminate length of service group***		18 (26)		12 (48)
Number of different direct services****	12.9 ± 6		8.9 ± 4	
Number of different referrals for services	7.9 ± 6		6.8 ± 6	

*$F(1, 93) = 8.23$, p=.005
**$X^2=7.10$, df=1, p=.008
***Differences by treatment group were compared in a single chi-square test. $X^2=10.5$, df=2, p=.005
****$F(1, 93)=9.83$, p.=.002

the 3-month treatment group (94%) successfully completed the program compared to smaller percentages of completion in the other two groups. Successful completers also received more direct services on average than clients who did not successfully complete the program.

The multivariate analyses show the relationship of the independent variables to successful program completion. Specific to those results from Model 1 presented in Table 3, for each additional child living in the home, the odds of program completion decrease by 33% when holding all other variables constant. Similarly, for families that report being homeless or with unstable housing at the intake interview the odds of completing the program decrease by 77% when holding all other variables constant. The results

Table 3. Logistic Regression Models of Factors Predicting Successful Program Completion

Independent Variables	B	p	Odds Ratio	Confidence Intervals
Model 1: Caregivers' Demographic and Descriptive Characteristics				
African American	-0.61	.295	0.54	0.17, 1.71
Age in years	0.03	.378	1.03	0.96, 1.11
Number of children in household	-0.41	.030*	0.67	0.46, 0.96
Married or serious relationship	-0.19	.722	0.83	0.29, 2.34
Currently working for pay	-0.18	.769	0.83	0.25, 2.83
Homeless or unstable housing	-1.49	.044*	0.23	0.05, 0.96
Personal history of domestic violence or abuse in adulthood	-0.62	.342	0.54	0.15, 1.93
Personal history of drug and/or alcohol abuse	-0.29	.649	0.75	0.22, 2.56
Model 2: Standardized Measures				
Support Functions Scale	-0.03	.229	0.97	0.92, 1.02
CES-D	-0.04	.128	0.96	0.91, 1.01
Everyday Stressors Index	-0.01	.747	0.99	0.99, 1.06
CAGE-AID	-0.62	.361	0.54	0.14, 2.03
Pearlin Mastery Scale	-0.19	.051	0.83	0.69, 1.00
Model 3: Program and Service Variables				
3-month treatment group	2.38	.006*	10.83	1.97, 59.6
9-month treatment group	0.13	.826	1.14	0.36, 3.57
Number of different direct services	0.27	.002*	1.31	1.10, 1.57
Number of different referrals for services	-0.10	.127	.905	0.80, 1.03

Model 1: $X^2(8, N = 94) = 16.2$, $p = .040$; Model 2: $X^2(5, N = 89) = 8.9$, $p = .113$; Model 3: $X^2(4, N = 94) = 26.0$, $p < .001$.
*$p < .05$

of this model are significant (model $X^2(8, N = 94) = 16.2$, $p = .040$) and classify 78% of the sample into their respective groups (successful completion or not). The model successfully classifies 96% of families that successfully completed services but only 28% of those families that did not. This suggests that other key variables explaining unsuccessful completion are not included in this model.

Next, no independent variables emerge as significant predictors of program completion in Model 2. While scores on the Pearlin Mastery Scale approach statistical significance ($p = .051$),

they do not reach the threshold and thus cannot be considered as related to program completion. This is especially true given the study's sample size. Moreover, the regression model is not significant (model X^2(5, $N = 89$) = 8.9, $p = .113$) though it does successfully classify 75% of the sample into their respective groups.

The third model presented in Table 3 focuses on program and service use variables. In this model, when statistically controlling for the other independent variables, the estimated odds of successfully completing the program were 10 times greater for participants in the 3-month treatment group than for participants in the 9-month and reference groups. Furthermore, receiving more direct services emerges as a predictor of program completion. For each different direct service received, families are 31% more likely to successfully complete the program. This model, X^2(4, $N = 94$) = 26.0, $p < .001$, is significant and classifies 78% of clients, including 93% of those who successfully completed the program and 36% of those who did not.

Discussion and Implications for Practice

Before discussing the implications of this study for child welfare practice, it is important to note the study's limitations — the most notable of which concerns the study's modest sample size. Given that the analyses were limited to 94 families, all findings should be viewed as preliminary and interpreted cautiously. It is important that additional research involving larger samples is done before any definitive conclusions are made.

This potential limitation aside, most of the study's findings are consistent with existing research. For example, the finding that participants in the 3-month treatment group are more likely to complete the program than participants in the 9-month and reference groups

corresponds with the research done by Girvin, DePanfilis, and Daining (2007). As they noted in their study, this may reflect that it is easier for families to complete a briefer program compared to one requiring a longer period of involvement. Such results also are important for agencies interested in offering FC or a similar model of care but lack the resources and staff needed to provide services for 9 full months.

In other consistent findings, the present study highlights the difficulties associated with housing problems and having more children in a family. Housing problems contribute to numerous long-term challenges and negative outcomes (Courtney et al., 2004; Staerkel & Spieker, 2006), including poor program participation and high residential mobility (which in turn can lead to problems like disrupted employment and education, and difficulties establishing formal and informal support networks in the community). When noted at intake, service providers should attempt to stabilize a family's housing situation as quickly as possible to help ensure better program participation and increase the likelihood that the family will successfully complete the program. It is acknowledged, however, that finding solutions to meet families' housing needs may be a significant challenge due to growing need in the face of limited resources. Service providers may need to engage in substantial advocacy, community awareness, and collaboration efforts in order to achieve this goal and improve completion rates.

Likewise, caregivers with more children living in the home might need additional services such as respite and child care to improve program completion rates. This latter result does differ somewhat from the study done by Girvin, DePanfilis, and Daining (2007), who found that families completing the program had more children than non-completing families. Remembering the possible limitations of the

present study's analysis, more research should be done to clarify the impact of more children on program involvement and completion.

Perhaps this study's most important finding, however, is that offering more direct services is related to successful program completion. This might suggest that families become more engaged and persevere to completion when a program is able to provide a diverse range of different services directly rather than providing fewer services or relying on a series of referral services. Likewise, when a program is able to provide more direct services, this might foster a greater sense of connection between the family and program. This feeling of alliance between the family and its caseworker has been shown to be an important predictor of successful program completion (Girvin et al., 2007).

Conversely, while more direct services might convey attention, investment, and competency to clients, fewer direct services might convey the opposite message. This might be especially true if future research shows that offering fewer direct services is associated with more referral services. While such a relationship was not tested here, provision of fewer direct services combined with a growing number of referrals might put considerable pressure on clients to initiate contact with numerous providers, navigate different agency bureaucracies, establish new helping relationships, and make their own arrangements regarding appointments, transportation, child care, and missed work. In such a scenario, it is easy to imagine how clients might grow frustrated and end their involvement prior to successfully completing a program. One implication then is that programs should examine the breadth of services offered and explore ways to provide as many services as possible to families either directly or through collaborative arrangements that are functionally "invisible" to the clients. Co-locating related services is one example of such

a strategy. Moreover, when an agency is unable to provide comprehensive services directly, care should be taken to provide sufficient support for clients to access and engage in services from other organizations. This might include assisting the client with the first appointment, making a personal introduction, or even accompanying the client to a first meeting at another organization.

African Americans and Program Completion

Given extensive research documenting problems and disparities confronting African Americans in the child welfare system, it was expected that they would be less likely to complete the program. It is noteworthy, then, that ethnicity was not related to program completion in the bivariate or multivariate analyses. This outcome may reflect one of FC's philosophical principles that specifically emphasizes culturally competent practice (DePanfilis, Glazer-Semmel, Farr, & Ferretto, 1999) as well as Bridging the Gap's emphasis on cultural competence in staff training and service delivery. Caseworkers received extensive training stressing self-awareness, assessment of clients within the context of their environments, and need-based service delivery. Such programmatic actions are critical to the development of culturally competent child welfare practices (McPhatter & Ganaway, 2003).

By completing a comprehensive family assessment that then informs a customized intervention plan tailored to meet each family's specific needs, program staff were able to consider all aspects of a family, including the influence of culture and ethnicity on family functioning. According to Gina Whitmore, Bridging the Gap program manager, "The most important thing with Bridging the Gap was the individual service plan and services…looking at the whole person, the whole aspect of the family, their whole life to determine a plan instead of some

'cookie-cutter' thing" (personal communication, March 13, 2009). This emphasis on personalized service delivery and being responsive to client needs requires that a program be accessible and maintain clear communication with families. These too are key components to culturally centered child welfare practice (Miller & Gaston, 2003).

Future Research

To address this study's limitations and build upon its findings, several avenues for additional study are recommended to fully understand the results. Beyond those areas for future research identified in previous paragraphs, efforts to replicate this study with diverse families and programs located in other regions and settings will strengthen the general application of this study. Furthermore, given the significance of comprehensive service use, it is critical for future research to investigate the specific types and frequency of services related to successful program completion. Such research will inform program development and help to better target service delivery, especially for programs lacking the resources to directly provide a full complement of services to clients. Finally, it should be repeated that research involving larger samples of families is needed. Such research will elaborate on this study's results, help identify small effect sizes that are hard to detect in smaller samples, and allow for the development of a single regression model that tests all independent variables together.

Notwithstanding these needs for future research, the finding that using a greater number of different direct services predicts successful program completion is important. As child welfare programs are implemented and evaluated, this study suggests that programs should seek to directly provide a diverse array of services to families while being mindful of the number of different types of referral services being offered. Combined with previous research on the effectiveness of FC to reduce the occurrence of child maltreatment, the results of this study suggest that FC and Bridging the Gap are promising interventions to engage culturally diverse families in a comprehensive program of services that will benefit both parents and children.

References

Ards, S. D., Myers Jr., S. L., Chung, C., Malkis, A., & Hagerty, B. (2003). Decomposing black-white differences in child maltreatment. *Child Maltreatment, 8*(2), 112-121.

Bagdasaryan, S. (2005). Evaluating family preservation services: Reframing the question of effectiveness. *Children and Youth Services Review, 27*, 615-635.

Brown, R. L., & Rounds, L. A. (1995). Conjoint screening questionnaires for alcohol and drug abuse. *Wisconsin Medical Journal, 94*, 135-140.

Centers for Disease Control and Prevention. (2009). *Parent training programs: Insight for practitioners.* Atlanta, GA: Author.

Courtney, M. E., McMurtry, S. L., & Zinn, A. (2004). Housing problems experienced by recipients of child welfare services. *Child Welfare, 83*, 93-422.

DePanfilis, D., & Dubowitz, H. (2005). Family Connections: A program for preventing child neglect. *Child Maltreatment, 10*(2), 108-123.

DePanfilis, D., Glazer-Semmel, E., Farr, M., & Ferretto, G. (1999). *Family Connections intervention manual.* Baltimore, MD: University of Maryland, Baltimore.

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

Ernst, J. S. (2001). Community-level factors and child maltreatment in a suburban county. *Social Work Research, 25*(3), 133-142.

George, D., & Mallery, P. (2001). SPSS for Windows step by step: A simple guide and reference 10.0 update. Needham Heights, MA: Allyn and Bacon.

Girvin, H., DePanfilis, D., & Daining, C. (2007). Predicting program completion among families enrolled in a child neglect preventive program. *Research on Social Work Practice, 17*(6), 674-685.

Hall, L. A., Williams, C. A., & Greenberg, R. S. (1985). Supports, stressors, and depressive symptoms in low-income mothers of young children. *American Journal of Public Health, 75*, 518-522.

Kelly, P. J., Blacksin, B., & Mason, E. (2001). Factors affecting substance abuse treatment completion for women. *Issues in Mental Health Nursing, 22*, 287-304.

Knoxville-Knox County, Tennessee Metropolitan Planning Commission. (2008). *Population data.* Retrieved April 11, 2009, from http://www.knoxmpc.org/locldata/cenhome.htm

Lau, A. S., McCabe, K. M., Yeh, M., Garland, A. F., Hough, R. L., & Landsverk, J. (2003). Race/ethnicity and rates of self-reported maltreatment among high-risk youth in public sectors of care. *Child Maltreatment, 8*(3), 183-194.

Littell, J. H., & Tajima, E. A. (2000). A multilevel model of client participation in intensive family preservation services. *Social Service Review, 74*(3), 605-635.

Marts, E. J., Lee, E. O., McRoy, R., & McCroskey, J. (2008). Point of engagement: Reducing disproportionality and improving child and family outcomes. *Child Welfare, 87*(2), 335-358.

McPhatter, A. R., & Ganaway, T. L. (2003). Beyond the rhetoric: Strategies for implementing culturally effective practice with children, families, and communities. *Child Welfare, 82*(2), 103-124.

Miller, O. A., & Gaston, R. J. (2003). A model of culture-centered child welfare practice. *Child Welfare, 82*(2), 235-250.

Pearlin, L. I., & Schooler, C. (1978). The structure of coping. *Journal of Health & Social Behavior, 18*, 2-21.

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

Rivaux, S. L., James, J., Wittenstrom, K., Baumann, D., Sheets, J., Henry, J., et al. (2008). The intersection of race, poverty, and risk: Understanding the decision to provide services and remove children. *Child Welfare, 87*(2), 151-168.

Staerkel, F. J., & Spieker, S. (2006). Unstable housing — A significant challenge to home visiting programs: An Early Head Start case example. *Journal of Family Social Work, 10*(1), 61-76.

Theriot, M. T., Segal, S. P., & Cowsert Jr., M. J. (2003). African-Americans and comprehensive service use. *Community Mental Health Journal, 39*(3), 225-237.

Trask, B. S., Taliaferro, J. D., Wilder, M., Jabbar-Bey, R. (2005). Emerging trends: Holistic, comprehensive family support programs. *Journal of Family Social Work, 9*(2), 67-93.

U.S. Department of Health and Human Services. (2009), *Child maltreatment 2007.* Washington, DC: U.S. Government Printing Office.

Integrating Research and Clinical Practice Through Collaborative Therapeutic Assessment

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Introduction

Collaborative, Therapeutic Assessment (TA) is a comparatively new technique that has been demonstrated to enhance client self-efficacy and compliance with treatment (Newman & Greenway, 1997; Ackerman, Hilsenroth, Baity, & Blagys, 2000). Based in the humanistic tradition of psychological assessment (Fischer, 1994, 2006), TA seeks to use the assessment process to help clients modify the narrative they apply to themselves, and to encourage positive feelings about their own therapeutic experiences (Finn, n.d.; Tharinger, Finn, Wilkinson, & Shaber, 2007). Much of the research on TA has been done with adult clients, and though the process

shows potential in terms of positive changes in symptomology and family functioning in work with children and families (Tharinger et al., 2007), the literature base for the use of TA in the field of child welfare is still developing.

This article aims to contribute to filling this gap in the literature and offers suggestions for using TA both as an individual therapeutic technique for high-risk families and as an avenue to collect data on program performance in a community-based mental health setting. The Family Connections-Dickinson (FC-D) Project applied aspects of TA to enhance the working alliance between clients and providers, aligning with the Family Connections (FC) practice principles of using comprehensive family assessments, tailored interventions, helping alliances, empowerment approaches, and outcome-driven service plans (DePanfilis, 2002; DePanfilis & Dubowitz, 2005). Much of the success of implementing TA in FC-D came from a successful integration of research and practice objectives at DePelchin Children's Center.

TA, as defined by Finn (2007), is a structured yet flexible approach to collaborative assessment, involving six steps completed over several sessions. More broadly used is the lowercase "therapeutic assessment," which is an assessment philosophy that intends to make an assessment positive, helpful, accessible, and understandable (Finn, 2007). FC-D used the latter TA philosophy as a therapeutic tool with the implementation of FC.

Implementing TAs

The goal of the FC-D Program was to provide family-centered services based on the individual needs of each family to reduce risk factors and increase factors associated with protecting against child maltreatment. The FC-D intervention was structured around a set of philosophical principles derived from the FC model. These principles included: community outreach; family assessment; individualized, tailored intervention; the helping alliance; empowerment approaches; a strengths-based perspective; cultural competence; developmental appropriateness; and outcome-driven service plans. All of these principles were applied in the FC-D Program across the service delivery spectrum to ensure fidelity to the FC model, and adherence to these principles guided the implementation of TA in the FC-D Program.

All families in the FC-D Program received a comprehensive family assessment, which included the use of direct clinical observation and standardized clinical assessment instruments to identify the risk and protective factors associated with child maltreatment. Information gathered from comprehensive family assessments was used to develop hypotheses about the ways in which the presenting symptom(s) influence and were influenced by the interactions of family members with one another, their immediate environment, and their larger social context. These hypotheses, along with input from all family members, provided the focus and direction for each individualized service plan. Incorporating the individualized assessments, the clinicians worked collaboratively with family members to help them define their strengths and needs, produce measurable outcomes to reduce the risk of neglecting their children, and create tailored service plans. The service plans specified modality, frequency, and duration of services, as well as the person who was responsible for each task. The intervention further incorporated the empowerment approach in the helping alliance that was formed between each family and clinician. As a participatory intervention, the FC model empowered family members to gain control over their lives and move toward healthier physical, social, and emotional family

environments. As such, implementing TA in the FC-D Program was a natural extension of several of the FC philosophical principles.

In order to facilitate the use of TA as an integrated component of the replication of FC, frontline project clinicians were thoroughly trained on the purpose of all assessments, methods to decrease observer bias, clinical applicability, and the interpretation of results. Self-report inventories were completed by clients using computer-assisted interviewing, the results of which were sent by clinicians to research staff, who then returned a summary report of each of the inventories within 48 to 72 hours. During project supervision meetings, clinical staff discussed the developmental level and clinical readiness of clients to determine the appropriate level of clinical feedback to share. All clients received the results of their assessments at varying levels; some clients received an oral report, while others were shown graphs or summaries created by research staff.

The assessment feedback often provided a platform for discussing difficult issues with clients, such as caregiver drug use or parenting attitudes regarding corporal punishment, and for facilitating a more comprehensive service plan. Clients were encouraged to express their reactions to the results and had the opportunity to ask questions and express concerns, an integral element of the interactive, two-way feedback recommended for TA (see Finn, 2007;

> The assessment feedback often provided a platform for discussing difficult issues with clients, such as caregiver drug use or parenting attitudes regarding corporal punishment, and for facilitating a more comprehensive service plan.

Fischer, 2006). After sharing assessment results, clients and clinicians further discussed needs and defined intervention goals with agreed-upon action plans, measurable outcomes, and timeframes, thus enhancing the collaborative process.

FC-D used therapeutic assessment with all clients (115) over a period of 4 years. Clinicians used knowledge of each family to guide the presentation of assessment results. The following case studies delineate various ways in which TA was used.

Case Studies

Family No. 1

Family characteristics: The family was headed by an underemployed single mother struggling with unstable living conditions. The family members relied heavily on social services, were behind on bills, and were in danger of losing their home. The home was in desperate need of repair and family members demonstrated a general lack of knowledge about home cleanliness. There were no cleaning supplies in the home. The mother was identified as having developmental difficulties and her IQ was estimated to be in the mid- to low 70s. She was illiterate and needed assistance completing forms. A total of five children were living in the home, all with impetigo, lice, and scabies. The family lacked transportation for medical care. The family was enrolled in the 6-month FC-D intervention and successfully completed services.

Presenting problems: The children were at risk of neglect due to lack of cleanliness and insufficient finances to provide for their basic needs. The children were identified as having inadequate nutrition, inadequate clothing, poor hygiene, and inadequate/delayed health care. There was also a lack of supervision and discipline in the home.

Assessment results: Initial results revealed that the mother presented with depressive symptoms, clinically significant parental stress, low parental self-efficacy, and inappropriate parental expectations. The target child was identified as having clinically significant problem behaviors as reported by the mother. Assessment results were presented to the family by the clinician at the next visit and, collaboratively, the clinician and the mother outlined a service plan with a primary focus on increasing the mother's authority in the home to facilitate change in the children's behavior and attitudes.

A mid-point assessment conducted after 3 months demonstrated no clinically significant problem behaviors in the target child. Changes in the caregiver were also evident at reassessment, as demonstrated by reported improvements in parental self-efficacy and parental expectations, as well as fewer depressive symptoms. The level of parental stress, however, remained clinically significant. The clinician reviewed these results with the caregiver, highlighting successes, and the caregiver chose to continue working on the same goals for the duration of receiving services, with a focus on addressing her level of stress as a parent. Specifically, the remainder of the services concentrated more on individual counseling with the mother, focusing on reframing her sense of self to a more positive and empowered self-narrative.

Use of TA: The clinician considered ways to use TA that would be comprehensible and beneficial

for this client. While client profiles include both narrative and graphic descriptions of assessment results, none of the narratives were used with this client. Rather, graphs were used as visual references while the clinician provided her feedback in simple and concrete language, and to illustrate to the mother specifically how she had progressed and which areas showed continued need for improvement. Sharing assessment results was beneficial in that they helped empower the client to take actions that would lead to targeted improvements for her and her family. She commented to the clinician that she was proud of herself for understanding the graphs and being able to use the results to identify areas where she and her family needed counseling and assistance.

Outcome-driven service plan: As a result of the use of TA, the mother was able to direct her service plan based on these results. Prior to the introduction of the assessment results, she had not been able to concretely identify problem areas within her family system. Thus, by adapting the therapeutic process to the needs and capabilities of the client, TA helped empower the client, causing her to become an active participant in the intervention process.

Family No. 2

Family characteristics: The caregiver in the family was a single mother assessed to be capable of understanding both concrete and abstract topics. The family had two children living in the home. The family received various social services, including help with day care and Food Stamps. The mother worked full-time, but she did not have health-care insurance and did not qualify for medical assistance. The mother was concerned that her son may be bipolar. The mother reported that the child's father, who was not living in the home, had been diagnosed with bipolar disorder and was not able to function without medication. The children had witnessed domestic violence

between the biological parents and the mother showed signs of depression. She was permissive of maladaptive behavior in the children and expressed that she did not have the energy to deal with them effectively. This family was enrolled in the 6-month FC-D intervention and successfully completed services.

Presenting problems: The children were at risk of physical abuse due to the mother's problems with anger and the children's level of misbehavior in the home. The mother was identified as being under a great deal of stress and having high-risk childrearing and parenting practices.

Assessment results: Initial results demonstrated clinically significant levels of problem behaviors in the target child, and revealed high levels of parenting stress, low parental self-efficacy, and poor parenting attitudes. The mother was certain that all the family problems were due to the misbehavior of the target child. While assessment results supported her perception of the target child's behavioral problems and a service plan goal was created to address these problem behaviors, assessment findings also raised other issues for discussion. The assessments related to parenting attitudes and parental stress were used to approach the delicate topic of changing parenting behaviors. The clinician used the assessment results to reframe poor parenting attitudes as a byproduct of high parental stress. By using the assessment results as a tool for discussion, the clinician was able to work with the mother and the family to create a goal of more positive communication between the mother and the target child.

> Many families enroll in services to "fix" a child's problem behaviors and are unaware of the underlying family system factors that contribute to the presenting problem.

The family was reassessed after 3 months of service, and assessment results were shared during a therapeutic session. Overall problem behaviors of the target child were improved, and levels of depressive symptoms were reduced. Levels of parental stress improved somewhat but were still in the clinical range, and attitudes about parenting were generally the same. Due to the high level of negativity the mother displayed toward the target child, it was important to highlight the improvements, and have the mother focus on the positive changes. The session provided an opportunity to discuss ways to build on improvements, and pointed to areas still needing attention for the remainder of services.

Use of TA: Using TA with this client was challenging since the mother was distrustful of counseling and had only accepted services because she felt that the clinician would be able to make her oldest son behave at home. Assessment of the child revealed that he demonstrated no behavior problems at school; assessment results indicated that his behavioral issues at home stemmed from his relationship with his mother. These results had to be presented in a way that would not cause the mother to feel victimized or pathologized. In this case, the clinician presented the results to the mother and asked her to interpret them herself. The mother concluded that many of the child's problems were a result of her negative patterns of communication with him. The clinician was then able to reframe this in a more positive light and to discuss ways that counseling and the FC-D Program could help the family. TA helped the mother acknowledge her own problem areas, and it gave her hope that she

and her family could make positive changes. It also helped build a therapeutic alliance, as the mother saw the clinician as someone capable of being positive and helping her family instead of as someone judgmental and negative. By allowing the client to process the results on her own, the clinician was able to help the client reframe the negative results into specific actions that could lead to change. Furthermore, the TA process helped the client identify personal behavioral patterns that contributed to problem behaviors in her child.

Outcome-driven service plan: Many families enroll in services to "fix" a child's problem behaviors and are unaware of the underlying family system factors that contribute to the presenting problem. By using assessments as a therapeutic tool, the clinician is able to redirect the caregiver from a rigid and inflexible focus on child misbehavior to a more systemic view. This allows the family to create a more comprehensive action plan focusing on a broader range of issues, thus leading to greater and more positive change within the family.

Programmatic Considerations

Many procedures in the FC-D Program helped facilitate the successful implementation of TA with families. Thorough assessment training on administration protocols with regular booster trainings, regular supervision, team meetings, case record reviews, and ongoing monitoring/ reviewing of fidelity components helped ensure adequate adherence to the implementation of the TA process. Using assessment results appropriately for clinical use requires extensive training, including detailed discussions on the use and limitations of assessments, and the appropriate interpretation of results. Supervision and team meetings are also important as they allow the clinician to discuss the most appropriate ways to present the assessment results to the family in order to make the assessments therapeutic and beneficial. Additionally, an

external evaluation team conducted case record reviews to ensure fidelity to the core components of the program model. Internal processes were also in place to monitor program fidelity and foster optimal TA implementation. Each of these process components ensures structured, yet flexible, implementation of TA.

Discussion

TA does have several limitations. The practice may be detrimental and even harmful if not practiced with extreme care, especially in complex family cases (see Finn, 2007, p. 179-192). Using TA may also be problematic when the assessments are used to gauge program performance, as they were in FC-D. When generalized assessment results are shared with clients who complete the same assessment at multiple evaluation points (intake, case closure, follow-up), assessment reactivity, or the reduction of reported symptomology in response to assessments or standardized measures, can occur. This may confound the results of the intervention, and can potentially affect the outcome results of the evaluation (see Epstein et al., 2005). However, since use of clinical assessment instruments to guide intervention is one of the FC fidelity criteria, it is less likely that TA is a diversion from the program model.

Despite these limitations, TA still appears to be a promising enhancement in this setting and in conjunction with the replication of FC. There are several advantages to using a TA model with high-risk families. Central to the TA model is that clients are viewed as collaborators in their own service planning. Clinicians share assessment results with clients, and clients are then able to help plan their own services and set their own goals in conjunction with clinicians. Another advantage to the model is that it provides an opportunity for reframing. Many clients have negative personal narratives prior to intervention, and may believe that their problems confirm their own negative ideas about themselves. However,

TA provides an opportunity for clinicians to show that assessment results do not confirm self-assessed "craziness," "bad" parenting, or just being a "bad person." Rather, assessment results may highlight strengths, normalize feelings, or help reframe family issues as modifiable behaviors or attitudes, or feelings such as depression or stress. By reframing, clients are able to see their strengths while also seeing that their problems are solvable and that negative beliefs about themselves are perhaps inaccurate.

Recommendations

Successful implementation of TA with clients is possible and beneficial with strong adherence to the practice principles of the FC Program. Future clinicians desiring to implement TA as part of the process with clients must use clinical skills to assess the family unit and the individual members, paying specific attention to development and culture. TA is meant to empower clients to better understand their situations by providing them the opportunity to view these situations in light of concrete assessment results. TA is meant to be a strengths-based process; it is not intended to focus negative attention on problem areas of the individual or family. Nor is TA meant to replace clinical judgment, which is a key factor in sharing assessment results with a family.

While the results are typically consistent with clinical observation, there are times when the clinician and the family may disagree with the results. In these situations, the clinician and client(s) are encouraged to engage in discussion and come to an understanding. Assessment results benefit the client in ways that clinical observation alone cannot by bringing problem areas into focus quickly — and without harming the helping alliance. During the beginning stages of counseling, the clinician must focus on creating a helping alliance and suggesting

which client issues may harm this alliance and negatively impact the clinician's efficacy. Since the assessment results come from the family answers rather than the clinician's judgments, the clinician can be seen as a positive facilitator of change rather than a judgmental "stranger" who points out family flaws. Thus, when used in conjunction with clinical expertise, the TA process can provide a more comprehensive view of the family in an empowering and participatory atmosphere.

In using the FC practice principles of the comprehensive family assessment, the helping alliance, and the empowerment approach, TA allows clients to identify areas in which they would like to work more specifically, facilitating outcome-driven service planning and individualized, tailored interventions. Clinicians desiring to implement TA may find it beneficial to follow FC fidelity and practice principles and use a systematic process of implementation.

References

Ackerman, S. J., Hilsenroth, M. J., Baity, M. R., & Blagys, M. D. (2000). Interaction of therapeutic process and alliance during psychological assessment. *Journal of Personality Assessment, 75*, 82-109.

DePanfilis, D. (2002). *Helping families prevent neglect final report* (Report No. 18). Retrieved December 1, 2008, from http://www.family.umaryland.edu/ryc_research_and_evaluation/ publication_product_files/selected_presentations/presentation_files/pdfs/final_report.pdf

DePanfilis, D., & Dubowitz, H. (2005). Family Connections: A program for preventing child neglect. *Child Maltreatment, 10*, 108-123.

Epstein, E. E., Drapkin, M. L., Yusko, D. A., Cook, S. M., McCrady, B. S., & Jensen, N.K. (2005). Is alcohol assessment therapeutic? Pretreatment change in drinking among alcohol dependent females. *Journal of Studies on Alcohol, 66*(3) 369-378.

Finn, S. E. (n.d.). *Therapeutic assessment: Basic concepts and techniques.* Retrieved November 10, 2008, from http://hpa.portalbase.com/members/Workspace%20for%20 Introduction%20to%20 Therapeutic%20Assessment/Document%20 Library/1/BasicsofTherapeuticAssessment.doc

Finn, S. E. (2007). *In our clients' shoes: Theory and techniques of therapeutic assessment.* Mahwah, NJ: Lawrence Erlbaum Associates.

Fischer, C. T. (1994). *Individualizing psychological assessment.* Mahwah, NJ: Lawrence Erlbaum Associates.

Fischer. C. T. (2006). Phenomenology, Bruno Klopfer, and individualized/collaborative assessment. *Journal of Personality Assessment, 87*(3), 229-233.

Newman, M. L., & Greenway, P. (1997). Therapeutic effects of providing MMPI-2 test feedback to clients at a university counseling service: A collaborative approach. *Psychological Assessment, 9*, 122-131.

Tharinger, D. J., Finn, S. E., Wikinson, A. D., & Schaber, P. M. (2007). Therapeutic assessment with a child as a family intervention: A clinical and research case study. *Psychology in the Schools, 44*, 293-309.

Replication of Family Connections: Lessons Learned From Grandparents

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Dr. Sharpe is an assistant professor at the University of Maryland, School of Social Work. She has extensive training and interdisciplinary practice and research experience related to public health, diversity, and violence. Dr. Sharpe's area of practice and research includes working with African American families that are surviving the homicide of a loved one. She has designed and implemented numerous community-based violence prevention and intervention programs specifically targeting children and families from diverse, marginalized communities. She also has experience developing, implementing, and conducting culturally appropriate research studies and trainings in the areas of children and families coping with school, community violence, and manmade and natural disasters. Dr. Sharpe is the recent recipient of the Henry C. Welcome Faculty Research Fellowship. Her future research includes conducting comparative studies that examine racial, ethnic, and generational differences in coping among homicide survivor populations for the purpose of developing interventions that may best serve these survivors.

Dr. DePanfilis is professor and associate dean of research at the University of Maryland School of Social Work. She is also director of the Ruth H. Young Center for Families and Children, a research center designed to promote the safety, permanency and stability, and well-being of children, families, and communities through education and training, research and evaluation, and best-practice service programs.

During the last 35 years, she has: (1) Provided child welfare services at the local level as a caseworker, supervisor, and administrator; (2) worked as a consultant at the national level conducting program evaluations and providing training and technical assistance to child welfare and community-based programs; and (3) conducted extensive studies related to the delivery of child welfare services, the prevention of child maltreatment, and the implementation of policies and community service programs.

Dr. DePanfilis is principal investigator of research for the Family Connections Program, a community-based family strengthening outreach service program designed to support vulnerable families to meet the basic needs of their children without the need for formal public child welfare services. Recognized by the U.S. Department of Health and Human Services for its efforts to prevent child neglect, Family Connections is being replicated in multiple sites across the United States.

Recent research and publications relate to the epidemiology and prediction of child maltreatment recurrences; child protective services risk assessment, safety evaluation, and decision making; the role of social support in preventing neglect; the costs of caring for children in foster care; outcomes of youth transitioning from child welfare services to independence;

and the efficacy and cost effectiveness of Family Connections. Dr. DePanfilis is co-editor of the *Handbook for Child Protection Practice*, which brings together papers from over 70 interdisciplinary authors. The book is structured to follow the life of a case from the time a report of child maltreatment is made through various pathways in the child protection system. She is also co-author and author of U.S. government-published user manuals on the role of child protective services and the prevention, assessment, and intervention of child neglect.

Dr. DePanfilis is particularly interested in ways to bridge the gap between research, policy, and practice. She is a former president of the American Professional Society on the Abuse of Children, an interdisciplinary association that works to assure that everyone affected by child maltreatment receives the best possible professional response, and she is currently on the board of directors of the Society for Social Work and Research, an organization devoted to the promotion of human welfare through social work research.

Dr. Strieder is a clinical associate professor at the University of Maryland, Baltimore, School of Social Work, where he is the director of family connections/grandparent family connections for the Ruth H. Young Center for Families and Children — an interdisciplinary center dedicated to promoting safety, health, and well-being for children, families, and communities through community and clinical services, research, education, and advocacy. Over the past 32 years, he has: (1) Provided mental health and child welfare services as a practitioner, supervisor, and administrator; (2) served as a committee chair and board member on local, regional, and national levels regarding the development of outcome evaluation strategies and program development specific to treatment foster care; (3) developed and directed intern training programs at the Baltimore, Maryland, Kennedy

Krieger Institute Family Center and the Family Connections Program, and taught family therapy in the Johns Hopkins and University of Maryland Child Psychiatry Training programs; (4) developed best-practice models for children and families that have been the victims of maltreatment; and (5) developed community-based service models for families that struggle to meet the needs of their children — specifically grandparent-headed households.

Dr. Strieder's publications and presentations relate to: the needs of children placed in the child welfare system, community-based programs, and clinical practice related to families that have experienced trauma and families that struggle to meet the needs of their children.

Ms. Gregory is the research coordinator for the Ruth H. Young Center for Families and Children. She is also a family therapist for a community-based agency in Baltimore. Her practice experience includes working with families and children in public and private foster care agencies. She has also worked as a school mental health clinician in the Baltimore City Public School System. Ms. Gregory's experience in training and staff development enabled her to collaborate with the Baltimore City School System and Police Department to train officers in using strengths-based interventions when interacting with students and their families. As a social worker, her personal mission is to serve families in a variety of capacities that foster empowerment, self-sufficiency, and prosperity in all areas of life. Ms. Gregory is a licensed graduate social worker in Maryland and received her master's degree from the University of Maryland, Baltimore, School of Social Work.

Acknowledgments

Introduction

Grandparents as the sole primary caregivers are one of the fastest growing family types in the United States, representing a growing phenomenon in child welfare (Bowers & Myers, 1999; Jooste, Hayslip, & Smith, 2008; Kelley, Yorker, Whitley, & Sipe, 2001; Sands & Goldberg-Glen, 2000). Between 1990 and 2006 the number of children living in households maintained by grandparents increased by 44%. This roughly translates into more than 2.5 million children living with grandparents who were responsible for meeting the basic food, shelter, and clothing needs of their grandchildren (U.S. Census Bureau, 2006). Census Bureau data indicate that there are now more than 6.7 million children across the nation growing up in these unique "grand families," representing 9% of the nation's children living in families.

Although grand families provide a safe haven for many children, research suggests that these families face unique challenges. Grandparent caregivers often experience increased caregiver psychological stress and physical health problems (Climo, Patterson, & Lay, 2002; Kelley, Whitley, Sipe, & Yorker, 2000; Kelley, Whitley, & Sipe, 2007), social isolation (Musil, 1998), legal problems related to custody (Kelley et al., 2001), and added challenges due to inadequate and inaccessible resources (Ehrle & Geen, 2002; Grant, 2000; Scarcella, Ehrle, & Geen, 2003). Additionally, children who are placed in their grandparents' care due to unfavorable circumstances (e.g., abuse, neglect) often have a high percentage of emotional and behavior problems (Scarcella et al., 2003). Caring for a grandchild with psychological and/or physical problems is associated with caregiver stress (Sands & Goldberg-Glen, 2000). Thus, grandparent caregivers often find themselves addressing ongoing, significant personal problems while facing the financial, medical, and mental health challenges associated with parenting vulnerable children (Dowdell, 1995; Jooste et al., 2008).

> Grandparent caregivers often fall between the cracks of foster care, aging, education, and disability service systems.

Grandparent caregivers often fall between the cracks of foster care, aging, education, and disability service systems (McCallion, Janicki, Grant-Griffin, & Kolomer, 2000). Services, if available, are not coordinated and seldom apply the comprehensive perspective that comes from working with an entire family. Additionally, grandparents are often not aware of services or may avoid seeking services because of perceptions of and experiences with stigma related to accepting services. Access to services may be impeded by diminished mobility, lack of public transportation, demands of caregiving, and other barriers to receiving services for which grandparents are eligible. The conditions faced by grandparent families suggest that services need to have strong connections to community organizations that are touchstones for grandparents (Ehrle & Geen, 2002).

Replication of Family Connections With Grandparent Families

Hayslip and Kaminski (2008) suggest that multilevel, multimodal approaches are needed to successfully intervene with grandparents and grandchildren; therefore, the design of the Grandparent Family Connections (GFC) Program was structured to respond to the unique strengths and needs of grandparent families. This service delivery strategy was consistent with the Family Connections (FC) framework. The approach to revising the program to be responsive to grandparent families involved incorporating the literature about grandparents raising grandchildren to adapt the family assessment protocol, and to test the relevance of appropriate interventions. In addition, practitioners were trained on the unique needs of grandparent families. Outreach strategies were revised to directly reach grandparent caregivers, and clinical supervision emphasized the challenges for families during weekly individual and group meetings.

Importance of Advocacy and Interdisciplinary Intervention

Reviews of grandparent family-based interventions suggest that advocacy services are particularly important for these families (Ehrle & Geen, 2002). Thus, a component of GFC services includes providing GFC families with legal advocacy services that are particularly relevant for grandparent families (e.g., services relating to issues of housing, custody, appropriate school placements). Prior research on interventions with grandparent families also suggests that interdisciplinary programs for grandparent caregivers can improve well-being in the areas of psychological distress, mental health, and social support (Kelley et al., 2001; Kelley, Whitley, & Sipe, 2007). Therefore, a component of GFC involved providing grandparent families with social work and health-related services.

Tailoring Assessments to the Unique Roles and Needs of Grandparent Families

Other modifications to the intervention manual, family assessment protocol, and the training and supervision focused on parenting-role and life-stage issues that grandparent caregivers face when they take on "parenting" functions. These role conflicts lead to struggles in integrating their parenting and personal roles related to timing, conflict, and ambiguity (Landry-Meyer & Newman, 2004). For example, grandparents may experience role conflict as a sense of loss, as they lose a traditional grandparent role in order to incorporate a new role as primary caregiver (Landry-Meyer & Newman, 2004). And in many cases, grandparents are assuming caregiving duties at a point and/or age in their lives when they had expectations of abandoning parenting responsibilities (Landry-Meyer & Newman, 2004). Finally, grandparents may experience uncertainty in their functioning as caregivers due to the "lack of clear guidelines or socially agreed on behaviors regarding a role" (Landry-Meyer & Newman, 2004, p. 1008).

Training and Supervision Tailored to Unique Strengths and Needs

The special nuances of grandparent families were particularly important to address in the training of practitioners because there are special factors that need to be considered:

- Experiencing the loss of a parent (for both the grandparent caregiver and the grandchild)

- The relationship of each child's special needs to previous caregiving experiences

- Becoming a blended family with potential implications for lingering intergenerational conflict

- The grandparents' attitudes about assuming the role as caregiver and their mental and physical health status

- Overcoming poor housing, financial insufficiency, and overall health status of family members

- Managing complicated legal matters pertaining to school, access to health care (including mental health care), and guardianship and custody

- Addressing the need for the acquisition of specialized parenting skills to respond to children who often have behavioral and emotional problems

Comprehensive assessments must address these factors and service plans need to be formulated that are sensitive to grandparents' adjustment to their new caregiving role.

Quantitative research methods alone would not convey the degree to which the modifications made to FC to address the needs of grandparent families were perceived helpful; therefore, a qualitative study was conducted to explore which interventions were the most helpful from the perspective of grandparent participants.

Method

A qualitative study was conducted with a self-selected sample of 16 grandparent caregivers using a semi-structured interview guide designed to discover insights about each participant's perceptions of the GFC Program, the quality of services they received, and the strategies they used to manage stressors that coincided with caring for themselves and their grandchildren. The interview guide was created based on information obtained from grandparent caregiving literature and quantitative program evaluation results.

Sample

The inclusion criteria for this sample were that respondents be grandparent caregivers who had completed the GFC Program. Respondents were recruited by generating a mailing to 89 previous GFC participants. Seventeen grandparents agreed to be interviewed. However, only 16 met the inclusion criteria. The participant who was excluded from the sample was the daughter of a deceased participant of the GFC Program. Respondents were primarily low-income, female, and African American.

Procedures

Informed consent and biographical information were obtained on the same day face-to-face interviews were conducted. Each participant was interviewed once, was asked the same questions in the same order, and received a $25 stipend immediately following the completion of the interview. Interviews lasted approximately 60 to 80 minutes at a location of convenience for the respondents (e.g., the participant's home). Interviews were individually conducted by members of the research team. Interviews were audiotaped and transcribed. A code number was assigned to each participant upon completion of the interview so no identifying information was included on the interview material or tapes. Transcriptions of the interviews were carefully read and analyzed, looking specifically for insights into each participant's perceptions of the GFC's impact on aiding his or her capacity to care for his or her grandchildren.

Data Analysis

Responses to the interview questions were organized into domains, which were determined by the common themes that emerged from participant responses. Interviews were transcribed by an external resource. Each transcript was reviewed and coded first

individually and then collectively by the primary researcher and two research assistants assigned to the project. The primary researcher has extensive knowledge relevant to practice and qualitative research with diverse populations. Research assistants received training in the area of qualitative program evaluation and analysis. Data analysis consisted of an inductive process to identify and cluster themes found throughout participant narratives. Charmaz (1983), Chenitz (1986), and Glaser and Strauss (1967) refer to this method as the constant comparative method of analysis. This analytical method requires that the researcher constantly compare findings, from the point of collection to the coding, and generate plausible themes. The researcher analyzes data to the point of redundancy and saturation of themes.

For this study, the researcher determined that a theme was saturated if it appeared in at least half of the interviews and if it resonated with the study respondents in member checks (Tutty, Rothery, & Grinnell, 1996). "Member checking" incorporated a review and approval of the transcribed data by respondents to ensure internal validity of findings (Tutty, Rothery, & Grinnell, 1996). Finally, transcripts and findings were reviewed by three additional readers and respondents to ensure neutrality and credibility of the results (Creswell, 2003).

Results

Qualitative findings revealed that the perceived impact of the program fell into three domains: Support and Services, Skill Building, and Affect and Behavioral Changes.

Support and Services

The first domain, Supports and Services, encapsulates the GFC Program's ability to connect grandparents to social support networks, community resources, and services.

Social Support Network

Interacting with other grandparent caregivers appeared to be very meaningful for many GFC clients. This is evidenced by the experience of a 47-year-old grandmother, who stated:

> Well, I think the thing that helped me the most is to see that I'm not the only one. It's a lot, I know, I mean since I been in the program, I see there's a lot of grandparents raising their children; so why (I just thought) I'm the only one who's out here having to suffer to take care of my grandchildren…it's hard.

A 60-year-old grandmother expressed a similar sentiment, stating, "And there were other grandmothers who would say to me a lot of times, don't feel like you're by yourself because I go through this with my grandchildren…" GFC social activities such as potluck dinners, arts and crafts expos, and stress management seminars were described as "fun" and "helpful." Moreover, social activities enabled GFC participants to "just sit down and dialogue" with other grandparents who were caring for their grandchildren and eventually create a network of support for grandparents.

Community Resources/Services

Grandparent caregivers often relied on GFC for support in meeting some basic, concrete needs. For example, a 47-year-old grandmother of six found GFC to be very helpful in navigating the educational system for her grandchildren:

> I needed help with registering them for school and taking them, too; find out how I take them to the doctor to get their shots and stuff like that. I was able to do it, but I couldn't do it because I didn't have no guardianship or nothing over them. So I needed to know my steps and what I need to do. So they told me

my steps there. I had to get — she gave me temporary custody of them and then I could register them for school and take 'em to their doctor appointments and stuff like that.

Several grandparents commented on assistance they received from GFC to secure housing and tend to financial matters. One 42-year-old grandmother of two explained,

> It took until after I got out of Grandparent Family Connections to get a place, but it wasn't like they didn't help me to try to find a place. One time I had a problem with the gas and electric, they helped me with that. There was another time that I needed some food, they helped me with that.

A 60-year-old grandmother of one reported, "I thoroughly love my apartment, which the Grandparent Connections were very instrumental in helping me to obtain."

Many respondents indicated that they have experienced financial difficulty as the result of becoming the primary caregiver for their grandchildren. Some cited GFC as a resource for connecting grandparent families to services. One grandparent caregiver reported that GFC connected her to the University of Maryland, School of Law:

> He did some paperwork and I was able to increase my income from $467 to…about $600, about $200 more…I wouldn't knew [sic] about it if I had not came through this program because I didn't even know…that I was qualified for this particular aspect of Social Security.

Skill Building

The second domain, Skill Building, refers to grandparents' learning about the social, emotional, behavioral, and developmental challenges that their grandchildren may have

exhibited and the skills they developed through GFC to better understand how to manage them. The following excerpts reflect participant perspectives of the development of skills designed to better assist them in caring for their grandchildren.

For example, one grandparent of five children commented on skills that she acquired as a participant of GFC that helped improve her caregiving skills:

> One thing she had taught me [a GFC worker] and they told me, when they [grandchildren] couldn't get their way, put them in time out, take the TV from 'em. But I wasn't doing that. And don't give what they want. She said just punish them. Like they want an ice cream or something; just take their snack and stuff from 'em.

Another 42-year-old respondent and grandparent of five grandchildren stated,

> Well, I'm a little bit more patient now compared to what I used to be; because I wasn't patient at all. I did a lot of cussing and my daughter had to get on me like that because my favorite word is that 'B' word. And every time [name of a grandchild] would make me mad, it would come out my mouth just entirely too frequently. And [name of worker] was like, 'Sometimes you just gotta count to 10 and hold your breath and don't do that.' I'm doing a lot better compared to what I used to be 'cause I wasn't, I just didn't care no more.

A 60-year-old grandmother of one commented on the knowledge gained through her participation in GFC relevant to the social, emotional, behavioral, and developmental challenges that grandchildren often experience and how she discovered ways to adapt to and/or manage the behavior of her grandchildren:

Grandchildren are not like they were when, you know, when I was raising mine in the 60s and the 70s, right. I've learned that with children these days you got to be a lot more flexible than, you know, then…when I was raising my children right. And that's what I learned through this program, you know, is that children today you've got to be able to listen to them more. You've got to be a lot more patient, you know, especially with a child like [name of grandchild], because [name of grandchild] had extra problems 'cause for one thing she had lead poisoning like when she was little…Well, hers [grandchild's behavior] was improved but mine was, mine was improved more so because with hers she's an adolescent and they go through (you know, their cerebral cortex is developing) so this girl, she'll do well for a while, and then like any other typical adolescent she will switch up, you know, so what I've learned is that with her when she switch up I still stay the same…But the program has been instrumental in teaching me how to better cope with her changes, you know.

Affect and Behavioral Changes

Affect and Behavioral Changes consists of (1) Those opportunities for respite and acknowledgement of the contributions of grandparent caregivers to the well-being of the family that allowed participants to relieve stress; and (2) observed behavioral changes in grandchildren.

The GFC's ability to provide respite to the caregivers was instrumental in reducing grandparents' stress. For example, a 47-year-old grandmother of six stated:

> …they had the pampering day where they took us (the grandparents) out for pampering…just little stuff. And it's no children, there were no children. I think my grandchildren were at school that day. It was during school hours while the children [were] in school. And they just took us there, they fed us and we did arts and crafts and then people had to share; we had a speaker talking. That stuff just means so much to me, just little stuff. And then it's free. It was like nobody looked at how many chicken wings you got or how many pieces of chicken you got. If you sitting down they'll bring you more. They see our plate gone, they bring you more. They just some real people. I never ever been around real people like that. They picked us up and carried us to where the gathering was at. And then leftovers, they let you bring it home. It's just real to me. That stuff means so much to me.

A 58-year-old grandmother of four further elaborated on components of the GFC that enabled her to mange her stress:

> Well, I think of all the different things that my staff counselor has been talking to me about. And just to have somebody to talk to about the kids and things that they're doing that's upsetting me. And with them just talking to me and listening to me, that sort of takes some of the stress away…I felt a lot better because I didn't feel so burdened…

> **The GFC's ability to provide respite to the caregivers was instrumental in reducing grandparents' stress.**

And I wasn't stressed out a lot. And I wasn't depressed a lot because they came in and they helped me with a lot of my problems.

In response to how her quality of life has improved as a result of her participation in the program, a grandmother of three stated,

Makes me want to join something else or do something else instead of staying home and cleaning and ironing…Most of the time I don't dress up and put no clothes on. I might put on a pair of shorts or whatever around the house…it's more to life then taking care of grandchildren and just staying in the house… that made me feel good about myself.

Responding to observed behavioral changes in her grandchildren following participation in the GFC Program, a grandmother of two stated, "… they [grandchildren] were more respectful. They were more understanding to me. They listened to me more…They did things that I told them to do."

Discussion

The results suggest that grandparent caregivers benefit from programs that provide opportunities to engage in activities with other grandparents, promote the continuity of those relationships, focus on the well-being of the caregiver, and assist in meeting concrete needs (e.g., housing, food). The findings provide several implications for practice. First, the emotional support that grandparents provide to one another suggests that programs and services are best received by participants via a collective, communal group format that provides practical information and services, as well as opportunities for fellowship.

Although teaching new and innovative ways to parent grandchildren is an important component of many grandparent intervention models, it is imperative that practitioners assess the short- and long-term medical, mental health, and practical (e.g., food, clothing, shelter, education) needs of the grandparent family. To meet the needs of grandparent families, practitioners must be fully knowledgeable about an array of accessible resources and services that are available to grandparents and their grandchildren. An imperative component of obtaining such knowledge is fostering relationships with service providers for the purpose of informing and easily connecting grand families to services.

Strengths

Using a qualitative program evaluation design allowed for (1) The exploration of individual differences between participants' experiences and outcomes; (2) an understanding of the meaning of the GFC Program to its participants; and (3) the collection of data from a population of respondents in a manner that supported their heavy reliance on oral traditions for the sharing of information (Boyd-Franklin, 2003; Hill, 1997; Hill et al., 1993).

Limitations

There are limitations to this study that should be considered. There was a small number of participants ($N = 16$). In addition, there was significant variation within the purposive sample relevant to the age of participants and the number of grandchildren in their care. These characteristics limit the transferability of the findings to other populations.

Implications for Social Work Practice

Findings suggest that the distribution of services, resources, and support may best be implemented using a group format. Moreover, providing services in a group setting allows for grandparent caregivers to discuss processes, and empathize with and provide feedback to one another. Additionally, grandparent caregivers may benefit from engaging in regular self-care

routines, which could include reading, shopping, meditation/prayer, and exercise. Activities such as these are enjoyable and focus on self care, factors that are paramount to reducing stress and enhancing grandparents' capacity to identify and attend to their individual needs — which can ultimately increase their ability to care for their grandchildren.

Grandparents who assume the role of caregiver for their grandchildren take on an additional financial burden and often struggle to meet the basic needs of their families. Thus, taking care of practical needs is critical to the well-being of the caregiver and the family as a whole. With this in mind, programs should assist grandparent caregivers in meeting tangible needs such as securing food, clothing, and shelter.

Future Research

Further research pertaining to grandparent caregivers should focus on the relationship between engaging in self-care routines and grandparents' ability to meet the needs of their families. Understanding how caregivers attend to their own needs and are able to manage specific challenges associated with parenting vulnerable children would be imperative in developing more effective interventions and models of service delivery for this population. Additionally, a longitudinal mixed-method study that examines the development and progression of Support and Services, Skill Building, and Affect and Behavioral Changes could enhance understanding relevant to the needs of grand families as well as inform the development and implementation of interventions. Finally, an examination of service utilization before and after participating in grandparent caregiver interventions requires further examination.

References

Bowers, B. F., & Myers, B. J. (1999). Grandmothers providing care for grandchildren: Consequences of various levels of caregiving. *Family Relations, 48*(3), 303-311.

Boyd-Franklin, N. (2003). *Black families in therapy: Understanding the African American experience* (2nd edition). New York, NY: Guilford Publications.

Charmaz, K. (1983). The grounded theory method. In R. Emerson (Ed.), *Contemporary field research: A collection of readings* (pp. 109-126). Boston, MA: Little Brown.

Chenitz, W. (1986). Qualitative research using grounded theory. In W. Chenitz & J. Swanson (Eds.), *From practice to grounded theory* (pp. 3-15). Menlo Park, CA: Addison-Wesley.

Climo, J. J., Patterson, T., & Lay, K. (2002). Using the double bind to interpret the experience of custodial grandparents. *Journal of Aging Studies, 16*, 19-35.

Creswell, J. W. (2003). *Research design: Qualitative, quantitative and mixed methods approaches.* Thousand Oaks, CA: SAGE.

Dowdell, E. B. (1995). Caregiver burden: Grandparents raising their high risk grandchildren. *Journal of Psychosocial Nursing, 33*, 27-30.

Ehrle, J., & Geen, R. (2002). *Children cared for by relatives: What services do they need? Series B, No. B-47.* Washington, DC: Urban Institute. Retrieved on March 18, 2008, from http://www.urban.org/publications/310511.html

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research.* New York, NY: Aldine Publishing.

Grant, R. (2000). The special needs of children in kinship care. *Journal of Gerontological Social Work. Special Issue: Grandparents as Carers of Children with Disabilities: Facing the Challenges, 33*(3), 17-33.

Hayslip, B., & Kaminiski, P. (2008). Epilogue. In B. Hayslip & P. Kaminski (Eds.), *Parenting the custodial grandchild: Implications for clinical practice* (pp. 17-40). New York, NY: Springer Publishing Company.

Hill, R. B. (1997). *The strength of African American families: Twenty-five years later.* Washington, DC: R&B.

Hill, R. B., Billingsley, A., Engram, E., Malson, M. R., Rubin, R. H., & Stack, C. B. (1993). *Research on the African American family: A holistic perspective*. Westport, CT: Auburn House.

Jooste, J. L., Hayslip, B., & Smith, G. C. (2008). The adjustment of children and grandparent caregivers: Grandparent-headed families. In B. Hayslip & P. Kaminski (Eds.), *Parenting the custodial grandchild: Implications for clinical practice* (pp. 17-40). New York, NY: Springer Publishing Company.

Kelley, S. J., Whitley, D., & Sipe, T. A. (2007). Results of an interdisciplinary intervention to improve the psychological well-being and physical functioning of African American grandmothers raising grandchildren. *Journal of Intergenerational Relationships, 5*(3), 45-64.

Kelley, S. J., Whitley, D., Sipe, T. A., & Yorker, B. C. (2000). Psychological distress in grandmother kinship care providers: The role of resources, social support, and physical health. *Child Abuse & Neglect, 24*, 311-321.

Kelley, S. J., Yorker, B. C., Whitley, D. M., & Sipe, T. A. (2001). A multimodal intervention for grandparents raising grandchildren: Results of an exploratory study. *Child Welfare, 80*(1), 27-50.

Landry-Meyer, L., & Newman, B. M. (2004). An exploration of the grandparent caregiver role. *Journal of Family Issues, 25*(8), 1005-1025.

McCallion, P., Janicki, M. P., Grant-Griffin, L., & Kolomer, S. R. (2000). Grandparent careers II: Service needs and service provision issues. *Journal of Gerontological Social Work, 33*(3), 57-84.

Musil, C. M. (1998). Health, stress, coping, and social support in grandmother caregivers. *Health Care for Women International, 19*, 441-453.

Sands, R. B., & Goldberg-Glen, R. S. (2000). Factors associated with stress among grandparents raising their grandchildren. *Family Relations, 49*(1), 97-105.

Scarcella, C. A., Ehrle, J., & Geen, R. (2003). *Identifying and addressing the needs of children in grandparent care. Series B, No. B-55*. Washington, D.C.: Urban Institute. Retrieved on March 18, 2008, from http://www.urban.org/publications/310842.html

Tutty, L. M., Rothery, M. A., & Grinnell, R. M. (1996). *Qualitative research for social workers*. Needham Heights, MA: Allyn and Bacon.

U.S. Census Bureau. (2006). *American community survey. Estimates based on sample data from the 2006 American Community Survey*. Retrieved March 13, 2008, from http://factfinder.census.gov

Engaging Program Staff in Economic Evaluation: Lessons Learned and Recommendations for Practice

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Acknowledgments

Introduction

Economic evaluation can provide valuable information for program directors and policymakers who need to make decisions about resource allocation. However, most child maltreatment prevention program staff members are unfamiliar with the purpose and methods of economic evaluation. The extent to which economic evaluation is relevant and useful for direct-practice staff has not been well-examined, and the published literature has provided limited information about the involvement and engagement of program staff with respect to guiding the data collection, analysis, and interpretation of economic evaluation (Yates, 1996; Yates, 1999). Studies rarely mention whether and how direct service staff were involved in the research. With the increased interest in using economic evaluation for promoting evidence-based practices, it is critical that program staff are actively involved in the planning, implementation, and interpretation of the cost data being collected for these studies.

This paper addresses a significant gap in the literature by examining how program staff were engaged in the process of conducting an economic evaluation of a child neglect prevention program, Family Connections (FC). The lessons learned in conducting a comprehensive multi-site cost analysis for eight FC replication grants are highlighted. This evaluation effort facilitated a mutually beneficial learning experience for the research team and the program staff. The paper concludes with key recommendations for practice and offers insight into how the process of conducting an economic evaluation can be used to facilitate ongoing learning and reflection regarding program practice, implementation, and research.

Economic Evaluation and Cost Analysis

Several authors provide an overview of economic evaluation in general (Brosnan & Swint, 2001; Foster, Dodge, & Jones, 2003; Haddix, Teutsch, & Corso, 2003; Health Economics Research Group, n.d.; Honeycutt et al., 2006; Yates, 1999). In addition, Corso and Filene's aggregate cost study of the FC replications projects included in this issue of Protection Children (see page 78) provides more detailed information about the methodology used to conduct that study.

Cost analysis, which should be included in any effort to fully assess the impact of child maltreatment prevention programs, is the critical first step in any economic evaluation and provides the essential foundation for all other types of analysis (Foster, Porter, Ayers, Kaplan, & Sandler, 2007). Belenko, Patapis, and French (2005) highlight the importance of calculating specific costs for different substance abuse treatment components since this may help identify the unique elements of treatment that contribute the most net benefits. Tracking the time (and costs) spent implementing specific programmatic components is also important because it provides

an accurate reflection of the activities that comprise an intervention, as well as the level of effort and resources needed to fully implement each program component or the program as a whole. However, reviews of the literature have identified a paucity of research studies that report unit costs of the different components of interventions (Belenko, Patapis, & French, 2005; Brosnan & Swint, 2001; Foster, Dodge, & Jones, 2003; Foster, Porter, Ayers, Kaplan, & Sandler, 2007). Similarly, few cost-effectiveness and cost-benefit studies provide information about the actual programmatic cost estimates that form the basis for their analyses, making it difficult to compare results across studies (Foster et al., 2007).

A few researchers have recommended cost-inclusive evaluations, which emphasize the engagement of program staff to illuminate the practice on which the cost data are collected (Yates, 2009; Yates, 1996). The role of practitioners in economic evaluation has been addressed in a substantive way by a few authors in mental health (Yates & Siegert, 1980). For example, Yates (1996, 1999) developed the Cost-Procedure-Process-Outcome-Analysis (CPPOA) framework as a qualitative method for economic evaluation that intentionally seeks input from program staff in identifying the key resources and processes used to achieve specific outcomes for a program. Stebbins and Langford (2006) recommend establishing a stakeholder advisory group at the start of any effort to conduct an economic evaluation of an early childhood program. Patton (2008) has described utilization-focused evaluation as one that "is done for and with specific, intended uses…and should be judged by [its] utility and actual use" (p. 37), which is a philosophy that can be applied to economic evaluation. In other words, it is critical that program staff provide ongoing feedback about the cost-analysis process to ensure that the findings are accurate and reflect what they do in day-to-day practice.

The Family Connections National Cross-Site Cost Study

The FC National Cross-Site Evaluation was the Children's Bureau's first foray into requiring a cost analysis for a set of research and demonstration projects (see Corso and Filene's article in this issue of *Protecting Children* for more details). For most of the FC replication sites, this was workers' first experience with planning and conducting any type of formal economic evaluation of a program. A few of the local evaluators had some prior experience with conducting a cost analysis. A participatory approach was used to ensure that the plans for the cost study were developed in partnership and with input from all eight FC replication sites.

One of the pivotal cross-site decisions made was to collect case-level cost data (i.e., staff and family-level service utilization data) as well as programmatic cost data. As such, the FC Program staff tracked the time they spent providing services to each family, engaging in activities on behalf of each family, and conducting administrative activities, in 1- or 5-minute increments using cross-site activity categories. For example, program staff tracked how much time they spent providing counseling and support to each family member served by the FC Program — and since this was one of the fidelity criteria for replicating the FC Program, this task allowed staff to collect both types of cost data. (For a list of the cost activity categories, see Corso and Filene's article on page 78. For a list of the fidelity criteria, see DePanfilis, Filene, and Brodowski's article on page 4). Workers at the FC replication sites agreed

that having this detailed data was useful for their own program planning and management. In addition to providing estimates of service costs per family, the case-level data allowed evaluators to examine whether the amounts (i.e., dosages) and types of services families received had any relationship to the outcomes.

Lessons Learned

Engaging program staff in the process of planning and implementing a multi-site cost analysis is not an easy task for an experienced researcher, let alone community-based agencies that are new to economic evaluation. The process of conducting the cross-site cost analysis of the FC replication projects was no different, and a number of challenges and opportunities were encountered throughout the projects' planning and implementation phases. Direct service staff and researchers offered unique perspectives and identified real-world issues facing those who collected and reported the cost data. It is clear that seeking program staff input as early as possible in the process and maintaining ongoing communication are necessary for building commitment and buy-in for a cost study. The next sections describe the key lessons learned in three areas: (1) Defining and using terms for economic evaluation; (2) communication and feedback; and (3) staffing and resource issues.

> Engaging program staff in the process of planning and implementing a multi-site cost analysis is not an easy task for an experienced researcher, let alone community-based agencies that are new to economic evaluation.

Defining and Using Terms for Economic Evaluation

The process of examining whether staff within and across sites were using common definitions for activities and the process of establishing greater consistency required more attention than originally anticipated. A two-phase process was used to identify and define the cost activity categories that served as the building blocks for the national evaluation. An ad-hoc cost workgroup with membership from each of the eight replicating sites was established in the first year of the project. This group developed an initial draft of the cost activity categories and definitions. After the first year of the study, it became clear that the initial draft of cost categories and definitions needed to be revised. Sites reported that program staff had an ongoing need for more clarification and refinement of the activity categories as they were implementing the program and trying to track their time doing so. In addition, as a data verification check, the national evaluators conducted a series of calls with each of the FC replication sites to understand how each site was operationalizing each cost activity category, collecting data, and reporting data. Through these site-level conversations, the national evaluators learned that some of the FC replication sites were operationalizing, collecting, and reporting the cost data in vastly different ways.

As a result, the researchers revisited the operationalization of each cost activity category with the FC replication sites. Time was spent at a grantees meeting and through follow-up conference calls engaging in open dialogue about the specific activities that should and should not be included in each cost activity category, as well as discussing whether the list of cost activities was comprehensive and exhaustive. This time-consuming process ultimately served another important purpose of promoting critical

examination, reflection, and active discussion regarding the key components of the FC Program, which may not have occurred otherwise. Interestingly, these extended discussions about the cost activity categories turned out to be as much about how staff operationalized the FC fidelity criteria as they were about the cost study.

The decision was made to track time spent implementing FC, but exclude time conducting research activities to evaluate process and outcomes. However, the use of clinical assessment instruments to guide the identification of risk and protective factors associated with child neglect (or maltreatment) as part of a comprehensive family assessment is a core component of the FC Program. As such, "assessment" was identified as a direct service activity category. This resulted in a blurring of the lines between an assessment conducted to guide service delivery and the assessment conducted for research purposes. This was particularly confusing for some sites since some of the clinical assessment measures were also used as outcome measures.

The decision was made to include time spent conducting an assessment if at least one purpose was to guide service delivery. In addition, sites that wanted to capture the time spent conducting research- or grant-related activities (i.e., not FC activities) could use an optional item labeled "grant-related activities." Additional "optional items" were identified to reflect site-specific activities. For example, workers at one site used an optional category called "parent training workshops" to track time spent implementing parent training workshops (which were not part of the FC fidelity criteria) for a group of families as part of the site's evaluation design. Depending on the nature and activities conducted for the site-specific category, it may have been included under direct, indirect, and administrative categories. This optional category was developed in response to the FC replication sites' own desire to track

and analyze the cost data that also met their own purposes.

While most economists agree that collecting cost data from a societal perspective (e.g., tracking the time a parent takes to participate in the program) is ideal, the real-world challenges of applying this approach became evident as the FC replication sites tried to collect and report on the cost data. A societal perspective considers all the costs of the program regardless of who pays for them, and would include volunteer time, client time, costs to the public, and other costs. An agency perspective only considers the costs to the agency implementing the program.

Despite cross-site agreement to use a societal approach, the nuances of the data that were needed to track costs from a societal perspective were not well understood by all sites. FC Program and accounting staff were accustomed to tracking costs from an agency perspective, using their existing agency budget and records to track the costs for the federal grant. Only two sites collected data on volunteers, two sites attempted to collect data on the clients, and one site reported donations received for the project. As a result, the sites that reported volunteer, client costs, and donations tended to have higher total costs than other sites that did not include them. However, it was equally likely that the costs associated with donations, client time, and volunteer time were underreported since it may have been too burdensome to try to collect or estimate these costs for the purposes of the cross-site cost analysis. In light of such inconsistencies across sites, the aggregate cost study was unable to use the additional data on client costs, volunteer time, and donations.

> Some program staff felt that the intensive data collection (i.e., tracking their time in 1- or 5-minute increments) took away time and energy that should have been spent providing direct services to families.

Communication and Feedback

A critical element of the cross-site cost analysis was ongoing communication with and feedback from the FC replication sites. During the first year of planning, a cost workgroup was established that initially met twice monthly to build consensus regarding the cross-site activity categories and definitions, cost elements, and reporting templates. Cost workgroup conference calls or calls with individual sites were convened regularly during the grant period. In some cases, discussions about the cost study occurred with all sites in order to review recommendations or proposed definitions and protocols. In other cases, site-specific conversations were initiated to discuss discrepancies in the data that required further clarification, resolve data quality issues, consider the validity of findings, and provide assistance in interpreting site-specific findings produced by the national evaluator. In addition to these conference calls, cost analysis was a standing agenda item at every grantees meeting. The research team's experts in economic evaluation presented preliminary findings from the cross-site data at the grantees meetings.

Staffing and Resources

The cost analysis presented significant workload issues for staff involved with the cost data collection. Program staff, including frontline service providers, had to take on an additional role as cost data collectors. Some program staff felt that the intensive data collection (i.e., tracking their time in 1- or 5-minute increments) took away time and energy that should have been spent providing direct services to families. Staff at a few

sites expressed frustration when the cost activity categories were revised, necessitating additional training and modifications to their data collection forms and databases. In addition, site staff reported that they did not originally plan to conduct such an intensive cost analysis and their original budget was not commensurate with the level of resources needed. Despite these general concerns, the mid-course changes were perceived as beneficial because the activity categories were further operationalized and clarified, and the definitions better reflected what program staff were doing in the field.

Although the research team included experts in economic evaluation, limited technical assistance was available during the first 2 years of the project because the cross-site evaluation was not funded until the third year. This minimal technical assistance and feedback during the initial planning and start-up phases of the projects presented significant challenges as changes were needed in the original cost analysis plans and definitions. The national evaluators ultimately were able to provide more direct consultation and technical assistance on the cost analysis to the FC replication sites in the final phases of the study.

Recommendations for Practice

The lessons learned point to a number of recommendations that we offer to agencies and funders who are considering incorporating cost analysis and economic evaluation into their research plans. We strongly encourage agencies to take the opportunity to foster the meaningful engagement of their program staff in all aspects of the study from the very beginning. First and foremost, the process of conducting the economic evaluation should be used to facilitate a mutually beneficial learning experience for the research team — specifically, the economists — and the program staff. Lessard (2007) proposes a new paradigm for economic evaluation that

emphasizes the importance of perspective and context. Experts in economic evaluation may have little direct experience in implementing programs, in general, and it is important to challenge their assumptions about the process of conducting their research in the real world. Program staff can provide invaluable feedback on identifying and defining the types of cost activity categories that best reflect their daily activities. Moreover, program staff can greatly benefit from gaining a better understanding of how rigorous research can help build support and needed resources for their program over the long run. Through this dialogue, research and program staff can engage in more reflective practices, which may lead to more useful and meaningful information for improving direct services.

All parties involved need to fully understand the analytic perspective, terms, and definitions used for the economic evaluation. Agencies should make concerted efforts to include case-level cost data. As we learned, collecting and using case-level cost data is a powerful way to engage staff in discussions regarding economic evaluation, because it offers a concrete process for them to talk about what they do and what they know. Within this context, clear distinctions should be made regarding costs that will be included and excluded from the data collection and analysis.

Ongoing staff training and support is critical. Staff should receive initial training on the analytic approach being taken. Equally important is the ongoing training effort. In a multi-site cost analysis, there must be a strong focus on obtaining agreement across sites regarding a limited number of common cost data elements that will be collected. Ideally, an external source (e.g., cross-site evaluator) should do on-site adherence checks and provide re-training on the cost definitions as needed throughout the life of the project. Ongoing monitoring and

quality assurance checks need to be built into the research design to ensure reliability in cost data collection and reporting across multiple sites. A key aspect of this work is sharing cost data with frontline staff on a routine basis to discuss the implications and issues of the cost study, with the discussion framed in terms of direct practice.

Agencies can minimize staff burden by collecting data over a shorter period of time. Cost data were collected for 3 years as part of the FC National Evaluation. The case-level data were collected on all participants served during 1 full year of the projects. Agencies could choose to obtain data from staff daily or over a period of weeks or months instead. Other ways to minimize the burden may be to hire additional administrative support staff who would be responsible for working with the program staff to collect and report on the cost data. Administrators need to recognize, positively reinforce, and support those staff asked to collect cost data in addition to their regular duties.

Project staff should work with their economic analysts or evaluators to identify the most relevant data collection period for the study (typically when the program is working at its full operating capacity). A consultant with expertise in economic evaluation should be available to explain the overall purpose of the cost analysis, answer questions, and provide feedback and support throughout the entire data collection process.

> The FC replication sites often acknowledged the messy, real-world issues they faced during the cost data collection process.

Conclusion

A key factor aiding the success of this effort was the active engagement of both program and research staff throughout the entire study. The Children's Bureau emphasized early and often that those involved with the FC replication grants were in a unique position to make a significant contribution to the field of child maltreatment prevention research and practice. This shared sense of ownership and inclusion in a larger peer learning community was evident across all the FC replications projects. Participants' commitment allowed the Children's Bureau to successfully implement a comprehensive national evaluation, which included process, outcome, and cost components. In addition, the FC replication sites' investment in this initiative allowed the national cross-site cost analysis to reach a more sophisticated level. Collecting case-level data ensured analysis could be done and provided more relevant data that could be used by program staff. The case-level cost data analysis is currently under way and the findings will be shared in future publications.

The FC replication sites were encouraged to be open and honest about their challenges and identify the resources that they needed to successfully implement the projects. The FC replication sites often acknowledged the messy, real-world issues they faced during the cost data collection process. Despite the limited resources available to collect and report the data for the cost study, FC replication sites were generally amenable to implementing the requirements for the cross-site study.

Over time, program staff seemed to recognize and appreciate the potential for the cost data, and were committed to carrying out what was needed for the cross-site evaluation. As a result, staff contributed to problem-solving by identifying more efficient cost data collection processes. In turn, this helped establish a foundation for assuring data quality and increased the validity of the interpretation of the findings from the study. As evidence of the capacity built from this experience, two of the FC replication sites were better positioned for securing other Children's Bureau grants and have incorporated economic evaluation into their new local projects. These FC replication sites report that using cost data is now incorporated into their day-to-day agency practices.

Finally, the impact of the shared sense of ownership of the process for the entire FC replications initiative cannot be overstated. The demands on the FC replication sites to rigorously evaluate and implement an evidence-based program were quite significant. Nonetheless, the staff's communal recognition of the work's importance was likely the reason the FC replication sites were able to adapt to the complex and changing circumstances that often emerged over the course of the project. Fostering a culture of learning, flexibility, and adaptation — while maintaining high standards of rigor and relevance in the research — was critical for engaging program staff in a more meaningful, practice-based, participatory, and utilization-focused economic evaluation.

References

Belenko, S., Patapis, N., & French, M. T. (2005). *Economic benefits of drug treatment: A critical review of the evidence for policy makers*. Philadelphia, PA: Treatment Research Institute at the University of Pennsylvania.

Brosnan, C. A., & Swint, J. M. (2001). Cost analysis: Concepts and application. *Public Health Nursing, 18*(1), 13-18.

Foster, M., Dodge, K. A., & Jones, D. (2003). Issues in the economic evaluation of prevention programs. *Applied Developmental Science, 7*(2), 76-86.

Foster, M., Porter, M. M., Ayers, T. S., Kaplan, D. L., & Sandler, I. (2007). Estimating the costs of preventative interventions. *Evaluation Review, 31*(3), 261-286.

Haddix, A. C., Teutsch, S. M., & Corso, P. S. (Eds.). (2003). *Prevention effectiveness: A guide to decision analysis and economic evaluation* (2nd ed.). New York, NY: Oxford University Press.

Health Economics Research Group, Division of Prevention Research and Analytic Methods, & Centers for Disease Control and Prevention. (n.d.). *Applying cost analysis to public health programs: A self-study course with exercises and case-study questions*. Washington, DC: U.S. Department of Health and Human Services.

Honeycutt, A. A., Clayton, L., Khavjou, O., Finkelstein, E. A., Prabhu, M., Blitstein, J. L., et al. (2006). *Guide to analyzing the cost-effectiveness of community public health prevention approaches*. Retrieved October 21, 2007, from http://aspe.hhs.gov/health/reports/06/cphpa/report.pdf

Lessard, C. (2007). Complexity and reflexivity: Two important issues for economic evaluation in health care. *Social Science & Medicine, 64*(8), 1754-1765.

Patton, M. Q. (2008). *Utilization-focused evaluation* (4th edition). Thousand Oaks, CA: Sage Publications, Inc.

Stebbins, H., & Langford, B. H. (2006). *A guide to calculating the cost of quality early care and education*. Washington, DC: The Finance Project.

Yates, B. T. (1996). *Analyzing costs, procedures, processes, and outcomes in human services*. Thousand Oaks, CA: Sage Publications.

Yates, B. T. (1999). *Measuring and improving cost, cost-effectiveness, and cost-benefit for substance abuse treatment programs*. Retrieved October 21, 2007, from http://www.nida.nih.gov/IMPCOST/IMPCOSTIndex.html

Yates, B. T. (2009). Cost-inclusive evaluation: A banquet of approaches for including costs, benefits, and cost-effectiveness and cost-benefit in your next evaluation. *Evaluation and Program Planning, 32*, 52-54.

Yates, B. T., & Siegert, F. E. (1980). Behavioral child-management cost-effectiveness: A comparison of individual in-office, individual in-home, and group delivery systems. *Evaluation & the Health Professions, 3*, 123-152.

Programmatic Cost Analysis of the Family Connections Program

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Acknowledgments

Introduction

Policymakers, program administrators, and researchers increasingly acknowledge the importance of economic analysis. Policymakers want economic analysis for determining how to allocate scarce resources; program administrators want economic analysis for resource allocation, as well as to help identify which programs to implement; and researchers are interested in economic analysis because it makes their program evaluations more comprehensive (Corso & Lutzker, 2006; Courtney, 1999; Dubowitz, 1990). The demand for economic analysis is evident in strategic planning being developed at the federal level. For example, in the Centers for Disease Control and Prevention's research plan for injury and violence prevention, a top priority is to describe service delivery

use and impact, in addition to the costs of interventions for child maltreatment.

Despite the need for information about the economic cost and impact of implementing child and family development or child maltreatment programs, few studies have conducted economic analysis in this area (Armstrong, 1983; Brooten et al., 1986; DePanfilis, Dubowitz, & Kunz, 2008; Karoly et al., 1998; Olds, Henderson, Phelps, Kitzman, & Hanks, 1993), and fewer still have used standard economic principles when conducting such research.

Although some guidelines to conduct economic analysis do exist for community-level interventions in general (Haddix, Teutsch, & Corso, 2003) or for cost analysis within other areas of prevention (Foster & Jones, 2006) or treatment (French, 2000), there are insufficient guidelines in the literature on how to specifically conduct programmatic cost analysis for family and child development interventions. The objective of this paper is to outline the methods for conducting rigorous programmatic cost analysis and to demonstrate their applicability to family-centered programs. As an example, this article describes methods used to estimate the costs of replicating the Family Connections (FC) Program in eight different geographic locations in the United States. The article concludes with lessons learned in undertaking this cost analysis, with suggestions for improving the methodology for future studies.

Cost Analysis Methodology

The assessment of the economic costs of implementing an intervention is called programmatic cost analysis or CA (Yates, 2009). CA involves the systematic collection, categorization, and analysis of intervention delivery costs, including those required during the pre-implementation (developing the program delivery infrastructure) and implementation (delivering the program) phases (Haddix et al., 2003). Programmatic costs are compared to either short- and long-term monetary benefits of a program, or to a program's effectiveness in reducing adverse behaviors or improving child and family health and social outcomes.

I. Frame the Study

Framing the CA begins with identifying the audience for the study, because the audience determines the perspective of the analysis and which costs (or benefits, in the case of a full-blown economic evaluation) are included. Typical audiences of CAs include the funding agency or agencies, other organizations considering implementing an intervention, or society in general. From the perspective of the funder, one might consider only including those costs that are market-based, which are explicit and can be located on a budget or financial sheet. From the perspective of another organization considering implementation of an intervention, however, in addition to those costs located on the budget sheet, the CA should include the value of resources used for which money did not exchange hands. In other words, the use of all resources — whether valued in monetary terms or not, and whether donated or not — is critical for others considering implementation of an intervention because they would need to obtain those resources. Such resources should be valued according to the lost opportunities they resulted in when used for one program and not another (i.e., opportunity costs), as a proxy value for the monetary cost of the resource. Donated space or goods and services are examples of non-market resources that have real value in terms of resources used despite their not showing up on a budget sheet.

Additionally, from the perspective of society in general, those resources required to deliver the intervention that fall outside the realm of provider-specific costs, such as the time required by parents to participate in an intervention, are also considered. Again, this type of cost could be considered non-market-based because there is an opportunity cost associated with parent participation, in that there are other opportunities the parent would have missed by participating in the intervention (such as going to work or participating in another preventive intervention).

For the FC Program replication, the CA was conducted from the perspective of other funders or other agencies that might consider replication of the FC Program. As such, an attempt was made to value all market- and non-market-based resources required of an agency delivering the intervention, so that other organizations interested in implementing the FC Program in the future would have a real sense of the resources required.

Determination of the timeframe during which programmatic costs will be assessed is

Table 1. Definitions of Activities Used to Categorize Programmatic Costs During the Implementation Phase of Analysis

A. Service Activities Directly Related to Client	B. Service Activities Indirectly Related to Client
Advocate with client: To work with the family network to obtain services and resources that might not otherwise be provided.	*Advocate without client:* To work on behalf of the family network to access services or resources. To work on behalf of the family network to shape or change legislation or social policies related to resource provision and/or social justice.
Assess: To formally analyze the individual, the family system, the ecological system, and the client's situational context on an ongoing basis.	*Clinical documentation:* To complete written materials that describe all activities with and on behalf of the client system.
Counseling/support: To assist a client in processing past or current life events, to provide affirmation and the opportunity to ventilate, to listen, or to reflect.	*Research:* To search for additional information that assists in assessing or developing services for a specific client, formulate ideas for treatment plans, and prepare for client sessions.
Provide: To help, aid, and/or acquire concrete resources with client present.	*Consult/collaborate:* To provide information to staff/collateral providers or seek information from staff/collateral providers who are knowledgeable in specific areas in an effort to assist or work closely with the family network.
Plan: To mutually establish a scheme/purpose for doing, making, or arranging an activity, objective, goal, etc. (to be conducted at a future time).	*Locate resources:* To identify and secure resources (without the client present) for the family network or collateral providers that might otherwise be unavailable or difficult to obtain.
Refer: To effectively link clients to services and/or resources not provided by FC.	*Schedule:* To set a time for an appointment on behalf of a client.
Schedule: To set a time for an appointment or activity with a client.	*Staff travel:* Travel for client-related activities, when a client is not present.
Teach: To demonstrate, model, and/or instruct a client in a specific skill.	*Other indirect activities:* To conduct indirect activities not previously defined.
Transport: To provide transportation for the client (e.g., to a clinic appointment).	
Program attempts: To attempt an interaction/communication with a client, when client is not available.	
Other direct activities: To conduct direct activities not previously defined.	

C. Administrative Activities Related to Client	D. Administrative Activities Related to Management
Give supervision: To provide supervision to interns and staff that is related to their functioning in providing services to individual families, and family groups. To provide supervision to interns and staff that is related to their involvement in activities that support the program operations. *Receive supervision:* To receive supervision from a direct supervisor or other program staff member that is related to service provision to individual families, and family groups. To receive supervision from a direct supervisor or other program staff member that is related to activities that support the program operations. *Team meeting/Group consultation:* To participate in regularly scheduled team meetings/group consultation meetings that focus on providing services to families. *Provide training:* Provide training to FC staff. *Attend training:* To attend activities that teach or inform practice with individual families or family groups, or that relate to activities that support the program operations. *University of Maryland training and technical assistance:* To participate in training activities related to the FC Program provided by the University of Maryland, Baltimore. *Professional/Community committees:* To attend or be a member of a standing or ad hoc committee, not sponsored by the organization, that teaches, informs, or influences organization and community practice and activities related to providing services to individual families and family groups, or activities that support the program operations. *Organization committee:* To attend or be a member of a standing or ad hoc committee, sponsored by the organization, that teaches, informs, or influences organization and community practice and activities to provide services to individual families and family groups, or activities that support the program operations. *Other administrative activities:* To conduct administrative tasks not previously defined.	*Referral screening:* To conduct screening activities related to establishing family eligibility for the program. This includes providing referrals to families that are not eligible for the project. *Outreach/marketing:* To educate other agencies, organizations, schools, and families about the services available through the FC Program. This includes the development (i.e., drafting, copying, compiling) and distribution of brochures, fliers, and newsletters, presentations, and meetings, as well as travel associated with outreach/marketing activities. *Writing:* To engage in writing activities associated with documenting program policies and procedures (e.g., revising the Implementation Plan and Replication Manual). *Management information system entry:* To complete documentation or enter information related to data entry. *Staff/organization meetings/committees:* To prepare for or attend staff meetings that focus on administrative functions or program operations. *Other administrative activities:* To conduct administrative tasks not previously defined.

another step in framing the CA. The timeframe needs to be decided a priori and should be based on whether the intervention has a pre-implementation phase that should be considered separately, whether there is a seasonal component to the intervention that should be accounted for, and whether, once implemented, there is a substantial start-up period during which the program may not be operating at full capacity. Cross-site comparisons should follow a common timeframe. In this study, costs were evaluated separately for the 1 year required for pre-implementation, Year 1 of implementation, and Year 3 of implementation.

II. Categorize Costs

The next step in the CA is to define the cost categories that will be included in the study and the types of costs that will be considered within each category. A common method for defining cost categories is specifying activity areas in terms of those that are client- versus non-client-related. Table 1 describes how these activity areas were defined in the CA of the FC Program during the implementation phase. These activities included service and administrative activities. Care was taken to include all sites in the development of these definitions, to make sure that the definitions were uniform across all of the sites, and to create an activity list that was exhaustive and mutually exclusive. Any activities that were directly research-related or part of the initial program development were not included in these definitions, because the purpose of this study was to examine the cost of implementing the intervention only. Quality controls were put in place by periodic reassessment of activity definitions throughout the data collection process.

Activity categories included in the pre-implementation phase were different from the activity categories defined during

implementation, and included: (1) Initial training; (2) community outreach; (3) implementation planning; and (4) case management system development.

Once activity categories have been defined for all phases of the CA, the next step is to define the types of costs that will be tracked within each activity. The two broad types of costs typically included in CAs are personnel and non-personnel resources. For most behavioral family-centered interventions, the largest contributor to programmatic costs is related to personnel expenditures.

In aggregating the costs across sites implementing the FC intervention, sites chose to delineate personnel costs as service-related or administrative, as described in Table 1. Service-related costs could either be directly or indirectly related to (on behalf of) the client, and administrative costs could be either client- or management-related. Although activities were specified within each broad category of personnel costs (e.g., trainings, meetings, and supervision, as administrative activities related to the client), for the purposes of this CA, personnel costs were aggregated to direct personnel and indirect personnel categories. This strategy allowed for the examination of the varying degrees to which total personnel costs were directly related to client activities, which is important information for many funding agencies.

Non-personnel costs included in the CA of the FC replication project included space and utilities, travel costs, and supplies and equipment. For space and utilities, rent and costs for electricity, phone, etc. were included. If not all of a facility was used for the implementation of the FC Program, the site provided the percentage of these total resources required for program implementation. For travel, sites provided the number of miles and the mileage

reimbursement rate, airfare, and per diem for overnight travel. For supplies and materials, sites differentiated between resources that were considered consumables, or variable costs, versus non-consumables, or fixed costs. Consumable supplies included office supplies (e.g., paper), printing jobs, postage, supplies for clients (e.g., transportation vouchers, cell phones, educational materials), non-research incentives for clients, event- or program-specific supplies, promotional materials, office equipment leases, food, donated materials, and computer systems repair and maintenance. Non-consumable supplies included computers and other electronics, computer software, and automobiles.

Specific costs not included in this analysis were participant time costs, the costs of community services to which parents were linked by the FC Program staff, and volunteer time. While some attempt was made to collect these costs at the site level, data inconsistencies across sites prevented inclusion of these costs in this aggregate analysis.

III. Collect Costs

Many CAs (Foster & Jones, 2006) and cost-effectiveness analyses, including the DePanfilis et al. 2008 study of the FC demonstration project, have relied solely on retrospective collection of intervention costs — primarily from budgetary or accounting documents. Although budget information is a useful foundation for analyzing programmatic costs, this approach is limited. Retrospective cost collection can be affected by poor record-keeping and study design flaws that cannot be corrected. For example, the time participants spend taking part in the intervention, completing assigned intervention homework, and accumulating any other unreimbursed expenses cannot be reliably documented retrospectively. A benefit of prospective cost collection includes increased accuracy of estimates, an ability to distinguish between programmatic versus research costs (the latter of which should not be

included in a CA; see Foster & Jones, 2006, for more clarification on this important topic), and the ability to refine cost collection methods as the messiness of real-world implementation takes place.

Because of delays in establishing the cost-collection protocols, in the FC Program, collection of pre-implementation costs occurred retrospectively for the period between October 2003 and September 2004. Year 1 implementation costs were collected prospectively from October 2004 through September 2005, and Year 3 implementation costs were collected prospectively from October 2006 through September 2007.

IV. Adjust and Analyze Costs

Before analysis of programmatic costs can occur, there are several areas of cost adjustments that might need to be addressed, including: (1) Defining unit cost estimates to value resources for which a monetary value is not readily apparent (e.g., donated space); (2) adjusting unit cost estimates to the same base-year dollars; and (3) recalculating the value of fixed consumables (or capital equipment) that might outlast the time period of the intervention.

In the CA of the FC Program replication, sites were asked to estimate the square footage required to implement the intervention and to value that square footage based on commercial retail space in the area. Personnel expenditures were adjusted to include not only wages, but the value of employee fringe benefits as well. In cases where unit costs were only available from years other than the year of implementation, sites were asked to adjust those unit costs to the year of implementation. Adjusting unit cost estimates in this way can be easily accomplished using consumer price inflators (e.g., U.S. Census Bureau, 2003).

Finally, to account for those resources purchased for the delivery of the intervention that have value beyond a year, such as a computer, one would need to use annual (or amortized) costs based on assumptions about the resource's length of usefulness and scrap value at the end of its useful life, particularly if the analysis relies on costs aggregated on an annual basis. This adjustment must be made because the full value of the resources may go beyond the time period of the intervention.

For the CA of the FC Program replication, non-consumable fixed costs were annualized using a straight-line depreciation with no scrap value at the end. Nonconsumables purchased in the Pre-Implementation Year were assumed to last the entire length of the project (5 years); nonconsumables purchased in Year 1 of implementation were assumed to last the remaining length of the project (4 years). Nonconsumables purchased in Year 3 of implementation were not annualized.

Results

Table 2 and Table 3 present the annual programmatic costs of providing the FC Program in eight geographically dispersed sites in the United States, in Year 1 of implementation (Table 2) and in Year 3 of implementation (Table 3). All costs are presented in the year in which they were incurred and are annualized, if applicable, using the methods described previously. Information is provided on the four major types of cost categories, aggregated by service activities that are directly client-related (Category A in Table 1) compared to all other personnel costs.

Implementation costs in Year 1 of the FC Program replication ranged from $98,126 to $402,028 across all sites (Table 2). Personnel costs ranged from 62% to 92% of total costs (average = 76%). Implementation costs in Year 3 of the FC replication (Table 3) ranged from $121,980 to $447,483 across all sites. Personnel costs ranged from 60% to 83% of total costs (average = 74%).

Table 2. Year 1 FC Implementation Costs ($), by Cost Category for *n* = 8 Replication Sites

Cost Category	Site							
	A	**B**	**C**	**D**	**E**	**F**	**G**	**H**
Total personnel	**78304**	337447	359336	200521	174794	194129	134773	68644
Table 1 – A	7009	87015	65470	15509	21852	38192	21795	19935
Table 1 – B,C,D	52574	178131	222356	129924	121876	129260	89581	37426
Other*	6720	15259	7569	9240	6000	12296	18000	0
Space & utilities	19275	16899	6870	9377	27424	2997	10445	5051
Travel	1650	12944	5703	11967	8974	5312	2998	3714
Total supplies	13344	19479	12297	14250	27264	13755	51686	20717
Consumables	5217	17939	11468	8249	28890	12034	47919	20489
Non-consumables**	8127	1540	829	6001	4454	1721	3768	1038
TOTAL	$119,293	$402,028	$391,775	$245,354	$244,456	$228,489	$217,902	$98,126

* Other includes contractual services for delivery of FC intervention or for evaluation, but not research, purposes.
** Non-consumables purchased in Year 1 were annualized based on straight-line depreciation, assuming no scrap value at the end and a length of life of 4 years.

Table 4 presents the total, average, median, and range of programmatic costs of providing the FC Program, by phase of implementation, including the Pre-Implementation Phase. Pre-implementation costs ranged from $107,799 to $224,181 across all sites; the average was $151,672, and the median was $135,550. In comparison, the average programmatic cost for the FC Program in Year 1 of implementation was $243,428, with a median of $236,472. The average programmatic cost for the FC Program in Year 3 of implementation, $233,746, was slightly lower than the average Year 1 cost, as was the median cost in Year 3, $207,948. This suggests that the programs were, on average, operating more efficiently with time. However, the range of costs is higher in Year 3 compared to Year 1, likely stemming from variability in a few specific sites.

For example, three sites had significant changes in total aggregate costs from Year 1 implementation to Year 3 implementation: Sites C, D, and H, and this was largely driven by changes in personnel expenditures. For example, Site C's Year 1 implementation costs were $392,000, compared to $156,000 in Year 3. This large difference is due to a drop in personnel expenditures from $359,000 in Year 1 to $129,000 in Year 3. Site D's Year 1 implementation costs were $245,000, compared to $122,000 in Year 3. This large difference is also due to a drop in personnel expenditures from $200,000 in Year 1 to $82,000 in Year 3. In contrast, Site H's total aggregate costs nearly doubled from Year 1 ($98,000) to Year 3 ($182,000). This change is due to an increase in personnel expenditures from $68,000 in Year 1 to $134,000 in Year 3.

Table 3. Year 3 FC Implementation Costs, by Cost Category for *n* = 8 Replication Sites

Cost Category	Site							
	A	B	C	D	E	F	G	H
Total personnel	**130461**	350657	128870	82431	191430	231776	140200	134706
Table 1 – A	17702	96600	6874	17395	24794	11527	47279	19225
Table 1 – B,C,D	81132	195637	94598	65036	126576	182230	62983	82068
Other*	0	0	0	0	1438	45265	45884	0
Space & utilities	20494	12890	13904	11684	18146	2241	9712	15255
Travel	6122	12073	3105	8845	14327	10431	9252	4574
Total supplies	20321	71863	9834	19019	22327	14119	28459	27854
Consumables	10597	70323	9005	11723	17802	12398	24258	26815
Non-consumables**	9724	1540	829	7295	4525	1721	4202	1038
TOTAL	$177,398	$447,483	$155,712	$121,980	$247,667	$303,832	$233,507	$182,389

* Other includes contractual services for delivery of FC intervention or for evaluation, but not research, purposes.
** Non-consumables purchase in Year 3 were not annualized.

Table 4. Aggregate FC Implementation Costs for *n* = 8 Replication Sites

Implementation Phase	Total Costs	Average Costs	Median Costs	Range
Pre	$1,213,372	$151,672	$135,550	$107,799 - $224,181
Year 1	$1,947,423	$243,428	$236,472	$98,126 - $402,028
Year 3	$1,869,968	$233,746	$207,948	$121,980 - $447,483

Discussion

This paper estimated and presented the economic costs of replicating the FC Program across eight sites in the United States. On average, it is expected that implementing the program in other sites will cost $150,000 in the development and pre-implementation phase of the intervention, and approximately $235,000 for every year of the intervention thereafter. Personnel costs represent the largest burden of total costs, as one would expect in a behavioral intervention program.

The process for analyzing programmatic costs across multiple sites and the variability in results led to some important lessons learned and recommendations for future evaluators undertaking the same type of research. First, analysis across sites is strengthened if sites are implementing the same program model, hypothetically requiring the same program inputs. Second, variability in costs is reduced if sites use similar operational definitions of costs and comparable data collection tools or systems to aggregate costs. In this study, we developed standardized data collection tools to be used by all sites that included uniform definitions of activity categories associated with the pre-implementation and implementation phases of the intervention. This process was strengthened by reaching group consensus on activity definitions and performing quality control checks to monitor the use of these definitions throughout the data collection process. Third, programmatic cost analysis is improved if data collection occurs prospectively with the implementation of the intervention, as opposed to retrospectively after the intervention is already in the field. Taking this approach in our study was a marked improvement over how others have conducted programmatic cost analyses in the past (Foster & Jones, 2006; Aos, Phipps, Barnoski, & Lieb, 2001; Aos, Lieb, Mayfield, Miller, & Pennucci, 2004).

Finally, having multiple cost data collectors over time within and between sites may lead to inconsistencies in reporting. One way to deal with this issue in the future is to have program costs collected prospectively by one full-time cost coordinator, even if multiple sites are involved. This would ensure the collection of comparable costs across sites by using a unique cost collection template and applying standardized assumptions (e.g., which fringe rate to use on personnel costs). Until programmatic cost collection guidelines are developed for the field, this approach may be the only option.

Despite the approaches one may take to ensure consistent collection of program costs across multiple sites, costs may be associated with a number of factors not accounted for in the basic assessment of personnel and non-personnel expenditures. These factors include variables at the program, provider, participant, and community levels.

Program-level variables can include such components as length of service delivery (e.g., number of months), intensity of service delivery (e.g., number of home visits), and implementation (e.g., ongoing versus a start-up program). For example, implementation of the FC Program for some sites was an incremental addition to an already existing family intervention program targeting the same population and with an established infrastructure. In such cases, sites may have had pre-existing relationships with referral partners and other community-based service providers, and the ability to capitalize on existing data collection systems that would have streamlined the transition to an additional service provision.

In comparison, other FC replication sites experienced increased expenditures because they had to develop the intervention infrastructure. For example, for some programs the location of

service delivery was different (i.e., home- and community-based), requiring the purchase of a project automobile. For others, the target population was new, requiring the need to establish relationships with new partners in the community, establish alternative recruitment strategies, and provide additional training regarding the target population.

Provider-level variables that may impact the variation in costs include the delivery of direct service and administrative support by differently trained and compensated personnel. In this study, personnel delivering the intervention ranged from bachelor's to master's level. Participant variables can include differences in age, race/ethnicity, or risk status that may impact service utilization and costs. For example, the amount of resources required to deliver a behavioral intervention with a high-risk family could be considerably greater than resources required for a non-high-risk family. Community-level variables correspond to such factors as rural versus urban locations, cost-of-living, or workforce demand and supply issues that may impact program costs. For example, one FC site was in a rural, sparsely populated location, which was less expensive in terms of space requirements needed for the intervention, but which required considerably more resources for travel compared to the urban FC sites.

To account for the program-, provider-, participant-, and community-level variables that also may impact program costs, cross-site evaluations should control for these factors in estimating a program's average costs. To do this correctly, one would need a very large sample size of sites to account for these multiple layers of association and accurately determine which (if any) of the variables significantly impact costs (and in which direction). Without this large sample, the most an evaluator can do is descriptively discuss the differences across sites as potential explanations for the programmatic

cost variation, particularly in studies where care has been taken to collect standardized costs across sites and over time. We recommend that future cost analyses incorporate enough sites to overcome these challenges.

The next step in our research is to estimate the cost per family served in the intervention, and eventually determine if the intervention is cost-effective in reducing risk factors or enhancing protective factors associated with child maltreatment.

References

Aos, S., Lieb, R., Mayfield, J., Miller, M., & Pennucci, A. (2004). *Benefits and costs of prevention and early intervention programs for youth.* Olympia, WA: Washington State Institute for Public Policy.

Aos, S., Phipps, P., Barnoski, R., & Lieb, R. (2001). *The comparative costs and benefits of programs to reduce crime.* Seattle, WA: Washington State Institute for Public Policy.

Armstrong, K. A. (1983). Economic analysis of a child abuse and neglect treatment program. *Child Welfare, 62*, 3–13.

Brooten, D., Kumar, S., Brown, L. P., Butts, P., Finkler, S. A., Bakewell-Sachs, S., Gibbons, A., & Delivoria-Papadopoulos, M. (1986). A randomized clinical trial of early hospital discharge and home follow-up of very-low-birth-weight infants. *The New England Journal of Medicine, 315*, 934–939.

Corso, P. S., & Lutzker, J. R. (2006). The need for economic analysis in research on child maltreatment. *Child Abuse & Neglect, 30*, 727–738.

Courtney, M. E. (1999). National call to action: Working toward the elimination of child maltreatment. The economics. *Child Abuse & Neglect, 23*, 975-986.

DePanfilis, D., Dubowitz, H., & Kunz, J. (2008). Assessing the cost-effectiveness of Family Connections. *Child Abuse & Neglect, 32*, 335-351.

Dubowitz, H. (1990). Costs and effectiveness of interventions in child maltreatment. *Child Abuse & Neglect, 14*, 177–186.

Foster, E. M., & Jones, D. (2006). Can a costly intervention be cost-effective? An analysis of violence prevention. *Archives of General Psychiatry, 63*, 1284-1291.

French, M. T. (2000). Economic evaluation of alcohol treatment services. *Evaluation and Program Planning, 23*, 27-39.

Haddix, A. C., Teutsch, S. M., & Corso, P. S. (Eds.). (2003). *Prevention effectiveness: A guide to decision analysis and economic evaluation.* New York, NY: Oxford University Press.

Karoly, L. A., Greenwood, P. N., Everingham, S. S., Hoube, J., Kilburn, M. R., Rydell, C. P., et al. (1998). *Investing in our children: What we know and don't know about the costs and benefits of early childhood interventions* (pp. 73–102). Santa Monica, CA: The Rand Corporation.

Olds, D. L., Henderson, C. R., Jr., Phelps, C., Kitzman, H., & Hanks, C. (1993). Effects of prenatal and infancy nurse home visitation on government spending. *Medical Care, 31*, 155–174.

U.S. Census Bureau. (2003). Table 713. Consumer price indexes (COI-U) by major groups: 1980 to 2002. *Statistical Abstract of the United States: 2003.* Washington, DC: Author.

Yates, B. T. (2009). Cost-inclusive evaluation: A banquet of approaches for including costs, benefits, and cost-effectiveness and cost-benefit analyses in your next evaluation. *Evaluation and Program Planning, 32*, 52-54.

Further information about Family Connections can be located at the following websites:

Program information from the Baltimore site: http://www.family.umaryland.edu/ryc_best_practice_services/family_connections.htm

Information about the Children's Bureau funded replications:
http://www.family.umaryland.edu/ryc_best_practice_services/family_connections_replication.htm

Research from the Baltimore projects: Helping Families Prevent Neglect:
http://www.family.umaryland.edu/ryc_research_and_evaluation/community_school_based_research_files/hfpn10-07.htm

Family Connections with Intergenerational Families: http://www.family.umaryland.edu/ryc_research_and_evaluation/community_school_based_research_files/fcif10-07.htm

Information on the Child Welfare Information Gateway:
http://www.childwelfare.gov/preventing/programs/whatworks/report/emergingb.cfm

Description at the California Evidence-Based Clearinghouse:
http://www.cachildwelfareclearinghouse.org/program/84/detailed#relevant-research

Programs interested in replicating Family Connections should review information available at the web sites above and contact Diane DePanfilis at ddepanfilis@ssw.umaryland.edu

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