Applying Case Characteristics to Expand Outcome Measures and Strengthen Effectiveness in a State Family Preservation Services Program

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APPLYING CASE CHARACTERISTICS TO EXPAND OUTCOME MEASURES AND STRENGTHEN EFFECTIVENESS IN A STATE FAMILY PRESERVATION SERVICES PROGRAM

by

Randy Jay Baxter

A Dissertation
Submitted to the
Faculty of The Graduate College
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Advisor: Udaya Wagle, Ph.D.

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This research evaluates the effectiveness of Family Preservation Services (FPS) in a Midwestern U.S. state. The research setting is an Intensive Family Services Program (IFPS) component connected with a state agency, with data gathered from selected contractor sites. This research is guided by the dual techniques of the Five-Tier Approach (FTA) model and the logistic regression data analysis process. The hypotheses posit that specific intensive clinical, safety, skill-building, and concrete services provided to families at a high risk level increase the likelihood of positive proximal case outcomes for up to 1 year after case closure, after controlling for family characteristics. Following similar studies, the program success has been operationalized using a singular measure of avoidance of out-of-home placement regarding service goals/outcomes. Findings indicate the value of service intensity in promoting safety and satisfaction and the value of specific clinical, skill-building, and concrete services in increasing the likelihood of success. Programmatically, these findings focusing on proximal outcomes provide new knowledge that can be applied to expand FPS outcome measures beyond distal outcomes. Components and characteristics that do not help increase success as much but remain important include risk assessment/referral process,
family characteristics, and aftercare services infrastructures. These findings suggest that public contracting or private agency management and program staff act collaboratively to improve the program in areas with lower likelihood of success, among other things, by focusing on abuse case type for referrals, conducting ongoing qualitative research on family characteristics for better matching of services, and increasing utilization of the aftercare services infrastructure including specialty services as a higher priority. The usefulness of applying these specific proximal outcomes may include benefits for families of better preservation/effectiveness through gains in safety, skills, social supports, and community linkages as well as through greater administrative effectiveness to enhance program integrity.
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Randy Jay Baxter
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CHAPTER I

INTRODUCTION

The United States places a high value on protecting children, both from abusive parents/caretakers and from systems that oppress and exploit children (e.g., child labor, pornography). Our nation holds that children have a right to be cared for, by the community if not by parents. Our country gives significant attention and resources to the Child Protective Services (CPS) system. Movements dedicated to the protection of children have shaped CPS historically.

Current legislation defines CPS as a program functioning with state or local public child welfare agencies. “CPS workers must investigate complaints, draw conclusions about allegations, determine safety issues, and decide whether to involve law enforcement, courts, other service providers, or support services” (Berg & Kelly, 2000, p. 28).

Since the 1970s, the role of CPS has narrowed more toward investigation of child abuse and neglect, but the public continues to expect a full range of services from them to ensure protection and safety. Unfortunately, the public may quickly blame CPS when a child dies or there is a high profile case of abuse. CPS staffs, under these high expectations and pressures, face a formidable challenge in their work, such as ever increasing referrals to investigate and to locate services that ensure both ongoing safety and improved family functioning. Service provision is made more difficult when
contrasted with the role of investigator, as the family may be reluctant to accept help and support immediately from a CPS worker.

A more effective contemporary CPS system must “not only work toward ensuring the safety of the high-risk children and families who become part of the formal system, but also support parents not involved in the formal CPS system to keep their own children safe from harms in their homes and communities . . . a wide range of partners is needed to assist in this challenge” (Berg & Kelly, 2000, p. 29). The Midwestern state selected for this study created a Family Preservation Services (FPS) program in the 1980s which sought to work closely with CPS to create this type of partnership.

History of the IFPS Program

This program was initiated in the 1980s by the state agency responsible for Child Welfare Services (CWS) as several pilot projects in selected county geographical areas. The program eventually became available statewide, covering every county by the early 1990s. The state agency implemented the program mostly due to a growing public concern among state and private agency CWS providers and the community regarding the high costs of foster care placements. Reviewing service impacts for families resulting from a significant statewide increase in child abuse, neglect, and delinquency cases, the state agency identified a tide in escalating numbers of out of home placements of children and youth. This new FPS program was viewed as an innovative alternative to traditional children’s service treatment options such as foster care and residential care.

This new FPS program established administrative procedures through a Request for Quote (RFQ) for awarding competitively bid contracts to link public and private
service providers. Contracts were granted to agencies serving defined geographical areas.
For implementation of these family preservation services, a partnership was formed
linking the state CW agency with private non-profit child welfare agencies. The role
played by designated staff of the state agency was to monitor these private contractors for
contract compliance and model integrity, while providing technical assistance. Specific
targeting of Family Preservation within the program’s service model highlighted a
significant philosophical and programming shift of the manner child welfare services
were provided in the past. Both politicians and public/private CWS providers embraced
this model. The RFQ process model implementing the 3-year cycle of contracts statewide,
continues to this date, the most recent 3-year bidding cycle occurring in 2008.

The program model selected by the state CWS agency and included in the RFQ
process was based on the Homebuilders program model which was founded in 1974 by
David Haapala and Jill Kinney at Catholic Community Services in Tacoma, Washington.
Homebuilders spread as a nationwide program model through training provided through
their Behavioral Sciences Institute. The major components of this model, such as
therapist/worker availability 24 hours a day, 7 days a week and low caseload allowing for
more intense contacts and availability; intervention in the client’s environment (i.e., their
homes); flexible scheduling for sessions; a variety of clinical and concrete services that fit
the family’s life style, skill level, and values; and each intervention to last only from 4-6
weeks, focus a very intense and flexible nature of services within Homebuilders.

Berry (1997) captures the crux of this focus, by stating, “Homebuilders are often
considered a model program of intensive family preservation services. Its main
components are family therapists who are on call twenty-four hours a day, a flexible limit of about 6 weeks of service to families, and in-home provision of service” (p. 75).

Basic Theoretical Discourse on FPS Effectiveness

There are a limited number of studies focusing on specific program components and their role in determining effectiveness. These components when identified, including specific program, family, or provider characteristics, may help to enhance effectiveness outcomes. Details from the following studies explain how general characteristics of Family Preservation Services (FPS) may be used to more succinctly define more specific characteristics.

Two studies about a specific FPS state program, the provide examples of such details. Both studies find that program appears to maintain its model integrity. The study by University Associates (1993) found a consistent and cohesive family preservation program accurately replicated across multiple sites. The study by Blythe and Jayaratne (1999) looks at one geographic area site, with a large county population that has a majority of child welfare cases, staff, and agencies. Additional results from both studies highlight success for children at risk of abuse or neglect still residing at the parental home at initial case closure and procedurally scheduled 3-6-12 month follow-ups. If the child at these milestones was at home, the case was noted a successful outcome (i.e., placement prevention).

University Associates (1993) identifies outcomes for other at-risk children/families groups such as delinquency cases and family reunification. The category of abuse/neglect (A/N) forms the bulk of FPS referrals. Results for the referrals of these
new groups demonstrate a lesser success rate of placement prevention for A/N referrals. These evaluators note how both referring workers and families responded to length of service (set at 4-6 weeks), concluding that “It is critical to implement internal evaluation procedures which document any variation in outcomes for different groups of children or types of cases” (University Associates, 1993, p. 20). Use of these internal procedures suggests the necessity to measure use of community services needed and reoccurrence of the cause of the referral (i.e., abuse and neglect or delinquency, and removals from the home). These conclusions indicate an obligation to conduct expanded FPS evaluation research enlarging the historical sole success measure of placement prevention.

Berry, Bussey, and Cash (2001), conducting a comprehensive review of a significant number of FPS studies, identify a series of characteristics to operationally develop data elements/variables to expand the study of measuring effectiveness outcomes. These authors note the result of these studies demonstrate deficits in the research base concerning client characteristics such as ethnicity or poverty issues and their effect on outcomes. Few of the reviewed studies report findings of the chronic nature of maltreatment or which families are treated for child abuse and/or neglect. Berry et al. illustrate the importance of expanding research of these characteristics to fill a research void by stating, “Well-delineated, direct and logical connection between service characteristics and program outcomes becomes particularly salient and critical to the issues of program integrity and replication” (p. 302). These authors name specific categories of characteristics linked with outcomes, such as demographic; referral information; CPS case assessment and eligibility; services accessibility and availability;
progress results in the program identified by referral staff, FPS staff, and families receiving services; and follow-up contacts with past families.

Problem Statement

A number of other research studies acknowledge and confirm the importance of the specific characteristics just mentioned being linked to outcomes. This linkage must be added to the current and future action agenda for FPS evaluation (see, e.g., Berry, 2005; Berry, Bussey, & Cash, 2001; Cash, 1998; Fraser, Pecora, & Haapala, 1991; Jacobs & Kapuscik, 2000; Nelson, 2001; Petr, 2004; Raschick & Critchley, 1998; Ryan, 2002; Schuerman, Rzepnicki, & Littell 1994; Tracy, 2001).

Figure 1.1 portrays the array and continuum of Family Preservation Services where the FPS model used in this research is embedded. It offers a detailed picture of the continuum of services that comprise the public child welfare system. The complexity of this system hint at problems of effective implementation and use of services by both provider and recipient, and how to evaluate the effectiveness of services, especially for FPS and its place on this continuum.

The problems regarding effective evaluation of FPS are detailed in Jacobs and Kapuscik (2000). These authors identify three historical waves of FPS program evaluation studies, including those directly looking at the IFPS model. For our research, this information, best described in their third wave, represents the need for expanded research looking for specific characteristics to expand outcome measures. In their first wave studies, evaluation findings showed positive effects, but methodological grounds such as weak research designs and problematic choice of outcome measures opened the
way for criticism. In their second wave studies, evaluation findings suggested family preservation does not demonstrate a broad, significant effect on children, families, or on the operation of the child protective services system. This wave also pointed out glaring shortcomings of the first wave, especially two methodological criticisms: (1) the lack of treatment integrity, and (2) undocumented control group activity.

Figure 1.1. Array and Continuum of Family Preservation Services

Regarding the third wave studies, using classical experimental designs helped to remove some of the methodological concerns of the first two waves. Jacobs and Kapuscik noted the most effective studies illustrating the third wave upgrade were: (1) the Michigan Families First Effectiveness Study (Blythe & Jayatrane, 1999), and (2) the national 5-year longitudinal study of FPS programs sponsored by the U.S. Department of


(Adapted from Pecora, Reed-Ashcraft, & Kirk, 2001)
Health and Human Services 1996-2001. The U.S. DHHS (2001) interim 5-year report found that functions, target groups, and characteristics of FPS program services are closely intertwined. The report recommends that services be rethought so FPS programs offer a range of service lengths and services intensities. This range suggests a continuum meeting the specific service needs of child welfare clients. Whittaker and Tracy (1990) note a continuing question concerning FPS and the continuum asking “should intensive families services be seen as a discrete service in the overall continuum or as one manifestation of a more general approach to family helping which has application far beyond prevention of imminent out of home placement” (p. 9).

After reviewing all three waves, Jacobs and Kapuscik (2000) summarize the problematic condition of current FPS effectiveness research. The findings on the review are mixed, denoting that services are likely to work for a number of families, but with little guidance on the standards to identify these families and situations. As a remedy, these authors recommend next steps for researchers. These steps call for a changed focus to implement different techniques improving validity and reliability, illustrated by their statement of “historically evaluations, except for a few notable exceptions, pay too little attention to providing a detailed picture of what is actually going on in family preservation services, including a number of program, client, and provider characteristics to provide these details” (2000, pp. 31-32). FPS should be considered a discrete service and research with a goal of providing a more detailed picture can address the issues within this problematic condition.
Purpose of Research

Our research context is a state IFPS program consisting of a continuum of private agency service providers linked by 3-year contracts with a state agency responsible for family preservation child welfare services. This program uses a services model based on the Homebuilders program.

The goal of this study is to paint a detailed picture of specific FPS program, client, and provider characteristics (i.e., proximal outcomes). Currently most effective measures within FPS are based on placement prevention (i.e., distal outcomes). Applying more proximal outcomes to evaluation of effectiveness may lead to expansion and enhancement of defining service outcome effectiveness within FPS and perhaps along the child welfare services continuum.

The major research questions guiding and focusing this study toward this goal seek to answer level of risk in abuse and neglect of children, duration/intensity of program participation and types of services for each family intervention, and how family and program characteristics affect the distal and proximal outcomes of FPS/IFPS. More specifically, these questions are:

1. How does the level of risk for abuse and neglect of children affect the distal and proximal outcomes for each family?

2. How does duration/intensity of program participation and types of services for each family intervention affect services duration/intensity and services availability/accessibility and the distal and proximal outcomes for each family?
3. How does the identification of family and program characteristics (i.e., services) by both worker and families affect the distal and proximal outcome results of FPS/IFPS? How do these characteristics relate to the family designation of specific services satisfaction through gains in safety, supports, skills, and community linkages?

These questions should address the study of all the major factors necessary to find those proximal outcomes important to expansion and enhancement of effectiveness measures.

Limitations

This study captures aggregate data from just a few contract sites in a program that is implemented across all the counties of an entire state. It is able to use data from actual interventions toward the goal of identifying characteristics that we could use to better define proximal outcomes, or those that impact family functioning.

The study is not designed to prove that FPS is superior or inferior to other child welfare programs but an attempt to find those unique characteristics/outcomes that might be useful to expand effectiveness measures. The study is also not designed to evaluate individually the level of performance of the agencies or this statewide program in general. We do assume that as the agency sites selected are contractually bound to use a specific model, there is public/private promotion of the ideal of program integrity on a statewide basis governing this study.

Considering these factors, some limitations must be assumed within our study. One is that within program integrity, there are unique program features for each site, such as individual differences in staff, client interactions, activities, or community dynamics.
For community dynamics, there are also historical events surrounding each site, or that outcomes for one historical time may be different at another time. This uniqueness does not destroy program integrity, but assists to more uniquely and realistically determine effectiveness enhancement.

The use of data from actual interventions, or the natural experiences of both services provider and recipient minimizes the impact of potential design contamination, or when the subjects may behave in a certain expected manner being in the study. Intervention documentation from both families and contract agency workers suggest many services offered that provide social support and skill-building and not just solely compliance. These limitations will be further discussed in the Chapter VI.

Significance of this Study

This study seeks to promote understanding across the child welfare continuum, with the focus on Family Preservation Services and trying to improve their effectiveness. Improving the services throughout this continuum ultimately benefits services recipients the most. The hope is that the specific needs of each family may be more effectively matched to and throughout the services provided, or, in other words, be more family-centered. This hope is echoed best by Hutchinson (2002), calling for collective responsibility to re-imagine and reconstruct the U.S orphaned child welfare system, to “replace the inadequacies of a child welfare discourse with a family-centered discourse” (p. 150). This discourse can be implemented as we foresee other significant impacts/benefits from this study are possible other than just for the families themselves are possible.
One impact/benefit is the idea of closing the research gap and expanding the FPS research agenda where past studies suggest distal outcomes (i.e., placement prevention) as the current primary effectiveness measures. If we can identify and use specific characteristics such as services as proximal outcomes, they can be appended to distal outcomes to enhance our measures. Applying expanded measures, other significant impacts within FPS and along the continuum may happen.

One of these impacts is a public/private collaborative promotion of program model integrity and administrative efficacy, through intra-agency, interagency, and community action. Although this study does not look directly at costs, better integrity and efficacy may impact fiscal issues. Public sector funding such as the federal government, state legislature or public agencies may hinge on outcome result. Private funding such as through child welfare foundations makes outcome effectiveness a prime consideration in awarding funding. These program impacts prop up the primary significance of this study, an adequate family-centered service provision discourse.
CHAPTER II

LITERATURE REVIEW

Family Preservation Services

Berry (1997) defines Family Preservation Services (FPS), as both a philosophy of services and practice method (see also Roberts, 2002; Shireman, 2003). Morton (1993) notes that FPS “is now a professional service with a system of values, theories, and interventions” (p. 13). I see FPS as a system that has a supportive philosophy of values and theories resulting in practice methods that guide interventions. The general philosophy originates from the premise that children are better off if they remain in their own families as long as they are safe. The values I feel are most prevalent is that of client strengths, used to promote bonding, skill building, competency building, and better use of formal and informal resources. The practice methods selected that guide interventions use theories that support safety but especially the philosophy and values I have outlined.

Barth (1990) sees five primary goals identified for FPS services delivery. The goals outline in more detail the theoretical philosophy, values and practice methods guiding interventions. These goals for each family being served include: (1) allowing children to stay safely in their own homes, (2) maintaining and strengthening their bonds with each other, (3) stabilizing any crises that may require placement, (4) increase their coping skills and competencies, and (5) facilitating their use of formal and informal helping resources. By strengthening bonds, removing crises, being more skilled and
competent, and using both formal and informal resources to achieve these other goals, children should be able to stay with their own families safely. These five goals exist within the FPS program, the focus of this study. To better understand Family Preservation Services, we must understand the typologies of family-centered programs themselves. The three typologies that denote these program types are described in Figure 2.1.

1. Family resource, support and education service consists of community based services assist and support adults in their role as parents, available to all families with children with no imposed agency criteria for participation.

2. Family-centered services (i.e., Family-based services) encompass a range of activities such as case management, counseling/therapy, education, skill building, advocacy, and provision of concrete services toward problems that threaten their stability. Can be called FPS- i.e., such as “Healthy Start”.

3. Intensive family centered-crisis services are services designed for families “in crisis” at the time when removal of a child is perceived as imminent, or the return of a child from out-of-home care is being considered. Type # 3 shares the same philosophical considerations as family centered services (Type #2). The services are delivered with more intensity (including shorter time frames and smaller caseloads. Type # 3 is often referred to as “intensive family preservation services” (IFPS) programs.

Adapted from Pecora, Fraser, Nelson, McCroskey, & Meezan (1995, p. xix)

Figure 2.1. Three Typologies of Family-Centered Programs

Among the three typologies, there are common characteristics, best summarized in Corcoran (2000), such as children remaining in their own home with attached caretakers, and services consist of working with the whole family and linked with comprehensive community services to meet concrete needs. I see the factors outlined in Typology #3 used to operationally define the FPS program in this study. We could additionally classify it as an Intensive Family Preservation Services (IFPS) program. The
families served are considered in crisis, with the perceived imminent removal or return under consideration. The services are delivered with more intensity in shorter time frames.

All three typologies of FPS are based on several theories. One theory is that of Crisis Intervention, one of its prime tenets being that intervening while families are in the midst of a crisis is the best time to do so. Family Systems is another theory, its prime tenet being that working with the whole family and not just individuals is the most effective intervention. Ecological theory promotes that starting with and trying to improve the family’s environment and current social conditions (usually their home) is of prime importance.

Another theory is Social Learning where finding reinforcement and rewards to implementing useful behavior now and in the future needs to be learned. Communications theory, linked with Social Learning, sees that improving verbal and non-verbal communication among family and community members can affect their family/societal functioning (adapted from Barth, 1990; Corcoran, 2000; Fraser et al., 1991).

Figure 2.2 portrays the ecological framework, an illustration of a model of the manner in which families at risk can be understood and helped and the potential outcomes/effectiveness that may result.

This framework pictures a number of factors noted above for each of the theories and in turn components of each of the three typologies we have discussed. The framework column, Ecological model of helping families, best describes the primary
service components (characteristics) that affect the outcomes of services provision, that of teaching life skills, connecting with support systems, and procuring basic resources.

Cash and Berry (2003) provide details on how these components occur in effective service programs using the ecological paradigm. These include: skill acquisition, provision of social support, and assisting families in procuring basic resources or necessities. “These components comprise a comprehensive and systematic approach in services in building family strengths in order to reduce the risk of child abuse and child removal” (p. 68). The outcomes resulting from this provision may be identified as proximal outcomes, or that of family integrity and functioning and child well-being, all factors that appear to be paramount considerations of family preservation services.

Researchers have conducted studies on programs under all three typologies. The following studies cut across these typologies to offer the broadest theoretical foundation regarding research findings on the effectiveness of all family-centered programs. First
defining what FPS/IFPS advocates feel, we will first detail the Homebuilders model (the program model within this study). Studies where this model is used will be detailed. We will focus on what the critics note about their concerns regarding FPS/IFPS effectiveness measures/results. We will then discuss the meaning of both distal and proximal outcomes and their importance to FPS/IFPS research, followed by detailing the nature of the characteristics that assist us to define proximal outcome measures. We will conclude with details on the conceptual framework that arises from all this literature. This framework presents the model that guides and directs this research study.

**Homebuilders Model**

As we detailed previously, the Homebuilders family preservation model/program was founded in 1974 in Tacoma, Washington by David Haapala and Jill Kinney of Catholic Community Services, and became a model used nationwide through training. Homebuilders have a number of values guiding the model, illustrated in Figure 2.3.

| 1. | In most cases, it is best for children to grow up with their natural families. |
| 2. | One cannot easily determine what types of families are “hopeless,” and which will benefit from intervention. |
| 3. | It is our job to instill hope. |
| 4. | Clients are our colleagues. |
| 5. | People are doing the best that can do. |
| 6. | We can do harm as well as good; we must be careful. |

Adapted from Berry (2005), p. 321

*Figure 2.3. Values of the Homebuilders Family Preservation Model*
The values within this model encourage collegial client relationships starting with the best where people are at, the services provider instilling hope and not harm, not viewing any families or children as “hopeless” and children best growing up within their natural families.

I would argue that these values allow for the provisions of services that focus on strengths and not weaknesses. The weaknesses are not ignored but the goal is to turn them into strengths.

To implement these values, there are essential components of services delivery that have been identified among several researchers (Berry, 1997; Cameron & Vanderwoerd, 1997; Fraser et al., 1991; Kinney, Haapala, & Booth, 1991; Kinney, Haapala, Booth, & Leavitt, 1990; Nelson, 2001).

Figure 2.4 illustrates these essential components of services delivery within Homebuilders.

1. Therapist/worker availability 24 hours a day, 7 days a week.
2. Intervention in the client’s environment (i.e., their homes).
3. Flexible scheduling for sessions with a wide range of services that fit the family’s lifestyle, skill level, and values, including use of a variety of clinical and concrete services.
4. Therapist/worker is expected to have a low caseload, which allows for more intense contacts and availability.
5. Each intervention is anticipated to last only from 4-6 weeks due to this intensity.

Figure 2.4. Homebuilder Services Components
The training module that Homebuilders uses to implement the model emphasizes these values and components. Within this training, this structure is linked with a focus on crisis intervention theory and programming. Underlying the foundations of the Homebuilders model are assumptions noting that in periods of high stress or crisis, people will have a breakdown in regular coping mechanisms, leaving them more open to change within crisis toward either a positive or negative direction (Corcoran, 2000, Fraser et al., 1991). Fraser et al. further sharpens this focus, noting “the family within its social-physical environment is viewed as the “client” or “focus of service” (p. 14).

The research context for this study consists of private agency child welfare service providers linked by contracts with a state agency, using a services model under contract requirements that mirrors the Homebuilders program, and these values and components. We will now present research studies related to the Homebuilders model.

Studies Relating to the Homebuilders Model

To gain better insight into the values and components we have identified and how they relate to program outcomes, we will look at several studies where Homebuilders was the foundational model for looking at FPS program outcomes.

One study by Fraser, Pecora and Haapala (1991) used an experimental and comparison group. They measured family change and placement rate outcomes at 12-month follow-up. Their findings showed significant improvement in most risk factors for families, and improvement in family relations and decrease in problems, these factors being types of proximal outcomes.
Schwartz, AuClaire, and Harris (1991) used an experimental group-comparison group methodology with intensive FPS provided to adolescents. They found that the Homebuilders model supported the outcomes of preventing placements and keeping families together. Due to a significant number of placements for the experimental group, these authors detail limitations to applying these findings. Despite these limitations, the study appears to raise the necessity for further research to test how FPS programs determine what is effective and in what types of cases.

Feldman (1991) studied the 1987 implementation of a Family Preservation Services program modeled after Homebuilders through the New Jersey state public child welfare agency (DYFS) in 4 of its 21 counties. The experimental group was randomly assigned to IFPS (96 families) or standard services (87 families). The study focus was how their staff employed the model, trying to determine if IFPS families were more successful than families in traditional programs. The measure of success was achieved when maintaining children in their home, seeing if these gains were maintained over time, whether these families had higher level functioning at case closure, and if differential outcomes were related to client characteristics or other variables. Findings were that: (1) staff followed the model as shown by the median number of weeks of service by each provider was 6, within a range of one 9 weeks; (2) IFPS families had fewer children entering placement and if entered did so at a slower rate through 1-year post termination, with no statistically significant differences in types or restrictiveness of placement; (3) to some extent, IFPS families functioned at a higher level at case closure, but did not generally improve to greater degree than did control families; and (4) using a bivariate
analysis to measure relationship between key variables and placement entry found that no statistical significance that family characteristics were related to placement entry.

Feldman concluded that IFPS intervention was effective to meet the goal of preventing/delaying placement, with program impact dissipating after 9 months. He pondered whether this drop-off could be prevented with a plan of scheduled follow-up reinforcement visits for families after closure. The reinforcement issue he raises suggests the importance of IFPS as an essential component of the continuum to help families develop coping resources to function successfully over the long haul. Some out-of-home placements are not inappropriate or harmful to children or their families if their specific needs dictate this necessity.

Critics of FPS/IFPS Effectiveness

Some critics of FPS effectiveness claim that outcomes for FPS programs show few or limited results. Most do not consider them outright failures, instead stating they work only for some families under certain conditions. Their greatest issue appears to be FPS programs do not promote the safety of children being free of abuse or neglect as their first priority. A number of critics (Fiermonte, 2001; Gelles, 1996; MacDonald, 1994) advocate for the increase in child safety as the primary outcome variable and criterion for FPS/IFPS effectiveness.

MacDonald’s (1994) criticism is a lack of evidence to support claims of FPS/IFPS. She sees case outcomes as promoting negative ideological effects, identified as (1) “legitimate illegitimacy”; (2) translate deficits of values into deficits of resources; (3) non-judgmental approach to family formation leads to a growing number of “families”
who survive only with constant state support, and (4) a percentage of troubled families may need short-term intensive service in the foster care system, not putting all or most resources only into FPS/IFPS (pp. 45-60). Lindsey (2004) supports McDonald’s systems concerns, noting that many studies including FPS outcomes within general child welfare show a failure in finding evidence of effectiveness.

Altstein and McRoy (2000) and Barthalet (1999) cite lack of evidence/credible results, or little/no demonstration of effective FPS outcomes. Altstein and McRoy specifically state that IFPS programs (e.g., Homebuilders) ownership of goals of placement prevention/reunification need alternate resolutions. Altstein et al.’s challenge to these programs regards their belief that the Multiethnic Placement Act of 1996 and the Adoption and Safe Families Act of 1997 (ASFA) should become primary statutes utilized to promote alternate resolutions such as adoption. Barthalet advocates for speedier timetables for terminating parental rights, suggesting “we need to revamp our child welfare policies so that we remove children and make it possible for them to be adopted much earlier” (p. 121).

Fiermonte (2001) echoes all of the previous critics, seeing the necessary use of AFSA where the primary legal basis for this act requires a judge’s role under reasonable efforts to make safety a paramount consideration, appearing to favor placement over preservation.

Schwartz and Fishman (1999) see FPS professionals as well meaning, believing in the value of families and as advocates for their best interests, but that these professionals are underestimating or ignoring the social and economic context where these families live. Schwartz and Fishman propose FPS must be delivered as a part of much broader and
more comprehensive social and economic strategy so that they call a more positive impact. Hutchinson (2002) further points out that the concept of FPS may be laudable in its goal of preserving families, but the method used to promote it, promising prevention of foster care, was flawed. Henegan, Horwitz, and Leventhal (1996) found that large evaluations of family preservation programs ownership of placement rates to be identical between treatment and comparison groups, thus questioning the special efficacy of FPS programs.

Distal and Proximal Outcomes

Distal Outcomes

The findings of Corcoran (2000) and Rossi, Lipsey, and Freeman (2004) report outcomes classified as both distal and proximal. Distal outcomes can be defined as long-term goals and the desired results of a constellation of program services and activities (i.e., placement of children outside the home). Rossi et al. stress that impact theory sees program outcomes as part of a logic model that connects activities to proximal (immediate) outcomes leading to more distal outcomes (p. 209). For measuring success currently present in FPS programs, the outcome criteria of preventing placement can be identified as distal. Cameron and Vanderwoerd (1997) discuss studies focusing on effectiveness for the Homebuilders model and found distal outcomes dominated as success measures, stating “these studies also focused exclusively on placement aversion as the primary outcome variable and provide little information on the impact of Homebuilders participation on personal or family variables” (p. 110).
Corcoran (2000) also reviewed several quasi-experimental designs where several types of random assignment were used. Findings revealing evidence of overall success of FPS programs was again based on (distal outcome) placement prevention. Corcoran discovered very limited findings in a small number of studies where specific characteristics (as proximal outcomes) as standardized self-report measures helped predict success other than distally, with little impact.

*Proximal Outcomes*

To expand the current FPS success criterion measures beyond distal outcomes, it is essential to examine more closely the concept of proximal outcomes. Proximal outcomes can be defined as measuring changes associated with family functioning such as gains in safety, supports, skills, and community linkages.

Corcoran (2000) sees programs such as FPS/IFPS that are concerned with improving the family’s level of functioning needing to find measures of functioning as a proximal means to assess program effectiveness. Proximal outcomes have the greatest capability to affect, so we should know whether they are attained. “If the program fails to produce these most immediate and direct outcomes, and the program theory is correct, more distal outcomes are unlikely to occur” (Rossi et al., 2004, p. 212).

For critics and concerned advocates alike, the preceding information appears to call for expansion of measuring proximal outcomes in IFPS program effectiveness research. Rossi et al. (2004) support this notion stating that FPS programs “must produce more balance and interpretable results by assuring that information about proximal
outcomes were attained as the potential results in distal outcome may be ambiguous” (p. 212).

Characteristics to Define Proximal Effectiveness Measures

After studying a number of FPS/IFPS studies, Nelson (2000) offers considerations toward using proximal outcomes to expand proximal effectiveness measures, including (1) outcomes differed by age; successful placement prevention programs, with the exception of Walton (1997) and University Associates (1993), have focused on adolescents only; (2) physical abuse cases appear to be much more successful than those based on neglect; and (3) recidivism is not typically reported in studies; therefore, we do not know the difference in repeat referrals for maltreatment between FPS/IFPS and standard services.

The Child Welfare League of America (CWLA) standards of excellence for FPS indicate that “successful outcomes for intensive family-centered crisis services (IFC) are measured in terms of the family’s ability to stay safely together or reunify safely” (CWLA, 2003, p. 92). This information identifies outcomes noting distal current measures of success. Additional standards direct us toward other success outcomes that address child and family needs. The outcomes suggested are proximal and include: “improved safety of family members, enhanced child well-being, improved family functioning and informed decision-making, which include placement of the child outside of the home, when necessary” (CWLA, 2003, p. 92). These outcomes can help to enhance effectiveness measures. We need to recognize specific proximal outcomes and characteristics that delineate support services and expanding measures.
An action plan implementing expansion proposed by Kaplan and Girard (1994) assists in this process. These authors first cite a concern of the lack of persuasive theory and evidence supporting lasting effects of brief FP interventions where only distal outcomes are used (placement prevention). To counter this concern, their plan advocates research engagement for evaluating programs by targeting children at imminent risk for abuse and neglect. Current placement prevention measures, or distal outcomes, pit preservation vs. out-of-home care. They suggest the “field” must rethink its position and incorporate family-based services along a continuum also including out-of-home care. Their plan moves success definitions along toward proximal outcome measures, proposing, “We must determine which program components as well as which length and intensity of service work best for what type of families. . . . Most important, we must redefine success” (p. 114).

Roberts (2002) further comments on the necessary system structure for FPS to be effective, stating, “For family preservation efforts to truly work, they must be incorporated into a radically reformed child welfare system whose paramount goal is to support families, not break them apart” (p. 149).

Ryan (2002) found that FPS researchers have not addressed the issue of client heterogeneity while studying service effectiveness as well as not exploring various subgroups within the client population. Ryan’s premise to conduct future research was a requisite to study specific client characteristics of these subgroups to explain the variance of the effects of Family Preservation Services programs.

Nelson (2001) suggests the necessity for deeper study of these characteristic components in tandem with time. Specifically the necessity is for “studies that test
specific service models for physical abuse and neglect are needed to determine the optimal mix and length of services for different types of cases” (p. 16). Fraser et al. (1991) trumpet the benefit of FPS program research using a “common” core of criteria and measures that assess the major aspects of change in the intervention related to child parent and family functioning.

Shireman (2003) detailed more optimistic conclusions for FPS outcomes that can occur through using family well-being to reanalyze data. Tracy (2001) called for continued research focused beyond placement prevention alone toward multiple measures (i.e., characteristics) for outcomes. Schuerman et al. (1994) recommend broadening the examination of FPS evaluation objectives to look at improvements in family and child functioning, placement delay, or other desirable outcomes. The main theme of all of these researchers focuses on the necessity to enlarge and expand effectiveness measures by use of specific components and services (characteristics), a.k.a. proximal outcomes.

Conceptual Framework

The conceptual framework for my research is a logic model that allows for methodologies analyzing effectiveness using both distal outcomes, now widely used, and identifying additional proximal outcomes, or specific characteristics, used more rarely now. Figure 2.5, using the second column starred (short-term, intermediate, and long-term outcomes) lays out short-term (proximal), intermediate (proximal), and long-term outcomes (distal) as the primary components defining our logic model. All four of these factors—case statuses/outcomes, individual outcomes such as skill development,
stakeholder satisfaction, and quality service by workers—are a primary way for us to identify characteristics in relation to outcome.

<table>
<thead>
<tr>
<th>Who are we serving and what are the needs and problems?</th>
<th>Short-term, intermediate, and long-term outcomes</th>
<th>Service delivery model and theory of change</th>
<th>What are the costs of these services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Risk factors (e.g. family history, poverty)</td>
<td>• Program outcomes/Case status</td>
<td>• Kinds of interventions</td>
<td>• Per child service cost</td>
</tr>
<tr>
<td>• Social problems or mental illness—severity, chronicity</td>
<td>• Individual outcomes such as development or demonstration of skills and competencies</td>
<td>• Modality of service e.g. theoretical orientation, mode of service delivery</td>
<td>• Per family cost</td>
</tr>
<tr>
<td>• Family strengths/tolerance for stress</td>
<td>• Stakeholder satisfaction</td>
<td>• Intensity, frequency, and duration of services</td>
<td>• Cost-effectiveness data</td>
</tr>
<tr>
<td>• Social supports</td>
<td>• Aspects of quality service linked to positive outcomes, e.g. worker engagement of parents or children in services</td>
<td>• Location of services</td>
<td>• Benefit-cost data</td>
</tr>
<tr>
<td>• Skills of each family member in mediating the service delivery system</td>
<td>• Ability and motivation of parents and youth to implement intervention methods</td>
<td>• Variety and sequencing of services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Integrity of services (e.g. how much consistency is there to the service, to the treatment model, program ‘drift’, and treatment fidelity?)</td>
<td></td>
</tr>
</tbody>
</table>

Adapted from Hernandez and Hodges (1996) and Savas (1996) by Pecora et al. (1998)

Source: Pecora (2003) p. 103

**Figure 2.5. Major Program Logic Model Components**

To expand our framework, we need to look at what factors in the first and third columns are necessary parts of our model. We can secure a fuller picture of who we are serving and under what service delivery theory of change and model leads to the outcomes and in turn effectiveness. In the first column (What are we serving and what are the needs and problems?) the family and program factors important for us to include are: risk factors, social supports, skills of each family members, and family strengths. In the third column, the service delivery model and theory factors are: modality of service; intensity, frequency, and duration of service; location; and variety and sequencing of services. No factors in the fourth column were looked at in this study. As an introduction
to our data analysis in Chapter V, we will reiterate this model and its importance to the understanding of our findings.

Berry, Bussey, and Cash (2001) discuss distal/proximal outcomes in more detail as this logic model envisions them, observing most critics agree that child placement prevention is “a woefully inadequate and misleading indicator of family preservation program effectiveness” (p. 308). These authors suggest other critical indicators of effectiveness such as changes in family functioning, parenting and child behavior, or gains in resources/supports, concluding that “the most meaningful outcomes in family-centered programs are changes in those characteristics that brought the family to treatment” (p. 308). This conclusion supports again the essential need to broaden FPS/IFPS evaluation research to include proximal outcomes toward their affect on effectiveness. In another study, Cash and Berry (2003) see future research allowing program administrators and researchers “to determine efficacy of specific service elements by analyzing their association with case outcomes” (p. 84). Juby and Rycraft (2004) note that social supports for families in poverty offered through specific service elements are highly associated with individual and family resiliency, and enhance the probability of the family remaining intact.

Several additional studies further establish the use of this logic model approach. Cash (1998) conducted a study focusing the examination of the IFPS services program process using a Homebuilders model seeking to identify characteristics that contribute to outcomes beyond the placement prevention criterion. Findings of the study suggest support for matching family characteristics to service needs yields both positive and negative data as the services contributed to outcomes and their future measurement. One
important finding highlighted a modest relationship between services and outcomes while controlling for family characteristics.

A study by Jacobs and Kapuscik (2000) concluded that FPS evaluators shift their focus and their audiences, from global results of whether FPS works to providing a detailed picture on what is actually going on in FPS programs. They argue that “in the absence of this information, disappointing impact evaluations are difficult to implement, critique, and use in ways that benefit and improve programs” (pp. 31-32). These authors suggest it is important to consider implementing site strategies that promote the study of specific characteristics of programs. Their site-based evaluation paradigm, the Five-Tier Approach (FTA) is used in this study.

Guidelines to conduct site-based evaluations (i.e., FTA) are identified by Raschick and Critchley (1998) and include: (1) a utilization-oriented research model where researchers make the most of techniques delineating components which demonstrate complex details of IFPS worker interventions; (2) establishing systematic ongoing feedback mechanisms to programs being evaluated, such as in FTA; and (3) conducting measurement of data over an extended span of time. Regarding time, Berry (2005) notes many studies have “identified the contribution of direct service time with the caseworker as a critical correlate of successes, including placement prevention, prevention of re-abuse, and improvement in family skills and relations” (p. 329).

Berry et al. (2001) identified a series of specific FPS characteristics that serve as operational definitions for proximal outcomes and be used as data components to expand FPS program effectiveness measures. Figure 2.6 lists these characteristics.
1. Characteristics (demographic and others) of families, caregivers and their children

2. Characteristics of referral information

3. Characteristics of case assessment for CPS eligibility as identified by referral staff, especially imminence of risk at referral and family and individual functioning and past child welfare and other public system involvement

4. Characteristics of service availability and accessibility in FPS program, including after-care services planning.

5. Characteristics of progress results throughout the program, including service planning, demand and utilization, types and duration and location of contacts, goal achievement, as identified by referral staff, FPS staff, and the families receiving the services.

6. Characteristics of other results of any follow-up contacts with past families served to assess the current family preservation status, and initiate further planning services if possible.

(Adapted from Berry, Bussey, & Cash, 2001)

Figure 2.6. Characteristics to Define Proximal Outcomes

These characteristics match well with the program variables from the ecological framework outlined in the previous section. Fraser et al. (1991) note that program variables associated with IFPS services effectiveness include types of clinical and concrete services, and use of ancillary services, as well as intensity and duration of treatment. Their findings are families who receive more intensive services, but for a shorter period of time, are less likely to experience placement.

Upon reviewing many types of FPS studies, Berry et al. (2001) conclude these researchers identified deficits in the research base regarding client characteristics and outcome success, indicating services provision receives very little attention in past research. Few studies report the chronic nature of presenting problems and whether
families were treated for child abuse, neglect, or both. These authors continue to say the purpose and focus of future research is thus: “Well-delineated, direct and logical connection between service characteristics and program outcomes becomes particularly salient and critical to the issues of program integrity and replication” (p. 302).

Another study by Berry, Bussey, and Cash (2002) tested and evaluated if recent IFPS service models achieve positive outcomes based on the premise that families differ in the risks they present and services must be differentially tailored individually to these different risks. They concluded that their findings, focused significantly on both IFPS process and outcomes, demonstrate that measuring proximal outcomes and service provision goes beyond the usual crude outcomes of placements or recidivism. This measurement allows for a finer examination of the interplay of family risk factors and services provision. Very significant for this research is their observation that: “The inclusion of measures of risk at intake and of services provision throughout the case will allow researchers to predict case and program outcomes with richer detail and great accuracy, thus helping practitioners to predict what works best, for whom, and under what circumstances” (p. 124).

This study will attempt to build on the studies I have already detailed, toward a focus on providing a detailed picture of specific IFPS program, client, and provider characteristics in terms of child, parent, and family functioning. Some studies suggest using a site-based evaluation. The researchers I have reviewed suggest the limitations of this detailed picture in current FPS research. Additionally, the concept of time (intensity/duration) and family risk factors in relation to outcomes has been studied on a limited basis and lacking a detailed picture. Our results should fill a current gap in
FPS/IFPS knowledge and practice with a picture of how more extensive use of proximal outcomes enhances/expands FPS/IFPS effectiveness measures.
CHAPTER III

RESEARCH METHODOLOGY

The goal of this study is to assess the FPS program, and its client and provider characteristics (i.e., proximal outcomes). Distal outcomes, based on placement prevention, are the majority of the evaluation measures of services effectiveness now used within FPS. Applying more proximal outcomes to the evaluation of effectiveness, I intend to contribute to the expansion and enhancement of defining service outcome effectiveness within FPS and perhaps along the child welfare services continuum through this study.

Pecora (2003) details issues he identifies to evaluate family supportive services and their relationship to effectiveness and functioning. We need greater detail on what special focus types of child, parent, or family functioning indicate services effectiveness measures. He sees four ways to view this focus, including increase in functioning, such as cognitive; maintenance of functioning, such as emotional health in times of stress; prevention of a problem or relapse, such as children in risk of placement; and slowing of progressive deteriorating conditions, such as certain health conditions (pp. 102-103). All of these functioning factors have elements that stress family functioning which throughout our previous information we see as an element helping to indicate proximal outcomes. We should be able to utilize these factors to promote better efficacy throughout
our analysis on how proximal outcomes can be used to promote enhanced FPS/IFPS effectiveness measures.

Overall Approach

I am employing the Five-Tier Approach (hereafter FTA) model (see Jacobs & Kapuscik, 2000, pp. 37-52; Weiss & Jacobs, 1988) as the methodology uses various evaluation tiers to discover and fit the current optimum tier within an IFPS program’s stage of organizational history and development. The span of intensity and complexity of evaluation required for an IFPS program increases from 1 to 5 as the purposes of evaluation for each tier detailed in Table 3.1.

Table 3.1. Five-Tier Approach (FTA) Research Design

<table>
<thead>
<tr>
<th>Tier</th>
<th>Purposes of Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>I - Needs Assessment</td>
<td>Document size/nature of public problem; determine unmet community needs; propose program policy options to meet needs; set a data baseline for later progress measurement; broaden the base of support for a proposed program.</td>
</tr>
<tr>
<td>II - Monitoring and Accountability</td>
<td>Monitor program performance; meet demands for accountability; build a constituency; aid program planning and decision-making; provide a groundwork for later evaluation.</td>
</tr>
<tr>
<td>III - Quality Review and Clarification</td>
<td>Develop more detailed picture of the program as it is implemented; assess the quality and consistency of intervention; provide information to staff for program improvement.</td>
</tr>
<tr>
<td>IV - Achieving Outcomes</td>
<td>Determine what changes, if any, have occurred among beneficiaries; attribute changes to the program; provide information to staff for program improvement.</td>
</tr>
<tr>
<td>V - Establishing Impact</td>
<td>To contribute to knowledge development in the field; to produce evidence of differential effectiveness of treatments, to identify models worthy of replication.</td>
</tr>
</tbody>
</table>

(Adapted from Jacobs & Kapuscik, 2000)
FTA was selected as it is very advantageous for the measurement and analysis of both proximal and distal outcomes in this study. This study takes several purposes from Tiers II through V. I would argue that our study is concentrated mostly in Tier III. Developing a detailed picture of the program, assessing quality and consistency of intervention, and providing information to staff for improvement are all of the purposes in Tier III. There is a more limited study of changes in beneficiaries and some attribution to changes by the program under Tier IV, plus the factor in Tier V about contributing to knowledge development to the field.

Using FTA, I am able to show the multiple purposes included in this study allow us to measure and analyze both proximal and distal outcome offer the advantage of these as legitimate evaluation activities. Jacobs and Kapuscik (2000) themselves support this observation, indicating that FTA “uses a broad and inclusive definition of evaluation, considering needs assessment, program planning, implementation studies, monitoring activities, client surveys, and outcome studies as legitimate evaluation activities” (p. 38).

Other researchers support the previous statement about the FTA advantage. Pecora et al. (1995, as detailed in Weiss & Jacobs, 1988) see FTA as “helpful” for determining research design issues in constructing IFPS/FPS evaluation. FTA can be classified as a Utilization Oriented Evaluation (UOE) model (Patton, 1978; Raschick & Critchley, 1998). Use of a UOE model permits delineating treatment components (service characteristics), or the complex details of IFPS worker interventions. Another significant feature of FTA is how it permits a systematic, ongoing feedback loop for research environment decision makers (Raschick & Critchley, 1998). All of these identified factors mirror the intent of this research study.
To apply the FTA toward this research, the FTA committee was formed which commenced data gathering planning in June 2007. This activity was directly linked with state agency approval permitting data gathering for these contractors, which was required by earlier approval of the Western Michigan University (WMU) Human Subjects Institutional Review Board (HSIRB) (see documentation attached in Appendix A).

Activities implemented in FTA planning included:

- I presented specific program characteristics listed by Berry, Bussey, and Cash (2001) to the Committee intending to mutually establish items for inclusion in the data entry form, and establishing future collaboration techniques.

- Mutual agreement was reached on the study sampling process to assure credibility, validity, and reliability. After several meetings of the FTA, a final consensus was reached on the nature of the data entry form to be implemented (see Appendix E) for data collection.

Piening and Warsh (2002) note the importance for consensus and collaboration regarding instrumentation to implement data gathering in how essential it is for agency staff to have confidence in the measures. These authors support this efficacy factor when they state “if variables and their respective categorical choices were not clearly defined at the outset, our attempts to analyze the data amounted to a qualitative rather than a quantitative exercise” (pp. 166-67). Both public and private agency staffs share the potential to use evaluation results with confidence to guide their family interventions and offer mutual feedback throughout their work together on how the FTA can be used further to enhance their effectiveness.
To implement our research methodology using the Five-Tier Approach (FTA) process, I identified along with a research advisory committee (the FTA committee) a review of a list among private service agency contractors resulting in a purposive selection by the FTA committee of a statewide sample of program sites for data collection. This activity established a diversity of demographic areas (urban, suburban, and rural), socioeconomic groups, and ethnicities and determined the selection of the two agency contractors and five contracting sites represented by these contractors. The FTA committee additionally found identified staff from the providers to serve as data gatherers. This action was necessary to meet the WMU HSIRB and state agency requirements for human subject protection. Approval for these agencies/sites from the state agency to conduct data collection was granted in June 2007 and dovetailed with the WMU-HSIRB approval granted in January 2007, allowing data gathering to commence. The selected agencies used a list of clients and in mutual agreement with the researcher on the procedures to be used, the staff at each site compiled the list of all cases from 2002-2005. They randomly selected case files to encompass a systematic random sample up to the maximum number agreed to for that site.

Research Questions

Summarizing what we have discussed previously about the purpose and goals of this research, we are trying to provide a detailed picture of specific FPS program, client and provider characteristics which we can identify as proximal outcomes that exist within a state research context. Our major focus is to understand how services are determined
and what the major predictors of distal and proximal outcomes are. The following research questions and hypotheses will guide this determination and prediction:

1. How do the level of risk for abuse and neglect of children affect the distal and proximal outcomes for each family?

2. How does duration/intensity of program participation for each family intervention affect the duration/intensity and availability/accessibility of the services and their distal and proximal outcomes for each family?

3. How does the identification of family and program characteristics (i.e., needed services) by both worker and families and types and levels of services affect the distal and proximal outcomes of IFPS? How do these characteristics relate to the family designation of specific services satisfaction through gains in safety, supports, skills, and community linkages?

Research Hypotheses

The following are the hypotheses developed to address the above research questions.

*Hypothesis 1:* The level of risk of abuse or neglect such as type and severity of child maltreatment has significant negative effects on the proximal outcomes of FPS services.

This hypothesis was proposed as the nature of FPS programs is to work with high risk clients who are most likely to be within the abuse or neglect case type. The program under study works with other types, such as reunification, but predominantly with these
case types classified in two categories, 1 being those of severest risk, and 2, still high but less severe. Due to this severity, we expect the direction of effects will be negative.

Hypothesis 2: The intensity of services (the number of hours and days spent in direct contact with the family) will positively affect the proximal outcomes of FPS services.

This hypothesis is proposed as the literature presented, especially concerning the Homebuilders model notes that a large number of face-to-face (direct) contact over a short-term time period will result in successful (positive) case outcomes. It appears very important to closely study if this impact has merit within the program under study and other FPS programs.

Hypothesis 3: Characteristics of families at risk of abuse and neglect significantly affect the proximal outcomes of FPS services. More specifically, I hypothesize the direction of effects as the following:

1. Minority background: negative
2. Multiple parents: positive
3. Gender of the child: female and male – negative
4. Age of the child (0-18): positive
5. Large families (# of children in the home): negative

This hypothesis is proposed as these demographic characteristics will play a significant role in how these families enter into the child welfare system and what specific programs and services are the best for them, and also will affect the nature of the receipt and use of these services. We are looking at characteristics of the entire family, and the children themselves as they are likely to be the most affected if they are placed.
We expect the direction guided by the literature will be positive if the family has at least two parents and of any age in our range. We expect the direction to be negative, if the family has multiple children, is a minority, and if the child is female.

Hypothesis 4: The types and levels of services provided produce significant effects on the proximal outcome results of FPS services. More specifically, the effects of providing risk assessment/management, general clinical, resource referral, advocacy, linkage with social supports, and concrete services will be positive, whereas those of family violence/ safety planning, substance abuse, and sexual abuse services will be negative. Families receiving specifically designated types and levels of service will be more likely to succeed.

This hypothesis is proposed as the purpose and goal of this research revolves around our identification of the types and levels of service that are the characteristics we also want to identify as proximal outcomes. We have listed the major categories of services within the hypothesis that the program under study recognizes and we collected data on for the various services listed under each category to decide on the effects. As this program is a high risk program with a priority for assuring safety, risk assessment services should have a positive direction. As general clinical services list over half of the potential services subcategories, they should have a positive direction, as should concrete services. The other positive categories suggest supplemental services other than the program itself that can be tapped anytime by families, likely a positive direction. The three categories seen having a negative direction are service areas where the risk is likely to be the highest and with the most potential for safety issues, and affect a smaller number of children within these families. These risk and safety factors suggest why there is likely
to be a negative effect. For all of the services we expect that specifically identified types and services have a positive effect on successful outcomes.

List of Variables

The list of the independent variables and the dependent variable (Figure 3.1) were used to gather data so we can attempt to study and analyze our research questions and hypotheses.

<table>
<thead>
<tr>
<th>Independent Variables/ Operational Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Type of Contacts - Face-to-face to Contact with Families</td>
</tr>
<tr>
<td>2. Intensity/Duration of Contacts - Face-to-face Hours, Total Case, Day/Time of Contact</td>
</tr>
<tr>
<td>3. Location of Contacts - Family Home or other</td>
</tr>
<tr>
<td>4. Services Availability/Accessibility - Services provided and received during or after Intervention for 24 hour a day/ 7 days a week for up to maximum of 6 weeks.</td>
</tr>
<tr>
<td>5. Family and Program Characteristics - Demographic and referral characteristics for at risk families and services offered by providers, including case type; level of maltreatment race and ethnicity, age and gender of children, levels of social support evidenced by services identified by the provider and family.</td>
</tr>
</tbody>
</table>

Dependent Variable/Operational Definition

1. Placement Events for each Family Case - Child placement at case closure, and at 3-6-12 months

Figure 3.1. List of Variables

These independent and dependent variables and operational definitions are in line with the components of the Homebuilders services model detailed earlier. These variables are elements of the ongoing implementation/evaluation of the FPS/IFPS program under study.
Regarding these variables, additional clarification is necessary on factors relating to them. One factor is what constitutes face-to-face contacts. Contacts occur ideally in the family home, but also include time (hours) spent together with all or any family members going to other service providers, medical care, schools, or other activities mutually determined to be helpful to the intervention partnership. The contract requirement regarding these types of contacts established an ideal standard of at least 10 hours per week feeling this standard allows for the intensity necessary for best practice effectiveness and program integrity.

Another set of factors regarding services availability and accessibility is the requirement that the services worker is required to be accessible 24/7, even on holidays and weekend. Training and technical assistance provided by state agency staff reinforces the magnitude of this factor. Another vital area regarding availability is that the maximum duration of any intervention is set at 6 weeks or 42 days. Another contract requirement sets up an ideal standard for case duration is 4 weeks or 28 days, also related to the intensity necessary for best practice effectiveness and program integrity.

For factors regarding services provided and received, the services worker is responsible for detailing all services provided to the family on the Checklist, and the family assesses their services satisfaction, including all the services they found helpful, as well as worker and program quality.

Finally, regarding the dependent variable of placement event for each family case, the placement of each child is detailed at case closure, and using a follow-up log, the family is contacted at 3, 6 and 12 month intervals. At these intervals, the current placement of each child is again determined and coded on the log. Service success for this
program would be indicated by the absence of out-of-home episode and services that produced successful measures of satisfaction defined by family and/or referring staff at case closure and follow-ups.

Target Population/Sampling

The sample selected came from a target population from agency sites selected through our Five Tier Approach (FTA) committee, among all potential research sites for this state Homebuilders program. It is a small segment of all the cases and agency sites statewide that was served during the contract years under study. Annually, there was the potential within the contract for over 30 sites and a population of over 3,000 families to be served statewide. Within the agency sites that were selected, not every case served during 2002-2005 was selected either, but any cases served at our sites became our target population from which our purposive random sample was selected.

The purposive sample is composed of 250 families who received services from the contract years 2002-2005 within the potential target population at those sites. The database established for this study included all the individual children represented within the families in this sample. The final total of children for the 250 families for which data was gathered was 629.

At each site, designated staff conducted a systematic random sample in the sampling frame with criteria approved collaboratively with the researcher, and was part of HSIRB and state approval. These criteria assured maximum confidentiality protection and freedom from harm for the clients under their state contracts, and the researcher never saw any identifying information. The researcher discussed with all five sites how each
sample was conducted and verified that each site used techniques that comprised a systematic random sample. The consistent factors among the sites was the use of a list of closed cases from contract years 2002-2003, 2003-2004, and 2004-2005, and a systematic random procedure so cases were selected to equal the number of data entry forms to be completed. The final number of forms per agency was as follows: Agency 1A = 50, Agency 1B = 50, Agency 1C = 50, Agency 2A = 80, and Agency 2B = 20. Originally Agency 2A and 2B were scheduled to have 50 each, but Agency 2B was a smaller rural county and its census did not allow enough cases to equal 50. Agency 2A, a larger urban county with a high census, was mutually agreed to increase to 80. This specific number of forms added up to our designated total of 250 planned for this study.

Using our systematic random sample of families and children within the program, our intent is to identify all the significant system characteristics denoting distal and proximal outcomes. These outcomes which define current IFPS program success measurement often consist of distal outcomes. Our primary research emphasis is capturing in our data those characteristics (services) defined also as proximal outcomes which include gains in safety, supports, skills, and community linkages for the children and their families. These are identified by specific services in our data that are statistically significant or demonstrate an effect on these outcomes. The goal is to use these findings to enlarge the IFPS success measure designation. As a secondary activity, we also seek to capture how distal outcomes, herein defined as placement prevention, or how many of the children represented in our data by the families remain in the home at 3, 6, and 12 month follow-ups (i.e., placement prevention)
The agency staff, in mutual agreement with their FTA agency contact and this researcher, implemented data gathering to reach mutual agreement regarding all of the parameters for conducting data gathering. They completed data gathering using the data entry form. The form mutually agreed upon (see Appendix E) meets the criteria set forth by the HSIRB and state agency approval noted above. The form was provided to the agencies and data gathering commenced in July 2007. Data gathering was completed November 3, 2007.

Data Collection

Data were gathered at specific contract agency sites within the state IFPS used in this study. Using participant case files included in the systematic random sample from the contract years 2002-2005, designated staff as data gatherers completed the data entry form (see Appendix E).

For entry on the data entry form, the following mandated monitoring documents for the program under study in each participant case file were used as sources: the Referral Information Form, Time Sheet, Services Checklist, Family Satisfaction Survey and Follow-Up Log. All data entry forms were provided to the researcher over a period from July 2007 until November 3, 2007. All forms were minus all identifying information over this period. The agency is identified by a code known only to the researcher, and each case is assigned a code number to assure the correct number of forms was received from each site.

The data received (minus participant identifying information) were transferred to an Excel spreadsheet by this researcher creating a statistical database detailing each data
element selected from the documents, used later for analysis. Table 3.2 details data elements and sources.

Table 3.2. Data Collection Elements

<table>
<thead>
<tr>
<th>Variables</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Independent</strong></td>
<td></td>
</tr>
<tr>
<td>Type of Contacts</td>
<td>Time Sheet</td>
</tr>
<tr>
<td>Intensity/Duration of Contacts</td>
<td>Time Sheet</td>
</tr>
<tr>
<td>Location of Contacts</td>
<td>Time Sheet</td>
</tr>
<tr>
<td>Service Availability/Accessibility during and after intervention</td>
<td>Time Sheet, Services Checklist (Worker), Satisfaction Survey (Family)</td>
</tr>
<tr>
<td>Demographic and Program Characteristics regarding at-risk families, and services offered by providers</td>
<td>Referral Form, Services Checklist (Worker), Satisfaction Survey (Family)</td>
</tr>
<tr>
<td><strong>Dependent</strong></td>
<td></td>
</tr>
<tr>
<td>Placement Events for each Family Case</td>
<td>Follow-Up Log</td>
</tr>
</tbody>
</table>

Timetable for Data Collection Activities

Phase I—Data Collection Activities

Data collection was implemented in July 2007 with all data logged from the selected sites and purposive random sample according to the following mutually agreed data-gathering parameters:
1. In cooperation with the FTA committee, and each agency site (total – 5) selected for data collection, specific staff for each site were identified as data recorders.

2. The researcher conducted a training session in July using the data entry form (see Appendix E) with each agency and data recorder to assure consistency in data recording.

3. Special emphasis was placed on the addenda in the data entry form, providing operational definitions and item clarification for the data gatherers as they recorded data.

4. Designated staff implemented the data plan above using the data entry form (see Appendix E). The staff used these mandated program monitoring documents: Referral Information Form, Time Sheet, Services Checklist, Family Satisfaction Survey, and Follow-Up Log. Each data element selected from case documents gathered for all variables present in each sample case, using only specific non-identifying information. All forms received by the researcher had only non-identifying information.

5. The researcher reimbursed the data recorders for their work using mutually agreed upon procedures and amounts.

Data from all the sites selected were received by November 3, 2007. Data were aggregated by the researcher in an Excel data base prior to proceeding to Phase II—Data Analysis.
Phase II—Data Analysis Using Logistic Regression

Data Analysis Process—General

Using the Excel database, we first identified and conducted a descriptive analysis of the data. Our next step was to use binary logistic regression analysis to predict the outcomes. Generally we established data components such as:

1. The number of days each case file was opened, including case hours, indicating duration, for the family and children represented by each file.
2. Identify the significant special family and program characteristics that contributed to successful distal and proximal outcomes for children and their families. Primary emphasis was directed to designate proximal outcomes and their effect toward expanding success measures for IFPS programs. Emphasis was also placed on how distal outcomes can be useful to assess impact of program model integrity.
3. Assess testing of the research hypotheses and inferring and the ability to generalize the results for this sample population and others.

Logistic Regression Analysis

Crown (1998) feels this type and other forms of regression analysis is a powerful way for researchers to test hypotheses between variables as it allows control of factors that help determine outcomes. He stresses the necessity in using this technique for having a theory about the nature of the relationship among the variables.
According to Garson (2009), logistic regression is used to predict a dependent variable (DV) via continuous and/or categorical independent variables (IV). Weinbach and Grinnell (2004) support this procedure as one used for prediction through measurements of one or more predictor variables (IV). Crown (1998) sees the prediction component for regression indicated by predicting the DV by one or more IV (p. 27). Using this technique allows the determination of the percentage of variance in the dependent variable explained by the independents, to rank relative importance of independents and to assess interaction effects (Garson, 2009).

There are several types of logistic regression, such as multinomial, ordinal, and binary (or binomial). These types provide estimates that capture the effects of the independent variables in terms of changing the log of the odds of the dependent variable. For continuous independent variables these logs of the odds change in the same direction as their probabilities. For dichotomous independent variables, it can estimate the odds of a certain event occurring with the impact of the independent variable explained in terms of odds ratios. Odds ratios capture the expected change in the probability of the dependent variable given the movement from the reference category to the category in question with odds greater than one signifying an expected change by a multiplication of greater than 1. If the odds ratio is below 1, the log likelihood is less than 1. The ongoing assumptions concerning use of logistic regression include a non-linear relationship between IV and DV, non-normal distribution and homoscedasity (Garson, 2009).

Binary logistic regression is a form of regression used where the dichotomous dependent variable is binary and the independent variables are of any type. Use of this technique allows all variables by default to be continuous covariates (Garson, 2009).
For this study we have selected the use of binary logistic regression for our data analysis. From the factors listed above, it is special utility since the assumptions for all types of logistic regression noted above negate some areas of error that often affects validity. I would argue here that all our outcome variables are binary. Using our binary variables which act as continuous covariates allows us to rank the relative importance of independents and assess their interaction effects.

Validity and Reliability

Patton (1978) reports that a measure is scientifically valid if it measures the concept it intends to measure. As a quantitative instrument, regression validity can be established through three common criteria: (1) consistency with usage or that past work has used the concept; (2) consistency with alternative measures, or used effectively with other evaluators; and (3) internal consistency, or its questions relate to each other consistently (p. 223). These factors relate to our sampling, data collection, and measurement.

Additionally, Rossi, Lipsey, and Freeman (2004) establish important criterion to govern our data analysis. The criterion shows that data are more interpretable when accompanied by information about program process and services utilization. They observe “development of a framework providing a judging standard of data what are better or worse outcomes within the inherent limitations of this data” (p. 228). The Homebuilders model used in the IFPS under study is consistently implemented through a standard program process and measuring services utilization spelled out by the contracts that are given to the private child welfare agency.
I would argue using what Patton (1978) and Rossi et al. (2004) have suggested that our sampling, data collection, and measurement are internally valid and reliable. We attempt to use appropriate indicators for data collection and measurement and systematic random sample provide a reasonable basis for maximizing our reliability.

O’Sullivan, Rassel, and Berner (2003) have studied research methods for public administrators regarding threats to internal and external validity. These factors offer a representation of issues that may contribute to the limitations in our validity and reliability.

Internal threats such as History, Maturation, Statistical Regression, Selection, Experimental Mortality, Testing and Instrumentation do not apply as they relate to experiments which I am not doing in this study. The threat of Design Contamination does apply. If study subjects have an incentive to behave in a certain way, there is contamination. Although I did not witness any actual interventions so see if this did occur, one value of this program is that of clients as colleagues. With the recipients more mutually involved in the service planning, there is potentially a lesser impact for this threat. The fact that the relationship is a natural experience would also suggest these issues do not apply. An external threat of unique program features may also apply. Even though these contract agencies apply a similar model, there may be individual differences in staff, client interactions, activities, or community dynamics. This is a minimal threat but any utilization of our findings must consider this uniqueness.
CHAPTER IV

DESCRIPTIVE DATA/FINDINGS

The data presented in this chapter are the essential, descriptive statistics giving us the necessary picture of the families and children who were served by this IFPS program. Our overall purpose is to present information to assist us to understand our sample population. Our focus is on the demographic and program characteristics of this population, which are important components in our understanding and identification of characteristics potentially considered as proximal outcomes. These findings can also be utilized as workings in our later data analysis.

Demographic Characteristics

Data were gathered from 250 case files using the data entry form. A case file represents a family served by the IFPS agency caseworker, and includes the number of parents (1 to a max of 3) and number of children (1 to a max of 6) within each case. Of the 629 children included in the random sample, data were available for 550 children, making 550 the effective sample size.

Figure 4.1 details the frequency of number of children per family occurring per case file/referral. The frequencies listed are weighted by Service Checklist item SC1A, which is providing the family a business card. This was an automatic result for any frequency calculation using SPSS. Figure 4.1 indicates the number of children per family
within each case referral, with slightly over 70% of the families in the 1–2 children range. The total of the first three bars accounts for roughly 90% of the total children served.

Figure 4.1. Frequency of Child Number Categories

Figure 4.2 indicates a number of personal characteristics of each child important to consider in this study. The first one is the age of the children at time of referral entry. Each child was assigned a whole number from 1-18, comparing their birth date to the date of referral. Fifty-two children or 9.5% of the total sample from our data base represented by the zero bars and one bars in this figure include children under the age of 1, where .25 represents 0–3 months, .50 notes 4–7 months, and .75 means 8–11 months.

Figure 4.2 also shows the age of 81.5% of the children served are aged 12 years old or less, meaning less than 20% of the children are teenage and older. It appears that
younger children (less than 12) are more frequently the targets of services provided at the program sites. From ages 2–8 there is a significant cluster of the apexes of the bar line percentages.

![Age at Entry](image)

*Figure 4.2. Percentages for Age at Referral Entry (N = 545)*

The second personal characteristic identified for each child is their gender. Table 4.1 data denotes that there is nearly an equal mix of both sexes within our child population. Anecdotal evidence within the profession often recognizes that male children are more problematic as services recipients, due to the likelihood they would engage in more aggressive behavior and get into more trouble within their family and in the community setting.
Table 4.1. *Gender of Children*

<table>
<thead>
<tr>
<th>Gender</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female (F)</td>
<td>262</td>
<td>47.6</td>
</tr>
<tr>
<td>Male (M)</td>
<td>288</td>
<td>52.4</td>
</tr>
<tr>
<td>**Total N</td>
<td>**550</td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

The third personal characteristic to consider for our child population is race/ethnicity. Table 4.2 provides useful numerical totals for the race/ethnic categories officially identified in forms that are implemented by the United States Census Bureau. We immediately note that around three-quarters or slightly more than 75% of the sample children may be identified as White/Non-Hispanic. If we add this figure with those of African-American race/ethnicity, this accounts for around 94% of the total sample children. Although our sample was a systematic random sample, and there was no established mandate to select specific racial or ethnic groups, these results suggest a concern/issue about representation.

**Family Composition**

Other characteristics are also important in further defining the status of each child identified at the time of referral. The first of these is the location of the child (At Home = AH). A second such characteristic is the risk status of each child (At Risk = AR). These characteristics are important as a number of researchers (Berry, 1997; Corcoran, 2000; Fraser et al., 1991; Maluccio, Pine, & Tracy, 2002; Nelson, 2000; Pecora et al., 1995;
Shireman, 2003) discuss them as indicators supporting the FPS program philosophy of keeping children at home and intervening during family crisis as cited in this literature. Table 4.3 combines the frequencies for both location and risk status. The percentages show that a large percentage of our sample children are located at home and at risk as determined by the referral staff.

Table 4.2. Race/Ethnicity of Children

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander (API)</td>
<td>1</td>
<td>.2</td>
</tr>
<tr>
<td>African-American (AA)</td>
<td>95</td>
<td>17.3</td>
</tr>
<tr>
<td>American Indian/Alaska Native (AIN)</td>
<td>5</td>
<td>.9</td>
</tr>
<tr>
<td>Hispanic (HISP)</td>
<td>10</td>
<td>1.8</td>
</tr>
<tr>
<td>White/Non-Hispanic (WNH)</td>
<td>423</td>
<td>76.9</td>
</tr>
<tr>
<td>Other/Multi-Racial/Unknown (OUNK)</td>
<td>16</td>
<td>2.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>550</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Table 4.3. Child at Home/Child at Risk at Referral

<table>
<thead>
<tr>
<th></th>
<th>% Yes</th>
<th>% No</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child at Home</td>
<td>94.7</td>
<td>5.3</td>
<td>100</td>
</tr>
<tr>
<td>Child at Risk by DHS</td>
<td>94.9</td>
<td>5.1</td>
<td>100</td>
</tr>
</tbody>
</table>

*N = 548*
The ones not at home are likely in a foster home placement and another potential referral type is a reunification case, where the referral allows the agency worker to preserve the family by reuniting them after placement. Additionally, with regard to those not considered at risk the referral agent has determined they do not meet the risk level and they are not designated as such but still need to be part of the intervention.

In determining risk status, the referral staff is further required to assess level of risk. The specific CPS law that the referral agent follows to refer cases to the agency providers has five category dispositions to define level of risk. Only cases denoted as Category Disposition 1 (CatDisp1), considered the highest risk and Category Disposition 2 (CatDisp2), the next highest risk, are eligible for IFPS referral out of a potential 5. The legal mandate for these high-risk categories suggests that the referral agent consider the preponderance of child abuse and neglect evidence and the risk assessment indicates high or intensive risk services must be provided by CPS.

For both categories, the indication is that services are provided in conjunction with community-based services, such as this IFPS program. For Category 1, the referral agent is required to consider if a court petition is necessary, which has the potential to lead to out-of-home placement. The worker must exhaust all reasonable efforts as defined under the law to keep the children safely at home. This IFPS program gives one avenue of referral to provide further reasonable efforts to the family before decisions on removal are considered. They would also likely see this option in “the best interest of the child” which is another mandated legal factor. Table 4.4 points out the number of children in our sample who are represented in these categories. This table indicates that around three
quarters of the children in our sample population are in the lesser high risk category. It provides a deeper insight to enhance the at-risk status data we presented previously.

Table 4.4. *Number of Children in CPS Category Dispositions 1 and 2*

<table>
<thead>
<tr>
<th>Category Dispositions</th>
<th>CatDisp1</th>
<th></th>
<th>CatDisp2</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>%</td>
<td>Frequency</td>
<td>%</td>
</tr>
<tr>
<td>Yes (child in this category)</td>
<td>103</td>
<td>18.7</td>
<td>416</td>
<td>75.6</td>
</tr>
<tr>
<td>No (child not in this category)</td>
<td>447</td>
<td>81.3</td>
<td>134</td>
<td>24.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>550</strong></td>
<td><strong>100.0</strong></td>
<td><strong>500</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Another important component of the family characteristics data is how many parents are in each home at time of referral. The data here are classified under three titles: one parent (ParHome1), two parents (ParHome2), or three or more (ParHome3). Table 4.5 provides the frequency of children listed under each of these titles. These data expand the depiction of all prospective family members present in each case referral.

Table 4.5. *Number of Children in One, Two, or Three or More Parent Homes at Referral*

<table>
<thead>
<tr>
<th>Number of Parents in Home</th>
<th>ParHome1</th>
<th></th>
<th>ParHome2</th>
<th></th>
<th>ParHome3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>%</td>
<td>Frequency</td>
<td>%</td>
<td>Frequency</td>
<td>%</td>
</tr>
<tr>
<td>Yes (child under this parent #)</td>
<td>245</td>
<td>44.5</td>
<td>251</td>
<td>44.6</td>
<td>55</td>
<td>10.0</td>
</tr>
<tr>
<td>No (child not under this parent #)</td>
<td>305</td>
<td>55.5</td>
<td>299</td>
<td>54.4</td>
<td>495</td>
<td>90.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>550</strong></td>
<td><strong>100.0</strong></td>
<td><strong>500</strong></td>
<td><strong>100.0</strong></td>
<td><strong>500</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
Using the figure under Yes, we observe that the number of children for one parent is 245 or 44.5%; for two parents, the number is 251 or 45.6%; and for three parents or more, the number is 55 or 10%. The fact that nearly half of the children are from single parent homes is very significant. The public perception is often that single parenthood is a major contributing factor why these types of families are often part of the child welfare system. However, the perception does not often mention that child abuse can occur in larger numbers of two parent homes as well. In our two parent numbers, it is significant that the number of children represented in two parent families is nearly the same percentage as those under one parent, which indicates we must revise our perception to consider that these child welfare concerns are not unique to just single parent homes. Around 90% of the children in our study population are in a one or two parent home.

Finally, the three or more parents number represents 1/10 of the children in this study or 55 children. Most often when this parental number is cited for a case referral, there is usually a grandparent or other relative designated by the referral staff as legally responsible for these children in addition to the two parents already present.

Another overarching component that affects analysis of our sample population is case type. For each referral, the service provider accepts the case type as designated by the referral agent, based on how the actions of the parents are classified under CPS law and referral agency policies. We will address additional case type information later.

Within Table 4.6, frequencies in first three columns show the identified case type data per family referral ($N = 245$), while the final column denotes number of children ($N = 550$) represented under each case type. Presenting this information offers a wider picture concerning the referral process, addressing that the service agency cannot control
this classification and any positive or negative ramifications from this labeling regarding services provision initially felt by the family.

Table 4.6. Case Type–Number by Referrals and Children in Each Type

<table>
<thead>
<tr>
<th>Case Type</th>
<th># by Referral</th>
<th>% Type</th>
<th>Cumulative %</th>
<th># Children by Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse (CT1)</td>
<td>75</td>
<td>30.6</td>
<td>30.6</td>
<td>182</td>
</tr>
<tr>
<td>Neglect (CT2)</td>
<td>108</td>
<td>44.1</td>
<td>74.7</td>
<td>221</td>
</tr>
<tr>
<td>Abuse &amp; Neglect (CT3)</td>
<td>13</td>
<td>5.3</td>
<td>80.0</td>
<td>29</td>
</tr>
<tr>
<td>Delinquency (CT4)</td>
<td>1</td>
<td>.4</td>
<td>80.4</td>
<td>11</td>
</tr>
<tr>
<td>Reunification (CT5)</td>
<td>19</td>
<td>7.8</td>
<td>88.2</td>
<td>38</td>
</tr>
<tr>
<td>Domestic Violence (CT6)</td>
<td>3</td>
<td>1.2</td>
<td>89.4</td>
<td>8</td>
</tr>
<tr>
<td>Adoption (CT7)</td>
<td>3</td>
<td>1.2</td>
<td>90.6</td>
<td>9</td>
</tr>
<tr>
<td>Other (CT8)</td>
<td>23</td>
<td>9.4</td>
<td>100.0</td>
<td>52</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>245</strong></td>
<td><strong>100.0</strong></td>
<td><strong>100.0</strong></td>
<td><strong>550</strong></td>
</tr>
</tbody>
</table>

Looking at each specific case type in greater detail, the highest is Neglect (CT2) = 44% of referrals, accounting for 221 children in our sample population. The Child Protection Law (CPL) cited in the CPS manual defines child neglect as negligent treatment as physical or medical (i.e., failure to provide adequate food, clothing, shelter, or medical care, etc); failure to protect (i.e., not take appropriate measures to stop abuse or neglect); improper supervision (i.e., placing or failing to remove the child from harm or threatened harm); and abandonment. That this case type is higher than the Abuse type (CT1), around 31% of the referrals accounting for 182 children is very surprising. The CPL defines abuse as physical (i.e., non-accidental injury leading to death, disfigurement,
brain damage, fractures, bruises, burns, etc.); mental injury (i.e., physical or verbal acts resulting in psychological or emotional injury/impairment, etc.); child maltreatment (i.e., excessive cruelty such as locking children in a closet as punishment, tying a child to a stationary object, etc.); and sexual (i.e., improper contact or penetration by a perpetrator or inducing a minor to commit these acts, such as prostitution). As we have explained earlier concerning the high risk nature of Category Dispositions 1 and 2, ideally we would suspect a higher number of abuse referrals, but here we only have about 1/3 of the referrals among the children in our sample. Adding the Abuse & Neglect (CT3), where the referral agent felt from the definitions presented above, classification included these types. CT1, CT2 and CT3 account for 80% of the referrals and very near 80% of the children in our sample. All IFPS case types designated for the service agency providers have at least one referral or more, with numbers accounted for within our sample population.

Other types with larger numbers of referrals and children accounted for are Other (CT8) = 9.4% of referrals or 52 children; and Reunification (CT5) = 7.8% of referrals or 38 children. Reunification is designated when a child, who has been placed in an out-of-home placement and his family, can receive intense services to reunite. The referral staff in this case may be other than a CPS worker, usually a Foster Care worker. With very high caseloads, these workers often do not have sufficient time to provide all necessary intensive services themselves to allow safe return as a permanent placement. This option has only been available to referral workers in the past few years and can benefit their system. For the Other (CT8) category, there are no data available that provide specific information why the referral agent selected this designation. In tandem with the issue of
less than expected numbers under the Abuse (CT2) type, the nearly 10% of unclassified types is very intriguing.

Intensity of Services Intervention

The components that are most important in addressing the intensity of services include: 24-hour contacts by the service provider with family, total case days, total case hours, total face-to-face hours and other factors of face-to-face contacts provided to the family and children by the IFPS services provider.

Initially we will review and discuss the 24-hour contact information. This factor is a vital piece for the service agency toward accepting a family referral from the referral agent. The service agency is required by contract compliance standards to contact the family face-to-face in 24 hours or less as a means to initiate the intensive nature of this services program. This standard relates to the best practice program component of engagement, or gaining the voluntary cooperation of the family as quickly as possible.

Table 4.7 provides a dual look at both the numbers of case referrals and also the children accounted for within these referrals. The table indicates that nearly 90% of the 247 family cases (denoted by “Yes”) and nearly 91% (denoted by “Yes”) of the 550 children accounted for in these cases were contacted face-to-face in 24 hours or less by the service agency. These data appear to show general contract compliance and reasonable efforts to implement the best practice of engagement.

Table 4.8 introduces data to enhance our continued definition of intensity of services and the effect on the proximal outcomes of the case referrals. The data describe results relating to the sample of children. The numbers represented by the means are
Table 4.7. 24-Hour Contact—Number by Referrals and Children

<table>
<thead>
<tr>
<th>24-Hour Contact</th>
<th>Referrals</th>
<th>%</th>
<th>Children</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes (24 contact made)</td>
<td>222</td>
<td>89.9</td>
<td>499</td>
<td>90.7</td>
</tr>
<tr>
<td>No (24 contact not made)</td>
<td>25</td>
<td>10.1</td>
<td>51</td>
<td>9.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>247</strong></td>
<td><strong>100.0</strong></td>
<td><strong>550</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Table 4.8. Total Case Days/Hours and Face-to-Face Hours

<table>
<thead>
<tr>
<th>Children = 550</th>
<th>Total Case Days</th>
<th>Total Case Hrs.</th>
<th>Total F-to-F Hrs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid N</td>
<td>550</td>
<td>545</td>
<td>550</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Mean</td>
<td>28.15</td>
<td>66.7954</td>
<td>39.68</td>
</tr>
<tr>
<td>Std. Deviation</td>
<td>5.913</td>
<td>19.94862</td>
<td>11.331</td>
</tr>
<tr>
<td>Variance</td>
<td>34.959</td>
<td>397.947</td>
<td>128.381</td>
</tr>
<tr>
<td>Minimum</td>
<td>3</td>
<td>8.50</td>
<td>3</td>
</tr>
<tr>
<td>Maximum</td>
<td>42</td>
<td>131.50</td>
<td>69</td>
</tr>
</tbody>
</table>

Important in that for total case days the mean is very close to the contract ideal of 28 days (4 weeks) of service per intervention. A case day is any 24-hour day or portion thereof that the intervention is active according to program standards. Additionally for total case hours there is no ideal contract standard, but if we divided the total case days mean into this mean, we would end up with around 16–17 hour average per week spent on each intervention. Total case hours are all the hours, including face-to-face hours that the
worker can document as specified in the program standards. Finally the total face-to-face hours mean is very close to the ideal contract standard of 10 of these hours per week (= 40 hours for 28-day case).

Using all of these categories of data, we note that the service agencies generally comply with the total case days and face-to-face hours required standard, with no case exceeding the 42 case day’s maximum. Despite no proscribed standard for total case hours per intervention, the results here shows reasonable efforts by workers to support their personal family contacts with other necessary service activities away from the family. While contract compliance is not the focus of this study, understanding these results will help us as we attempt to assess the impact of services.

Figure 4.3 details the specific number of children represented within case day duration totals represented among our sample (minimum 3, maximum 42). From this figure we observe over 300 of the 550 children are enclosed in the 28 day (4 weeks) cases bar. For durations leading up to and including 28 days, the frequency concentration of children appears as the most frequent. Up to the 31 day bar, frequency remains high. The bars slightly before 40 days and up to 42 days indicate there are concentrations of cases that need to be near the maximum to achieve the goal of success. These numbers appear to support the conception of intensity of services in this IFPS program is indeed intense. For total case days, the critical issue is whether this intensity data positively affects the proximal success outcomes for the children in these family case referrals.
Figure 4.3. Number of Children—Case Day Total–Active Cases
(Minimum 3, Maximum 42)

Figure 4.4 provides a picture of the next variable to consider in greater detail, which is Total Case Hours. As reported previously and cited in this graph also, the mean for these data is around 67. The normal curve appears at its highest point between the 50-75 range. Keeping in mind that 28 day cases have been identified as the most frequent, with an ideal face-to-face total being around 40 hours, the services agencies appear to demonstrate intensity using a great number of hours per case for overall service activities. These often include many contacts with other necessary community supports besides the referral agent, providing contacts to help the family to build a service network.
Our final time variable indicating the intensity factor most likely to have the greatest impact on proximal outcomes are Total Face-to-Face hours. The importance of this data toward intensity of services in this IFPS program is the expectation that service agency workers provide a significantly high level of face-to-face services with clients. This affects contract compliance, but even more importantly the best practice of engagement and reasonable efforts in ongoing service provision. Specific services used to enhance best practice and compliance will be discussed later.

Figure 4.5 presents a useful illustration of where these hours are concentrated. As we reported previously and here also the mean remains at just less than 40. The curve detailed in the graph appears to be at its highest point near the bars ranging from 40-42
hours. Keeping in mind that 28 day cases have been identified as the most frequent, with an ideal face-to-face total being around 40 hours, the services agencies appear to demonstrate intensity and service provision geared toward personal contacts. The majority of these hours occur in the clients’ homes, or in the community with other helpful agencies, retail stores, churches or organizations. This factor as a component of this IFPS program supports a notion that the family knows itself and its environment best, meeting together especially on its own turf and in the community. It helps to strengthen the worker/family working partnership and the participants themselves toward the goal of initial and long-term success of keeping children in the home safely.

![Histogram of face-to-face hours](image)

**Figure 4.5.** Total Face-to-Face Hours per Case by Frequency (Minimum 3, Maximum 69)

Table 4.9 is included in this summary as it is important to document those results that help both the service agency and the referral agents to continually monitor findings
concerning 24 hour/7 days week availability. These data were not part of our database used for analysis. It does not specify the number of children from our sample affected by these results but is based on the number of interventions \((N = 250)\) that the sample of children \((N = 550)\) have been drawn from. The intervention is the case referred that is being served by the worker. Literature presented earlier in this study theorizes families in crisis are more willing to work cooperatively and accept help more effectively during a crisis. These crises more often than not can occur after regular weekly business hours, or on weekends or holidays.

Table 4.9. *Weekly and Non-Traditional Face-to-Face Hours*

<table>
<thead>
<tr>
<th>By Case</th>
<th># of Cases</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>F to F NTW</td>
<td>176</td>
<td>5.0682</td>
</tr>
<tr>
<td>F to F NTN</td>
<td>215</td>
<td>9.0093</td>
</tr>
<tr>
<td>F to F Holiday</td>
<td>27</td>
<td>2.2037</td>
</tr>
<tr>
<td>F to F Wk 1</td>
<td>248</td>
<td>9.5151</td>
</tr>
<tr>
<td>F to F Wk 2</td>
<td>244</td>
<td>9.5758</td>
</tr>
<tr>
<td>F to F Wk 3</td>
<td>231</td>
<td>9.97</td>
</tr>
<tr>
<td>F to F Wk 4</td>
<td>218</td>
<td>10.38</td>
</tr>
<tr>
<td>F to F Wk 5</td>
<td>41</td>
<td>9.05</td>
</tr>
<tr>
<td>F to F Wk 6</td>
<td>17</td>
<td>8.40</td>
</tr>
</tbody>
</table>
Our table first lists these three 24/7 components as: NTW indicates worker in-person weekend service hours; NTN indicates in-person night (after regular) service hours and Holiday notes in-person holiday visits. For NTW around 75% of all cases were visited on weekends (mean = 5 hours). For NTN around 85% of the cases were visited after regular hours (mean = 9 hours). From these two areas we can note that ¾ or more of the cases had services provision that appear to demonstrate noteworthy 24/7 availability and accessibility. A lesser number of holiday visit cases occurred but the maximum among them = 8.5 hours. Again these limited numbers again identify efforts for services provision to further define 24/7 availability and accessibility.

The remainder of the table offers the details of how total face-to-face hours are broken down by individual weeks (week = 7 days). These data are used again by both the service agency and the referral agent toward contract compliance, but more importantly to assess services to families’ best practice standard of 10 face-to-face hours per week. The data indicates weeks 1–4 are very near that ideal standard. Weeks 3-4 have even higher means than weeks 1–2. These data appear to show that services increase in face-to-face intensity rather than decrease as the intervention continues. As reported previously, total case days had at least 80% of cases ending at 28 days or less, with a large number at exactly 28 days. One consideration for further research upon reviewing these data may be that it suggests the funding structure of the contract process may reward this result most frequently as a potential ideal outcome. For the remaining 20% of cases that do extend to a 5th or 6th week, the means for these weeks = 9, again near the ideal standard.
Intervention Service Characteristics

Services Identified by the Provider

Worker identification of the various services provided for each family case referral is documented on the Services Checklist. As part of required case documentation and no later than the conclusion of each case, the worker checks off those identified services they provided by for each family case to which they are assigned. These workers had received thorough training in use of the checklist, including its Glossary, necessary to qualify to take cases.

For the purposes of presenting the rest of this descriptive data, Figure 4.6 identifies the classification of specific service categories and subcategories that comprise the Services Checklist. This provides a picture of all the potential services that could be identified as being provided by the agency to the specific family that is the target of the FPS intervention. Each of these services is presented in greater detail in the Checklist Glossary (see Appendix F in this study). Essential information from this glossary along with information from the chart will be presented with our data for clarification and discussion.

Our plan for detailing descriptive services data is as follows: First we will list 5 selected services (more if an * appears) for each subcategory listed in descending volume (potential maximum is 550) as checked off by the service agency worker as received by the family and aggregated for all the children in the sample. Table 4.10 will include the subcategories listed for Categories I, II, V, and IX, while Table 4.11 will include
Categories III–IV, and VI–VIII. The rationale for this breakdown will be addressed below.

<table>
<thead>
<tr>
<th>I</th>
<th>Risk Assessment &amp; Risk management (RA&amp;RM) - 16 services subcategories*</th>
</tr>
</thead>
<tbody>
<tr>
<td>II</td>
<td>Family Violence Info &amp; Safety planning (FVI &amp; SP) - 10 services subcategories*</td>
</tr>
<tr>
<td>III</td>
<td>Substance Abuse Services- (SUBAS) 9 services subcategories*</td>
</tr>
<tr>
<td>IV</td>
<td>Sexual Abuse Services (SEXAS) - 8 services subcategories*</td>
</tr>
<tr>
<td>V</td>
<td>General Clinical Services (GLS) Total - 60 services subcategories*</td>
</tr>
<tr>
<td></td>
<td>a) Parenting/ Limit Setting (P/LS) - 13 services subcategories*</td>
</tr>
<tr>
<td></td>
<td>b) Emotional Management (EM) - 19 services subcategories*</td>
</tr>
<tr>
<td></td>
<td>c) Personal/ Interpersonal Skills (P/IPS) - 19 services subcategories*</td>
</tr>
<tr>
<td></td>
<td>d) Additional Clinical (AC) - 9 services subcategories*</td>
</tr>
<tr>
<td>VI</td>
<td>Referral to other Resources (REFOR) - 15 services subcategories*</td>
</tr>
<tr>
<td>VII</td>
<td>Advocacy with………. (ADVOC) - 15 services subcategories*</td>
</tr>
<tr>
<td>VIII</td>
<td>Linkage with Social Supports (LINKSS) X - 11 services subcategories*</td>
</tr>
<tr>
<td>IX</td>
<td>Provision or Assistance with Concrete Services (PACS)</td>
</tr>
<tr>
<td></td>
<td>Total - 36 services subcategories*</td>
</tr>
<tr>
<td></td>
<td>a) Services provided (SP)- 18 services subcategories*</td>
</tr>
<tr>
<td></td>
<td>b) Circle if Funds used with services provided in (a) (SPF)- 18 services subcategories*</td>
</tr>
</tbody>
</table>

**Figure 4.6. Service Checklists Categorical Headings (= 9)/Services SubCategories (= 180)**

It is important to include this particular descriptive data as this study is very concerned with identifying services that may be considered characteristics we can attempt to also identify as proximal outcomes. The categories in Table 4.10 are chosen first and foremost as they have many of the higher aggregate totals for each service. Specifically, Category I and II relate very closely to risk and safety, a paramount concern for this program working where high risk of abuse and neglect is a concern, family violence a potential result. Although Category II totals are not as high, the fact that this program also accepts referrals directly from a number of domestic violence shelters warrants its inclusion here. Categories V (a–d) and IX also appear in this table as they denote about
2/3 of the service subcategories in the Checklist and intertwine directly with the purpose and goal of this study. Table 4.11 categories are placed in their own table as their services focus is related to specialty areas such as substance or sexual abuse or social supports provided mostly outside of the agency itself and important for aftercare planning. Category III and IV are more specialized services assessed for every case but not found or used as routinely as some other categories, but very important links in aftercare planning when needed. Categories VI–VIII relate more to specific services provided or referrals to agencies and other community resources in aftercare planning. They can also be more strongly used leading to the 3, 6, and 12 month follow-ups.

*Table 4.10 Results/Discussion*

Through reviewing Table 4.10, initially looking at Category I, we note the large count of children served through the subcategories of safety planning and risk assessment. These subcategories linked to the providers’ engagement process with the family can be used toward establishing a useful working relationship. Literature promotes that safety and risk data facilitate identification of successful IFPS outcomes (CWLA, 2003). Critics of IFPS (see especially Alstein & McRoy, 2000; Bartholet, 1999; Fiermonte, 2001; MacDonald, 1994) say safety and risk are not paramount concerns of IFPS workers. This data concerning safety and risk appear to demonstrate vital consideration by these contract agency providers in our study, and the referral agent ultimately responsible for the legal safety of every child with whom they work. These data may also suggest that the contract requirements may drive the selection of these elements.
Table 4.10. Services Categories I, II, V, and IX/Frequency of Subcategory Services

<table>
<thead>
<tr>
<th>I. Risk Assessment/Risk Management*</th>
<th>II. Family Violence Info/Safety Planning*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Planning (SCIK) 454</td>
<td>Safety Planning (SCIIDA) 78</td>
</tr>
<tr>
<td>Risk Assessment (SCIB) 432</td>
<td>Child Experience (SCIIHA) 42</td>
</tr>
<tr>
<td>Routine DV Inquiry (SCIE) 315</td>
<td>FV/DV Dynamics (SCIIFA) 39</td>
</tr>
<tr>
<td>Child Monitor/Super (SCIH) 253</td>
<td>Planning to Leave (SCIIGA) 32</td>
</tr>
<tr>
<td>Environ Safety Assess (SCIC) 190</td>
<td>Custody/Visit Info (SCI 1A) 28</td>
</tr>
<tr>
<td>Use of Crisis Card (SCIJ) 187</td>
<td>Obtain/Use PPO (SCIIBA) 26</td>
</tr>
</tbody>
</table>

V. General Clinical Services

<table>
<thead>
<tr>
<th>a. Parenting/Limit Setting*</th>
<th>b. Emotion Management*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Role Model (SCV#3) 381</td>
<td>Building Hope (SCVb8A) 282</td>
</tr>
<tr>
<td>Time Out (SCV#2) 305</td>
<td>Building Self-Esteem (SCVb5A) 257</td>
</tr>
<tr>
<td>N/L Consequences (SCV#1) 281</td>
<td>Depression Mgmt. (SCVb2A) 208</td>
</tr>
<tr>
<td>Structure Routine (SCV#9) 250</td>
<td>Anger Mgmt. (SCVb1A) 202</td>
</tr>
<tr>
<td>Clarify Fam Rules (SCV#10) 225</td>
<td>Handle Frustration (SCVb6A) 195</td>
</tr>
<tr>
<td>Clarify Fam Roles (SCV#6) 209</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>c. Personal/Interpersonal Skills*</th>
<th>d. Additional Clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Solving (SCVc2B) 219</td>
<td>Active Listening (SCVd6C) 439</td>
</tr>
<tr>
<td>Relationship Bldg. (SCVc7B) 193</td>
<td>Worker/Role Model (SCVd2C) 391</td>
</tr>
<tr>
<td>Teach Active Listen (SCVc6B) 187</td>
<td>Provide/Review Liter (SCVd3C) 282</td>
</tr>
<tr>
<td>Teach “I” Messages (SCVc5B) 184</td>
<td>Use of Reinforcement (SCVd5C) 142</td>
</tr>
<tr>
<td>Boundary Concepts (SCVc4B) 125</td>
<td>Therapeutic Games (SCVd1C) 119</td>
</tr>
<tr>
<td>Negotiation Skills (SCVc3B) 120</td>
<td></td>
</tr>
</tbody>
</table>

IX. Provision or Assistance with Concrete Services

<table>
<thead>
<tr>
<th>a. Services provided/no funding*</th>
<th>b. Services provided/ with funding*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food (SCIxBG) 303</td>
<td>Food (SCIxA1A) 141</td>
</tr>
<tr>
<td>Transportation (SCIxBAG) 269</td>
<td>Other (SCIxA1) 85</td>
</tr>
<tr>
<td>Furniture/HG (SCIxbNC) 137</td>
<td>Toys/Recreation Act (SCIxaO1) 80</td>
</tr>
<tr>
<td>Toys/Recreation (SCIxaOC) 125</td>
<td>Transportation (SCIxaA1A) 78</td>
</tr>
<tr>
<td>Clothing (SCIxbEG) 115</td>
<td>Furniture (SCIxaN1) 75</td>
</tr>
<tr>
<td>Housing (SCIxbGG) 110</td>
<td></td>
</tr>
<tr>
<td>Other (SCIxbR) 106</td>
<td></td>
</tr>
<tr>
<td>Utilities (SCIxbIF) 102</td>
<td></td>
</tr>
</tbody>
</table>
Other Category I and II data show significant numbers of services provided that are related to the assessment of safety and risk. One important subcategory is the numbers related to the dynamics of how children experience family or domestic violence. The data under Category II are surprising in that the numbers of children under each category are significantly lower than in Category I and other parts of Table 4.10. I would expect with this program working with very high risk clients that these totals should be higher; especially to assure that this aspect of safety planning remains a high priority. It may need to be emphasized more in training and in ongoing supervisory work, as well as in technical assistance and administrative oversight. For clarification of the subcategory of Safety Planning listed under both Category I and II, the glossary (Appendix F) defines them the same. The worker determines where to list this factor for each case based on their discretion.

In implementing their engagement to develop a working partnership with the families and children, these providers of IFPS offer services that ideally seek to meet the specific needs of each family individually. Literature indicates that data concerning services offered relating to goal achievement, personal/interpersonal skill acquisition, and social support from services (especially concrete services) help to facilitate successful IFPS outcomes (Berry, Bussey, & Cash, 2001, 2002; Cash & Berry 2003; Corcoran, 2000; Juby & Rycraft, 2004). Reviewing and discussing Table 4.11 services data from Categories V and IX will allow us to identify specific services that help to effectively implement goal achievement, skill acquisition and social support.
Category V Data Factors

In reviewing Category V, General Clinical Services (GLS) data, this category is further subdivided into four sub-areas, which are Parenting/Limit Setting (a. P/LS), Emotional Management (b. EM), Personal/Interpersonal Skills Acquisition (c. P/IPS), and Additional Clinical (d. AC). The subcategories under each sub-area allow the provider to list in more precise detail what specific services are or were offered to the parents and children.

Using Figure 4.6 totals, Category V names 33% (60 out of 180) of all the service subcategories. Category IX, Provision or Assistance with Concrete Services (PACS), to be discussed later, is subdivided into services provided (SP) and whether funds were provided with a specific service (SPF). This category identifies another 20% (36 out of 180) of all services subcategories. Over 50% of the services subcategories (96 out of 180) are accounted for in Categories V and IX, so our analysis later in this study should take note of how this large volume affects our results.

Category V Descriptive Data

Reviewing the first three sub-areas in this category (from Figure 4.6), (a) P/LS, (b) EM, and (c) P/IPS, we can identify subcategories that account for the family to experience personal/interpersonal skills acquisition and social support, which may subsequently lead to family goal achievement. Area (d) AC (from Figure 4.6) appears to focus more on the provider techniques used effectively to implement these services provision.
For area (a) P/LS, the numbers for children served would be considered high. These high numbers relate to the subcategory service of assisting parents to be role models to their children. Using time-out (a non-abusive alternative for child management) with their children is a numerically large subcategory. Other numerically important subcategories are teaching activities, such as daily routine, family rules and roles, and resulting logical consequences that offer improved family structure. These activities may be directed to improving family strengths through skill acquisition and increased family structural social support. These same activities also have the potential to identify alternatives to further abuse, such as increased child safety and decreased harm.

Next, reviewing subcategories under (b) EM indicate high numbers under the subcategories of building hope and building self-esteem. These services may provide enhanced personal and interpersonal skill building. Other subcategories have higher numbers such as those helping parents to better manage areas such as depression, anger, and frustration have the potential to lessen the impact of these problematic factors which often lead to further abuse and neglect of children.

Next, reviewing subcategories under (c) P/IPS we note the overall numbers of many of these services subcategories are much less than in other sections in Category V. There are, however, many of these subcategories used together to promote a more detailed characterization of the concept of skills acquisition. The highest numbers are in subcategories of teaching/learning skills. The subcategories with higher numbers are problem solving, relationship building, active listening, and “I” messages. While shared and discussed mutually in the working partnership of provider/family during active services provision, the skills under these categories possess a utility while the case is
active, and can continue after the case is closed as future strengths for family and children relationships.

Under these subcategories in (c) P/IPS, describing a specific subcategory will help us clarify and discuss skill acquisition and its impact, which is an area that this FPS program places great emphasis for those needing more clarity of what it is. This subcategory is the concept of teaching I-messages. Generally we can describe this service as being designed to help family members use direct statements to maximize communication by disclosing feelings rather than making statements that blame each other. Blaming among parents and children often leads to anger and other concerns that may manifest themselves in abuse. This service provides an alternative that is strength-based toward helping to defuse both immediate and future crises and perhaps toward preventing future abuse.

Finally, under (d)-AC, more closely related to those techniques the provider recognizes as useful to services provision, the largest subcategory number is that providers used active listening with everyone in the family they are serving. We posit that this listening was used by the provider to convey empathetic and non-judgmental attention to family members. This use assumes their provision consisted of verbal and non-verbal content to properly consider what the family was trying to say. It appears this activity allows favorably for family strengths, aiding the provider’s ability toward effective engagement and partnership with the family, enhancing the chances for a successful outcome.

The second highest subcategory number under (d) AC is that the provider is being a role model. Acting in this manner dictates the provider demonstrates teaching skills,
such as direct communication or “I” messages. These two skills work hand-in-hand with many other skills implemented under sub-areas a, b, and c toward mutual goal achievement for provider/family.

*Category IX Descriptive Data*

The top numbers under Category IX (PACS) indicate that provision or assistance with food was the top item for both services provided only (SP) and when funds were included (SPF). Other high numbers for both SP and SPF are transportation, furniture, and toys/recreational activities. For this category, the themes presented here are that these concrete services must be present for the family and children to have an opportunity to be safe and children at less risk of harm, especially during crises that often arise from lack of these daily needs.

From our review of the numbers in Table 4.10, we can infer that a significant number of our sample children experienced favorable services availability and accessibility, and this implementation positively affects our proximal outcomes results.

*Table 4.11 Results/Discussion*

An ongoing special program component is the specialized training each agency worker service receives to assess for and plan for both substance and sexual abuse assessment and treatment for both in-case and post-closure referral. Additional program components training for each agency worker places an emphasis on worker advocacy on behalf of families for both in-case and post-closure referral and linkage to other necessary agency and resources. The hope is that the family can use these resources toward their
goal achievement of preservation at closure, and a long-term goal to maintain and preserve their families safely and prevent future abuse.

Conducting our initial review of Table 4.11, among all subcategories listed, we observe the overall numbers of children under each subcategory are much less than those in Table 4.10, especially noting the smaller numbers for Substance Abuse and Sexual Abuse Services.

Table 4.11. Services Categories III, IV, VI, VII, and VIII/Frequency of Subcategory Services

<table>
<thead>
<tr>
<th>III. Substance Abuse Services</th>
<th>IV. Sexual Abuse Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>SubAb Education (SCIIAB)</td>
<td>67 AgeAppSexDevelop(SCIVDC)</td>
</tr>
<tr>
<td>Sobriety/ Abstinence (SCIIIBB)</td>
<td>42 Boundary Concepts (SCIVAC)</td>
</tr>
<tr>
<td>Identify/Assess Use (SCIIIDB)</td>
<td>42 SexAb Education (SCIVBC)</td>
</tr>
<tr>
<td>SubAbEffect-Child (SCIIHB)</td>
<td>32 Identify Signs/Sympt (SCIVFC)</td>
</tr>
<tr>
<td>Relapse Prevention (SCIIIFB)</td>
<td>28 Prevention Skills (SCIVCC)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VI. Referral for Other Resources*</th>
<th>VII. Advocacy with …</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling Serv (SCVIKB)</td>
<td>87 Social Services (SCVIIAE)</td>
</tr>
<tr>
<td>Social Services (SCVILA)</td>
<td>54 Mental Health Sys (SCVIIIBE)</td>
</tr>
<tr>
<td>Mental Health (SCVIMA)</td>
<td>52 Education Sys (SCVIIIEE)</td>
</tr>
<tr>
<td>SubAbAT/DV Vic (SCVIAD)</td>
<td>29 Landlord (SCVIIGE)</td>
</tr>
<tr>
<td>Other (SCVIOA)</td>
<td>28 Utility Companies (SCVIIICE)</td>
</tr>
<tr>
<td>SubAbAT (SCVI IC)</td>
<td>24</td>
</tr>
<tr>
<td>DV Vic Support Grp (SCVIED)</td>
<td>23</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VIII. Linkage with Social Supports*</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Family/Kin/Fictive Kin (SCVIIIBF)</td>
<td>104</td>
</tr>
<tr>
<td>Gen Relationship Bldg. (SCVIIIAF)</td>
<td>103</td>
</tr>
<tr>
<td>School (e.g., Head Start) (SCVIIIDF)</td>
<td>91</td>
</tr>
<tr>
<td>Neighbors (SCVIIICF)</td>
<td>63</td>
</tr>
<tr>
<td>Child Support Groups (SCVIIHF)</td>
<td>48</td>
</tr>
<tr>
<td>Adult Support Group (SCVIIJD)</td>
<td>38</td>
</tr>
</tbody>
</table>
Conducting a further individual review of Table 4.11 categories and subcategories, we note first the highest numbers under the advocacy category (VII). The subcategories are: Social Services (a.k.a. DHS), and Mental Health. Advocacy with these vital agencies is important for families, but overall these numbers account for only about 20% to 30% of the children covered in this study. Despite this limitation, it is important to denote the program does indeed provide advocacy on behalf of the children and in turn for their families. If this advocacy is not present at all the potential for everyone to receive social support and meeting resource needs is not present, negating any potential for gaining additional helpful skills.

Looking next at another category, Links to Social Supports category (VIII), two higher subcategory numbers were (1) Family et al., and (2) General Relationship Building. These services could be helpful means to social supports assisting to meet resource needs, skill enhancement, and reinforcement. But as under Advocacy (VII), the numbers account for less than 20% of the children being studied.

Looking next at the category, Referral to other Resources (VI), the highest overall number is Counseling Services, much closer to only 15% of the children studied. The subsequent two, Social Services and Mental Health, account for about 10% of the children studied. Although limited in numbers, any use of these activities in each case may help families to garner social supports and enhance skill over the long run.

Finally, for both Categories III Substance Abuse Services and IV Sexual Abuse Services, the subcategories account for around 10% of all children in our sample for the highest numbers. Our data base does not allow us to denote how many actual case interventions this may affect. For these categories, a possibility is that every referral may
not include the need for these special categories, either in-house or through referral. We should also consider whether insufficient funding exists through the contract or in the community referral agencies that decrease the emphasis on these services being utilized. For the subcategories denoted, we should note that the overall themes represented, despite limited numbers, are appropriate safety, education, treatment and prevention for both adults and children. It appears that safety and skill development are emphasized as necessary with the children while their goal achievement and the program goal of preserving their families is pursued.

Although a lesser emphasis was placed on the categories and subcategories of Table 4.11 due to more limited aggregate totals for each service, we can infer a lesser count of our sample children experienced favorable services availability and accessibility for these specific categories and subcategories. These services remain essential due to the fact they can play a much larger role in after-care services necessary to keep families together during the 1-year follow-up that is part of this program.

*Services Identified by Families*

This IFPS program provides opportunities for feedback by every family served to indicate those services they feel are helpful or not. This action is exercised by their voluntary completion of the Family Satisfaction Survey (Survey) form at case closure, and the contract service provider can identify how many are returned. A typical implementation of this program policy/procedure is the agency providing the form with a self-addressed agency envelope with family discretion to return it or not. Figure 4.7 summarizes the contents of the Survey.
Question 1 - Goals to help family to stay together (1 = Yes, 0 = No)

(Italicized information below provides additional FSS format details)

1) Children living with family - A. Living with you Yes, No B. If not where living
2) Best Living Situation - Yes C. Best for Family
3) Best for Children - Yes D. Best for Children

Question 2 - Helpful Services during intervention (Yes = 1)

4) Service A, B, C…………..Service P

Question 3 - Specify most helpful service during intervention (from Question 2)

5) Service A, B, C…………..Service P

Services as they appear on the Data Entry Form for Questions 2 & 3 (see Appendix E)

- Service A Helped obtain services for our family
- Service B Taught us new ways to communicate
- Service C Helped understand my children better
- Service D Taught new ways to manage children’s behavior
- Service E Helped me to feel better about myself
- Service F They listened to me
- Service G Taught me/us to work with other agencies . . . needs
- Service H Taught me/us to manage money better
- Service I Helped me/us to manage our time better
- Service J Helped us to manage and understand our feelings
- Service K Helped get additional MH/SA services
- Service L Helped us find a place to live
- Service M Helped us organize our home (Cleaning, etc. . . .)
- Service N (Other) - Note thing identified:

Question 4 - Worker Quality of Service (Yes = 1)

6) Services provided at family home - Yes Worker A
7) Convenient Appointment Times - Yes Worker B
8) Worker Listened and Understood - Yes Worker C
9) Satisfied with Services - Yes Worker D

*Figure 4.7. Family Satisfaction Survey Components (as completed by family receiving services)*
Question 2 on the Survey is where this feedback data from the family on Helpful Services is located. The Survey distributed indicates services A–P; the A–N format on the Data Entry form is included in the chart for further clarity. The data form components are the specific statements that appear word for word on the Survey itself.

Table 4.12 below provides the compilation of the surveys returned among all five service agency sites regarding Question 2. The notes below the table offer the specific information parameters for each column. Consistent with our review and discussion of the Services Checklist, we will selectively include the services from Table 4.12 with the higher number totals using only the last two columns. The process of using N2 (N = 550), resulted from using the first column to help in our rank order process and help us elect the top six services ranked. In tandem with this child focus, another factor identified as vital is how their caretakers of the sample children provided on a voluntary basis what services were helpful. Under ideal program standards, these caretakers and their children are to be treated in a strength based manner, or jointly partnering, planning, and implementing services with their agency provider to best and safely meet their specific needs.

Table 4.13 presents the helpful service rankings by aggregate percentage of children affected by that service. These six highest services selected account for the identification of nearly two-thirds to three-quarters of the children in our study sample.
### Table 4.12. Family Satisfaction Survey Question 2—Helpful Services During Intervention

<table>
<thead>
<tr>
<th>Helpful Services</th>
<th>N = 207 Q2-Yes (N1)- (1)</th>
<th>Rank Order- (2) X, of Each Service</th>
<th>N = 550 Children (N2)- (3)</th>
<th>% of Total N2- (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A- Help obtain services for our family</td>
<td>163</td>
<td>3</td>
<td>371</td>
<td>67.5</td>
</tr>
<tr>
<td>B- Taught us new ways to communicate</td>
<td>168</td>
<td>2</td>
<td>403</td>
<td>73.3</td>
</tr>
<tr>
<td>C- Understand children better</td>
<td>159</td>
<td>4</td>
<td>361*</td>
<td>65.6</td>
</tr>
<tr>
<td>D- Taught new ways to manage children’s behavior</td>
<td>146</td>
<td>6</td>
<td>341</td>
<td>62.0</td>
</tr>
<tr>
<td>E- Helped me feel better about myself</td>
<td>157</td>
<td>5</td>
<td>378</td>
<td>68.7</td>
</tr>
<tr>
<td>F- They listened to me</td>
<td>180</td>
<td>1</td>
<td>409</td>
<td>74.4</td>
</tr>
<tr>
<td>G- Taught me to work with other agencies…needs</td>
<td>123</td>
<td>8</td>
<td>290</td>
<td>52.7</td>
</tr>
<tr>
<td>H- Taught me/us to manage money better</td>
<td>79</td>
<td>11</td>
<td>190</td>
<td>34.5</td>
</tr>
<tr>
<td>I- Taught me/us to manage money better</td>
<td>97</td>
<td>9</td>
<td>226*</td>
<td>41.2</td>
</tr>
<tr>
<td>J- Helped us mange and understand our feelings</td>
<td>125</td>
<td>7</td>
<td>294</td>
<td>53.5</td>
</tr>
<tr>
<td>K- Helped get additional MH/SA services</td>
<td>80</td>
<td>10</td>
<td>199</td>
<td>36.2</td>
</tr>
<tr>
<td>L- Helped us find a place to live</td>
<td>29</td>
<td>14</td>
<td>75</td>
<td>13.6</td>
</tr>
<tr>
<td>M- Helped us organize our home</td>
<td>71</td>
<td>12</td>
<td>171</td>
<td>31.1</td>
</tr>
<tr>
<td>Service N- Other- Note things identified:</td>
<td>48</td>
<td>13</td>
<td>109</td>
<td>19.6</td>
</tr>
</tbody>
</table>

*Note.* (1) N1 = Out of 250 family files where data were gathered, 207 individual surveys were returned. Yes (Y) is the number of times each family cited each service on their survey. (2) Rank Order is the rank in descending order (1–14) of the aggregate total of each service cited across all 207 surveys- X-as complied by researcher. (3) Aggregate Number (Y) of Children (N2 = 550) affected by each service- * Service C and I ➞ N=549. (4) % of Total N2=550-percentage of total children affected. (See also Appendix E-Table 4 for more details.)
Table 4.13. *Family Satisfaction Survey Question 2—Top 6 Helpful Services During Intervention—% of Children Affected*

<table>
<thead>
<tr>
<th>Rank</th>
<th>Helpful Services</th>
<th>% of Children Affected</th>
</tr>
</thead>
<tbody>
<tr>
<td># 1</td>
<td>Service F - They listened to me.</td>
<td>74.4</td>
</tr>
<tr>
<td># 2</td>
<td>Service B - Taught us new ways to communicate.</td>
<td>73.3</td>
</tr>
<tr>
<td># 3</td>
<td>Service E - Helped me feel better about myself.</td>
<td>68.7</td>
</tr>
<tr>
<td># 4</td>
<td>Service A - Helped obtain services for our family.</td>
<td>67.5</td>
</tr>
<tr>
<td># 5</td>
<td>Service C - Helped understand my children better.</td>
<td>65.6</td>
</tr>
<tr>
<td># 6</td>
<td>Service D - Taught new ways to manage my children’s behavior</td>
<td>62</td>
</tr>
</tbody>
</table>

Comparison of Checklist and Survey Descriptive Data

Helpful services from Question 2 on the Survey documented in Table 4.13 can be compared by linking them to Checklist subcategories in Tables 4.10 and 4.11. There is some mutual support and reinforcement among services identified by services recipients (Survey) and those named by providers (Checklist). We will now present what these data comparisons are like and what they mean for the IFPS Program model presented in this study.

One such comparison is the Checklist subcategory *Worker seeing themselves as a role model* ($N = 391$), while also identifying the *Parent as a role model* subcategory ($N = 381$). The agency worker appears to indicate both partners (worker and parent) in the IFPS working relationship see themselves as models of strength and favorable examples to follow. This could establish a more mutually favorable starting point for both of these working partners for services collaboration.
Table 4.14 provides the comparisons and matching of the top six survey rankings by the family with checklist subcategories identified by workers. The match in ranking #1 appears to indicate that the worker actively listened and taught it as a skill, and the family felt listened to. Rankings #2 and #3 denotes mutually reinforced skills teaching that enhance the family’s personal and family communication, as well as enhanced emotional management. Ranking #4 recognizes that the family received many additional services they could use while the case was active and for aftercare. Rankings #5 and 6 denotes mutually reinforced skills teaching that enhance better child knowledge and understanding and management.

### Table 4.14. Comparisons—Satisfaction Survey Ranking/Checklist Subcategories

<table>
<thead>
<tr>
<th>Satisfaction Survey Top Ranking (by Family)</th>
<th>Checklist Subcategory Comparisons (by Worker)</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1- Service F- They listened to me</td>
<td>Active listen to client family; Teach active listening</td>
</tr>
<tr>
<td>#2- Service B- Taught us new ways to</td>
<td>Relationship building; Teaching “I” messages; Boundary concepts; Negotiation skills</td>
</tr>
<tr>
<td>communicate</td>
<td></td>
</tr>
<tr>
<td>#3- Service E- Help me feel better about</td>
<td>Building hope; Building self-esteem</td>
</tr>
<tr>
<td>myself</td>
<td></td>
</tr>
<tr>
<td>#4- Service A- Help obtain services for the</td>
<td>Many subcategories in Categories VI–IX such as Concrete Services - Food and transportation</td>
</tr>
<tr>
<td>family</td>
<td></td>
</tr>
<tr>
<td>#5- Help understand my children better</td>
<td>Time out; Natural and logical consequences; Structure family routine</td>
</tr>
<tr>
<td>#6- Taught new ways to manage my children’s</td>
<td>Time out; Natural and logical consequences; Structure family routine</td>
</tr>
<tr>
<td>behavior</td>
<td></td>
</tr>
</tbody>
</table>
The comparison illustrated further by Table 4.14 provides a picture of how the service recipients themselves and the families view services availability and accessibility. It appears families see a favorable implementation, especially those top ranked as helpful. As with the services categories and subcategories identified by providers, these family-identified services from Survey Question 2 are useful for further analysis.

We are using only the data from Question 2 later in our data analysis. We did gather data initially for Questions 1, 3, and 4, with the specific components of these questions highlighted in Figure 4.7. Data gathered from Questions 1, 3 and 4 are important to provide enhanced insight/details to what the service recipients themselves view as satisfactory in aspects of the services received from the providers in this IFPS program. We will concentrate on the results as they relate to the aggregate number of children represented in this study (N = 550) represented in Appendix G, Tables G1, G2, and G3.

Descriptive Data Summary—Survey Questions 1, 3, and 4

*Question 1—Goals to Help Family to Stay Together*

The theme presented for this question relates to goal achievement as determined by the service recipients themselves. Overall three-fourths of the respondents, over 400 children, confirm they are living with family and feel this is best for both the children and the family. These data appear to support the idea that a larger number of recipients report satisfactory achievement.
Question 4—Worker Quality of Service

The theme presented for this question relates to satisfaction with the provider’s quality of service as determined by the service recipients themselves. Overall nearly 80% of the children had services focused on them in the family home; over three-fourths of the children were served with convenient appointments indicating flexible services availability and accessibility, and over three-fourths of the sample children had caregivers acknowledge their worker listened and understood. These findings link with the Active Listening checklist subcategory aggregate total (see Table 4.11), as this service was checked the most frequently of any by the agency worker. These findings appear to indicate recipients indicated worker satisfaction.

Question 3—Specify Most Helpful Service Intervention from Question 2

It can be reported that 5 out of the 6 services answered as the most helpful matched the top rankings in Table 4.12 for Question 2, or a likely outcome to be expected.
CHAPTER V

DATA ANALYSIS AND FINDINGS

The Logistic Model

Chapter II introduced the conceptual framework (Figure 2.2) that outlined the logistic model that forms the foundation for our study. We especially want to be able to analyze our data so we can identify both proximal and distal outcomes, but with our emphasis on specific characteristics (proximal) toward expanding FPS/IFPS effectiveness measures.

For this chapter, Table 5.1 offers a summary picture and depiction of the model used in this chapter for using regression analysis. The components in column III are used to identify our dependent variable, the Outcome variable, which relates to the placement/case status of children at case closure and 3, 6, and 12 month follow-ups. The core predictors of the outcome as our base independent variables are in column I, or the family strengths, also identified as demographic and program characteristics. These characteristics to be included are: Category disposition, status at referral, race/ethnicity, age, and gender of children, and number of parent and children in the home (i.e., family size). Our logistic regression analysis framework will use these base independent variables in tandem with our Outcome dependent variable to create our base model. Our goal in all of our analysis is to rank the relative importance of our independent variables.
Table 5.1. *Logistic Model Components for Data Analysis/Individual Variables**

<table>
<thead>
<tr>
<th>COMPONENTS</th>
<th>COMPONENTS</th>
<th>COMPONENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Who are we serving and what needs/problems ➔</td>
<td>II. Service Delivery Model and Theory of Change ➔</td>
<td>III. Short Term, Intermediate, and Long-term Outcomes *</td>
</tr>
<tr>
<td>• Risk Factors</td>
<td>• Modality of Service</td>
<td>• Case Status</td>
</tr>
<tr>
<td>• Social Supports</td>
<td>• Intensity, Frequency, and Duration/Service</td>
<td>• Individual Skill Development</td>
</tr>
<tr>
<td>• Skill of Family members within service system</td>
<td>• Location</td>
<td>• Stakeholder Satisfaction</td>
</tr>
<tr>
<td>• Family strengths</td>
<td>• Variety/Sequencing of Services</td>
<td>• Worker Services Quality</td>
</tr>
<tr>
<td>Variables ➔ Base Model</td>
<td>Variables ➔ of Interest</td>
<td>Variables ➔ Outcomes</td>
</tr>
<tr>
<td>IV - Level of Risk: Category Risk Disposition; Family Characteristics: Child gender and race/ethnicity; # of parents in home</td>
<td>IV - Services checklist: Risk Assessment; Safety Planning; Substance Abuse and Sexual Abuse services; General clinical and concrete services; referral to other resources; advocacy; linkage with social supports; Survey: Helpful services</td>
<td>DV - Outcome Variable- 12 month status from 3-6-12 month follow-ups</td>
</tr>
<tr>
<td>Variables ➔ of Interest</td>
<td>IV - Services intensity- Total face-to-face hours; total case hours; total case days; 24 hour contact; 3-6-12 month follow-ups</td>
<td></td>
</tr>
<tr>
<td>IV - Level of Risk- Case type; child risk status at referral, # of children at home and child age at entry</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Adapted from Figure 2.2 - Conceptual Framework)

* Short Term and Intermediate seen as proximal outcomes, long-term as distal outcomes
** IV = Individual Variables, DV = Dependent Variable

Using this base model we will create a series of tables within this logistic regression framework, regarding other important variables of interest as they relate to research questions and hypotheses. We will create a series of tables to complete this analysis. After this process is complete we will select specific variables of interest that will be integrated into a table in tandem with our base variables to model our hypotheses testing, followed by analysis and discussion.
Data Analysis Results

In our database, we put codes in for each child at 3, 6, and 12 month columns to indicate the placement status at that interval. A code of 30 meant the child was at home. Our outcome variable was determined to be 1 on our data base if all three columns had Code 30. This outcome variable as our dependent variable is consistently used in the following analysis activities using our logistic regression framework.

Table 5.2 provides the results of our regression conducted on our base model variables. These variables are some of the important family and program characteristics that we need to compare to each of our variables of interest. Specifically these variables are: gender: female as compared to male; number (#) of parents in the home: single as compared to two or more; category risk dispositions, high risk category 1 and low risk category 2, both compared to the no risk category; and race/ethnicity, African-American or all others compared to the reference category of white. Regarding category risk dispositions, we need to reiterate that the FPS program accepts only risk levels 1 and 2 (out of 5 categories present in CPS).

For statistical purposes for these binary variables, in order to conduct our analysis, it is necessary to provide the log of the coefficient as well as the odds ratios to explain their importance in this and successive tables. In further review of Table 5.2, with the very low explanatory power of the model indicated by the pseudo R2s justified given the binary value of the explanatory variables, we find the statistically significant variables are both category risk dispositions 1 and 2. Both variables have high negative coefficients, which indicate that for both risk categories there is a likely negative impact on case
success, even greater for the high disposition than the low one, supported further by the low odds ratio scores. These odd ratio scores indicate a low likelihood of impact that these significant variables will have on success.

Table 5.2. Base Model Variables

<table>
<thead>
<tr>
<th>Variables</th>
<th>Coefficient (Standard Error)</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Base Model</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender: Female</td>
<td>−0.037 (0.183)</td>
<td>0.963</td>
</tr>
<tr>
<td># Parents in Home: Single</td>
<td>−0.331 (0.185)</td>
<td>0.704</td>
</tr>
<tr>
<td>Category Risk Disposition</td>
<td>(Reference Category: No Risk)</td>
<td></td>
</tr>
<tr>
<td>High Risk Disposition 1</td>
<td>−1.437* (0.527)</td>
<td>0.237</td>
</tr>
<tr>
<td>Low Risk Disposition 2</td>
<td>−1.282* (0.505)</td>
<td>0.277</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>(Reference Category: White)</td>
<td></td>
</tr>
<tr>
<td>African-American</td>
<td>0.110 (0.246)</td>
<td>1.116</td>
</tr>
<tr>
<td>Others (All of the rest)</td>
<td>−1.712 (0.813)</td>
<td>0.181</td>
</tr>
</tbody>
</table>

N: 536

Pseudo R2: .049

*p = < 0.05. **p = < 0.01.

The coefficients of all other variables—gender-female, number of parents in home-single, and race-ethnicity are not statistically significant. With the exception of African-American, their coefficients are mostly negative, with odds ratios mostly close to or just above 1. It appears as we apply these base model variables within the following
tables, we must consider that there is less likelihood that these factors would increase the chances for success. The significant variables remain highly important for our consideration relating to the high risk nature of this FPS program.

**Family Referral Characteristics Model**

Table 5.3 initiates specific analysis of our variables of interest. In this table and those to follow, we look first for consistency using coefficient findings for the base variables. Then we will discuss our findings for our variables of interest by using a reference category variable when necessary. We will look for variables with statistically significant coefficients and compare to the reference category when it appears. The reference category variable selected for each set is most often the highest N detailed in Tables 4.10 and 4.11.

For Table 5.3, we find the base variable coefficients remain consistent with those in the Base Models Table, both the high and low risk dispositions with high statistically significant negative coefficients. In this table as well, the Others-Race/Ethnicity category also has a high significant negative coefficient. Comparing to the reference category of White, this result appears to indicate that if race/ethnicity is other than white and black, there is a lesser chance for success.

For our referral characteristics as variables of interest, we selected child at home at referral as the reference category as the goal of this program is to assist families to keep their children at home instead of experiencing out-of-home placement. There are no referral characteristics in comparison to child at home with coefficients that are
statistically significant. Tied in the limited R2 for this table, these results provide limited predictability of the importance of these variables to our analysis.

Table 5.3. *Family Referral Characteristics Model*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Coefficient (Standard Error)</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Base Model</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender: Female</td>
<td>−0.065 (0.188)</td>
<td>0.937</td>
</tr>
<tr>
<td># Parents in Home: Single</td>
<td>−0.348 (0.192)</td>
<td>0.704</td>
</tr>
<tr>
<td>Category Risk Disposition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Risk Disposition 1</td>
<td>−1.366* (0.532)</td>
<td>0.255</td>
</tr>
<tr>
<td>Low Risk Disposition 2</td>
<td>−1.232* (0.509)</td>
<td>0.292</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>African-American</td>
<td>0.029 (0.252)</td>
<td>1.030</td>
</tr>
<tr>
<td>Others (All of the rest)</td>
<td>−1.651* (0.813)</td>
<td>0.192</td>
</tr>
<tr>
<td><strong>Referral Characteristics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Reference Category: At Home)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child at Risk at Referral</td>
<td>0.511 (0.543)</td>
<td>1.668</td>
</tr>
<tr>
<td>Age at Entry</td>
<td>0.003 (0.020)</td>
<td>1.003</td>
</tr>
<tr>
<td># of Children at Home</td>
<td>0.082 (0.087)</td>
<td>1.085</td>
</tr>
<tr>
<td><em>N</em></td>
<td>529</td>
<td></td>
</tr>
<tr>
<td>Pseudo R2</td>
<td>.054</td>
<td></td>
</tr>
</tbody>
</table>

*p = < 0.05. **p = < 0.01.
Case Type/Intensity Models

Table 5.4 models case types for referrals. For this table, we find the base variable coefficients remain consistent with those in Table 5.2, both the high and low risk dispositions with high statistically significant negative coefficients. In this table as well, the Others-Race/Ethnicity category also has a high significant negative coefficient, as found in Base models table.

For our case types as variables of interest, we selected abuse as the reference category as this type and neglect are often the types most often designated for FPS cases in this program. There are no case types in comparison to abuse with coefficients that are statistically significant or very high numbers. Tied in the limited R2 for this table, these results provide limited predictability of the importance of these variables to our analysis.

Table 5.5 models the variables of interest regarding intensity of intervention. For this table, we find the base variable coefficients consistent with those in Table 5.2, both the high and low risk dispositions with high statistically significant negative coefficients, as well as the Others category in the Base Models table. The first two columns model regression of the intensity variables at initial case closure of each intervention. We also included three additional columns to address regression for the 3, 6, and 12 months follow-ups for each variables of interest. These follow-up variables are included as they are necessary for us to understand intensity over the potential 1-year duration of each intervention. The risk dispositions continue consistently from the first two columns, excepting the Others-Race/Ethnicity category not being consistent.
Table 5.4. *Case Type Model*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Outcome Variable: Success</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Base Model</strong></td>
<td></td>
</tr>
<tr>
<td>Gender: Female</td>
<td>Coefficient (Standard Error)</td>
</tr>
<tr>
<td></td>
<td>−0.066 (0.137)</td>
</tr>
<tr>
<td># Parents in Home: Single</td>
<td>−0.341 (0.185)</td>
</tr>
<tr>
<td>Category Risk Disposition</td>
<td></td>
</tr>
<tr>
<td>High Risk Disposition 1 (Reference Category: No Risk)</td>
<td>−1.415** (0.540)</td>
</tr>
<tr>
<td>Low Risk Disposition 2 (Reference Category: No Risk)</td>
<td>−1.183* (0.522)</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
</tr>
<tr>
<td>African-American</td>
<td>0.078 (0.250)</td>
</tr>
<tr>
<td>Others (All of the rest)</td>
<td>−1.678* (0.819)</td>
</tr>
<tr>
<td><strong>Case Types</strong></td>
<td></td>
</tr>
<tr>
<td>(Reference Category: At Home)</td>
<td></td>
</tr>
<tr>
<td>Neglect</td>
<td>−0.117</td>
</tr>
<tr>
<td>Abuse/Neglect</td>
<td>0.364 (0.479)</td>
</tr>
<tr>
<td>Delinquency</td>
<td>0.089 (0.694)</td>
</tr>
<tr>
<td>Reunification</td>
<td>−0.192 (0.378)</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>0.647 (0.842)</td>
</tr>
<tr>
<td>Adoption</td>
<td>−0.192 (0.775)</td>
</tr>
<tr>
<td>Other</td>
<td>0.465 (0.331)</td>
</tr>
<tr>
<td>N</td>
<td>536</td>
</tr>
<tr>
<td>Pseudo R2</td>
<td>.054</td>
</tr>
</tbody>
</table>

*p = < 0.05. **p = < 0.01.*
### Table 5.5. Intensity Model

<table>
<thead>
<tr>
<th>Variables</th>
<th>Outcome Variable: Success</th>
<th>Follow-Ups After Case Closure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 months</td>
<td>6 months</td>
</tr>
<tr>
<td><strong>Base Model</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Coeff. (S.E.)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender: Female</td>
<td>–0.067</td>
<td>(0.190)</td>
</tr>
<tr>
<td># Parents in Home: Single</td>
<td>–0.406*</td>
<td>(0.192)</td>
</tr>
<tr>
<td>Category Risk Disposition</td>
<td>(Reference Category: No Risk)</td>
<td></td>
</tr>
<tr>
<td>High Risk Disposition 1</td>
<td>–1.633**</td>
<td>(0.551)</td>
</tr>
<tr>
<td>Low Risk Disposition 2</td>
<td>–1.497**</td>
<td>(0.528)</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>(Reference Category: White)</td>
<td></td>
</tr>
<tr>
<td>African-American</td>
<td>0.155</td>
<td>(0.258)</td>
</tr>
<tr>
<td>Others (All of the rest)</td>
<td>–2.460**</td>
<td>(0.825)</td>
</tr>
<tr>
<td><strong>Intensity</strong></td>
<td>(Reference Category: Total Case Days)</td>
<td></td>
</tr>
<tr>
<td>Face-to-Face Contact/24 Hours</td>
<td>0.670*</td>
<td>(0.720)</td>
</tr>
<tr>
<td>Total Case Hours</td>
<td>0.011</td>
<td>(0.008)</td>
</tr>
<tr>
<td>Total Face-to-Face Hours</td>
<td>0.020</td>
<td>(0.014)</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>531</td>
<td></td>
</tr>
<tr>
<td>Pseudo R2</td>
<td>.110</td>
<td></td>
</tr>
</tbody>
</table>

*p = < 0.05. **p = < 0.01.
For further analysis of our intensity variables our reference category is designated as Total Case Days, where all other time variables are embedded. In comparison to the reference category, we note that Face-to-Face Contact/24 hours has fairly high positive statistically significant coefficients begin and steadily increases across all the columns. This finding suggests the importance of engaging the client soon after the referral is made; this will impact the likelihood of success two to four times the odds than how many total days the case is open across all the time interval columns. In providing this suggestion, we must acknowledge the variations that may occur during these intervals between contact and reporting. The coefficients of the other variables of interest are not significant, although they have positive numbers across all time intervals. The R2 values begin low but steadily increases to be in the 12 month column denoted as nearly .9. The findings in this table permit some inference that intensity is a hallmark of this FPS program.

Service Checklist (SC) Models

The next series of tables will model identified components of the categories and subcategories of services that are listed on the Services Checklist. As these variables are selected randomly by the services worker/provider unique to each case, we will not indicate a reference category in our variables of interest in the remaining tables.

Table 5.6 models those services as variables of interest from Category I of the Checklist, denoted as Risk Assessment/Management. For this table, we find the base variable coefficients remain consistent with those in Table 5.2, both the high and low risk dispositions with high statistically significant negative coefficients. For this table and in
Table 5.6 *Risk Assessment/Management Services—SC*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Outcome Variable: Success</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Base Model</strong></td>
<td>Coefficient (Standard Error)</td>
</tr>
<tr>
<td>Gender: Female</td>
<td>-0.045 (0.194)</td>
</tr>
<tr>
<td># Parents in Home: Single</td>
<td>-0.413* (0.197)</td>
</tr>
<tr>
<td>Category Risk Disposition</td>
<td>(Reference Category: No Risk)</td>
</tr>
<tr>
<td>High Risk Disposition 1</td>
<td>-1.305** (0.538)</td>
</tr>
<tr>
<td>Low Risk Disposition 2</td>
<td>-1.020* (0.517)</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>(Reference Category: White)</td>
</tr>
<tr>
<td>African-American</td>
<td>0.285 (0.250)</td>
</tr>
<tr>
<td>Others (All of the rest)</td>
<td>-1.700 (0.819)</td>
</tr>
</tbody>
</table>

I. Risk Assessment/Management

<table>
<thead>
<tr>
<th>Variables</th>
<th>Coefficient (Standard Error)</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Assessment</td>
<td>-0.631* (0.264)</td>
<td>1.926</td>
</tr>
<tr>
<td>Safety Planning</td>
<td>-1.113** (0.207)</td>
<td>0.329</td>
</tr>
<tr>
<td>Routine DV Inquiry</td>
<td>0.453 (0.299)</td>
<td>1.573</td>
</tr>
<tr>
<td>Child/Monitoring/Supervision</td>
<td>1.011* (0.430)</td>
<td>2.747</td>
</tr>
<tr>
<td>Environ Safety Assessment</td>
<td>-0.111 (0.217)</td>
<td>0.895</td>
</tr>
<tr>
<td>Use of Crisis Card</td>
<td>-0.047 (0.244)</td>
<td>1.049</td>
</tr>
</tbody>
</table>

\[N = 536\]  
\[\text{Pseudo R2} = .152\]

*\(p = < 0.05\).  **\(p = < 0.01\).
Table 5.11 among all of our tables, the # of parents at home: single category also has a fairly high significant negative coefficient. This result appears to indicate that within risk assessment and management the likelihood of success is more likely for two parents or more than for single parents.

In Table 5.6 there are three variables of interest that are statistically significant, that of risk assessment, safety planning, and child monitoring/supervision. Risk assessment and safety planning have fairly high to high negative coefficients, while child monitoring/supervision has a high positive coefficient, and its odds to the likelihood of success as nearly 3 to 1. The coefficients of the risk assessment and safety planning indicate negative results, with higher odds nearly 2 to 1 for risk assessment and very low odds for safety planning pointing to less likelihood of success for both of these variables. With this FPS program very concerned about risk assessment and safety, this importance cannot be overstated but indicates a need for additional future clarification of the impact. The coefficients of the other variables of interest are not statistically significant. The R2 in this table is lower than those for intensity, but consistent with other tables, allowing us to infer some predictability to the importance of these variables.

Table 5.7 models those services as variables of interest from Category II of the Checklist, Family Violence Information/Safety Planning. For this table, we find the base variable coefficients remain consistent with those in Table 5.2, both the highest and lowest risk dispositions with high statistically significant negative coefficients. In this table as well, the Others-Race/Ethnicity category with a high significant negative coefficient, similar to in the Base Models table.
Table 5.7. *Family Violence Information/ Safety Planning Services–SC*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Outcome Variable: Success</th>
<th>Coefficient (Standard Error)</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Base Model</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender: Female</td>
<td>−0.012</td>
<td>(0.147)</td>
<td>1.012</td>
</tr>
<tr>
<td># Parents in Home: Single</td>
<td>−0.361</td>
<td>(0.190)</td>
<td>0.697</td>
</tr>
<tr>
<td>Category Risk Disposition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Risk Disposition 1</td>
<td>−1.508**</td>
<td>(0.540)</td>
<td>0.229</td>
</tr>
<tr>
<td>Low Risk Disposition 2</td>
<td>−1.329**</td>
<td>(0.510)</td>
<td>0.265</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African-American</td>
<td>0.141</td>
<td>(0.250)</td>
<td>1.163</td>
</tr>
<tr>
<td>Others (All of the rest)</td>
<td>−1.776*</td>
<td>(0.848)</td>
<td>0.169</td>
</tr>
</tbody>
</table>

II. Family Violence/Safety Planning

<table>
<thead>
<tr>
<th>Variables</th>
<th>Outcome Variable: Success</th>
<th>Coefficient (Standard Error)</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Planning</td>
<td>−0.382</td>
<td>(0.615)</td>
<td>1.465</td>
</tr>
<tr>
<td>Child DV Experience/Effects</td>
<td>−0.680</td>
<td>(0.536)</td>
<td>0.506</td>
</tr>
<tr>
<td>FV/DV Dynamics</td>
<td>−0.617</td>
<td>(0.430)</td>
<td>0.513</td>
</tr>
<tr>
<td>Planning to Leave</td>
<td>0.433</td>
<td>(0.440)</td>
<td>1.541</td>
</tr>
<tr>
<td>General Custody/Visit Info</td>
<td>0.778</td>
<td>(0.771)</td>
<td>2.177</td>
</tr>
<tr>
<td>Obtain Use/PPO</td>
<td>−0.391</td>
<td>(0.476)</td>
<td>0.676</td>
</tr>
</tbody>
</table>

\[N = 536\]

\[\text{Pseudo R}^2 = 0.063\]

\[*p = < 0.05. \; **p = < 0.01.\]
Regarding variables of interest for Table 5.7, we note that the variable with the designation of Safety Planning appears in this table as well as in Table 5.6. This variable is so important to the nature of this FPS program that appears as a component of both Risk Assessment and Family Violence/Safety planning defined the same. In this table, none of the coefficients of the variables of interest are statistically significant. The variables in this set as a group appear not impactful, also considering the low R2 result for the table, but family violence and safety planning components, especially for children and mothers in these families, remains an important safety component of this FPS program and require ongoing attention.

Table 5.8 models those services as variables of interest combining Categories III and IV of the Checklist, Substance Abuse Services and Sexual Abuse Services. These categories do not commonly appear among all referrals within this FPS program, but more specialized to certain types of referrals. The volume may not be the highest, but the potential for harm and its effect on safety and risk is higher when these categories are present during an intervention. For this table, we find the base variable coefficients remain consistent with those in Table 5.2, both the high and low risk dispositions with high statistically significant negative coefficients, but no other base variables are significant.

For Category III–Substance Abuse services, the only statistically significant variable of interest is Relapse prevention, with a high positive coefficient and the likelihood of success at odds of 4 to 1. This result is much higher in comparison to the coefficients of the other non-statistically significant variables. This variable is important
Table 5.8. *Substance Abuse Services/ Sexual Abuse Services–SC*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Outcome Variable: Success</th>
<th>Coefficient (Standard Error)</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Base Model</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender: Female</td>
<td></td>
<td>−0.004 (0.190)</td>
<td>1.004</td>
</tr>
<tr>
<td># Parents in Home: Single</td>
<td></td>
<td>−0.348 (0.196)</td>
<td>0.706</td>
</tr>
<tr>
<td>Category Risk Disposition</td>
<td></td>
<td>(Reference Category: No Risk)</td>
<td></td>
</tr>
<tr>
<td>High Risk Disposition 1</td>
<td></td>
<td>−1.563** (0.548)</td>
<td>0.209</td>
</tr>
<tr>
<td>Low Risk Disposition 2</td>
<td></td>
<td>−1.468** (0.526)</td>
<td>0.230</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td>(Reference Category: White)</td>
<td></td>
</tr>
<tr>
<td>African-American</td>
<td></td>
<td>0.023 (0.257)</td>
<td>1.023</td>
</tr>
<tr>
<td>Others (All of the rest)</td>
<td></td>
<td>−1.387 (0.843)</td>
<td>0.250</td>
</tr>
</tbody>
</table>

**III. Substance Abuse Services**

| Substance Abuse Services          |                           |                              |            |
| Substance Abuse Education         |                           | 0.310 (0.498)                | 1.477      |
| Sobriety/Abstinence Commitment    |                           | −1.085 (0.562)               | 0.338      |
| Identify/Assess Substance Use     |                           | −0.126 (0.455)               | 0.881      |
| Substance Abuse-Effects/Children  |                           | 1.118 (0.597)                | 3.057      |
| Relapse Prevention                |                           | 1.402* (0.650)               | 4.062      |

**IV. Sexual Abuse Services**

| Sexual Abuse Services             |                           |                              |            |
| Age Appropriate Sex Develop       |                           | −1.071 (0.672)               | 2.919      |
| Boundary Concepts                 |                           | −0.873* (0.356)              | 0.408      |
| Sexual Abuse Education            |                           | −0.360 (0.464)               | 0.740      |
| Identify Signs/Symptoms           |                           | −1.149* (0.529)              | 3.156      |
| Prevention Skills                 |                           | −0.286 (0.543)               | 0.752      |

| N                                 | 536                       |                              |            |
| Pseudo R2                         | .107                      |                              |            |

*p = < 0.05. **p = < 0.01.
as a service designed to prevent the problem from re-occurring and persistent damage to the success of the family during its intervention.

Regarding Category IV–Sexual Abuse services, the two statistically significant variables are boundary concepts and identify signs and symptoms, which suggests services inclined to prevention. Both variables have high negative coefficients with mixed odds, as do the remaining variables which are not statistically significant. When these services are required, Category IV findings suggest more potential negative impacts and much less of a likelihood of success than for Category III. Every variable listed must continue to be used toward preventing harm and assuring safety for services recipients within this FPS program, with the odds to better likelihood of success in mind. The low R2 for this table again suggests limited predictability.

Table 5.9 models those services as variables of interest for Category V of the Checklist, general clinical services and its four separate sections: (a) Parenting/Limit Setting, (b) Emotion Management, (c) Personal/Interpersonal Skills, and (d) Additional Clinical.

These subcategories comprise over one third of the services listed on the checklist. For this table, we find the base variable coefficients remain consistent with those in Table 5.2, both the highest and lowest risk dispositions with high statistically significant negative coefficients, but no other base variables are significant as we found in Table 5.8.

Moving to the variables of interest in Table 5.9, we need to be mindful that the R2 is mildly high, so predictability of importance can be inferred more favorably than for other tables. For section (a), the variables of natural/logical consequences, clarify
Table 5.9. *General Clinical Services (GCS) (a)–(d)–SC*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Outcome Variable: Success</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Base Model</strong></td>
<td>Coefficient (Standard Error)</td>
</tr>
<tr>
<td>Gender: Female</td>
<td>–0.009 (0.147)</td>
</tr>
<tr>
<td># Parents in Home: Single</td>
<td>–0.081 (0.232)</td>
</tr>
<tr>
<td>Category Risk Disposition (Reference Category: No Risk)</td>
<td></td>
</tr>
<tr>
<td>High Risk Disposition 1</td>
<td>–1.310* (0.592)</td>
</tr>
<tr>
<td>Low Risk Disposition 2</td>
<td>–1.305* (0.522)</td>
</tr>
<tr>
<td>Race/Ethnicity (Reference Category: White)</td>
<td></td>
</tr>
<tr>
<td>African-American</td>
<td>0.531 (0.319)</td>
</tr>
<tr>
<td>Others (All of the rest)</td>
<td>–1.992 (0.947)</td>
</tr>
<tr>
<td><strong>V(a). Parenting/Limit Setting</strong></td>
<td></td>
</tr>
<tr>
<td>Parent as Role Model</td>
<td>–0.338 (0.282)</td>
</tr>
<tr>
<td>Time Out</td>
<td>–0.131 (0.285)</td>
</tr>
<tr>
<td>Natural/Logical Consequences</td>
<td>0.901** (0.305)</td>
</tr>
<tr>
<td>Structure Routine</td>
<td>–0.108 (0.247)</td>
</tr>
<tr>
<td>Clarify Family Rules</td>
<td>–0.722** (0.252)</td>
</tr>
<tr>
<td>Clarify Family Roles</td>
<td>–0.722** (0.252)</td>
</tr>
<tr>
<td><strong>V(b). Emotion Management</strong></td>
<td></td>
</tr>
<tr>
<td>Building Hope</td>
<td>–0.603* (0.253)</td>
</tr>
<tr>
<td>Building Self-Esteem</td>
<td>–1.468** (0.261)</td>
</tr>
<tr>
<td>Depression Management</td>
<td>–0.695* (0.278)</td>
</tr>
<tr>
<td>Anger Management</td>
<td>0.152 (0.257)</td>
</tr>
<tr>
<td>Handling Frustration</td>
<td>–0.101 (0.259)</td>
</tr>
</tbody>
</table>
Table 5.9—Continued

| V(c). Personal/Interpersonal Skills |  
|------------------------------------|----------------------------------|
| Problem Solving                    | −0.378 (0.279) 1.460             |
| Relationship Building              | 0.546 (0.302) 1.727              |
| Teaching Active Listening          | 0.626 (0.348) 1.870              |
| Teaching “I” Message               | −0.998** (0.315) 0.387           |
| Boundary Concepts                  | −0.984** (0.285) 0.385           |
| Negotiation Skills                 | 0.472** (0.327) 4.357            |

| V(d). Additional Clinical Skills   |  
|------------------------------------|----------------------------------|
| Active Listening                   | −0.519 (0.298) 0.600             |
| Worker as Role Model               | −0.025 (0.289) 0.975             |
| Provide/Review Literature          | −0.243 (0.273) 1.275             |
| Use of Reinforcement               | 0.264 (0.293) 1.302              |
| Therapeutic Games                  | 0.087 (0.300) 1.090              |

<table>
<thead>
<tr>
<th>N</th>
<th>536</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pseudo R2</td>
<td>.107</td>
</tr>
</tbody>
</table>

*p = < 0.05. **p = < 0.01.

family rules and clarify family roles are statistically significant. Natural/logical
consequences alone has a high positive coefficient and the odds of the likelihood of
success are about 2.5 to 1, suggesting a very good impact for proximal outcomes
compared to the other two significant variables, These variables with negative
coefficients and low odds suggest much less likelihood for success compared to
Natural/logical consequences. None of the other variables of interest are statistically significant, and have negative coefficients.

For section (b), the variables of building hope, building self-esteem, and depression management are statistically significant. All three variables have negative coefficients, with only building hope with a high odds ratio of nearly 2 to 1. These findings suggest the odds for likelihood of success are less for these services than for other services but with some impact nonetheless. None of the other variables of interest in this section are statistically significant.

For section (c), the variables of Negotiation skills, teaching “I” messages and boundary concepts (a similarly named variable defined the same in Category IV) are statistically significant. Negotiation skills alone has a high positive coefficient and the odds of the likelihood of success are over 4 to 1, suggesting very high odds for impact on proximal outcomes compared to the other two significant variables. These variables with negative coefficients and low odds suggest much less likelihood for success compared to negotiation skills. None of the other variables of interest are statistically significant, but with mostly positive coefficients, and higher odds. For this section, the variables in this set as a group show more extensive levels of likelihood for success than in other sets, based on significance and generally high odds.

For both subsets (b) and (c) the results may suggest that these problems are difficult to overcome, but this fact also suggests how important these services need to be emphasized to help families remove these difficulties and improve their odds of success.

Finally, for section (d), none of the variables of interest was statistically significant. With active listening and worker as role model as variables with very high
\(N\)'s, the findings indicate negative coefficients and lower odds ratios. With the strength-based emphasis of this program, and these components likely to contribute strongly to this emphasis, this lack of significance and negative numbers is somewhat surprising.

For all four subsets, many of the services variables are used for teaching new ways of coping and encourage skill building and enhancement to improve family and personal functioning in many aspects of life. A number of the significant variables we have noted, along with higher predictability, allow us to identify many of them as characteristics used to expand our proximal outcome effectiveness measures and to test our hypotheses.

Table 5.10 models those services as variables of interest combining Categories VI–VIII of the Checklist, forming our referral infrastructure. These categories are VI–Referral to Other Resources, VII–Advocacy with., and VIII–Linkage to Social Supports. For this table, we find the base variable coefficients remain consistent with those in the Base Models table, both the highest and lowest risk dispositions with high statistically significant negative coefficients, but no other base variables are significant as we found in Table 5.8. The R2 within the table is mildly high, so predictability on importance can be inferred as in other tables with similar results.

For Category VI, the variables of substance abuse treatment/DV victim, social services, and mental health are statistically significant. Substance abuse treatment/DV and mental health have higher positive coefficients with the first-listed variable with a very high amount and mental health fairly high. The odds of both were 3.3 to 1 and 2.5 to 1, respectively, a high likelihood of success using these resources. Social services have a high negative coefficient and very low odds ratio, a much less likelihood of success.
Table 5.10. *Referral to Other Resources/Advocacy/Linkage to Social Supports–SC*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Outcome Variable: Success</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Base Model</strong></td>
<td>Coefficient (Standard Error)</td>
</tr>
<tr>
<td>Gender: Female</td>
<td>0.036 (0.196)</td>
</tr>
<tr>
<td># Parents in Home: Single</td>
<td>−0.456* (0.202)</td>
</tr>
<tr>
<td>Category Risk Disposition</td>
<td></td>
</tr>
<tr>
<td>High Risk Disposition 1</td>
<td>−1.598* (0.559)</td>
</tr>
<tr>
<td>Low Risk Disposition 2</td>
<td>−1.500** (0.522)</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
</tr>
<tr>
<td>African-American</td>
<td>0.017 (0.276)</td>
</tr>
<tr>
<td>Others (All of the rest)</td>
<td>−1.822 (0.933)</td>
</tr>
</tbody>
</table>

**VI. Referral to Other Resources**

- Counseling Services: −0.115 (0.717) 1.122
- Social Services: −0.142** (0.427) 0.317
- Mental Health: 0.941* (0.426) 2.562
- Sub Abuse Treat/DV Victim: −2.204* (0.505) 3.333
- Other: 0.833 (0.478) 2.304
- Sub Abuse Assess/Treatment: 0.774 (0.936) 2.179
- DV Victim Support Group: 0.692 (0.585) 1.985

**VII. Advocacy with . . .**

- Social Services: −0.100 (0.231) 0.905
- Mental Health: −0.520* (0.266) 0.594
- Educational System: 0.927* (0.409) 2.526
- Landlords: 0.731 (0.418) 2.077
- Utility Companies: −0.077 (0.388) 0.936
Table 5.10—Continued

<table>
<thead>
<tr>
<th>VIII. Linkage to Social Supports</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Family/Kin/Fictive Kin</td>
<td>-0.993**</td>
<td>0.393</td>
</tr>
<tr>
<td></td>
<td>(0.277)</td>
<td></td>
</tr>
<tr>
<td>General Relationship Building</td>
<td>0.098</td>
<td>1.103</td>
</tr>
<tr>
<td></td>
<td>(0.268)</td>
<td></td>
</tr>
<tr>
<td>School (e.g., Head Start)</td>
<td>-0.137</td>
<td>0.876</td>
</tr>
<tr>
<td></td>
<td>(0.345)</td>
<td></td>
</tr>
<tr>
<td>Neighbors</td>
<td>0.567</td>
<td>1.763</td>
</tr>
<tr>
<td></td>
<td>(0.348)</td>
<td></td>
</tr>
<tr>
<td>Child Support Groups</td>
<td>-0.587</td>
<td>0.556</td>
</tr>
<tr>
<td></td>
<td>(0.358)</td>
<td></td>
</tr>
<tr>
<td>Adult Support Groups</td>
<td>0.216</td>
<td>1.241</td>
</tr>
<tr>
<td></td>
<td>(0.469)</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>536</td>
<td></td>
</tr>
<tr>
<td>Pseudo R2</td>
<td>.149</td>
<td></td>
</tr>
</tbody>
</table>

*p = < 0.05. **p = < 0.01.

compared to the other significant variables. None of the other variables of interest are statistically significant, but with mostly positive coefficients, and higher odds.

For Category VII, the variables of educational system and mental health (similar to the variable in Category VI) are statistically significant. Educational system has a high positive coefficient with odds at 2.5 to 1, a high likelihood of success when the worker advocates with this institution. Mental health has a negative coefficient and very low odds ratio, a much less likelihood of success compared to the other significant variable. None of the other variables of interest are statistically significant, but with mixed coefficients and odds.

For Category VIII, family/kin/fictive kin was the only statistically significant variable, with a high negative coefficient and low odds ratio. This finding indicates this
linkage is indeed important, but its overall impact on the likelihood of success is limited. None of the other variables in this category were statistically significant, with mixed coefficients and odds.

Some of the statistically significant variables we have identified in Table 5.10 within Categories VI–VIII, allow us to consider them as characteristics to use to expand our proximal outcome effectiveness measures. Their ongoing importance is these categories form much of the after care services planning infrastructure the family uses after closure and follow-up while working to remain living together. For all of these categories, reducing their level of dysfunction which can affect their probability of success is a necessary future step for services provision

Table 5.11 models those services as variables of interest for Category IX of the Checklist, Concrete Services, and the two separate sections of services with special funding (a) and those with no special funding (b). These subcategories comprise over one-fifth of the services and combined with Category V are over half of all services on the Checklist. For this table, we find the base variable coefficients remain consistent with those in Table 5.2, both the high and low risk dispositions with high statistically significant negative coefficients. For this table and in Table 5.6 only among all of our tables, the # of parents at home: single category also has a fairly high significant negative coefficient. This result appears to indicate that within risk assessment and management the likelihood of success is more likely for two parents or more than for single parents. The R2 within the table is mildly high, so predictability on importance can be inferred more favorably than in other tables.
Table 5.11. Concrete Services–SC

<table>
<thead>
<tr>
<th>Variables</th>
<th>Outcome Variable: Success</th>
<th>Coefficient (Standard Error)</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Base Model</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender: Female</td>
<td>–0.073</td>
<td>(0.147)</td>
<td>0.930</td>
</tr>
<tr>
<td># Parents in Home: Single</td>
<td>–0.552*</td>
<td>(0.209)</td>
<td>0.576</td>
</tr>
<tr>
<td>Category Risk Disposition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Risk Disposition 1</td>
<td>–1.247*</td>
<td>(0.557)</td>
<td>0.287</td>
</tr>
<tr>
<td>Low Risk Disposition 2</td>
<td>–0.706</td>
<td>(0.531)</td>
<td>0.494</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African-American</td>
<td>0.345</td>
<td>(0.276)</td>
<td>1.411</td>
</tr>
<tr>
<td>Others (All of the rest)</td>
<td>–1.612</td>
<td>(0.916)</td>
<td>0.199</td>
</tr>
<tr>
<td><strong>IX(a). Services Provided/With Funding</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food</td>
<td>0.814*</td>
<td>(0.273)</td>
<td>2.444</td>
</tr>
<tr>
<td>Other</td>
<td>–0.589*</td>
<td>(0.262)</td>
<td>0.555</td>
</tr>
<tr>
<td>Transportation</td>
<td>–0.373</td>
<td>(0.265)</td>
<td>0.688</td>
</tr>
<tr>
<td>Furniture</td>
<td>0.260</td>
<td>(0.323)</td>
<td>1.297</td>
</tr>
<tr>
<td>Toys/Recreation</td>
<td>–0.495</td>
<td>(0.447)</td>
<td>0.604</td>
</tr>
<tr>
<td>Utility Benefits/Services</td>
<td>1.017*</td>
<td>(0.477)</td>
<td>2.766</td>
</tr>
<tr>
<td><strong>IX(b). Services Provided/No Funding</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food</td>
<td>1.059**</td>
<td>(0.329)</td>
<td>2.884</td>
</tr>
<tr>
<td>Other</td>
<td>–0.452</td>
<td>(0.534)</td>
<td>0.649</td>
</tr>
<tr>
<td>Transportation</td>
<td>–0.009</td>
<td>(0.394)</td>
<td>0.991</td>
</tr>
<tr>
<td>Furniture</td>
<td>–0.279</td>
<td>(0.453)</td>
<td>0.756</td>
</tr>
<tr>
<td>Toys/Recreation</td>
<td>0.502</td>
<td>(0.494)</td>
<td>1.652</td>
</tr>
<tr>
<td>(N)</td>
<td></td>
<td></td>
<td>535</td>
</tr>
<tr>
<td>Pseudo R2</td>
<td></td>
<td></td>
<td>.208</td>
</tr>
</tbody>
</table>

*\(p = < 0.05\). **\(p = < 0.01\).
The table sets compare variables of interest for both services with special funding and those without it. The only statistically significant variable in both columns is Food, with high positive coefficients and with odds of nearly 2.5 to 3 that providing food as a concrete service both with-funding and without-funding indicates a high likelihood of the odds of success compare to the other non-significant variables. In the with-funding column, both other and utility benefits/services were statistically significant, with the former likely to not contribute to success and the latter more likely with high odds to do so. No other variables in either column were statistically significant, and their coefficients both negative and positive being low. Within this category for both funding and non-funding, food as a concrete service can be identified as important for use to expand our proximal outcome measures.

*Family Satisfaction Survey (FSS) Model*

Table 5.12 identifies a limited number of services from the Family Satisfaction Survey. These are the top 6 ranked services seen as most helpful as identified by the families themselves. For this table, we find the base variable coefficients remain consistent with those in Table 5.2, both the high and low risk dispositions with high statistically significant negative coefficients. Under Race/Ethnicity, the Others-Race/Ethnicity category has a high significant negative coefficient such as we indicated previously similar to in the Base Models table. The R2 within the table is limited, so predictability on importance can be inferred less favorably than in past tables.
Table 5.12. *Most Helpful Services–FSS–Question 2*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Outcome Variable: Success</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Base Model</strong></td>
<td></td>
</tr>
<tr>
<td>Gender: Female</td>
<td>−0.016 (0.188)</td>
</tr>
<tr>
<td># Parents in Home: Single</td>
<td>−0.214 (0.185)</td>
</tr>
<tr>
<td>Category Risk Disposition</td>
<td></td>
</tr>
<tr>
<td>High Risk Disposition 1</td>
<td>−1.503** (0.535)</td>
</tr>
<tr>
<td>Low Risk Disposition 2</td>
<td>−1.349** (0.522)</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
</tr>
<tr>
<td>African-American</td>
<td>−0.109 (0.250)</td>
</tr>
<tr>
<td>Others (All of the rest)</td>
<td>−1.852* (0.815)</td>
</tr>
<tr>
<td><strong>Question 2–Rank Order 1-6</strong></td>
<td></td>
</tr>
<tr>
<td>2A. Helped obtain services for our family</td>
<td>0.792** (0.289)</td>
</tr>
<tr>
<td>2B. Taught us new ways to communicate</td>
<td>0.778* (0.328)</td>
</tr>
<tr>
<td>2C. Helped understand my children better</td>
<td>−0.141 (0.178)</td>
</tr>
<tr>
<td>2D. Taught us new ways to manage children’s behavior</td>
<td>0.002 (0.286)</td>
</tr>
<tr>
<td>2E. Helped me feel better about myself</td>
<td>−0.397 (0.343)</td>
</tr>
<tr>
<td>2F. They listened to me</td>
<td>−0.749 (0.367)</td>
</tr>
</tbody>
</table>

*p = < 0.05. **p = < 0.01.*
Regarding our variables of interest, the variables of 2A–Helped obtain services for the family, and 2B–Taught us new ways to communicate, are statistically significant. Both have a high positive coefficient and the odds of the likelihood for success for both variables are around 2.2 to 1. These significant variables impact our proximal outcomes expansion compared to the other variables, none significant, with negative coefficients and low odds.

**Models—Hypothesis Testing**

Using the base model variables highlighted in Table 5.2 we created and discussed the results of a series of tables (Table 5.3 to 5.12) to implement our logistic regression framework. We analyzed a number of important base variables and variables of interest comparing them to reference categories within each table.

**Findings—Model Testing of Hypotheses 1–4**

As a beginning foundation to conduct the testing and discussion of our hypotheses, we will re-introduce our research questions individually, followed by our linking the specific hypotheses that apply to that question in order to analyze and answer it.

Our first research question is: How does the level of risk for abuse and neglect of children affect the distal and proximal outcomes for each family? This question is addressed by Hypothesis 1.
Hypothesis 1: The level of risk of abuse or neglect such as nature and severity of child maltreatment has significant negative effects on the proximal outcomes of FPS services.

It is necessary to look at case types as an independent variable and category risk disposition as a base model variable in order to test this hypothesis. Table 5.4 addressed case types with category risk disposition listed also as a base model variable. The coefficients for both risk dispositions 1 and 2 in that table were consistently negative across all models, with very low odds, and both of these variables were statistically significant. This suggests these significant variables as likely to have a negative effect on the likelihood of case success.

None of the case types was seen as statistically significant. Abuse was selected as the reference category to compare to other case types. Neglect was the case type with highest $N$. Among neglect and the other case types there were generally negative coefficients, mostly with high odds, but none were statistically significant. Neglect had the lowest negative coefficient of any case type. With this trend toward negativity throughout the data in this table, we can infer this hypothesis is supported. Nelson (2001) has found that physical abuse cases have been more successful within FPS than neglect and our findings seem to bear out this observation. These findings also help us to answer our research question of how the identified level of risk for abuse and neglect affect case outcomes.

Our second research question is: How does duration/intensity of program participation for each family intervention affect services duration/intensity and services
availability/accessibility and the distal and proximal outcomes for each family? This research question is addressed by Hypothesis 2.

*Hypothesis 2:* The intensity of services (the number of hours and days spent in direct contact with the family) will positively affect the proximal outcomes of FPS services.

Table 5.5 presents our intensity of services intervention model, comparing our base variables with our variables of interest within the table. Total case days were selected as the reference category for our variables of interest, as the other variables are embedded in this category.

Descriptive data for this category indicated the mean for total case days among our case population was 28.15 days. This category was compared to the other variables: face-to-face contact within 24 hours, total case hours, and total face-to-face hours. Descriptive data for these variables reported that nearly 90% of the children and their families in our population were contacted within 24 hours; the means for total case hours was around 67 and for face-to-face hours was around 40. From this table only the 24-hour contact was found and continued to be statistically significant, with positive coefficients and high odds ratios that increased steadily initially, and among the 3, 6, and 12 months after case closure intervals. The odds for this variable among all intervals were from 2 to 4 to 1, the highest at the 12-month interval. None of the other intensity variables were statistically significant.

We can infer intensity is a hallmark of this FPS program throughout the 1-year case threshold. The dynamic of engaging the family quickly after a referral is an
especially important characteristic to include in our expansion of effectiveness outcomes. With these findings in mind, we can infer that this hypothesis is supported.

A study by Nelson (2001) found that the optimal mix of services and length of case time is important for a deeper study of characteristic components. The support of this hypothesis and the importance of intensity we have emphasized may be linked favorably with service characteristics as proximal outcomes and enhances credibility toward expansion of effectiveness measures. Berry (2005) stated that studies have “identified the contribution of direct service time with the caseworker as a critical correlate of successes, including placement prevention, prevention of re-abuse, and improvement in family skills and relations” (p. 329). Our findings support that direct service time are a critical correlate of success for this FPS program.

Our third and final research question is: How does the identification of family and program characteristics (i.e., needed services) by both worker and families and types and levels of services affect the distal and proximal outcomes of IFPS? How do these characteristics relate to the family designation of specific services satisfaction through gains in safety, supports, skills, and community linkages? This research question is addressed by Hypotheses 3 and 4.

**Hypothesis 3:** Characteristics of families at risk of abuse and neglect significantly affect the proximal outcomes of FPS services. More specifically, I hypothesize the direction of effects as the following:

1. Minority background: negative
2. Multiple parents: positive
3. Gender of the child: female–negative
4. Age of the child (0–18): positive

5. Large families (# of children in the home): negative

Family referral characteristics 1–3 (minority background, multiple parents, and gender of the child) became the base variables modeled first in Table 5.2 and carried through as a component of Tables 5.3 through 5.12. Characteristics 4–5 (age of child and large families) were first modeled in Table 5.3 and also carried throughout Tables 5.4 through 5.12. These base variables in both tables were selected as they were the non-binary variables present in this study.

A listing of these variables, which were defined more specifically in the narrative for Table 5.2, included gender of child: female; number of parents in the home: single; category risk disposition, high 1, low 2, with no risk as the reference category; and race/ethnicity: African-American and others with white as the reference category. In Table 5.3 these variables were included: number of children in the home at referral; child risk status at referral and child age at entry, with child at home-status at referral as the reference category.

For the base variables, measurements focused on the coefficients throughout all tables. Others with negative coefficients, and not statistically significant, were gender: female and race/ethnicity: others, and number of parents in the home: single.

The only variable with a positive coefficient and not significant was race/ethnicity: African-American. From Table 5.3, the base variables continued with similar results, but race/ethnicity: Others were also statistically significant with a high negative coefficient. Using at home-child status at referral as the reference category, the variables of child risk status at referral, age at entry, and number of children at home all
had moderate to low coefficients and were not statistically significant. We will now address each family referral characteristic listed in the hypothesis using a composite of the findings from each of our tables as they apply. We will then support or non-support as hypothesized for the direction of effects either positive or negative.

Effect #1 was: Minority background–negative. Initially in Table 5.2 the results under Race/Ethnicity, with white as a reference category was a very low positive coefficient for African-American and a high negative co-efficient for Others-Race/Ethnicity (RE), neither of them statistically significant. The coefficients remained the same value/direction/significance for each type in Tables 5.6, 5.8, 5.9, 5.10, and 5.11. For Others-RE, the values and direction remain the same, but there is statistical significance detailed in Tables 5.3, 5.4, 5.5, 5.7, and 5.12.

With these mixed significance results among the tables, with no significance for African-American in any table and consistent low positive coefficients, we need to identify the models where the significance occurs for Others-RE, which consistently has a very high negative coefficient. The models are: family referral characteristics; case types; intensity, family violence information/safety planning; and most helpful services–FSS.

With no significance identified in any table throughout the African-American variable, with positive but low coefficients, in tandem with a limited number of models with significance for others, having high negative coefficients, it appears these findings suggest this component of the hypothesis with an effect trending to a negative direction, which these findings support. From our descriptive data, one contributing factor to this lack of support may be that nearly 80% of our sample population was the White/Non-Hispanic type.
Effect #2 was: Multiple parents–positive. Initially in Table 5.2 the results under number of parents in the home: single was a low negative coefficient, which was not statistically significant. The coefficients remained the same value/direction/significance in Tables 5.3, 5.4, 5.7, 5.8, 5.9, and 5.12. The values and direction remained the same, but statistical significance was detailed in Tables 5.5, 5.6, 5.10, and 5.11. The models identified as statistically significant are: intensity, risk assessment/management, referral to other resources, advocacy, linkage to social supports, and concrete services. With these negative findings present for the single parent variable and with significance in some of the models, we can infer that two parent (multiple) homes would be likely to be more successful and this hypothesis is partially supported. It appears also we cannot specify the volume of this positive effect and it is likely to be limited.

Effect #3 was: Gender of the child: female-negative. Initially in Table 5.2 the results under gender: female was a very low negative coefficient. There was a similar negative result that remained consistent in all the Tables 5.3 through 5.12, with the exception of Table 5.10, the resource referral, advocacy, and linkage model, with a low positive coefficient.

In none of the tables was this variable identified as statistically significant. With these negative findings present for the female gender variable and with no statistical significance in any of the models, we can infer that gender: male would be more likely to be more successful, but with no statistical significance we can infer a negative direction for either gender. As with number of parents, specifying the volume of effect is difficult. Our descriptive data indicated that are sample population was nearly evenly divided
between male and female. Our findings suggest this component of the hypothesis having a negative direction is not supported.

Effect #4 was: Age of child (0–18)–positive. For this effect, we will identify the findings from Table 5.3. The base model variables in that table were consistent with Table 5.2 as far as value/direction, and significance. Our descriptive data found the numbers of children affected in our sample population was 80% for those 12 years and younger. For the age of entry variable, findings indicate a very low positive coefficient, and odds of around 1, with no statistical significance. This lack of significance coupled with a very low coefficient and limited odds indicate this component of the hypothesis with an effect in a positive direction is not supported.

Effect #5 was: Large families–negative. For this effect, we will identify the findings from Table 5.3. The base model variables in that table were consistent as far as value/direction, and significance. For the number of children in the home variable, findings indicate a very low positive coefficient, and odds of around 1, with no statistical significance. This lack of significance coupled with a very low coefficient and limited odds indicate this component of the hypothesis with an effect in a negative direction is not supported.

With the findings on all five effects in mind which we have summarized above, we can infer their general trend as a group, with the exception of multiple parents, mostly in a negative direction. These family and program characteristics have continued utility in their effect on the proximal outcomes we wish to select to expand our effective measures.

Berry, Bussey, and Cash (2001) have outlined six characteristics that could be used to define proximal outcomes (see Figure 2.6). The #1 characteristic on Figure 2.6 is:
the characteristics (demographic and others) of families, caregivers, and children. These findings by Berry et al. (2001) about this #1 characteristic appear to support the importance of the continued utility we expect in using these characteristics. Keeping in mind our findings and those of Berry et al., we need to work toward changing their impact into a more positive direction while on the path to expanding our proximal outcome effectiveness measures. These factors assist toward starting the overall process to answer research Question #3 more directly.

Hypothesis 4: The types and levels of services provided produce significant effects on the proximal outcome results of FPS services. More specifically, the effects of providing risk assessment/management, general clinical services, resource referral, advocacy, linkage with social supports, and concrete services will be positive, whereas those of family violence information/safety planning, substance abuse, and sexual abuse services will be negative. Families receiving specifically designated types and levels of service will be more likely to succeed.

Tables 5.6 through 5.11 present the models for the subcategories (services provided) on the Services Checklist, which were first identified and outlined in Tables 4.10 and 4.11 in our descriptive data. I will report our findings using the Category numbers (I–IX) and the specific tables that model each category and report on specific service variables (subcategories). I will address each category as it is listed in the hypothesis using findings from the table related to it and indicate support or non-support for the direction of effects as hypothesized as either positive or negative. No reference category will be used when we look at the variables of interest.
Additionally, Table 5.12 takes a very limited look at Question 2 of the Family Satisfaction Survey to gain some insight into how families themselves denote and view the help they receive and report gains in safety, support, skills, and linkages. A study by Fraser, Pecora, and Haapala (1991) found that program variables associated with FPS program effectiveness include types of clinical and concrete services we are using to test model this hypothesis.

*Category I—Risk Assessment/Management Services—Positive Effect*

Using Table 5.6, the data for this category, we first note that the variables of interest of risk assessment, safety planning, and child monitoring/supervision were statistically significant. They all have high to very high N’s as indicated in Table 4.11. Corcoran (2000) found that assumptions of the Homebuilders model include that people are more open to change in a crisis. This factor supports the notion of the importance of risk assessment having an effect with the high-risk clients that are referred to this program. With the first two significant variables, they have moderate to high negative coefficients and both low and high odds. Child monitoring and supervision has a high coefficient, and odds of 3 to 1. With all of these findings in mind, this component of the hypothesis with an effect in a positive direction is supported, especially as it relates to what Corcoran has previously found.

Berry et al. (2001) have outlined six characteristics that may be used to define proximal outcomes (see Figure 2.6). Number 3 in Figure 2.6 is: the characteristics of case assessment by referral staff and imminence of risk. In this FPS program, there is further risk assessment by the services workers themselves after initial risk assessment by the
referring worker. With our findings supporting this component of our hypothesis, those significant services identified under this component are potential characteristics to be considered for expanding our proximal outcome effectiveness measures, especially child monitoring/supervision.

*Category II—Family Violence Information/Safety Planning—Negative Effect*

Using Table 5.7, the data for this category, we first note that no variables of interest in this category are statistically significant. Of these non-significant variables, General custody/visit info has the highest positive coefficient and odds of around 2.2 to 1. The rest of the variables have both moderately low negative and positive coefficients. With these findings in mind, this component of the hypothesis with an effect in a negative direction but no significance is not supported. There is limited potential to identify specific services across this category to utilize as characteristics for proximal outcomes measures expansion.

*Category III—Substance Abuse Services—Negative Effect, and Category IV—Sexual Abuse Services—Negative Effect*

These two categories were combined, and the data for them are contained in Table 5.8. For Category III, the only statistically significant variable of interest was relapse prevention, with a high positive coefficient, and odds of 4 to 1. Of the non-significant variables, substance abuse effects on children have the highest positive coefficient and odds of around 3 to 1. The rest of the variables have both moderately low negative and positive coefficients. For Category IV, the two statistically significant variables of interest
were (1) Identify signs/symptoms with a high negative coefficient, and odds of 3 to 1; and (2) Boundary concepts, also with a high negative coefficient and very low odds. Of the non-significant variables, all of them have negative coefficients and very low odds.

With these findings in mind, for both of these components of the hypothesis, an effect in a negative direction is partially supported. There is limited potential across this category for identified services, with the exception of the statistically significant to use as characteristics for proximal outcomes measures expansion. All of the services remain necessary to use when needed toward preventing harm and assuring safety for services recipients, so their use when needed remains essential.

**Category V—General Clinical Services—Positive Effect: Subsets (a) Parenting/Limit Setting, (b) Emotion Management, (c) Personal/Interpersonal Skills, (d) Additional Clinical**

Using Table 5.9, the data for this category, there are four subsets as detailed above. We will report our findings using each subset section. For section (a) we first note that the variables of interest of clarifying family rules, clarifying family roles, and natural/logical consequences safety planning, and child monitoring/supervision were statistically significant. With the first two significant variables, they have moderate to high negative coefficients and low odds. Natural/logical consequences have a high coefficient, and odds of 2.5 to 1. Of the non-significant variables, parent as role model has a very high $N$ as indicated in Table 4.10, but a low negative coefficient and high odds. For this section, especially with several variables as statistically significant and with higher $N$’s, the coefficients are lower and tend to a negative direction, although natural and logical consequences is an exception.
For section (b) we first note that the variables of interest of building self-esteem, building hope, and depression management were statistically significant. With all of the significant variables, they have moderate to high negative coefficients, with building hope as having high odds of around 2 to 1. The non-significant variables have low coefficients. All of these variables have high N’s as detailed in Table 4.10. As in the previous section, the tendency is toward a negative direction.

For section (c) we first note that the variables of interest of negotiation skills, boundary concepts, and teaching “I” messages were statistically significant. With negotiation skills, there is a high positive coefficient and odds of around 4.4 to 1. The latter two significant variables have moderate to high negative coefficients and low odds. Natural/logical consequences have a high coefficient, and odds of 2.5 to 1. Of the non-significant variables, they all have high odds but very low coefficients both positive and negative. For this section, especially with several variables as statistically significant and with higher N’s, the coefficients are moderately high but tend to a negative direction, although negotiation skills are an exception. Section (c) shows a greater focus on skill acquisition, although it is also emphasized to a lesser degree throughout this entire category a–d.

Finally, for section (d) we first note that no variables of interest in this category are statistically significant. Of these non-significant variables, the coefficients are low but mostly positive and most have high odds. With these findings in mind, this component of the hypothesis with an effect in a negative direction is supported, especially with the lack of statistical significance. There is limited potential across this category for identified services to use as characteristics for proximal outcomes measures expansion.
Considering our overall findings of mainly negative directions we have identified specifically for each subset, overall we infer there is lack of support for this component of the hypothesis, which was a positive effect. The statistically significant variables among all the sections tend to have negative coefficients, and with high odds that increase a higher likelihood of a negative impact on success, and we can infer non-support from these findings. Most of the non-significant variables discussed among all of the subsets also tend in a negative direction, but this lack of significance diminishes the consideration we can infer concerning the direction of this component.

*Category VI—Referral to Other Resources—Positive Effect; Category VII—Advocacy with—Positive Effect; Category VIII—Linkage with Social Supports—Positive Effect*

These three categories were combined, and the data for them are contained in Table 5.10. For Category VI, the three statistically significant variables of interest were (1) social services, with a high negative coefficient and low odds; (2) mental health, and (3) substance abuse treatment for DV victims, with high positive coefficients, and odds of 2.5 to 1 and 3.3 to 1, respectively. Of the non-significant variables, most have high positive coefficients and high odds. The N’s for all of the variables in this set are much less than in other sets and more similar to Categories III and IV. The variables in this set as a whole have more extensive levels of likelihood for success than in many other sets, due to much statistical significance and high positive odds among the variables even if not significant. We can infer a tendency toward a positive direction.

For Category VII, the two statistically significant variables of interest were (1) mental health, and (2) educational system, both with moderate to high negative
coefficients and odds high only variable 2 at 2.5 to 1. Of the non-significant variables, most have high negative coefficients and high odds. The \( N \)'s for all of the variables in this set are much less than in other sets and more similar to Categories III and IV. Especially with both significant variables being negative and positive, and the rest of them tending to a negative direction, we can infer the direction in this set tends negatively.

For Category VIII, the only variable in the set that was statistically significant and with the highest \( N \) is family/kin/fictive kin. It has a high negative coefficient and low odds. The other \( N \)'s are again less than many sets, but generally higher than Categories III and IV. The other variables are not significant, with a mixture of both mostly low to moderate positive and negative coefficients. This set tends to a negative direction and less strong than the other sets.

With these findings for Categories VI–VIII in mind, we infer these components of the hypothesis with an effect in a positive direction tend to be mixed. Category VI has stronger positive support due to the many variables that are statistically significant. Categories VII and VIII have lesser strength than the first set, and tend toward the negative more than the positive. There are some identified significant services within these sets that have potential use as characteristics for proximal outcomes measures expansion.

A study by Cash and Berry (2003) found that families receiving the provision of social support are an important component of effective programs using the ecological paradigm such as FPS. Juby and Rycraft (2004) found that social supports highly associate and enhance individual and family resiliency, and the probability of the family remaining intact. Thus, the importance of categories VI–VIII is how they form much of
the planning for the aftercare services infrastructure the family uses after closure and up to the follow-up visits while working to remain living together as evidenced by these studies. The differences in findings among the three categories relates to how much control both the family and worker have over the support that can be provided using a specifically identified service. More qualitative study of these issues is necessary to find more details on why this effect may occur.

Category IX—Concrete Services—Positive Effect: Subsets (a) Services Provided—With Funding, (b) Services Provided—No Funding

Using Table 5.11, the data for this category, there are two subsets as detailed above. We will report our findings using each subset section. The funding discussed above is not the money received to fund the entire program, but a small discretionary amount of money per case. This money is spent at the discretion of the service worker to assist in providing concrete services that support other safety and clinical services. In a study by Barth (1990) he found families facilitating their use of formal and informal resources as one of five goals for FPS service delivery.

For section (a) we first note that food, other services, and utilities were three statistically significant variables. Food has a high \( N \) as indicated in Table 4.10. All had high coefficients, but only other services were negative and had low odds. Food and utilities were positive and had very high odds. No other variables of interest were statistically significant, mostly with negative coefficients and moderate odds. For this section, with food (very high \( N \)) and utilities having positive coefficients and high odds with statistical significance, we can infer this section tends to a positive direction.
For section (b) the only statistically significant variable was again food. As in section (a) it had a very high positive coefficient and high odds. The variables that were not significant had mostly negative coefficients and moderate odds. The N’s in this section are higher than most of those in (a). All of these variables have high N’s as detailed in Table 4.10. As in the previous section, the tendency of food with the highest N tending to a positive direction, we can infer this set tends positively.

With these findings for the two subsections of this category in mind, we infer this component of the hypothesis with an effect in a positive direction is supported, more for services with funding than those without, but tending positive overall. A study by Cash and Berry (2003) found that families assisted in procuring basic resources or necessities are an important component of effective programs using the ecological paradigm such as FPS. Further study into each of these concrete services before naming them as potential characteristics used to expand proximal outcomes appears necessary, but food and utilities stand out as characteristics that can be used immediately as a launching point.

*Family Satisfaction Survey—Question 2*

Table 5.12 provides the data on a very limited number of services from the Family Satisfaction Survey concerning the 6 top ranked most helpful services from Question 2 as identified by the families themselves. The two statistically significant variables were 2A–Helped obtain services for our family, and 2B–Taught us new ways to communicate. Both had high positive coefficients and both had odds of 2 to 1. The other variables, 2C, 2D, 2E, and 2F, were not statistically significant, and with the exception of 2D, had moderate
negative coefficients and odds. 2D had a very low positive coefficient with moderate odds.

The N’s for all variables are moderately high. The variables in this set as a whole show more moderate levels of likelihood for success than in many other sets, and those with statistical significance a high likelihood. For this category, there is a tendency toward a positive direction. With this tendency and the findings in this section, the segment of the hypothesis concerning family designation of specific services satisfaction as more likely to succeed can be addressed on a limited basis. This inference is that general family satisfaction for services named exists and may indicate gains, but how much is difficult to suggest. As with concrete services, a necessary and more detailed study should be conducted of the Survey services before naming them as characteristics used to potentially expand proximal outcomes measures. These six services identified could be considered as a launching point for these activities.

With the findings on the direction effects of the nine categories of the Checklist, we can infer their general trend as a group is mostly going in the positive or negative direction as was hypothesized. Every service listed offers continued utility for this FPS program as potential characteristics/proximal outcomes to expand our effectiveness measures. The directional tendency of each service provides a way to determine their utility. Berry et al. (2001) outlined six characteristics that may be used to define proximal outcomes (see Figure 2.6). Number 5 on Figure 2.6 is: the characteristics of progress results such as service planning, demand and utilization, types and duration and location of contacts, and goal achievement as identified by referral staff, FPS staff, and families
receiving the services. These Hypothesis #4 findings linked with Hypothesis #3 findings help answer Research Question #3 in greater detail.
CHAPTER VI

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Throughout this study, our focus has been to locate family and program characteristics, and as those specific services that affect the proximal outcomes of FPS/IFPS services. We defined proximal outcomes as those outcomes measuring changing in family functioning. Corcoran (2000) noted that these types of outcomes have the greatest capacity to affect families and the children we are trying to keep safe now and into the future.

From the literature, we have noted the Child Welfare League of America (CWLA) (2003) Standards of Excellence for Family Preservation Services (FPS). This organization notes that excellence is related to successful outcomes measured by ability of the family to stay together or reunify safely. Several standards outlined indicate the basis for these successful outcomes, including family member safety; improved family functioning and informed decision-making, but especially enhanced child well-being. It seems the nature of these standards describe both distal (safety) and especially proximal outcomes (functioning, decision-making, and child well-being). Our discussion within this section will focus on our findings and their relation to our use of specific proximal outcomes to expand our FPS effectiveness measures. To focus this discussion we will return to our Conceptual Framework (Figure 2.2), which we also adapted into Table 5.1 to create our
logistic model components for data analysis. Table 6.1 will provide a visual summary of the important components of the themes presented in both of these previous illustrations.

Table 6.1 Conceptual Framework /Logistic Model Components

<table>
<thead>
<tr>
<th>I. Who are we serving and what needs/problems</th>
<th>II. Service Delivery Model and Theory of Change</th>
<th>III. Short Term, Intermediate, and Long-term Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMPONENTS</td>
<td>COMPONENTS</td>
<td>COMPONENTS</td>
</tr>
<tr>
<td>• Risk Factors</td>
<td>• Modality of Service</td>
<td>• Case Status</td>
</tr>
<tr>
<td>• Social Supports</td>
<td>• Intensity, Frequency, and Duration/Service</td>
<td>• Individual Skill Development</td>
</tr>
<tr>
<td>• Skill of Family members within service system</td>
<td>• Location</td>
<td>• Stakeholder Satisfaction</td>
</tr>
<tr>
<td>• Family strengths</td>
<td>• Variety/Sequencing of Services</td>
<td>• Worker Services Quality</td>
</tr>
<tr>
<td>(Adapted from Table 5.1 Logistic Model components)</td>
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<td></td>
</tr>
</tbody>
</table>

Column I addresses the factors of whom we are serving in this FPS program and what are the needs and problems of the services recipients. One of the important factors in this column addressed in this study was risk factors. In general we found the children in our sample population are in families with a high-risk potential for abuse and neglect and the mission of this program is to focus on these types of families. Throughout all our tables, the base variable of highest risk disposition 1 and lowest risk disposition 2 was consistently statistically significant. Although we had a high N for the case type neglect, and although the data analysis did not reveal any statistically significant types, using abuse as our reference category, neglect had a negative coefficient and moderate odds ratio. It appears from the data that this FPS program is connecting properly with its high-risk mission, and working toward the CWLA (2003) standard of family member safety. The fact, however, that many of the children served with our case/sample population appeared within the neglect type suggests public/private staff need to collaboratively and
closely evaluate their overall risk assessment process so the abuse case type is more prevalent, enhancing compliance with the family member safety standard.

Another important factor in this column is family strengths and skills within the service system. This factor could be used to increase the social supports which the family and children already bring with them into the casework relationship. Many of the family characteristics also studied in our base model and from Table 5.3 provide the data to study this factor. They will help denote what strengths, skills, and social supports of families currently exist and in turn the needs and problems that are present. These characteristics include race/ethnicity; number of children in the home, number of parents in the home: single, age of the child at referral, and gender.

Among these characteristics, our findings suggest that a minority background, age, and gender of the child are less likely to have a positive impact on the success of each intervention, as they were not statistically significant. These results indicate the importance of close scrutiny of these personal characteristics for each family after a referral is made by the agency service worker. The goal should be to assure that this scrutiny is an integral part of the assessment and engagement process for each intervention. This goal can be directed to selecting services that may affect a more positive impact for the family and children. Our findings also suggest that multiple parents and the number of children in the home is more likely to have a positive impact on success, and these characteristics must continue to be an integral part of the assessment/engagement process to assure their continued positive impact.

The overall theme presented by all of these findings these results appears to suggest that the necessity to find family and child strengths the family brings into the
casework relationship under each of these factors is important to reverse some any innate negativity and maintain/increase the positivity that is already present. Public contracting staff/administrators and private agency staff/administrators should study in more detail how the general negative direction suggested by these findings can be turned into more of a positive impact in the program structure itself. Any application of services characteristics as proximal outcomes to expand effectiveness may be hindered until any suggested negativity is changed. This may also affect the possibility of meeting the CWLA (2003) standard of improved family informed decision making regarding successful outcomes. The components of Column I in Table 6.1 segue nicely into the components of Column II regarding the service delivery model and theory of change. Services are necessary to impact in some manner the Column I components identified.

For Column II, one of the prime components we have studied about this program is the factors of intensity, frequency, and duration of service, even across the 1-year threshold potentially available to each referral. One of our most important findings, both statistically significant and with high odds is when using total case days as a reference category; comparing the variable of face-to-face contact within 24 hours stands out as important during the intervention and throughout the 1-year time span based on the 3, 6, and 12-month follow-up intervals. 24-hour contact as an intensity factor contributes a high likelihood for the odds of success. Total case and face-to-face hours, although not statistically significant, have positive coefficients and high odds, These findings about these intensity, frequency, and duration measures while the case is in progress having statistical significance and higher odds suggests why this program has a potential to be successful if these results remain positive on an ongoing basis. The components of the
Homebuilders model outlined in Figure 2.4 appear to be supported by these findings as well, as a modality of service named as another component here in Column II.

We must consider the possibilities suggested by the findings by Feldman (1991) suggesting the effect of FPS diminishes as time goes on, in his study after 9 months. Linked with our findings, there is a need for public and private staff to assess further the staying power of intensive services over a lengthy period of time after closure. Our findings concerning Categories VI–VIII of the Checklist, denotes a more limited services volume. Looking at the ones in those categories with statistical significance, an increased emphasis to assuring a higher volume of these services are provided and documented could be considered as part of any public/private collaboration among their staff and administrators to improve the effectiveness of this FPS program.

Finally, the component of the variety and sequencing of services from Column II is evidenced by extensive findings of the identification of many types and levels of services from both the Services Checklist and the Family Satisfaction Survey. Many services, with statistical significance can be delineated as characteristics that affect the nature and prospective expansion of proximal outcomes used within FPS evaluation. From the CWLA (2003) standards, the specter of improved family functioning and enhanced child well-being may be realized through best practices using these services (characteristics).

Significantly from Checklist Category I, risk assessment, safety planning, and child monitoring/supervision were statistically significant, but with negative coefficients. These factors have high volumes of children who are affected by these services being utilized, supporting what appears to be an emphasis to gain a better understanding of how
much risk each family being served actually has and what service may be necessary to positively address it.

For Checklist Category II, no variables were seen as statistically significant, but the importance of the focus on safety regarding family violence services planning and but further defining risk suggest continued study of their importance. Combining this category with Categories III (substance abuse services) and IV (sexual abuse services), the services in these categories act as more specialty services not routinely present in as wide a range as other categories denote a narrower focus and lower volumes. For substance abuse, the one statistically significant service with a positive coefficient and high odds was relapse prevention. For sexual abuse, a statistically significant service was identifying signs and symptoms with high odds. Among Categories II–IV, the services we have listed here, although limited in number, lean toward prevention of issues before they happen or lessening their impact when they do. An emphasis to find and use other preventive services in this program as important services characteristic/proximal outcomes to expand outcome measures should be considered by public/private staff. This emphasis can in turn strengthen the nature of how risk assessment is more effectively completed (Category I) as a program requirement, and thereby healthier for each family and child served.

For Checklist Category V, within subset (a) of parenting and limit setting there are statistically significant services with high volume, such as natural and logical consequences. Services such as this with high odds suggests skill teaching of what is appropriate behavior and consequences best to manage it that encourages changes, not discord when it is not appropriate that also protects children.
Subset (b) of emotion management showed some statistically significant services, although with negative coefficients, such as building hope, a direction of encouragement to services recipients, toward proximal outcome characteristics.

Subset (c) regarding personal/interpersonal skills, many services are statistically significant such as negotiation skills, with a positive coefficient and high odds, and high volumes. Other services in this set point toward an emphasis on skill acquisition. This acquisition can occur both short-term and long-term and increase coping skill and competencies in life for each services recipient.

Finally, for subset (d), no services showed statistical significance but all of these additional clinical skills can be implemented to enhance the repeating of helpful skills/behaviors leading to success.

Many of the services in Category V can be used to increase our understanding of significant services that are identified as characteristics/proximal outcomes. Using this understanding and identification suggests that public/private staff consider specific services that can be added to current FPS effectiveness measures. In doing so, these staffs contribute to establishing successful outcomes that work to meet the CWLA (2003) Standards of Excellence for FPS that promote improved family functioning and enhanced child well-being. This is especially true from Column III of the table regarding individual skill development that results from the components in Columns I and II, especially to continue for up to 12 months after case closure.

Tied in with Category V, we need to integrate our findings in Category IX regarding concrete services and Question 2 of the Survey. Among both subsets (a) and (b) in Category IX, food, stands out as the primary service/characteristic that defines concrete
services, with or without funding. Many of the services in Category IX have high volumes, but few are statistically significant. Closer scrutiny of all of these services is suggested for further study. They are important as a services group for their immediate capability to restrict the negative impact of family crises while their intervention is active and during the 1-year follow-up period after closure that may affect their ability to function and enhance their child’s well-being.

With our limited look at Question 2 of the Family Satisfaction Survey, we found families showed general satisfaction with services as helpful, suggesting some statistically significant services to be used as a starting point for further study before being named as potential characteristics to expand proximal outcomes. Question 2 allows another view of services provision so it is not just what the agency worker says about how services provision was undertaken. It provides a limited glance into stakeholder satisfaction, another component of Column III.

We can conclude that many components of our conceptual framework/logistic model from Table 6.1 have been addressed by the findings of this study. We have identified Column I components of whom we are serving and what needs and problem they bring into each intervention. We have addressed extensively the many Column II components regarding services that form the core of this study, especially to denote the modality, intensity, frequency, duration, and variety and sequencing of services. From Components I and II we also reported how their implementation affects the outcome components of Column III, especially individual skill development and, in a limited way, stakeholder satisfaction. From this conclusion, we will list some program/management
impacts and recommendations that appear necessary, keeping in mind some of the following limitations to qualify our data/findings.

One limitation concerns family member safety. Our data/findings indicate that the private agency providers, supported by public staff, appear to use services with safety of children as a priority. Our data/findings do not provide the level of this priority and further study is necessary so that even critics of FPS have an objective measure to assess this factor.

Another limitation concerns family characteristics. Our findings do not permit us to look in great detail at the social and political context where each family lives and the community dynamics that results as it relates to how their characteristics play out in their environment. These factors are especially important when looking at the aftercare services structure each family is to have toward staying together during the follow-up period, and their odds for success.

Another limitation is related to the intensity of intervention. Our data/findings show means in days and hours (including face-to-face) that appear to comply with contract standards. This compliance in an area like the 24-hour contract is consistent across the 1-year threshold possible for each case intervention. One factor this study cannot provide great detail on is the motivation behind this compliance. The descriptive data/findings on case days indicate that a large majority of cases end at 28 days exactly. As an example among time factors, this suggests the necessity to study further if this result may be driven by contract compliance and /or best service practice.

Finally, as it relates to general, aftercare, and concrete services, our data/findings identified a number of services that were statistically significant. The limitation with this
data is we cannot measure the volume of the impact these services contribute to the likelihood of success. Regarding aftercare services, the more limited use of these services compared to the other categories makes this limitation even more complicated. Without further qualitative study of any of these selective services, our data/findings can only provide a picture of some of the significant services to use as the basis of further research.

Policy and Management Impacts/Recommendations

We will now detail our policy and management impacts and follow up with recommendations which also include suggestions on how contracting practices may be changed for this state agency.

*Intensity*

The most evident policy impacts are: (1) maintaining the level of intensity of services that is one of the tenets of this program, especially the importance of the 24-hour contact; and (2) continued diligence in maintaining the contract standards for total case days, total face-to-face hours, and total case hours. Findings indicate that across all these agency sites meeting the contract ideals of weekly face-to-face hours and total case days, and extensive total case hours produce odds that increase the likelihood of successful outcomes. The 24-hour contact findings being statistically significant across the 1-year case threshold adds to the importance of keeping this activity continuous and strong. Findings that a larger majority of interventions ended at 28 days (4 weeks) further augments this importance, but with the necessity to study further how contract compliance factors play into this importance.
Recommendation on Intensity

Both FPS public and private management and staff should work collaboratively to monitor and encourage these intensity levels on an ongoing basis. This can help to maintain and improve the odds for success as better when they occur.

The public agency contracting staff should consider new practices that go beyond only compliance and seek to measure the effect of the quality of intervention with the intensity standards, as well as program and fiscal integrity.

Risk Assessment/Referral

Our findings also indicate a policy impact that necessitates ongoing study of risk assessment level. Our findings acknowledge the child at risk percentages was very high, which should occur in this high-risk FPS program. The abuse or abuse/neglect together as case types show the highest odds for success, and neglect was seen with lower odds. Within our case type numbers, we identified a higher number of neglect cases. This factor appears to indicate that the family member safety may not be as high a priority as it should be, with the potential for those interested in the program to be concerned about the overall priority of safety.

Recommendation for Risk Assessment/Referral

Both FPS public and private staff sectors should consider further study toward a mutual goal of increasing the prevalence of abuse case types. Management in both sectors needs to take an active lead role regarding this planning and implementation. This change
may allow for families to be better matched with services provision that meet their needs more effectively. The impetus would have to come from the public agency, whose risk assessment process governs most referrals, but needs the cooperation of the private agency to refer.

The public agency contracting staff, in consultation with both sectors, should implement any new practices that support risk assessment that affect the highest quality of intervention, as well as program and fiscal integrity.

*Family Characteristics*

Family characteristics play an important role on the impact of FPS provision and ongoing integrity, but our findings suggest a more negative effect on the proximal outcomes. In tandem with risk/assessment referral, it appears during each active case intervention that agency services providers focus on finding specific family and child strengths within each casework relationship that may reverse these negative effects and increase positivity.

*Recommendation for Family Characteristics/ Services Provision*

FPS management/staff should plan ongoing qualitative research regarding each of these family characteristics, in order to further enhance the proper match of family and child and services.

The public agency contracting staff, in consultation with both sectors, should implement any new practices that support service matching that affect the highest quality of intervention, as well as program and fiscal integrity.
Types and Levels of Services/Characteristics

One of the more important impacts on this FPS program is the types and levels of services, or characteristics identified in our findings. Our findings indicate that agencies appear to promote an atmosphere of safety for families while trying to keep them together, as the high numbers of sample children affected by services such as risk assessment/safety planning denote. Regarding general clinical services, many of those seen as significant appear to promote the goal of skill building toward self/family improvement/strengthening, and impact the odds of success. Families being able to use these skills continually after case closure may help them remain together. In a limited manner, some concrete services help impact the odds of success. From the Family Satisfaction Survey, a very limited number of helpful services that families themselves identified appear as important characteristics that impact odds of success. Looking at specialty services areas such as family violence, substance abuse, and sexual abuse when necessary in an intervention indicate importance services necessary to promote prevention and thereby safety and with our findings indicating the need to increase the volume of implementation of these services to increase the impact for success

Recommendation Regarding Case Intervention and Aftercare Services

FPS public/private management and staff should conduct collaborative planning to assure the increased utilization of the aftercare infrastructure as a higher priority both during the intervention and in the 1-year follow-up period.
Regarding case intervention services, one of the goals suggested for this study was for the application of specific proximal characteristics to expand the effectiveness measures of this program. I would recommend that both FPS public/private management and staff use our findings, especially under general clinical services, to reflect on many identified significant services/characteristics with high odds and how they may impact the likelihood of success. Both sectors may collaboratively develop a plan to study and apply these identified proximal outcomes toward the expansion of FPS outcome effectiveness measures.

**Recommendation Regarding Expanding Proximal Outcome measures**

FPS public/private management and staff, with management in both sectors instituting leadership and ongoing support, should encourage collaborative planning and discussion. This planning would have the long-range goal of the implementation of expanding effectiveness measures within this FPS program that increase the odds of the likelihood of success. The focus concerning increased effectiveness is to maintain/escalate the strengths of services already seen as strong, and to enhance services with concerns/issues toward improved strength.

The public agency contracting staff, in consultation with both sectors, should implement any new practices that support expanding effectiveness measures that maintain/escalate strong services and enhance services that need improvement to affect the highest quality of intervention, as well as program and fiscal integrity.
REFERENCES


Pecora, P. J., Reed-Ashcraft, K., & Kirk, R. S. (2001). Family-centered services: A typology, brief history, and overview of current program implementation and evaluation challenges.
In E. Walton, P. Sandau-Beckler, & M. Mannes (Eds.), *Balancing family-centered services and child well-being* (pp. 1-33). New York: Columbia University Press.


Appendix A

Human Subjects Institutional Review Board
Letter of Approval
Date: January 12, 2007

To: Matthew Mingus, Principal Investigator
   Randy Baxter, Student Investigator for dissertation

From: Amy Naugle, Ph.D., Chair

Re: HSIRB Project Number: 06-11-24

This letter will serve as confirmation that your research project entitled “Effectiveness of Family Preservation Services in” has been approved under the exempt category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: January 12, 2008
Appendix B

State Agency Letter of Approval
June 20, 2007

Randy Baxter
1851 Morningside Drive, S.E.
Grand Rapids, MI 49506

Re: Effectiveness of Family Preservation Services in - Research Request # 323

Dear Mr. Baxter:

We have completed our review of your request for the participation in the research project entitled, "Effectiveness of Family Preservation Services in [blank]."

Based upon our review, it has been decided that the Department will participate in this research project. This approval is contingent on the following conditions:

1. Any changes in the project design must be submitted to this Administration for review.
2. If you are unable to begin the project within the next six months, or need to continue the project beyond 18 months, you must notify this Administration.
3. A copy of the research results must be submitted to this Administration upon completion.

The contact person for the project will be [name] or CPS, FC, and Community Support. She can be reached at [phone number].

If you have any questions regarding this approval or the conditions of the approval, please contact

Sincerely,

[Signature]

Director of Planning, Evaluation & Survey Center
Performance Excellence Administration

cc:
Appendix C

Private Contract Services Agency I
Letter of Approval
November 14, 2006

Human Subjects Institutional Review Board
Western Michigan University
1903 W. Michigan Ave.
Kalamazoo, MI 49008

To whom it may concern:

The purpose of this letter is to support the request of Randy J. Baxter to conduct doctoral dissertation research using data from mutually agreed upon contract sites in our agency. This will allow him to implement the two phases of his data plan. These phases are: Phase I- Sampling and Phase II- Data Collection/Analysis Procedure and Variables. Mr. Baxter reported that this detailed information is contained in the documents to be submitted to your board when seeking approval. Under Phase I, he is using the Five Tier Assessment (FTA) process, where a current member of the advisory committee in this technique is our Director of Knowledge and Learning Strategies. We further understand that any data elements selected from case documents will gather only specific non-identifying information on all variables. When Phase II is implemented, data from all sites used will be aggregated, assuring non-identifying information will not be present.

We have also reviewed a summary of waiver of informed consent information from Mr. Baxter’s IISIRB request that addresses issues that may arise such as client confidentiality and agency or client exposure to risk. As part of our support for his research, we concur with recommendations in his summary that: 1) There will be minimal to no risk to subjects; 2) Mr. Baxter will have no direct contact with clients; 3) Mr. Baxter will not be viewing case files; 4) Using persons employed by our clearances to review case files and collecting aggregate data will protect the rights and welfare of our service recipients, and 5) sharing of the research results as administratively appropriate with all parts of our services system will increase our program effectiveness and in turn increase long-term benefits to our service recipients.

If you need further information or have further questions regarding this letter, please contact me. Thank you for your time and consideration.

Sincerely,

CEO
Appendix D

Private Contract Services Agency II
Letter of Approval
Human Subjects Institutional Review Board  
Western Michigan University  
1903 W. Michigan Ave.  
Kalamazoo, MI 49008  

To whom it may concern:

The purpose of this letter is to support the request of Randy J. Baxter to conduct doctoral dissertation research using data from assuming that he is able to obtain all other necessary approvals to gather data, including your Board.

Our agency has reviewed a research plan submitted by Mr. Baxter in a recent letter to our agency. As described in this plan, we understand our support will allow Mr. Baxter to receive aggregate data from mutually-agreed contract sites in our agency. This will enable him to implement the two phases of his data plan. These phases are: Phase I- Sampling and Phase II- Data Collection/Analysis Procedure for Variables. Mr. Baxter reported this detailed information is contained in the documents to be submitted to your board seeking approval. Under phase I, he is using the Five Tier Assessment (FTA) process, where a current member of the advisory committee in this technique is one of our supervisors. We further understand that any data elements selected from case documents will gather only specific non-identifying information on all variables. When Phase II is implemented, using the EHA process to conduct data analysis, data from all sites used will be aggregated, assuring identifying information will not be present.

We have also reviewed a summary of waiver of informed consent information from Mr. Baxter’s HSIRB request that address issues that may arise such as client confidentiality and agency or client exposure to risk. As part of our support for his research we concur with recommendations in his summary that: 1) There will be minimal to no risk to subjects; 2) Mr. Baxter will have no direct contact with clients; 3) Mr. Baxter will not be viewing case files; 4) using a person employed with clearance to review case files and collect the aggregate data will protect the rights and welfare of our services recipients, and; 5) sharing of the research results as administratively appropriate with all parts of our services system will increase our program effectiveness and in turn increase long-term benefits to our services recipients.

If you need further information or have further questions regarding this letter, please contact me. Thank you for your time and consideration.

Sincerely,
Appendix E

Data Entry Form
RESEARCH DATA ENTRY FORM (effective 7/25/2007)

DATA ENTRY FORM Random Sample- Record # ____________

Note for all components in this form: Only item numbers detailed in the tables will be entered in the data base, none which has any identifying information. Any results from data analysis will be in aggregate form.

<table>
<thead>
<tr>
<th>Referral Form Data (details/coding instructions for agency personnel only in attached table 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Referral</td>
</tr>
<tr>
<td>Agency # 1a 1b 1c 2a 2b</td>
</tr>
<tr>
<td>Case Type A N A/N Del Re DV Adopt Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent Info</th>
</tr>
</thead>
<tbody>
<tr>
<td># in Home (as checked)</td>
</tr>
<tr>
<td>Parent DOB=M/Y Race ## Sex</td>
</tr>
<tr>
<td># 1</td>
</tr>
<tr>
<td># 2</td>
</tr>
<tr>
<td># 3</td>
</tr>
</tbody>
</table>

| Race Codes (see table #1)- ## API AA AIN HIS WNH O/UN |

<table>
<thead>
<tr>
<th>Child Info</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child DOB=M/Y Race ## Sex At Home At Risk</td>
</tr>
<tr>
<td># 1</td>
</tr>
<tr>
<td># 2</td>
</tr>
<tr>
<td># 3</td>
</tr>
<tr>
<td># 4</td>
</tr>
<tr>
<td># 5</td>
</tr>
<tr>
<td># 6</td>
</tr>
</tbody>
</table>

If any additional children, please detail # and codes below for each child

<table>
<thead>
<tr>
<th>CPS Category Disposition</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>NR</th>
</tr>
</thead>
</table>

24 Hour Contact Yes No NR (see time sheet)

<table>
<thead>
<tr>
<th>Time Sheet Data (details/coding instructions for agency personnel only in attached table 2)</th>
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</thead>
<tbody>
<tr>
<td>Total Case Days</td>
</tr>
<tr>
<td>Total Case Hrs</td>
</tr>
<tr>
<td>F to F Total</td>
</tr>
<tr>
<td>F to F NTW</td>
</tr>
<tr>
<td>F to F NTN</td>
</tr>
<tr>
<td>F to F Holiday</td>
</tr>
<tr>
<td>F to F Wk 1</td>
</tr>
<tr>
<td>F to F Wk 2</td>
</tr>
<tr>
<td>F to F Wk 3</td>
</tr>
<tr>
<td>F to F Wk 4</td>
</tr>
<tr>
<td>F to F Wk 5</td>
</tr>
<tr>
<td>F to F Wk 6</td>
</tr>
<tr>
<td>Total Non F to F N/A- see table for details</td>
</tr>
</tbody>
</table>
## Services Checklist Data

(details/coding instructions for agency personnel only in attached table 3)

*Circle when service checked, leave blank if not checked*

### I. Risk Assessment & Risk Management

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>A</td>
<td>Provide business card &amp; explain 24/7 procedures</td>
</tr>
<tr>
<td>B</td>
<td>Risk Assessment</td>
</tr>
<tr>
<td>C</td>
<td>Environmental Safety Assessment</td>
</tr>
<tr>
<td>D</td>
<td>Suicide Assessment and Prevention</td>
</tr>
<tr>
<td>E</td>
<td>De-escalating/defusing crisis</td>
</tr>
<tr>
<td>F</td>
<td>Routine direct inquiry regarding DV</td>
</tr>
<tr>
<td>G</td>
<td>Developmental safety considerations</td>
</tr>
<tr>
<td>H</td>
<td>Lethality Assessment</td>
</tr>
<tr>
<td>I</td>
<td>Child Monitoring &amp; supervision</td>
</tr>
<tr>
<td>J</td>
<td>Identification of Appropriate caregivers</td>
</tr>
<tr>
<td>K</td>
<td>Use of Crisis Card</td>
</tr>
<tr>
<td>L</td>
<td>Safety Planning</td>
</tr>
<tr>
<td>M</td>
<td>Pre-empting crisis</td>
</tr>
<tr>
<td>N</td>
<td>Identifying Crisis</td>
</tr>
<tr>
<td>O</td>
<td>Health Management Issues</td>
</tr>
<tr>
<td>P</td>
<td>Other (Specify):</td>
</tr>
</tbody>
</table>

### II. Family Violence Info & Safety Planning

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>
| A | Use of and roles within the legal system  
[Police, Friend of the Court, etc.] |
| B | How to obtain or use a personal protection order  
B1 |
| C | Safety planning with victim and family  
C1 |
| D | Emergency planning / escape routes  
D1 |
| E | Planning to leave  
E1 |
| F | Dynamics of domestic / family violence  
F1 |
| G | Effects on children of witnessing/experiencing violence  
G1 |
| H | General Custody / Visitation information  
H1 |
| I | Addressing specific Visitation issues  
I1 |
| J | Identification of appropriate caregivers  
J1 |
| K | Other (specify):  
K1- Other (specify): |

### III. Substance Abuse Services

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>
| A | Education about substance abuse  
& recovery |
| B | Commitment to sobriety/abstinence |
| C | Accompanied to self help meetings |
| D | Identification and assessment of use |
| E | Confrontation with client/family |
| F | Relapse prevention planning |
| G | Identify a sponsor |
| H | Effects of substance abuse on children |
| I | Other (specify): |

### IV. Sexual Abuse Services

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Boundaries concepts</td>
</tr>
<tr>
<td>B</td>
<td>Sexual abuse education</td>
</tr>
<tr>
<td>C</td>
<td>Prevention skills</td>
</tr>
<tr>
<td>D</td>
<td>Identifying appropriate treatment services</td>
</tr>
<tr>
<td>E</td>
<td>Age appropriate sexual development</td>
</tr>
<tr>
<td>F</td>
<td>Identification of signs and symptoms</td>
</tr>
<tr>
<td>G</td>
<td>Linking to appropriate sexual abuse services</td>
</tr>
<tr>
<td>H</td>
<td>Other (specify):</td>
</tr>
</tbody>
</table>
### V. General Clinical Services

**a. Parenting/Limit Setting**

<table>
<thead>
<tr>
<th>#</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>Natural/logical consequences</td>
</tr>
<tr>
<td>#2</td>
<td>Time out</td>
</tr>
<tr>
<td>#3</td>
<td>Parent as role model</td>
</tr>
<tr>
<td>#4</td>
<td>Improving child compliance</td>
</tr>
<tr>
<td>#5</td>
<td>Family meeting(s)</td>
</tr>
<tr>
<td>#6</td>
<td>Clarifying family roles</td>
</tr>
<tr>
<td>#7</td>
<td>Child/adolescent development</td>
</tr>
<tr>
<td>#8</td>
<td>Clarifying problem behaviors</td>
</tr>
<tr>
<td>#9</td>
<td>Structure routine</td>
</tr>
<tr>
<td>#10</td>
<td>Clarifying family rules</td>
</tr>
<tr>
<td>#11</td>
<td>Tracking/charting behavior</td>
</tr>
<tr>
<td>#12</td>
<td>Identification of appropriate caregivers</td>
</tr>
<tr>
<td>#13</td>
<td>Other (specify):</td>
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</table>

**b. Emotional Management**

<table>
<thead>
<tr>
<th>#</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>Anger management</td>
</tr>
<tr>
<td>#2</td>
<td>Depression management</td>
</tr>
<tr>
<td>#3</td>
<td>Anxiety/Confusion management</td>
</tr>
<tr>
<td>#4</td>
<td>Self-criticism reduction</td>
</tr>
<tr>
<td>#5</td>
<td>Building self-esteem</td>
</tr>
<tr>
<td>#6</td>
<td>Handling frustration</td>
</tr>
<tr>
<td>#7</td>
<td>Impulse management</td>
</tr>
<tr>
<td>#8</td>
<td>Building hope</td>
</tr>
<tr>
<td>#9</td>
<td>Process of change</td>
</tr>
<tr>
<td>#10</td>
<td>Use of crisis card</td>
</tr>
<tr>
<td>#11</td>
<td>R.E.T. concepts</td>
</tr>
<tr>
<td>#12</td>
<td>R.E.T. techniques</td>
</tr>
<tr>
<td>#13</td>
<td>Pleasant events</td>
</tr>
<tr>
<td>#14</td>
<td>Relaxation</td>
</tr>
<tr>
<td>#15</td>
<td>Tracking emotions</td>
</tr>
<tr>
<td>#16</td>
<td>Use of Journal</td>
</tr>
<tr>
<td>#17</td>
<td>Stress management</td>
</tr>
<tr>
<td>#18</td>
<td>Other (specify):</td>
</tr>
</tbody>
</table>

**c. Personal/Interpersonal Skills**

<table>
<thead>
<tr>
<th>#</th>
<th>Topic</th>
</tr>
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<tbody>
<tr>
<td>#1</td>
<td>Conversational/social skills</td>
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<td>#2</td>
<td>Problem solving</td>
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<td>#3</td>
<td>Negotiation skills</td>
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<tr>
<td>#4</td>
<td>Boundary concepts</td>
</tr>
<tr>
<td>#5</td>
<td>Teaching “I” messages</td>
</tr>
<tr>
<td>#6</td>
<td>Teaching active listening</td>
</tr>
<tr>
<td>#7</td>
<td>Relationship building</td>
</tr>
<tr>
<td>#8</td>
<td>Values clarification</td>
</tr>
<tr>
<td>#9</td>
<td>Understanding/reframing system requirements</td>
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</tbody>
</table>

**d. Additional Clinical**

<table>
<thead>
<tr>
<th>#</th>
<th>Topic</th>
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</thead>
<tbody>
<tr>
<td>#1</td>
<td>Therapeutic games</td>
</tr>
<tr>
<td>#2</td>
<td>Worker as role model</td>
</tr>
<tr>
<td>#3</td>
<td>Providing &amp; review literature</td>
</tr>
<tr>
<td>#4</td>
<td>Video presentations</td>
</tr>
<tr>
<td>#5</td>
<td>Use of reinforcement</td>
</tr>
<tr>
<td>#6</td>
<td>Active listen to client family</td>
</tr>
<tr>
<td>#7</td>
<td>Role playing/Response exercise</td>
</tr>
<tr>
<td>#8</td>
<td>Paper/pencil tests</td>
</tr>
<tr>
<td>#9</td>
<td>Other (specify):</td>
</tr>
<tr>
<td>#10</td>
<td>Appropriate sexual behavior</td>
</tr>
<tr>
<td>#11</td>
<td>Accepting “no”</td>
</tr>
<tr>
<td>#12</td>
<td>Giving/accepting feedback</td>
</tr>
<tr>
<td>#13</td>
<td>Fair fighting guidelines</td>
</tr>
<tr>
<td>#14</td>
<td>Money management</td>
</tr>
<tr>
<td>#15</td>
<td>Time management</td>
</tr>
<tr>
<td>#16</td>
<td>Academic skills</td>
</tr>
<tr>
<td>#17</td>
<td>Employability skills</td>
</tr>
<tr>
<td>#18</td>
<td>Assertiveness</td>
</tr>
<tr>
<td>#19</td>
<td>Other (specify):</td>
</tr>
</tbody>
</table>
### VI. Referral to Other Resources

| A | Substance abuse assessment/ treatment-DV victim |
| B | Substance abuse assessment/treatment-perpetrator |
| C | Domestic Violence shelter |
| D | Domestic Violence non-residential services |
| E | Domestic Violence victim support group |
| F | Domestic Violence batterer's intervention program |
| G | Domestic Violence Legal Advocate |
| H | Substance abuse assessment & treatment |
| I | Credit Counseling |
| J | Counseling Services |
| K | Self-help Group |
| L | Social Services |
| M | Mental Health |
| N | Linking to appropriate sexual abuse services |
| O | Other (specify): |
| P | Other (specify): |

### VII. Advocacy with…..

| A | Social Services |
| B | Mental Health system |
| C | Utility Companies |
| D | Health Care/Medical system l |
| E | Education System |
| F | Child Care providers |
| G | Landlord |
| H | Employer |
| I | Legal system to obtain PPO |
| J | Legal system for custody arrangements |
| K | Court or legal system for ____________________ |
| L | Law Enforcement |
| M | Prosecutor’s Office |
| N | Domestic Violence Shelter Staff |
| O | Domestic Violence Victim Advocate |
| P | Other (specify): |

### VIII. Linkage with Social Supports

| A | General relationship building skills |
| B | Family/Kin/Fictive Kin |
| C | Neighbors |
| D | School [e.g. PTO, Homeroom Parent, LSCO, Head Start] |
| E | Civic Organizations / Community Activities [e.g. Neighborhood Watch, Tribal Center, Bowling League] |
| F | Faith Communities [e.g. Church, Bible Study, Synagogue, Mosque] |
| G | Child Organizations/Mentors [e.g. big Brother/Big Sister, 4H, Boy/Girl Scouts] |
| H | Child Support Group (specify): |
| I | Parent Aides/Mentors [e.g. Building Strong Families, Foster Grand Parents] |
| J | Adult Support Group (specify): |
| K | Paid/Unpaid Work Site [e.g. including volunteer activities/groups] |
| L | Other Social Support (specify): |
### IX. Provision or Assistance with Concrete Services

<table>
<thead>
<tr>
<th>Services Provided</th>
<th>Circle if Funds Used with Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Transportation</td>
<td>A1</td>
</tr>
<tr>
<td>B Food</td>
<td>B1</td>
</tr>
<tr>
<td>C Financial Assistance</td>
<td>C1</td>
</tr>
<tr>
<td>D Child Care/baby-sitting</td>
<td>D1</td>
</tr>
<tr>
<td>E Clothing</td>
<td>E1</td>
</tr>
<tr>
<td>F Legal Assistance</td>
<td>F1</td>
</tr>
<tr>
<td>G Housing</td>
<td>G1</td>
</tr>
<tr>
<td>H Phone</td>
<td>H1</td>
</tr>
<tr>
<td>I Other utility benefits or services</td>
<td>I1</td>
</tr>
<tr>
<td>J Doing housework/cleaning or help client obtain homemaker services</td>
<td>J1</td>
</tr>
<tr>
<td>K Medical/dental services</td>
<td>K1</td>
</tr>
<tr>
<td>L Job Search Assistance</td>
<td>L1</td>
</tr>
<tr>
<td>M Provide or help client get a job</td>
<td>M1</td>
</tr>
<tr>
<td>N Furniture/household goods</td>
<td>N1</td>
</tr>
<tr>
<td>O Provide toys or recreational Equipment/activities</td>
<td>O1</td>
</tr>
<tr>
<td>P Educational services/supplies</td>
<td>P1</td>
</tr>
<tr>
<td>Q Home security (locks, windows, Lighting, Security system)</td>
<td>Q1</td>
</tr>
<tr>
<td>R Other (specify):</td>
<td>R1 Other (specify):</td>
</tr>
</tbody>
</table>
### Family Satisfaction Survey Data (details/coding instructions for agency personnel only in attached table 4)

#### Question 1

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>NR</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Question 2 (If checked- circle; leave blank if not checked)

- Service A  Helped obtain services for our family
- Service B  Taught us new ways to communicate
- Service C  Helped understand my children better
- Service D  Taught new ways to manage children’s behavior
- Service E  Helped me to feel better about myself
- Service F  They listened to me
- Service G  Taught me/us to work with other agencies…needs
- Service H  Taught me/us to manage money better
- Service I  Helped me/us to manage our time better
- Service J  Helped us to manage and understand our feelings
- Service K  Helped get additional MH/SA services
- Service L  Helped us find a place to live
- Service M  Helped us organize our home (Cleaning, etc…..)
- Service N (Other)- Note thing identified:

#### Question 3  Most Helpful intervention from Q#2:

Note here by letter:

#### Question 4

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>NR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worker A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worker B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worker C</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worker D</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Follow-Up Log Data (details/coding instructions for agency personnel only in attached table 5)

- Referral Date  DO NOT RECORD
- Termination Date  DO NOT RECORD
- Follow-Up Month  3  6  12  SEE CHART BELOW

#### Child Info (CI)- see chart below

- Sex  see chart below
- Age  see chart below

#### List all placement codes for each child

<table>
<thead>
<tr>
<th>Child</th>
<th>Sex/M/Y</th>
<th>3</th>
<th>6</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td># 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If any additional children, please detail # and codes below for each child
Attachments - to data entry form
Tables 1-5 detailing operational definitions/location for data entry sections above
(REVISED 5/2008 for data transcription and to reflect revised Excel data base format)

Table 1- Referral Form Data (page 1 - Excel Data base)

<table>
<thead>
<tr>
<th>Referral Form Items</th>
<th>Operational Definition</th>
<th>Item # Form</th>
<th>Data Base Entry # ***</th>
<th>Variable * Operationalized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Referral Received</td>
<td>1 (+41a)</td>
<td>D</td>
<td>INDVA 1-4, DEPVA (**)</td>
</tr>
<tr>
<td>Agency</td>
<td>Agency Type (Rural, Suburban, Urban) 1= LCFS, 2=LSSM Letter for specific sites</td>
<td>E</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Type</td>
<td>A= Abuse=1, N=Neglect=2 A/N= both=3, D=Delinquency=4 R=Reunification=5, DV= Domestic Violence=6, Adopt=Adoption=7 O= Other=8</td>
<td>9</td>
<td>F</td>
<td>**</td>
</tr>
<tr>
<td>Parent Info (PI)</td>
<td># in Home as checked</td>
<td>15</td>
<td>H</td>
<td></td>
</tr>
<tr>
<td>Sex (PI)</td>
<td>Any checked above 1=Female 2=Male</td>
<td>16</td>
<td>J, N, R (As needed= AN)</td>
<td>**</td>
</tr>
<tr>
<td>DOB (PI)</td>
<td>Month/ Year Only- any checked above</td>
<td>17</td>
<td>K, O, S (AN)</td>
<td>**</td>
</tr>
<tr>
<td>Race (PI)</td>
<td>Any checked above  API= Asian/Pacific Islander=1 AA=African-American=2, AIN= American Indian/ Alaska Native=3, HIS= Hispanic=4 WNH= White/Non- Hispanic=5, O/UN= Other/Multiracial/Unknown= 6</td>
<td>18</td>
<td>L, P, T (AN)</td>
<td>**</td>
</tr>
<tr>
<td>Child Info (CI)</td>
<td>All children listed MAX- 6</td>
<td>21</td>
<td>U</td>
<td></td>
</tr>
<tr>
<td>DOB (CI)</td>
<td>Month/ Year Only- any listed above- Age at time of referral, for Newborn (NB) to 1 NB-3 months=.25 4-7 months=.50 8-11 months=.75</td>
<td>22</td>
<td>WX,AB,AG,AL,AG,AV (AN)</td>
<td>**</td>
</tr>
<tr>
<td>Race (CI)</td>
<td>Any listed above **</td>
<td>23</td>
<td>X,AC,AH,AM,AR,AW (AN)</td>
<td>**</td>
</tr>
<tr>
<td>Sex (CI)</td>
<td>Any listed above</td>
<td>24</td>
<td>Y, AD, AI, AN, AS, AX (AN)</td>
<td>**</td>
</tr>
<tr>
<td># at Home</td>
<td>Yes for any listed above</td>
<td>25</td>
<td>Z, AE, AJ, AO, AT, AY (AN)</td>
<td>**</td>
</tr>
<tr>
<td># at Risk</td>
<td>Yes for any listed above</td>
<td>26</td>
<td>AA, AF, AK, AP, AU, AZ (AN)</td>
<td>**</td>
</tr>
<tr>
<td>CPS Category</td>
<td>1, 2, 3- MI CPS manual</td>
<td>34</td>
<td>BA</td>
<td>**</td>
</tr>
<tr>
<td>24 Hour Contact</td>
<td>FFM-MI contract policy- check time sheet during first week</td>
<td>See page 1- Time Sheet</td>
<td>BB</td>
<td></td>
</tr>
</tbody>
</table>

(RFD- rev5/2008-RJB)

*- Code for Independent Variable= INDVA, Dependent Variable= DEPVA
**- Same as previous data box  ***- For electronic data base only

Table 2- Time Sheet Data (page 1- Excel Data base)

<table>
<thead>
<tr>
<th>Time Sheet Items</th>
<th>Operational Definition</th>
<th>Item #***</th>
<th>Data Base Variable *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Case Days</td>
<td>Cumulative Total Check for 24 hr contact</td>
<td>A</td>
<td>INDVA 2-4, DEPVA</td>
</tr>
<tr>
<td>Total Case Hours</td>
<td>Cumulative Total XX- (Time reported in ¼ increments- .25= 15 min.; .50= 30 min.; .75= 45 minutes, etc.)</td>
<td>G</td>
<td>INDVA 3-4 DEPVA (**)</td>
</tr>
<tr>
<td>F to F Total (Face to Face)</td>
<td>Cumulative F to F Service Hours-all weeks- see XX info</td>
<td>B</td>
<td>BH</td>
</tr>
<tr>
<td>F to F NTW</td>
<td>Non-Traditional-Weekend- see XX info</td>
<td>I</td>
<td>BI</td>
</tr>
<tr>
<td>F to F NTN</td>
<td>Non-Traditional-Night- see XX info</td>
<td>J</td>
<td>BJ</td>
</tr>
<tr>
<td>F to F Holiday</td>
<td>Non-Traditional-Holiday- see XX info</td>
<td>K</td>
<td>BK</td>
</tr>
<tr>
<td>F to F Week 1</td>
<td>Weekly Total by review see XX info</td>
<td>B</td>
<td>BL</td>
</tr>
<tr>
<td>F to F Week 2</td>
<td>**</td>
<td>B</td>
<td>BM</td>
</tr>
<tr>
<td>F to F Week 3</td>
<td>**</td>
<td>B</td>
<td>BN</td>
</tr>
<tr>
<td>F to F Week 4</td>
<td>**</td>
<td>B</td>
<td>BO</td>
</tr>
<tr>
<td>F to F Week 5</td>
<td>**</td>
<td>B</td>
<td>BP</td>
</tr>
<tr>
<td>F to F Week 6</td>
<td>**</td>
<td>B</td>
<td>BQ</td>
</tr>
<tr>
<td>Total Non F to F(Face to Face)- DO NOT LOG- COMPUTERED LATER</td>
<td>Cumulative Non-F to Face Hours all weeks</td>
<td>C+D+E+F=</td>
<td>H</td>
</tr>
</tbody>
</table>

(TSD-rev 5/2008-RJB)

*- Code for Independent Variable= INDVA, Dependent Variable= DEPVA
**- Same as previous data box  ***- For electronic data base only
<table>
<thead>
<tr>
<th>Service Checklist Items</th>
<th>Operational Definition (#1 below)</th>
<th>Item #- Form</th>
<th>Data Base Entry #***</th>
<th>Variable * Operationalized</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Risk Assess/ Management</td>
<td>See Glossary (**) for definitions of services</td>
<td>A-P</td>
<td>C-S</td>
<td>INDVA 3-4, DEPVA (**)</td>
</tr>
<tr>
<td>II. Family Viol Info/ Safety Planning / DV</td>
<td>**</td>
<td>A1- K1</td>
<td>U-AE</td>
<td>**</td>
</tr>
<tr>
<td>II. Family Viol Info/ Safety Planning / FF</td>
<td>**</td>
<td>A-K</td>
<td>AF-AP</td>
<td>**</td>
</tr>
<tr>
<td>III. Substance Abuse Services</td>
<td>**</td>
<td>A-I</td>
<td>AQ-AZ</td>
<td>**</td>
</tr>
<tr>
<td>IV. Sexual Abuse Services</td>
<td>**</td>
<td>A-H</td>
<td>BA-BI</td>
<td>**</td>
</tr>
<tr>
<td>V. General Clinical Service</td>
<td>See Glossary (**) for definitions of services</td>
<td>See Below</td>
<td>See BJ Below</td>
<td>See Below</td>
</tr>
<tr>
<td>A. Parenting/ Limit Setting</td>
<td>**</td>
<td>1-13</td>
<td>BK-BX</td>
<td>INDVA 3-4 DEPVA (**)</td>
</tr>
<tr>
<td>B. Emotion Management</td>
<td>**</td>
<td>1-18</td>
<td>BY-CQ</td>
<td>**</td>
</tr>
<tr>
<td>C. Personal/ Interpersonal Skills</td>
<td>**</td>
<td>1-19</td>
<td>CR-DK</td>
<td>**</td>
</tr>
<tr>
<td>D. Additional Clinical</td>
<td>**</td>
<td>1-9</td>
<td>DL-DU</td>
<td>**</td>
</tr>
<tr>
<td>VI. Referral to Other Resource</td>
<td>See Glossary (**) for definitions of services</td>
<td>A-O</td>
<td>DV-EK</td>
<td>**</td>
</tr>
<tr>
<td>VII. Advocacy With…..</td>
<td>**</td>
<td>A-P</td>
<td>EL-FB</td>
<td>**</td>
</tr>
<tr>
<td>VIII. Linkage With Social Supports</td>
<td>**</td>
<td>A-L</td>
<td>FC-FO</td>
<td>**</td>
</tr>
<tr>
<td>IX. Provis/Assis With Concrete Services/ SA</td>
<td>**</td>
<td>A1-R1</td>
<td>FQ-GH</td>
<td>**</td>
</tr>
<tr>
<td>IX. Provis/Assis With Concrete Service/ FF</td>
<td>**</td>
<td>A-R</td>
<td>GI-GZ</td>
<td>**</td>
</tr>
</tbody>
</table>

* Code for Independent Variable= INDVA, Dependent Variable= DEPVA
** Same as previous data box, *** For electronic data base only
<table>
<thead>
<tr>
<th>Family Satisfaction Items</th>
<th>Operational Definition</th>
<th>Item # Form</th>
<th>Data Entry #***</th>
<th>Variable * Operationalized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 1</td>
<td>Goals Satisfaction <em>(Mark Yes, No, NR for a, c, d- for b- note where living now if necessary)</em></td>
<td>A-D</td>
<td>D-G</td>
<td>INDVA 3-4, DEPVA (**)</td>
</tr>
<tr>
<td>Question 2</td>
<td>Helpful Things/ Services Identified <em>(Circle- all checked)</em></td>
<td>A-N</td>
<td>H-V</td>
<td>**</td>
</tr>
<tr>
<td>Question 3</td>
<td>Most Helpful from Question 2 <em>(list specific letter (s) that are circled)</em></td>
<td>From A-N</td>
<td>W</td>
<td>**</td>
</tr>
<tr>
<td>Question 4</td>
<td>Worker Satisfaction <em>(Mark Yes, No, NR for a-d)</em></td>
<td>A-D</td>
<td>Z, AA, AB, AC</td>
<td>**</td>
</tr>
</tbody>
</table>

*(FSSD-rev5/2008-RJB)*

*- Code for Independent Variable= INDVA, Dependent Variable= DEPVA
**- Same as previous data box, ***- For electronic data base only
## Table 5- Follow Up Log Data

<table>
<thead>
<tr>
<th>Follow Up Log Items</th>
<th>Operational Definition</th>
<th>Item #</th>
<th>Data Entry #</th>
<th>Variable * Operationalized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral Date</td>
<td>When Referral opened <strong>DO NOT RECORD</strong></td>
<td>1</td>
<td>272 DNR</td>
<td>INDVA 3-4, DEPVA (**)</td>
</tr>
<tr>
<td>Termination Date</td>
<td>When case closed <strong>DO NOT RECORD</strong></td>
<td>2</td>
<td>273 DNR</td>
<td>**</td>
</tr>
<tr>
<td>Follow Up</td>
<td>Specify 3, 6, 12 month <strong>DO NOT RECORD</strong></td>
<td>3</td>
<td>274-277 DNR-See Below</td>
<td>**</td>
</tr>
<tr>
<td>Sex -Child(ren)</td>
<td>Any listed above (maximum=6)</td>
<td>4</td>
<td>AM, AR, AW, BB, BG, BL (As needed)</td>
<td>**</td>
</tr>
<tr>
<td>Age- Child(ren)</td>
<td>Any listed above (maximum 6)</td>
<td>4</td>
<td>AN,AS, AX, BC, BH, BM (As needed)</td>
<td>**</td>
</tr>
<tr>
<td>3 mo (see below) Placem</td>
<td>List specific code # placement Code (PC) (maximum 6)</td>
<td>5</td>
<td>AO, AT, AY, BD, BI, BN (As needed)</td>
<td>**</td>
</tr>
<tr>
<td>6 mo PC</td>
<td>**</td>
<td>5</td>
<td>AP, AU, AZ, BE, BJ, BO (As needed)</td>
<td>**</td>
</tr>
<tr>
<td>12 mo PC</td>
<td>**</td>
<td>5</td>
<td>AQ, AV, BA, BF, BK, BP (As needed)</td>
<td>**</td>
</tr>
</tbody>
</table>

(FULD-5/2008-RJB)

*- Code for Independent Variable= INDVA, Dependent Variable=DEPVA
**- Same as previous data box, ***- For electronic data base only

**Placement Codes:**
- 32 – relative placement
- 35 – jail
- 38 – training school
- 30 – At home
- 33 – court paid placement
- 36 – camp
- 39 – unknown
- 31 – Foster care (inc. residential)
- 34 – mental health facility
- 37 – detention
- 40 – other (specify):
Appendix F

State Agency Services Glossary
State Agency
SERVICES CHECKLIST GLOSSARY

Note: After each service, the acronym identifies its label that appears on the data base

I. CLINICAL SERVICES:

Risk Assessment and Risk Management

Providing business card: Providing the family with basic information about the FFM Michigan (FFM) program and the agency providing the service. SCIA

Explaining availability procedures and back-up systems: Providing the family with the procedures to be used to access the FFM worker and/or the FFM supervisor; explaining the back-up system used by the program and the availability of the FFM worker and supervisor 24 hours, 7 days a week. SCIA

Risk assessment: Exploring various risk factors that impact family safety and identifying past and present risks that affect the family. Areas for consideration in assessing risk include: environmental safety, health, mental health, domestic violence, substance use, sexual abuse, and child management (abuse and/or neglect) behaviors. SCIB

Environmental safety assessment: Teaching how to assess and modify the household environment to ensure family safety. May include use of Housing Safety Checklist, e.g. SCIC

Suicide assessment: Assessment of the level of client risk for suicide with corresponding initiation of mental health services and implementation of a safety plan with the family. SCID

Suicide prevention: Structuring to reduce risk in the event a family member is suicidal; may include emergency hospitalization, removal of weapons from the home, structuring 24 hour monitoring, or any other means of preventing suicide. SCID

De-escalating / defusing crises: Helping families to diminish emotional intensity at a point of crisis, or assisting families in an actual crisis to manage the situation by structuring for safety. SCIE

Routine direct inquiry re: domestic violence: Exploring how conflict is handled within the family to assess for the presence of domestic Violence as a past or present dynamic affecting the family's present situation. SCIF

Development related safety considerations: Reviewing factors impacting child safety as related to stages of child development; involves planning to decrease risk by preventing injury or illness in relation to child behaviors occurring in various developmental stages. May include teaching around childproofing the environment, use of safety locks, etc. SCIG
**Lethality assessment:** Assessing the risks and level of lethality posed by the domestic violence. Assessment of lethality includes obtaining information from the victim about past experiences with the perpetrator, patterns and historical episodes of violence. Includes assessment of factors which point to an increased potential for violence, such as the batterer’s previous history of violent behavior or drug/alcohol use that contributes to the escalation of violence. *SCIH*

**Child monitoring and supervision:** Teaching a family skills to use in monitoring their child(ren) and/or their child(ren)’s behavior. (“Do you know where your child is?”) *SC1I*

**Identification of appropriate caregivers:** Helping the caregiver to identify appropriate persons to provide care for the children in his/her absence. May involve meeting the identified caregivers and assessing their appropriateness and developing a written plan to facilitate client recognition of the importance of using individuals who are known to be responsible to attend to the needs of the children appropriately. *SC1J*

**Use of crisis card:** A list of response behaviors a client agrees to try when he/she feels they are escalating toward a loss of self-control. *SCIK*

**Structuring for safety / safety planning:** Assisting the family to develop and/or identify strategies to address the risks posed to children or adult members. Includes domestic violence safety planning as well as planning to address other risks affecting the family to ensure safety of its members, such as emergency medical or psychiatric needs, e.g. With clients who use/abuse substances it may involve identifying appropriate caregivers for children when the parent intends to socialize/use substances, or developing strategies which ensure that the children’s needs will be met while the parent is using. May also include the identification of crisis resources (fire, police, poison control, neighbor, etc.) along with the creation of a phone list to be used by the family in the event a crisis occurs. *SC1L*

**Pre-empt crisis:** Assisting families to manage situations prior to the point of crisis, either by anticipating what could develop into a crisis and structuring accordingly or avoiding a crisis by advance planning and preparation. *SC1M*

**Identifying crisis situations:** Teaching the family what constitutes a crisis and when to access the FFM of Michigan worker in the event a crisis occurs. *SC1N*

**Health management issues:** Exploring and addressing health related issues that impact family members’ safety by assisting the family to identify needed actions and/or to structure routines to manage family health problems, or assisting the family to develop strategies to manage medical needs by taking prescribed medications appropriately. May include advocacy with or referral to medical systems to develop patient understanding of medical needs or address barriers to achieving follow through on health management routines. (Examples of health problems impacting families include the presence of medically fragile infants, chronic or acute health conditions, and dental or physical injuries resulting from domestic violence, substance use or sexual abuse.) *SCI0*

**Other:** Any interventions related to risk assessment or risk management not described above. (Identify service provided, purpose and rationale.) *SCI1P*
II. FAMILY VIOLENCE INFORMATION AND SAFETY PLANNING

Use of legal system, role of law enforcement: Information re: calling police, when police can arrest, exploring their responses in the past, as appropriate. SCIIAA

How to obtain or use a personal protection order: Providing information about personal protection orders, what they are, how to get them, what they do and their limitations. SCIIBA

Structuring for safety / safety planning with victim and family: Assisting the family to develop and/or identify strategies to decrease the risks posed to children or adult family members. Domestic violence safety planning includes planning to minimize the risks affecting the family in order to ensure safety of its members. With clients who use/abuse substances it may involve identifying appropriate caregivers for children when the parent intends to socialize/use substances, or to decrease the potential for violence when the parent is using. May also include the identification of crisis resources (fire, police, poison control, neighbor, etc.) and a list of family, friends or resources that may be used in the event a threat of physical assault or another crisis occurs. SCIICA

Emergency planning / escape routes: Assisting the victim to identify concrete safety strategies and escape routes specific to the family's home environment and the potential for assault from a domestic violence perpetrator. SCIIDA

Planning to leave: Providing concrete information to a victim regarding how to prepare to leave the home, papers that are important and necessary to establish one's own household, obtain financial assistance, etc. SCIIEA

Dynamics of domestic / family violence: Discussion of cumulative effects of battering and abuse on the victim, children, batterer and relationship, and impact on self-esteem, self-image and confidence; explanation of use of "tactics" used by batterer from Power and Control Wheel. May include information about the cycle of violence and how this cycle is used for the batterer's purpose of achieving power and control over the victim, and/or education about how living in a violent environment affects children and how behavioral signs and symptoms manifest with children. SCIIEA

General custody / visitation information: Providing information about how to work with Friend of the Court about custody and visitation related issues. SCIIHA

Addressing specific visitation issues: Reviewing concerns specific to a family's situation and locating advocates who can help address the issues. SCII IA

Identification of appropriate caregivers: Helping the caregiver to identify appropriate persons to provide care for the children in his/her absence. May involve meeting the identified caregivers and assessing their appropriateness and developing a written plan to facilitate client recognition of the importance of using individuals who are known to be responsible to attend to the needs of the children appropriately. SCIIJA
Other: Any interventions related to domestic violence not described above. (Identify service provided, purpose and rationale.) SCIIKA

III. SUBSTANCE ABUSE SERVICES

Education about substance use, abuse and recovery: Education about substance use and addiction. Includes indicators of addiction, the addictive process, and the process of recovery for those who desire to live a substance-free lifestyle. Includes reviewing the effects of substance use on children and fetal development. Education for families about the nature and availability of support groups for those who abuse substances or family members of those who abuse substances. SCIIIAB

Commitment to sobriety / abstinence: Assisting the client to commit to not using drugs or alcohol based on their identification that using drugs or alcohol is not healthy for them or their family and has resulted in a set of negative consequences in their or their family's life. SCIIIBB

Education about substance abuse support groups: Education for families about the nature and availability of support groups for those who abuse substances or family members of those who abuse substances.

Accompanying to self-help meetings: Accompanying the client to an open support group meeting to help him/her feel comfortable in attending their first meeting. SCIIICB

Identification and assessment of substance use: Identify patterns of substance use and any consequences for use the members have experienced as a result of their uses of substances to determine if the use is problematic at this point in time. May include review of past patterns of use and/or difficulties experienced previously that have contributed to the family's situation. SCIIIDB

Confrontation with client and / or family: Speaking with the family directly about observations regarding the impact of substance use on the individual or family. Confrontation can be done in a positive, friendly way --does not need to be demanding or punitive, i.e., "care-frontation". SCIIIEB

Relapse prevention planning / relapse management: Helping the client to identify feelings, foods, situations, events, etc. that may contribute to urges to use substances from which he/she is attempting to abstain, or assisting the client to identify situations or events that increase the risk of returning to using substances. Includes developing and implementing a plan (or crisis card) to prevent relapsing into active substance use, or reviewing what a client learns in substance abuse treatment, reinforcing how abstinence can be maintained, or assisting the client to become re-involved in attending support group meetings, counseling sessions. Relapse management may include assisting the client to access substance abuse treatment services, or helping the him/her identify their pattern of use and how the use is impacting on their personal and/or family life. Relapse management includes assisting the client to identify what the events were that led up to his/her using and to re-commit to abstinence or sobriety. SCIIIFB
Identify/ locate a sponsor:  Helped the client to identify a sponsor who can provide support in his/her recovery process. SCIIIGB

Effects of substance abuse on children:  Teaching about effects of substance use/abuse on children and family relationships. SCIIIHB

Other:  Any other substance abuse interventions not described above. (Identify service provided, purpose and rationale.) SCIII IB

IV. SEXUAL ABUSE SERVICES

Boundary concepts:  Teaching family members about their personal rights and how to protect those rights; may include teaching families about family member’s right to privacy and appropriate personal limits in areas of hygiene, sexual expression, and to personal, mental and emotional space for themselves without having to defend these rights. SCIVAC

Sexual abuse education:  Education about what constitutes sexual abuse and how to protect children from sexual predators; includes how to respond appropriately to children who have been sexually abused. SCIVBC

Prevention skills:  Assisting families to develop an awareness of how to protect their children from sexual assault or premature sexual development. Includes developing communication skills in the area of sexuality and sexual behavior, and prevention of unplanned pregnancies. May include raising awareness of the effects of sexual abuse victimization on parents in performance of parenting role. SCIVCC

Identification of appropriate treatment services:  Assisting families to locate treatment providers with expertise in the area of sexual abuse for either victims or perpetrators of sexual abuse. SCIVDC

Age-appropriate sexual development:  Teaching parents about age-appropriate child behavior in the areas of sexual knowledge, expressions of sexuality and sexual feelings; assisting parents to develop appropriate household and/or behavioral expectations around this issue. May include education around sexual abuse for parents and child victims of sexual abuse and what constitutes age-appropriate behaviors. May include teaching around overt and covert sexual abuse, personal privacy and boundary issues within the family. SCIVEC

Identification of signs and symptoms of sexual abuse:  Assisting parents to identify behavioral indicators of sexual abuse and to respond appropriately to any indicators. SCIVFC

Linkage to appropriate sexual abuse services:  Referrals to treatment providers with expertise in treating sexual abuse survivors or families in which children or adolescents have committed a sexual assault. SCIVGC

Other:  Any interventions related to sexual abuse not described above. (Identify service provided, purpose and rationale.) SCIVHC
V. GENERAL CLINICAL SERVICES
(Note: a, b, c and d added below to original glossary by researcher for clarity and consistency)

a. Parenting/Limit Setting

Assisting parents to identify appropriate or desired behaviors for their children and to set limits appropriately in a constructive manner.

Natural / logical consequences: Teaching parents to use consequences that are appropriate to manage behavior, or allowing a child to experience the negative consequences that occur naturally as a result of the behavior. Includes helping the parent to distinguish what is appropriate and helpful in protecting children while encouraging behavior change. SCVa#1

Time-out: Teaching how to use "time-out" as a technique for behavior control or emotion management, for both parent and child. SCVa#2

Parent as role model: Teaching the importance of the parent as a role model and how the process of identification between parent and child impacts the child. SCVa#3

Improving child's compliance: Assisting families to follow through with an established plan for modifying child behavior, eliminating risk, resolving problems, or maintaining a low-risk environment through the maintenance of new behaviors and skills. SCVa#4

Family meeting: Teaching a family how to have a democratic family meeting by developing a format and using the meeting to address issues and resolve differences effectively, independently of a third party. SCVa#5

Clarifying family roles: Helping families to identify the tasks and expectations that are appropriate and meet their family's needs. SCVa#6

Child / adolescent development: Teaching parents about the developmental milestones and age appropriate expectations for children and how developmental stages relate to behavior, methods of discipline and positive reinforcement. SCVa#7

Clarifying problem behaviors: Assisting parents to determine problem ownership ("Whose problem is it?") and to identify specific behaviors that are problematic in order to develop an intervention plan to alter the behavior. May include helping the parent to understand the motivation for behavior. SCVa#8

Structure routine: Assisting parents and families to develop a structure to aid in their organization and execution of the necessary functions of family life. SCVa#9

Clarifying family rules: Assisting parents and families to identify and teaching ways to codify family rules so that expectations are explicit versus implicit. SCVa#10

Tracking / charting behavior: Teaching parents ways to keep track of behavior for reinforcement purposes; may include teaching how to set up and use a behavior chart. SCVa#11
Identification of Appropriate Caregivers: Helping the caregiver to identify appropriate persons to provide care for the children in his/her absence. May involve meeting the identified caregivers and assessing their appropriateness and developing a written plan to facilitate client recognition of the importance of using individuals who are known to be responsible to attend to the needs of the children appropriately. SCVa#12

Other: Any other interventions related to parenting not described above. (Identify service provided, purpose and rationale.) SCVa#13

b. Emotion Management

Anger management: Teaching client to manage anger through identification of triggers, physical and behavioral cues, and learning skills to help reduce anger such as RET, time-outs, etc. SCVb1A

Depression management: Identification of physical and behavioral indicators of depression and interventions that enable client to remain safe when depressed moods occur. SCVb2A

Anxiety / confusion management: Identification of the physical and behavioral components of client's anxiety and learning specific techniques to reduce anxiety and mobilize client to action. SCVb3A

Self-criticism reduction: Assisting client to identify self-critical behaviors and to learn alternate ways to respond internally by substituting behaviors that are supportive and boost self-esteem rather than diminish it. SCVb4A

Building self-esteem: Assisting client to feel good about him/herself and to identify individual strengths. Teaching client to capitalize on strengths and how to generate other areas of skill and strength. SCVb5A

Handling frustration: Aiding client in the ability to withstand and tolerate tension arising from a build-up of an internal demand. SCVb6A

Impulse management: Teaching client to use a series of steps designed to help client stop and think before they act. SCVb7A

Building hope: Assisting family members to develop optimism in their current circumstances or for the future based on their previous successes, current strengths, and/or other positive experiences. SCVb8A

Process of change: Teaching how change occurs and that change is a process of growth that takes time and practice when working to develop a new set of skills. SCVb9A

Use of “Crisis Card”: A list of response behaviors a client agrees to try when he/she feels they are escalating toward a loss of self-control. SCVb10A
RET concepts: Teaching clients how thoughts can influence feelings and how by working to change thinking emotional states can be altered. SCVb11A

RET techniques: Teaching clients techniques of Rational Emotive Therapy such as examining their current self-talk, re-framing, self-enhancing ideas and behavioral rehearsal. SCVb12A

Pleasant events: Identification of those activities that may help reduces depression or tension. SCVb13A

Relaxation: Teaching both physical and mental techniques that will help family members gain a state of relaxation, such as focused breathing, progressive muscle relaxation, guided imagery, etc. SCVb#14

Tracking emotions: Teaching clients to use various interventions to recognize their feelings and emotional patterns, and assisting clients to understand the influence of their emotions on their behavior. SCVb#15

Use of journal: Teaching clients to use a journal for stress or emotion management purposes. SCVb#16

Stress management: Teaching techniques to reduce stress, such as meditation, visualization, self-care, etc. SCVb#17

Other: Use of any interventions not described above in relationship to emotion management. (Identify service provided, purpose and rationale.) SCVb#18

c. Personal and Interpersonal Skills

Conversational/social skills: Teaching and or modeling clients how to interact with others appropriately. May be directed to adults and/or children, and may include establishing positive peer relationships or how to express feelings to others or manage conflict appropriately. SCVc1B

Problem-solving: Assisting families to identify problem areas and potential solutions to identified problems, and to develop strategies for implementing selected solutions. SCVc2B

Negotiation skills: Teaching families to identify potential areas for give and take in order to reduce areas of conflict between family members. May include teaching members to think in non-black and white terms and to offer compromises in areas of conflict. SCVc3B

Boundary concepts: Teaching family members about their personal rights and how to protect those rights; may include teaching families about rights to privacy and appropriate personal limits in areas of hygiene, sexual expression, and the rights to personal, mental and emotional space for members. SCVc4B
Teaching active listening: Teaching families to convey empathic and non-judgmental attention to others' verbal and non-verbal content through verbal and non-verbal clues to engage them positively in the communication process. Includes modeling and teaching how to reflect what is heard to encourage the process of communication. SCVc6B

Relationship building: Teaching families how to improve relationships using skills such as active listening and reframing, reflecting or accentuating strengths. Includes modeling these behaviors within the family. SCVc7B

Teaching I-messages: Teaching family members how to maximize communication by using direct statements which clarify the concrete effect of the other person's behavior on the speaker by disclosing feelings rather than making statements that blame the other. SCVc5B

Values clarification: Teaching families how to identify their values and prioritize them, while identifying how they are acted on in daily life. May include structured exercises or thoughtful discussion of personal goals and ways to accomplish them with both adults and teens. SCVc8B

Understanding / reframing system requirements: Helping clients to understand what is desired or expected of them by "the system" and what to expect from "the system." SCVc9B

Appropriate sexual behavior: Teaching parents and children appropriate limits in the area of expressing sexuality and sexual feelings; assisting parents and teens to communicate around this issue. May include education around sexual abuse for parents and child victims of sexual abuse and age-appropriate behaviors. May include teaching around overt and covert sexual abuse, personal privacy and boundary issues. SCVc10B

Accepting "no": Teaching children to accept limits set by parents or peers; reinforcing personal boundaries by teaching families to set and honor limits of family members. SCVc11B

Giving / accepting feedback: Direct teaching and/or modeling of how to give and receive feedback to enhance communication. May include teaching family members how to recognize and avoid the use of "detonators" in interactions with others, the effects of doing so and the consequences of not doing so. SCVc12B

Fair fighting guidelines: Teaching families how to express their differences constructively. To be avoided in working with families where domestic violence is present or where there is an unequal distribution of power between partners. SCVc13B

Money management: Teaching families strategies or connecting them with outside resources to assist them in the area of money management; may include skill building in developing a budget, limiting spending or prioritizing expenses and spending needs. Advocacy in this area could include identifying and facilitating appointment of a conservator to assist families on an ongoing basis where appropriate. SCVc14B
Time management: Teaching families to develop routines, techniques, and/or schedules to assist in the daily or weekly management of identified family needs. SCVc15B

Academic skills: Obtaining, teaching or reinforcing skills to support or improve children's academic performance. May include the development of strategies to help support, maintain or facilitate parental involvement in the child's school, or the development of strategies or habits to improve child functioning in academic areas. May involve locating resources for ongoing academic support, or advocacy with teachers to help resolve academic difficulties. SCVc16A

Employability skills: Teaching families skills that will help them to obtain employment or assisting them to access services that will increase their employability. SCVc17A

Assertiveness: Teaching and modeling the right to communicate one's thoughts and feelings and how to do so actively without aggression. May include teaching clients how to advocate for themselves with systems or how to interact more effectively with peers or family members. SCVc18a

Other: Any other interventions not described above that relate to personal or interpersonal skill development. (Identify service provided, purpose and rationale.) N/A

d. Additional Clinical

Therapeutic games: The use of board games such as "The Ungame", "Jenga--the balanced family," and other experiential learning activities that may assist family members in gaining new skills or helpful insights. SCVd1C

The worker as a role model: The FFM worker's use of skills as a teaching demonstration for family members to learn from vicariously, such as joining in to demonstrate how to clean, using direct communication skills or "I" messages to set an example for family members. SCVd2C

Providing and reviewing literature: Giving and/or reviewing books, magazines, pamphlets and/or other handouts as a resource for the family. SCVd3C

Video presentation and review: Showing and/or reviewing video presentations with family members on various subjects for teaching purposes. SCVd4C

Use of reinforcement: Assisting the family to develop positive reinforcers for the purposes of motivating work on or achievement of goals and objectives during or subsequent to the intervention. Reinforcers may or may not require use of discretionary funds. SCVd5C

Active listening to client family: Conveying empathic and non-judgmental attention to family members' verbal and non-verbal content through verbal and non-verbal cues, as well as properly considering the intent of what the family is trying to say. SCVd6C
Role playing: Using role play exercises to assist in solidifying new skills for practice.  
SCVd7C

Paper & pencil tests: The completion of evaluative questionnaires with family members. Answers may be compared to a pre-established list of answers and/or ratings in order to increase self-awareness or assess areas for skill enhancement. SCVd8C

Other: Any other clinical services not described above. (Identify service provided, purpose and rationale.) SCVd9C

VI. REFERRALS TO OTHER RESOURCES

Substance abuse assessment /treatment--Dv victim: Arranging for or facilitating a referral for a substance abuse assessment or facilitating treatment by an outside provider during or following the FFM intervention. SCVIAD

Substance abuse assessment /treatment--perpetrator: Arranging for or facilitating a referral to a substance abuse assessment or facilitating substance abuse treatment by an outside provider during the FFM intervention. SCVIBD

Domestic violence shelter: Referral for the victim to the local shelter for emergency services, shelter, legal services or counseling services. SCVICD

Domestic violence non-residential services: Referral for services provided through a domestic violence shelter for clients who are not staying in the shelter. SCVIDD

Domestic violence victim support group: Referral to a domestic violence support group for the victim. SCVIED

Domestic violence batterer's intervention program: A referral for individual or group counseling for the perpetrator should be made to a batterer's treatment program. (Services for perpetrators of domestic violence should be provided by those programs developed to meet the needs of this particular population, out of concern for victim safety.) SCVIFD

Domestic violence legal advocate (victim): Referral the victim advocates assisting with negotiating legal issues pertaining to the domestic violence. SCVIAG

Legal aid: Referral for legal assistance for low income families. N/A

Substance abuse assessment and treatment: Assist family member to obtain a substance abuse assessment to facilitate accessing treatment services or for purposes of identification of a pattern of substance use that is problematic. SCVIHD

Credit counseling: Referral to Credit counseling providers to assist with budgeting or debt management. SCVI IC
Counseling services: Facilitating a referral to any service for ongoing counseling during or after the intervention. SCVIJB

Self-help groups: Referral for support groups (Alcoholics Anonymous, Narcotics Anonymous, Al-Anon, Nar-Anon, Ala-Teen, Ala-Tot, etc.) for abuser and/or family members. SCVIKB

Social services: Providing advocacy to facilitate or coordinate referrals for services available through the DHS, (such as Medicaid, food stamps, or other DHS program services), or other services offered by other social service agencies or providers. SCVIKA

Mental health: Linkage to mental health services through Community Mental Health or the community at large. SCVIMA

Linkage to appropriate sexual abuse services: Referrals to treatment providers with expertise in treating sexual abuse survivors or families in which children or adolescents have committed a sexual assault. SCVINA

Other: Any other referrals not described above. (Identify service provider, purpose and rationale.) SCVIOA

VII. ADVOCACY WITH . . .

Social service providers: Providing advocacy with DHS or other social service providers to obtain Medicaid, food stamps, or other services. May include assisting in resolving problems or barriers to accessing services, and teaching families skills to use in dealing with social service providers. SCVIIE

Utility companies: Providing advocacy to obtain, restore or maintain utility services to a family. SCVIIE

Health care / medical system: Advocating with a family's health care provider or provider network to locate or access needed health services. May involve problem resolution or contact with an ombudsman. SCVIIDE

Educational system: Advocacy with the educational system to help resolve academic difficulties or to identify strategies to get a child's educational needs met. May involve facilitating or coordinating services, or assisting the family to negotiate educational systems to access services. SCVIIEE

Child care providers: Advocacy services provided to assist with locating, accessing or working collaboratively with child care providers. SCVIIFE

Landlords: Advocating for the client to access housing, locate housing or resolve housing problems associated with current living conditions or financial circumstances. SCVIIGE
Employers: Advocating for families with employers to resolve employment-related issues or problems. SCVIIHE

Domestic violence shelter: Case management, activity planning or assisting the client to work through communication barriers and/or negotiate conflicts with shelter staff or other shelter residents. SCVIINB

Victim advocate: Obtaining assistance for the victim and her family by linkage and/or advocacy with the victim advocate around the domestic violence issue. SCVIIOB

Legal system to obtain PPO: Advocacy at juvenile court hearings, or with criminal or civil court, as related to obtaining a personal protection order. SCVIIID

Legal system for custody arrangements: Advocacy with Friend of the Court, at juvenile court hearings, or with the court related to custody issues affecting the victim and minor children. SCVIIJC

Court and legal (miscellaneous): Advocacy at court hearings with juvenile, criminal or civil court for any reason other than obtaining a PPO or resolving custody issues. (Specify on Services Checklist.) SCVIICK

Law enforcement: Assisting the victim by providing advocacy with law enforcement regarding the enforcement of personal protection orders. SCVIIIB

Legal advocate (victim): Victim advocate assisting with negotiating legal issues pertaining to the domestic violence. N/A

Other: Any other advocacy services not described above. (Specify service provided, purpose and rationale.) SCVIIIPA

Informal support systems: Aiding family to recognize, identify, and develop informal resources to assist in providing support and back-up. May involve development or use of an eco-map with the family. N/A

VIII. LINKAGE WITH SOCIAL SUPPORTS

General relationship building: Teaching and modeling how to build and strengthen positive relationships with others. This is used to engage clients and develop trust, but the principles of how to achieve trust in a relationship may be taught and built on both directly and indirectly. SCVIIIAF

Family kinship network ("family kin / fictive kin"): Assisting the family to connect with related or non-related individuals who constitute their "family". Identifying individuals or community resources available to assist family members in times of need, or those who provide social support for the family. Specific relationships and or resources utilized by or available to the family are identified from the list below: SCVIIIBF
Old Friends
New Friends
Neighbors SCVIIICF
School SCVIIIDF
Civic Organizations / Community Activities SCVIIIEF
Faith Communities SCVIIIFF
Children's Organizations / mentors SCVIIIGF
Parent Aids / Mentors SCVIII IE
Adult Support Group SCVIIJD
Paid / Unpaid Work Site SCVIIIKD
Other: Any interventions related to social support networks not described above. (Identify service provided, purpose and rationale.) N/A

IX. PROVISION OR ASSISTANCE WITH CONCRETE SERVICES

Transportation: Providing direct transportation services to the family, or assistance with obtaining transportation on an ongoing basis, for medical appointments or other needed services. May mean assisting family to utilize informal support networks, or teach them how to access public transportation services existent in the community. SCIXaA1A, SCIXbAG

Food: Providing foodstuffs to family on an emergency basis or assisting family to purchase food by providing specific assistance or access to food bank, etc. Assisting the family to identify and or access sources of assistance in this area, such as WIC, or food stamps. SCIXaB1A, SCIXbBG

Financial assistance: Assisting family to apply for financial assistance or remove barriers to accessing financial assistance through existing systems such as SER, ADC, SSI, Friend of the Court, etc. SCIXaC1A, SCIXbCG

Child care providers: Assisting family to identify appropriate caregivers for children from current support network, or establishing linkages to formal systems to get child care needs met. May include education about children's needs and how to identify appropriate caregivers, things to look for and ways to maintain positive communication with existing caregivers. May involve coordination with referring worker or referral to social services. SCIXaD1A, SCIXbDG

Clothing: Providing clothing to family on an emergency basis or assisting family to purchase clothing by providing specific assistance or access to retail or second hand stores, etc. Assisting the family to identify and/or access sources of assistance in this area, such as community clothes closets, churches or systems available to assist with the cost of clothing, such as Goodfellows, etc. SCIXaE1A, SCIXbEG

Obtain legal assistance and / or assist with payment for legal services: Referring the family to legal services or assisting the family to locate or access legal services or advocacy. SCIXaF1A, SCIXbFG
Housing: Providing resources or hands-on assistance to a family to locate housing or move family on an emergency basis. May include assisting family to obtain housing by providing specific assistance, or identifying resources the family can use to locate or access resources for assistance in this area, such as rental agencies, housing commissions, etc. In some cases assisting clients with housing needs may require advocacy services with landlords, rental agencies, DHS, etc., in order to overcome past evictions or poor credit ratings. SCIYaG1A, SCIYbGG

Obtaining a telephone or reinstating telephone service: Assisting with obtaining a telephone or telephone service to decrease isolation and increase family or victim safety. SCIYaH1A, SCIYbHG

Other utility benefits or services: Providing assistance to obtain or restore utility service to a family. May include arranging for hook-up for appliances or use of specific assistance to reduce or eliminate barriers to restoring or accessing services incurred by debt. SCIYaI1A, SCIYbIF

Do housework / cleaning or help client obtain homemaker services: Hands-on assistance for remedying environmental neglect, or teaching skills for household maintenance to reduce environmental disarray. May include advocacy for accessing ongoing services to aid in environmental maintenance. Includes skill-building with family to facilitate changes in routine, or development or improvement of housekeeping skills to resolve problem areas contributing to risk. SCIYaJ1A, SCIYbJE

Medical / dental services: Assisting family to locate or access needed medical or dental services, or support services for medical conditions already identified. May include advocacy with third party reimbursers or teaching clients how to advocate for themselves with systems, in addition to referral and/or transportation to appointments. May include identification of and referral to services/organizations designed to support specific health problems, such as the American Cancer Society, the Hemophilia Foundation of Michigan, Crippled Children, etc. SCIYaK1A, SCIYbKE

Job search: Referring clients to employment agencies, MESC, or other systems designed to aid in educational, vocational or career development or job placement. May include skill development in areas impacting employability, such as completion of resume, application completion, interviewing or enhancement in job skills, or referral to programs designed to build skills in these areas. May require problem-solving to resolve or negotiate barriers to employment, or systems advocacy with vocational or rehabilitation agencies, Social Security Administration, or other agencies designed to address employment related issues. SCIYaL1, SCIYbLD

Provide or help client get a job: Assist client by locating potential employers or making referrals on behalf of the client. SCIYaM1, SCIYbMC

Furniture / household goods: Providing resources or hands-on assistance to a family to locate or obtain household furnishings. May include assisting family to obtain goods by providing specific assistance, or identifying resources available to the family to meet household needs. May require networking with other agencies or resources, advocacy and or coordination of services. SCIYaN1, SCIYbNC
**Toys or recreational equipment / activities:** Assisting families by purchasing or providing resources to support or achieve healthy child development and/or aid in child management. Specific assistance is used to provide toys or recreational equipment for the purposes of directly or indirectly alleviating risk to children and families. Assisting families by identifying children's needs, existing resources, and/or arranging or paying for participation in activities designed to support or achieve healthy child development. Specific assistance is used to provide recreational activities for families and children for the purposes of directly or indirectly alleviating or preventing risk to children and families. **SCI\textit{X}a\textit{O}1, SCI\textit{X}b\textit{OC}**

**Educational services / supplies:** Facilitating attendance at classes designed to enhance family or individual functioning in areas such as parenting, employment skills, conflict resolution, assertiveness, etc. May require coordination of services with referring staff or other community resources. **SCI\textit{X}a\textit{P}1, SCI\textit{X}b\textit{PB}**

**Home security:** Assisting the victim to recognize and identify concrete protective measures to put in place for self and family such as alarms, locks, telephones, easy identification methods for home, protecting telephone wires, etc., as well as other ways the victim can protect herself and her children against assault, re-assault or harassment. **SCI\textit{X}a\textit{Q}1, SCI\textit{X}b\textit{Q}**

**Other Specific Assistance to individuals:** Use of program funds allocated to assist families with concrete or other needs. **See all IXb items**

**Other:** Any other concrete services not described above. (Identify service provided, purpose and rationale.) **SCI\textit{X}a\textit{R}1, SCI\textit{X}b\textit{R}**
Appendix G

Family Satisfaction Survey: Descriptive Data—Questions 1, 3, and 4
### Table G1 Family Satisfaction Survey \((N = 207)\)

**Question 1- Goals to help family to stay together (see Appendix E-Table 4 for more details)**

<table>
<thead>
<tr>
<th>Survey Question 1- Goals- (1)</th>
<th># of Surveys answered (2)</th>
<th>Yes (3)</th>
<th>Children under (4) each Yes ((N=550))</th>
<th>% of Total children- Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Living with you</td>
<td>198</td>
<td>187</td>
<td>412</td>
<td>74.9</td>
</tr>
<tr>
<td>B. If Not where living</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>C. Best for Family</td>
<td>195</td>
<td>187</td>
<td>422</td>
<td>76.7</td>
</tr>
<tr>
<td>D. Best for Children</td>
<td>193</td>
<td>183</td>
<td>412</td>
<td>74.4</td>
</tr>
</tbody>
</table>

**Table G1 Notes:**
1. Specific statements from survey- see Chart 4.2 for more details
2. Of 207 individual surveys N (81.2%) returned, number of times this item was answered Yes or No
3. Of number of times answered as described in (2) number of times answered Yes.
4. For all 207 surveys, number of total children covered NI=550, number listed is for those marked Yes
5. %= Number of children listed in (4) divided by NI

### Table G2 Family Satisfaction Survey \((N = 207)\)

**Question 4- Worker Quality of Service (see Appendix E-Table 4 for more details)**

<table>
<thead>
<tr>
<th>Survey Question 4- Quality</th>
<th># of Surveys answered (2)</th>
<th>Yes (3)</th>
<th>Children under (4) each Yes ((N=550))</th>
<th>% of Total children- Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worker A- Services Provided- family home</td>
<td>191</td>
<td>191</td>
<td>435</td>
<td>79.1</td>
</tr>
<tr>
<td>Worker B- Convenient Appt. Times</td>
<td>189</td>
<td>187</td>
<td>425</td>
<td>77.3</td>
</tr>
<tr>
<td>Worker C- Worker Listened/Understood</td>
<td>187</td>
<td>186</td>
<td>426</td>
<td>77.5</td>
</tr>
<tr>
<td>Worker D- Satisfied with Services</td>
<td>188</td>
<td>187</td>
<td>427</td>
<td>77.6</td>
</tr>
</tbody>
</table>

**Table G2 Notes:**
1. Specific Statements from survey- see Chart 4.2 for more details
2. Of 207 individual surveys N (81.2%) returned, number of times this item was answered Yes or No
3. Of number of times answered as described in (2) number of times answered Yes.
4. For all 207 surveys, number of total children covered NI=550, number listed is for those marked Yes
5. %= Number of children listed in (4) divided by NI
### Table G3 Family Satisfaction Survey \((N = 75)\)
**Question 3- Specify most helpful service during intervention from Question 2**
(See Appendix E-Table 4 for more details)

<table>
<thead>
<tr>
<th>Most Helpful Service</th>
<th>Total</th>
<th>% of (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service D- New ways to manage child behavior</td>
<td>15</td>
<td>20.0</td>
</tr>
<tr>
<td>Service B- New ways to communicate</td>
<td>12</td>
<td>16.0</td>
</tr>
<tr>
<td>Service F- They listened to me</td>
<td>10</td>
<td>13.3</td>
</tr>
<tr>
<td>Service A- Help obtain services for my family</td>
<td>8</td>
<td>10.7</td>
</tr>
<tr>
<td>Service C- Help understand my children’s behavior</td>
<td>7</td>
<td>9.3</td>
</tr>
</tbody>
</table>

### Table G3 Notes:
Only 75 \((N)\) out of the 207 surveys were marked- top 5 marked among 75 responses-
% of \(N\) = total marked divided by 75