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Community-Based Child Abuse Prevention Program Evaluation

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Executive Summary

Family Support Services (FSS) are voluntary services that are offered to families when a child protective investigator determines that a child is currently safe but at risk for future child maltreatment. Under the Florida practice model, families may be referred to FSS if they exhibit one or more risk factors associated with child maltreatment and are eligible for secondary prevention services. FSS are designed to build protective factors that will improve the long-term safety of children in the home, and may be provided along with case coordination depending on the assessed level of risk. This report presents results of an evaluation of FSS provided by six Community-Based Care (CBC) lead agencies in Florida. A mixed methods approach was used to address a variety of research questions about the provision of services, the impact of services on protective factors, and the effectiveness of services in reducing the incidence of child maltreatment. The evaluation team conducted focus groups with administrators and front-line staff (Study 1), a descriptive analysis of responses to a survey distributed to caregivers participating in FSS (Study 2), and an exploratory analysis of relevant data from the Florida Safe Families Network (Study 3). The report concludes with a summary of findings and recommendations.

Study 1: Focus group participants indicated that their main goals when working with families were to preserve the family unit and avoid child removals by connecting families to community resources and promoting healthy parenting skills. Participants discussed the many challenges faced by the families they serve, such as substance abuse, mental illness, poverty, homelessness, and generational involvement with the child welfare system. The CBCs operated different program models for FSS, although there were some common components such an in-home service delivery. There was variability in the frequency of face-to-face contact with families as well as the duration of programs, but all programs highlighted the inclusion of family team meetings as well as an individualized and flexible approach to service delivery. Family engagement was facilitated by emphasizing the benefits of the program, using a strengths-based approach, demonstrating empathy and respect, and giving the family an opportunity to provide input regarding services. However, many programs used coercive tactics to urge families to engage in these voluntary services. Agencies provided a variety of services, and family needs, strengths, and achievements were continually reassessed throughout the case.

Study 2: The Protective Factors Survey (PFS) was administered to families participating in FSS to evaluate whether they have sufficient resources in place at discharge to prevent the recurrence of maltreatment. Families indicated that they had received an array of services, including information about parenting and healthy relationships. Results also suggest that protective factors are well established in families that have completed FSS, and caregivers reported very high levels of satisfaction with the program. Family functioning/resilience had the lowest mean score, which may be an indicator that additional services, such as family therapy, could be beneficial.

Study 3: Data from the Florida Safe Families Network were used to examine whether FSS affected the likelihood of a family having a new investigation. Results indicate that families that completed FSS had a reduced risk of future investigations. Families that chose to stop services were at higher risk than families that completed services, but lower risk than families that refused services. In addition, stopping FSS due to adverse events was a marker for future investigations, and these future investigations were more likely to find the child to be unsafe.

Finally, families that stopped FSS due to an adverse event had higher rates of parental substance abuse, mental health issues, and domestic violence.

Overall Conclusions: FSS programs provide a wide range of in-home services, referrals, and other supports for at-risk families in order to prevent future child maltreatment. Although the programs utilize different models, the incorporation of family team meetings and individualized approaches were common to all programs. In spite of the use of some coercive tactics to facilitate engagement, program staff utilized a strengths-based approach, demonstrated empathy and respect, and gave the family an opportunity to provide input regarding services. Results of the PFS suggest that participating families were very satisfied with services and had a variety of protective factors in place prior to discharge. Moreover, families that completed FSS had a lower risk of future investigations, which is an explicit goal of the program.

Recommendations: The evaluation team recommends that the FSS programs (a) expand funding and eligibility requirements in order to serve low and moderate risk families, (b) modify the referral process to allow programs to begin working with families sooner, (c) provide comprehensive cultural sensitivity and trauma-informed training to staff, (d) address the use of coercive strategies for engaging families, (e) identify and implement a common set of assessment tools, and (f) solicit feedback from families that decline services or discontinue services prior to program completion.

Introduction

In 2016, the Florida Department of Children and Families (DCF) received funds under the federal Community-Based Child Abuse Prevention (CBCAP) program to implement Family Support Services (FSS). FSS are voluntary services that are offered to families when a child protective investigator determines that a child is currently safe but at risk for future child maltreatment. Under the Florida practice model, families may be referred to FSS if they exhibit one or more risk factors associated with child maltreatment and are eligible for secondary prevention services, which are designed to prevent the recurrence of maltreatment. Risk level is determined by an assessment that is completed at the conclusion of the investigation, and families may be deemed at low, moderate, high, or very high risk. FSS are designed to build protective factors that will improve the long-term safety of children in the home, and may be provided along with case coordination depending on the assessed level of risk. Families that are determined to be at high or very high risk of future maltreatment are especially encouraged to participate in FSS and are the primary target of these interventions, but families at lower levels of risk may also be referred for services as appropriate.

According to the scope of work in DCF's Request for Proposals for Enhanced Prevention Services for Child Welfare Clients (RFP#: RFP09J15GN2), the intended goals of FSS are to: (1) reduce the incidence of child maltreatment, (2) enhance the family's ability to create stable and nurturing home environments, (3) promote child health and development, (4) help develop positive parent-child interactions, (5) increase evidence-based and evidence-informed services and programs through secondary prevention, (6) focus on the continuum of evaluation approaches which use both qualitative and quantitative methods to assess the effectiveness of the program and activities, (7) promote the protective factors, (8) achieve well-being for vulnerable children and their families, and (9) enhance participants' ability to become more financially stable.

In February 2018, DCF contracted with the University of South Florida to conduct an independent evaluation of FSS. The evaluation team utilized a mixed methods approach consisting of focus groups with administrators and front-line staff, an exploratory analysis of relevant data from the Florida Safe Families Network (FSFN), and a descriptive analysis of responses to a survey distributed to families participating in FSS. Results of the evaluation are presented by these analytic approaches. The report concludes with a summary of findings and recommendations.

Background

The CBCAP program was established by amendments to the Child Abuse Prevention and Treatment Act (CAPTA) in 1996 and reauthorized in 2010 (USDHHS, 2012). The purpose of the program is to support community-based efforts to implement programs to prevent child abuse and neglect while strengthening and supporting families (USDHHS, 2012). In 2016, DCF received $1.3 million under the CBCAP program to support evidence-based child abuse prevention programs. As shown in Figure 1, DCF issued awards to seven lead agencies to implement these programs, known as FSS, beginning in January 2016.

FSS provides voluntary services to families when a child protective investigator determines that a child is currently safe but at risk for future child maltreatment. Under the Florida practice

model, families may be referred to Family Support Services if they exhibit one or more risk factors associated with child maltreatment and are eligible for secondary prevention services, which are design to prevent the recurrence of maltreatment. Risk is determined by an assessment that is completed at the conclusion of the investigation, and families may be deemed at low/moderate risk or high/very high risk. The primary target of these prevention programs are families who are designated as high/very high risk, but families at lower levels of risk may also be referred for services as appropriate. The FSS prevention programs are implemented by community-based care lead agencies and must be evidence-based or evidence-informed and promote at least one protective factor. Protective factors may include: nurturing and attachment, social connections, social/emotional competency of children, knowledge of parenting of child and youth development, concrete supports for parents, and parental resiliency.

Seven lead agencies were selected by DCF to provide enhanced prevention services (see Figure 1). These agencies are (1) Family Support Services of North Florida, (2) Kids Central Inc., (3) Eckerd Hillsborough, (4) Eckerd Pasco/Pinellas, (5) ChildNet, (6) FamiliesFirst Network, and (7) Community Partnership for Children. These lead agencies have implemented a variety of evidence-based or evidence-informed prevention programs, including Wraparound, Homebuilders, Nurturing Parenting Program, Family Connections, Strengthening Ties Empowering Parents (STEP), and Family Coach Program. Several lead agencies provide Wraparound, which is an intensive, individualized care planning and management process that aims to achieve positive outcomes so that children can live in their homes and communities (Miles et al., 2006). Families are engaged in the Wraparound process for an average of six months. Homebuilders provides intensive crisis intervention for families with children at risk of out-of-home care with the goal of teaching families problem-solving skills (Kinney et al., 2004). Families participate in Homebuilders for approximately 4 to 6 weeks. Three of the lead agencies in Florida are implementing Nurturing Parenting Programs® or C.A.R.E.S, which are evidence-based programs that are currently rated a 3 (indicating promising research evidence) by the California Evidence-Based Clearinghouse for Child Welfare. Nurturing Parenting Programs® are designed to meet the needs of families by offering parenting education in various settings. Instruction is based on changing the patterns of parenting behaviors that have been shown to contribute to the maltreatment of children. C.A.R.E.S. (Coordination, Advocacy, Resources, Education and Support) is a program model that utilizes family team conferencing to engage and serve families by identifying their needs and building on their strengths. It is based on the wraparound approach, which is a team-based planning process for families of children with serious emotional disturbance who need individualized services from multiple systems (e.g., mental health, child welfare, juvenile justice, special education). Services are provided in phases and include preliminary engagement and team preparation, initial plan development, subsequent implementation, and program transition. The remaining lead agencies are implementing a variety of prevention program models, including Safe at Home, Common Sense Parenting, and Strengthening Ties and Empowering Parents, which vary in average duration and specific objectives, but they are generally time-limited (6 months or less). All of these programs are intended to strengthen and support families with the aim of preventing future child maltreatment and the subsequent removal of children from their homes.

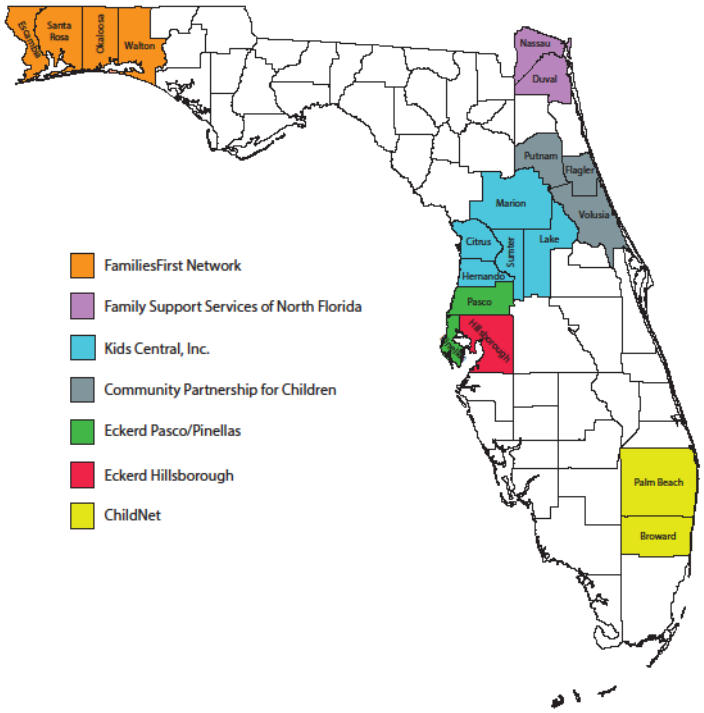

Figure 1
Map of CBC Lead Agencies Providing Enhanced Prevention Services

Purpose of the Evaluation

The purpose of this evaluation was to assess the overall impact of FSS prevention programs on participating families and provider organizations. Research questions included: (1) Do families who participate in FSS and families who decline to participate have similar characteristics? (2) Are families who participate in FSS more likely to stay intact? (3) To what extent are lead agencies utilizing the FSS module in the Florida Safe Families Network (FSFN)? (4) What are the implementation strengths and challenges according to key stakeholders?

The evaluation utilized a mixed method approach consisting of focus groups with administrators and front line staff, an exploratory analysis of relevant data from the Florida Safe Families Network (FSFN), and a descriptive analysis of caregiver responses to the Protective Factors Survey. In this report, we have designated each approach as a "study," and the methodology, data sources, analytic approaches, and results corresponding to each study are described separately.

Study 1: Focus Groups

Introduction

The purpose of Study 1 was to assess various aspects of FSS based on the perceptions and experiences of administrators and staff. A protocol was developed to address themes such as the purpose of services, characteristics of families served, program models, and structural barriers. These focus groups provided important information about FSS in general as well as specific details about program operations.

Method

In May 2018, the evaluation team contacted each lead agency to inform them about the evaluation and schedule a conference call to discuss the procedures and answer any questions. The team also developed a flyer that was distributed via email to the lead agencies (see Appendix A-1). Subsequently, the lead agencies and evaluation team worked together to schedule the focus groups with the FSS providers. At the conclusion of each focus group, participants were given copies of the PFS to distribute to families enrolled in FSS.

The evaluation team conducted 11 focus groups with providers between July 2018 and April 2019. A semi-structured protocol was developed and utilized to facilitate the discussion (see Appendix A-4). Focus groups were audio-recorded, with permission, and professionally transcribed. In addition, an informed consent letter and brief demographic questionnaire was distributed to each participant (see Appendices A-2 and A-3).

Data Sources

A total of 58 individuals participated in the focus groups, representing FSS providers affiliated with six of the seven CBCs. (One lead agency as well as one provider did not respond to repeated invitations to participate in the evaluation.) The size of the focus groups ranged from 3 to 10 individuals.

Table 1. Focus Group Participant Affiliations

	N	%
Families First		
90Works	10	17
Children's Home Society	4	7
Chautauqua Healthcare Services	2	3
Bridgeway Center	6	10
Family Support Services of North Florida		
Children's Home Society	3	5
Daniel Kids	5	9
Jewish Family Community Services	3	5
ChildNet		
Boys Town	8	14
Community Partnership for Children		
House Next Door	5	9
Kids Central, Inc.	5	9
Eckerd Hillsborough		
Safe at Home	4	7
Family Net	3	5
TOTAL	**58**	**100**

As shown in Table 2, focus group participants included program managers, supervisors, coordinators, case managers, facilitators, consultants, and other specialized positions. Participants reported that they had been employed in their current position anywhere from 1 week to 12 years, with an average of 29 months. Caseload size among frontline staff ranged from 3 to 20 families, but participants most commonly reported average caseload sizes of

around 10 families. Participants were predominantly female and the overall sample was racially and ethnically diverse.

Table 2. Demographics of Focus Group Participants

	N	%
Position Title		
Program Supervisor/Manager/Director	18	31
Care Coordinator/Case Manager	14	24
Facilitator/Consultant/Specialist	17	29
Other	9	16
Gender		
Male	9	16
Female	49	84
Race/Ethnicity		
Black/African American	20	34
Hispanic/Latino	10	17
White/Caucasian	25	43
Multiracial	3	5
Highest Degree		
Bachelor's	37	64
Master's	15	26
Other	6	10

Thematic Analysis

A grounded theory approach was used to analyze the focus group transcripts, in which open coding was performed to identify themes and concepts that emerged from the data. Three members of the evaluation team reviewed the focus group transcripts independently and generated a list of emergent codes. The team then met to discuss the codes they had each identified, and agreed upon a set of codes and code definitions. The identified themes were further analyzed in terms of their relation to other themes, resulting in families of codes that are related in terms of topic.

Next, the three team members selected a transcript to code independently, and then compared the coded transcript to assess the degree of inter-rater reliability among them. During this process, the team members further clarified code definitions and refined the code list (Appendix A-5). Once the code list was finalized and sufficient agreement and consistency were established among the coders, they independently coded the remaining transcripts using Atlas.ti, a qualitative analysis computer software program.

Results

Eight overarching thematic categories were identified through the analysis. These are: (1) Purpose of family support services, (2) Characteristics of families served, (3) Program models, (4) Family engagement, (5) Service array and gaps, (6) Assessment processes, (7) Program evaluation, and (8) Structural barriers to service provision. Within each category, several themes are identified and described in the following sections. Strengths and challenges to

service provision, as well as commonalities and differences across program providers are discussed.

Purpose of Family Support Services

The themes within this domain concern staff perspectives regarding the overall purpose and goals of family support service programs. Key themes that emerged in relation to this topic included prevention of future child maltreatment or further child welfare involvement, preventing child removals and preserving families, parenting skills development, building the self-sufficiency of families, linking families to community resources and supports, identifying and addressing the underlying causes of child maltreatment, and helping families to set and achieve realistic goals.

Respondents from FSS programs highlighted that their main goals when working with families were to preserve the family unit and avoid child removals from the home. Their purpose took shape in their desires to connect families to resources within the community and promote healthy parenting skills to empower parents to manage the household in positive ways for their child(ren) by prioritizing realistic goals. Practitioners further understood that they could not get to those desired outcomes without examining underlying factors that set a family up for intervention by the state. In the words of one respondent, their objective was,

> *Not just putting a Band-Aid on the situation, but to really engage with family intensively. Get to know them. Really find out what the root cause, you know, of the incident that happened. You know, so like I said, it is very intensive. It does require us really getting to know the family. You know, discussing all areas of their life, needs that they have and strengths that that have.*

The need to identify the underlying problem, as opposed to the allegations that led to the family's referral, was a theme reiterated across many focus groups. Another respondent speaking to this issue explained,

> *We saw this happen a few times early on and had that conversation with investigation about, "What's really the real issue here and what's important?" They were sending over Nurturing Parenting referrals of families that were homeless, parents that didn't work. You want us to address the parenting skills, where their real need is for stabilization to find them a living place and to get employed.*

As agencies uncovered the root issues contributing to the family's vulnerability, it enabled them to focus on set goals that would build self-sufficiency and prevent the need for future child welfare intervention. This was the overarching purpose described by participants across focus groups.

Family Characteristics

This domain explores participants' understandings and perceptions of the families that they serve through family support programs. Included within this domain are themes pertaining to the types of allegations or family needs involved in these cases (e.g. substance abuse, domestic violence, mental health issues, inadequate supervision, hazardous home conditions) as well as socio-demographic characteristics of the families that these programs typically serve (e.g. low income/poverty, homeless, single parents, young parents). Another theme that emerged was families who have a prior history of child welfare involvement or generational system

involvement. Indicators of worker biases against families who receive these services, such as the use of stereotypes or stigmatizing language, are also documented under this domain.

FSS programs identified various factors and significant details that characterized the families they interact with frequently. One agency reported working with families dealing with a child death and grief; others reported that child health and behavioral problems were a major factor contributing to families' need for services. Family conflict often exacerbated already fraught conditions within the home. Domestic abuse, substance use and abuse, sexual abuse, neglect and inadequate supervision, and hazardous conditions in home pertaining to hygiene and cleanliness were also noted as issues practitioners observed in the field.

Families comprised of single parents and young parents with few natural supports or inability to leverage community resources to help their family were significant elements outside their control that created structural barriers to safety. Additional risk factors included living in poverty, unsafe neighborhoods, families experiencing mild to severe bouts of homelessness, and having a prior history or generational ties to DCF intervention. These factors illuminate the cyclical trauma commonly experienced by families that result in the need for intervention. Resources were reportedly scarce in many communities, or difficult to access, and families' decision-making skills were frequently interlocked with being in survival mode. Interconnected to these processes, practitioners highlighted untreated mental health issues, whether apparent or undiagnosed, as undergirding family struggles:

> *We have a lot of co-occurring disorders with mental health and substance abuse. If an individual is diagnosed with a mental illness and is not being medicated or is receiving medication and not receiving talk therapy or treatment, there is no way that we can go in that home and get that parent or that family member to actively participate, actively engage, to be focused and concentrate on the curriculum that we're providing them. To me, I see that as a major issue because while they're receiving medications, the most appropriate way of providing mental health interventions is medication management with therapy counseling 'cause medication is nothing but a Band-Aid… That's when they start self-medicating [with drugs].*

This quote best encapsulates a majority of agency observations and the nuanced complexities of how families try to manage within difficult conditions and keep up with the requirements put forth by the state. Mental health issues comprised one of the most commonly reported characteristics observed by respondents, and represents a significant barrier to working effectively with families.

Unfortunately, not all practitioners shared an empathetic or respectful perspective as to why these vulnerable families have such challenging dynamics. Worker biases and assumptions that were grounded in and perpetuated stereotypes were expressed in a variety of ways during the focus groups. At times this occurred through direct and explicit value judgments, such as one respondent who stated, "Sometimes people will say something and you're just like, oh my god like, you should not be a mom." Other times, it was more subtle. One form this took was in the use of patronizing language that infantilized clients or characterized them as uneducated, ignorant, or irresponsible, as in the following examples:

> *And then during the meeting, it is our role to make sure that everybody plays nice and follows kindergarten rules and just guide them through the process.*

> *Sometimes they come to us high risk and they don't even know they have a problem. Like, they don't recognize that their substance misuse is actually an addiction and it's affecting their... Or that their fighting with their significant other is actually DV. You know, like they don't under[stand]... They don't recognize that.*
>
> *Anytime they ask for money, I say have you done a budget? So why don't they have enough money to pay the bills?*

Another form this took was in criticizing clients' perceived priorities, implying that some families prioritized the wrong things. The following excerpt from a focus group illustrates this point:

> *And that could be an issue of power, and that element of the CPI is coming to the home, and the parent feels like they've lost control and power, and so then they try and gain it back with us by, oh, I'm only available on this - like they're trying to maintain their schedule…the control…I go to the gym at 4:00, so you have to come after that. Where it's like, obviously, you're in a crisis management situation. You know, going - maintaining your regular gym appointment is not the priority.*

Statements such as this exhibited a failure to understand the importance that maintaining a sense of normality, and perhaps control, may have for a family that is struggling, and particularly the ways in which these routines may be an important part of a client's self-care. These kinds of statements also seemed to contradict respondent claims that their focus was on empowering families. Furthermore, the use of coded, racialized language appeared at various points in these conversations, such as one focus group in which participants chided that they were not going to schedule appointments around the family's "afternoon tea," a reference with racial undertones, hinting at the cultural image of black women getting together to "spill the tea," or gossip.

These sentiments obviously do not reflect the views of all participants, and there was considerable diversity in the perspectives shared during the focus groups. Indeed, some respondents actively spoke against these kinds of ideologies and stereotypical tropes, as in the following counter-narrative offered by one respondent:

> *I find this incredibly insulting the way it is assumed that if a family needs financial assistance then they need to be taught how to budget, as if their poverty is just the result of not knowing how to budget. This attitude is so common in child welfare and so detrimental to families.*

This statement reflected a more nuanced understanding of the complex nature of families and their vulnerability. Poverty was widely recognized as a substantial factor impacting families. On the other hand, there was little recognition of racial or gender inequalities and the ways in which these create and exacerbate vulnerability, not to mention the ways in which these inequalities may be reinforced by the child welfare system. These are areas that may require more comprehensive training.

Program Models

This domain concerns characteristics of the program models that have been implemented by the various family support service providers. Included under this domain are themes related to program eligibility criteria, how referrals are received, whether there is a specified evidence-based program model, the frequency of contact with families, duration of services, and other characteristics of service provision such as flexibility and individualization of services.

Eligibility criteria for all participating programs required that the children were deemed safe and living in the home for the family to receive family support services. There was some variability, however, in the risk level requirements across programs. While most programs were limited to serving only families assessed to be at high or very high risk of future maltreatment, two programs stated that they were also able to serve low and moderate risk families, and appeared to have leveraged additional funding sources in order to do so. Programs that were limited to serving only high/very high risk families commonly expressed a desire to serve lower risk families as well, believing that they could be more effective if they reached families sooner. An additional caveat that was noted in a couple focus groups was that CPIs had some flexibility to override a moderate risk determination and escalate it to high risk, based on mitigating factors not accounted for in the risk assessment, but this needed to happen on the CPI end before the case could be referred for FSS. All but one of the participating FSS programs were limited to receiving referrals from the CPI (either DCF or the Sheriff's office, depending on the county). The exception was the STEP program (operated through FSSNF), which reported that the majority of their referrals come from CPI, but they also accept community referrals, which come from a variety of sources such as schools, mental health providers, and even self-referrals. Focus group participants reported that there was someone either at the FSS program or at the CBC who was responsible for reviewing all referrals and verifying eligibility prior to accepting cases.

The six CBCs participating in the evaluation operated different program models for family support services, although there were some common program components. All programs used an in-home service delivery model, most included or were centered on parenting education, and several programs were either based on or used elements of the Wraparound Model. Most CBCs contracted their family support services to outside provider agencies, with the one exception being Kids Central, Inc., who had brought their FSS programs entirely in-house within the past year. A brief overview of each CBC's specific program model(s) is provided in Table 3. KCI offered two distinct program models in order to differentially serve families with varying needs. Similarly, ChildNet had created two separate program tracks, one of which was designated to offer less intensive services. The only CBC that had not implemented an overarching formal program model was Eckerd Community Alternatives (Hillsborough).

Another significant difference between Eckerd and the other CBCs was that their FSS providers also provided Safety Management Services (SMS), and were actually being engaged by CPIs early in their investigation to begin working with families through the SMS model before a safety determination was made. Although a benefit to this approach was that the providers were able to initiate services with families much earlier compared to other FSS programs, there are some considerable concerns about this approach as well. Most notably, this is a clear violation of DCF's practice model, whereby SMS are clearly designated as non-voluntary services that are provided to families whose children are deemed unsafe by the CPI assessment. To implement a non-voluntary service prior to making a safety determination goes against this protocol, and results in some families whose children are actually safe being forced to engage in these services. Focus group participants further articulated that when this happened, it often created greater conflict between program staff and families, because families viewed the workers as being aligned with CPI and had trouble differentiating the voluntary services they were currently being offered from the non-voluntary SMS they had previously received. Participants generally expressed that this approach was not ideal, and felt that it was better for SMS and FSS to be entirely separate programs, rather than having the same staff operate both services.

Table 3. Program Models for Family Support Services

CBC	Program Name/ Model	Program Description	Evidence Rating[1]
Families First Network	Wraparound	Team-based planning process intended to provide individualized, strength-based, and coordinated family-driven care. Emphasizes inclusion of natural supports and family voice and choice.	Level 3 – promising practice
ChildNet	Boys Town In-Home Family Services	Family Consultants work with parents in the home to teach parenting skills and address risk factors.	Not rated[2]
Community Partnerships for Children	C.A.R.E.S.	Community-based prevention model that utilizes high fidelity Wraparound and Family Team Conferencing.	Level 3 – promising practice
Kids Central, Inc.	Nurturing Parenting	Parenting education program with lessons that target parenting behaviors that contribute to child maltreatment: parental expectations, empathy, corporal punishment, parent-child roles, children's power and independence. Original program model is group-based, but has been adapted to be provided as in-home service.	Level 3 – promising practice
	Family Connections	Community-based prevention program with nine core practice principles: ecological developmental framework; community outreach; individualized family assessment and tailored interventions; helping alliance; empowerment principles; strengths-based practice; cultural competence; outcome-driven service plans with SMART goals; and a focus on the competence of the practitioner.	Level 3 – promising practice
Family Support Services of North Florida	Strengthening Ties Empowering Parents (STEPS)	In-home prevention model developed by FSSNF. Services include case management, parenting, behavior modification, and budgeting. Staff are trained in Wraparound.	Not rated[3]
Eckerd Community Alternatives - Hillsborough	No specified model	N/A	N/A

[1]Level of evidence according to the California Evidence Based Clearinghouse (CEBC) rating system.
[2]Focus group participants described the model as evidence-based, but no documentation or information supporting this claim could be found. The program does incorporate Common Sense Parenting, which is recognized by the CEBC as a level 2 EBP.
[3]The STEP model itself has not been evaluated, but is based on Wraparound, which has a level 3 rating. However, it is not clear whether the program has implemented high fidelity Wraparound, and there does not appear to be any Wraparound fidelity monitoring built in.

FSS programs varied somewhat in the frequency of face-to-face contact with families. The majority indicated that they had in-person contact with families a minimum of once per week, at least initially, and may gradually taper down the frequency of contact as cases progress and move towards closure. Many respondents reported more frequent contact in the initial stages of a case, as often as two to three times per week, depending on the family's particular needs. The only programs that reported less than weekly contact were the STEP program, whose prescribed timeframe was twice per month for high/very high risk families (although workers may have more frequent contact depending on the family's need) and once per month for low/moderate risk families, and Boys Town's "track 2" program (their less intensive track), which had biweekly contact. All participating agencies also reported having additional contact with families by phone in between their face-to-face contacts, which could be multiple times a week or even daily depending on the family.

There was also a considerable degree of variability in the duration of FSS programs. In general, programs were intended to be limited in duration. Eckerd and FSSNF's programs both had 90 day timeframes, but extensions could be requested up to six months. The Boys Town program was 10 weeks in duration, but could also be extended on an as-needed basis if families had not met all their goals. KCI's programs were reported to be three to four months on average, and CPC reported an average duration of five to six months. FFN's programs were the longest and most flexible in terms of timeframe; respondents reported that cases typically last six to twelve months, with twelve months being the absolute limit.

A common element across many of the FSS programs was the inclusion of family team meetings. Programs operated by four of the six CBCs included family team meetings as a core component of their program model. This approach emphasized the incorporation of both formal providers and natural supports as participants in the family's treatment team, as illustrated in the following narrative from one respondent:

> *It's not just going and meeting with the client or their family. It is literally every support that's connected to that family, are part of that meeting. That is the process throughout. And so it can be the uncle, the grandmother, the neighbor, the pastor. It could be the counselor or the targeted case manager, all of those people at the table, because they all see it from a different perspective as to what the family's needs are and the ways to meet the needs and all of that other stuff."*

Family team meetings were typically convened on a monthly basis and at a location convenient for the family, often the family's home. During meetings, program staff facilitated conversations that focused on identifying the family's needs, strengths, and goals, and developed action steps to achieve the family's goals. They also reviewed the family's care plan and progress made, identified any barriers to meeting the family's needs, and helped to brainstorm solutions to overcome identified barriers. Respondents reported very positive experiences with the family team meeting process and viewed the approach as a major strength of their programs, with several referencing the notion that "it takes a village" to raise a child. A challenge that providers sometimes faced, however, was families who lacked natural supports; respondents expressed that in some cases they needed to help the family build a support network and connect them to people and organizations in the community if they did not have anyone.

Finally, respondents across the board highlighted the flexibility of their programs and the individualized approach they take to service provision. Flexibility was incorporated in a variety of

ways, including working around the family's schedule to conduct visits at convenient times for them, having availability on weekends and evenings, being accessible to families in between visits, and flexibility in the frequency of visits based on the family's needs and choice. Respondents further emphasized that they go to the family to provide services, which could be in the family's home or another community location of their choice. As one respondent described, program staff literally "meet them where they're at." The in-home service approach was seen as a significant strength of these programs: "I mean, we go to them, we essentially link them up with resources… [it] doesn't get any better than that." Flexibility was also discussed in terms of having the ability to focus on what the family wants, as opposed to services being dictated to the family, and being responsive to fluctuating family needs and circumstances. Thus, service plans could always be amended, and workers were prepared to change course and "put out fires" as new situations arose.

Finally, flexibility also entailed the individualization and tailoring of services to each family's particular needs. Numerous respondents emphasized that their services were "not cookie cutter" and that they developed an individualized service plan based on the family's specific needs and interests. As one respondent eloquently summarized, "There is no typical task and responsibility. Every family is different, every need is different, every care plan is different, every situation is different. So, I think the only thing typical is just being able to go into a family with open mind." Individualization took many forms. For example, when providing parenting education, most programs used a specific curriculum, but staff might pick and choose which lessons were most appropriate to address the family's needs, or tailor and "tweak" individual lessons "to make it fit this family so it really will benefit [them]." Additionally, workers focused on incorporating services into the family's "normal routine," and described joining families as they carried out regular tasks like preparing dinner or cleaning up the house. A respondent provided the following illustration:

> *I've spent two hours combing a client's hair, because one of the stresses was the school was calling DCF saying that the child was coming to school unkempt, and her hair was matted. And this was a serious stressor for the grandmother… But with that, you're not just doing like - you're not just like - you don't just brush hair and sit there for two hours. There's a lot of teaching, there's a lot of, okay, what's the plan of how to do this in the future, or kind of what - who else are the supports to do those things? It's always going back to that service plan goals. You're always teaching those things throughout what you're doing.*

A common theme was that program staff were encouraged to "think outside the box" to find creative solutions to meet family's needs. In this regard, they had considerable flexibility to do "whatever it takes" to help the family achieve their goals. According to one respondent, "There's nothing that we can't do is what it feels like, you know, like within reason. It's just like I am very happy not to have to say no very often." In this way, programs were not limited to traditional services, but could explore a wide variety of formal and informal resources within the community and come up with innovative ideas to meet family needs.

Family Engagement

This domain includes themes relating to the strategies program staff use to engage families in services, the extent to which families have a voice and are active participants in their services, and the factors that may present barriers to family engagement. Major themes that emerged

within this domain include emphasizing the benefits of services to families, taking a strength-based approach, using accessible language, demonstrating empathy and respect, soliciting the family's input, giving families the power to design their service plan versus dictating services to the family, the use of coercive or manipulative tactics to get families to engage in services, distancing the provider agency from DCF, and the roles that fear and stigma (e.g. concern over the intrusiveness of services, fear of state intervention, not wanting others to know about their situation, etc.) play in creating hesitancy or resistance among families.

Respondents indicated that families were often resistant to engaging in services for a variety of reasons. Most commonly, families refused or expressed hesitancy to engage in services because they feared escalated intervention by DCF, they disagreed with the findings of the CPI's investigation, they were exhausted by the demands of the program, or they were concerned about the stigmas associated with behavioral healthcare or service involvement.

Caregivers feared that participation in services would make their household more vulnerable to further DCF intervention and child removal. Some respondents acknowledged that families were not entirely off-base with these concerns, since services brought additional eyes into the home and providers were mandated reporters. Other families, especially those that had been involved in the system multiple times or had experienced involvement in the system over multiple generations, felt fatigued by the push to continue services. Program staff encountered this frequently: "A lot of our families, they're generationally involved with the department and they grew up with services being in the home and so, if they've never work with [the program] before they have a jaded outlook of things." Workers spent much of their time distancing themselves and their agency from DCF. They explained the differences in their programs, including the use of new models and practices, the focus on individualized, family-driven treatment, and both the short term and long term benefits of enrollment.

Agency workers were limited in their ability to completely distance themselves, however, because of their dual roles as family advocate and mandated reporter. This was not always an issue, and one respondent explained, "They'll be like, 'You're DCF.' And then we're like, 'No we're not DCF, but we communicate with DCF,' and it's just really trying to make it like more of a positive outlook for them instead." Some respondents explained that the dual nature of their roles helped families. It provided evidence that they had tried to complete services and—for those that completed services successfully—that they had made progress. These positive reports would help families in the future should they become involved with DCF again.

Agencies approached engagement among resistant families differently, particularly when it came to explaining to families that service enrollment and completion was voluntary. Some agencies explained that they always told families that services were voluntary and cleared any misconceptions that may have originated from others in the system, like the CPI. Other agencies explicitly instructed workers not to explain that service engagement was voluntary "because you'll lose them, you will." One such agency pushed families particularly strongly, as demonstrated in the following quote:

> *The mom is like, 'Oh, well, you do what you have to do but if you're asking DCF to come back into my life because I won't continue, that's blackmail.' And it's a whole conversation. We're like, 'No, sorry. We're sorry that you feel that way but we did explain to you at the beginning if you choose not to continue at the beginning or at any point, this is what we have to do.'*

This examples illustrates the use of coercive practices to get families to engage in services, an approach that was reportedly quite common across many, though not all, programs. Workers would frequently tell families that participating in services was the only way to get DCF out of their life and would even ask the CPI to convince the family to cooperate if they were having trouble engaging.

Although services were advertised as family driven, the level of authority granted to families in crafting their treatment plan varied by agency. Most agencies encouraged families to discuss their needs, observe their strengths, and create their goals, with relatively limited guidance from investigative findings and agency input. Some agencies, on the other hand, crafted treatment plans that mostly followed the beliefs and observations of the provider. In some cases, this was to help families recognize and address needs: "Then I'll ask them, 'What are some of the things that you would like to add to this?' And a lot of times if I'm doing the assessment, I can tell right off." Other times, it was to act on the assumed expertise of the practitioner: "Because if it's your intent as an investigator to help strengthen that family and help give them some tools to help better themselves, you don't want to give them an out. You want to lay it on the table like, 'Here are the issues that I see with your family.'"

It was reported that families were most responsive to workers who expressed empathy and acknowledged the family's strengths. Psychoeducation was helpful in diminishing the stigma and fear families felt about services as well. Caregivers were appreciative of respect shown toward their skills in decision-making and their expertise about their lives and families. Although only a handful of agencies explicitly noted that they involved youth in the creation of a family treatment plan, workers from these agencies explained that this was a helpful technique. "We come together as a whole family team, we try to incorporate every individual statement into one family vision statement. And that kind of drives our direction, too." Overall, the importance of being able to engage families effectively in order for service provision to be successful was emphasized across focus groups.

Service Array and Gaps

This domain examines the specific variety of services that are available and provided to families who receive family support services as well as any identified gaps in the service array. The most prominent themes that emerged with regard to services that are provided were parenting, mental health services/counseling, family therapy, substance abuse treatment/counseling, vocational skills training, care coordination, and assistance with basic needs. The most prominent service gaps that were identified, on the other hand, included affordable housing, transportation, and childcare.

Overall, agencies provided a variety of services that included daycare, respite care, psychoeducation, mental health counseling, substance abuse counseling, parenting courses, assistance with basic needs such as food or clothing, financial assistance with utilities or rent, case management, independent living courses, transportation assistance, vocational skill development, and access to other agency programs like parent support groups. However, the array of services, and extent to which these services were made available to families, differed by agency. For example, some agencies did not provide transportation and had difficulty providing gas cards or bus passes, while other agencies offered to occasionally drive families directly to services and provided gas cards and bus passes. Case management, mental health

counseling, substance abuse counseling, parenting courses, and assistance with basic needs were among the most common services families received.

A variety of specific evidence-based practices and programs were also offered by FSS providers. When asked about evidence-based practices, agency workers listed practices relevant to case management, counseling, and parenting courses. These included Family Group Decision Making, SMART Goals, motivational interviewing, cognitive behavioral therapy, and various parenting courses—Common Sense Parenting, Nurturing Parenting, and Parenting 1, 2, 3, 4, among others. Most agencies incorporated at least one or two evidence-based practices in their service array, in addition to the evidence-based program models described earlier.

In addition to services that were provided in house, agencies also referred out for a variety of services. Those most commonly reported were services for basic needs, housing, daycare, respite care, educational services for adults, tutoring for children, and mentoring. Mentoring was identified as a particularly critical service, especially among children with special needs:

> *I also utilize NAMI for autism or kids with just behavioral stuff. And for the mentorship, that worked out really well for one of my clients. And to this day, his mom continuously thanks me for that… the mentor, will come to the house and will sit there and talk to him [the client], and kind of teach him different types of social skills.*

Some agencies referred out for targeted case management, mental health counseling, substance abuse counseling, and domestic violence treatment when it exceeded the agencies' capacities. Agency workers also helped families fill out applications for welfare services, such as food stamps and health insurance, as needed.

Service gaps were a common challenge. Agencies cited a lack of flex funding, or limited flex funding, as one issue. "I think it needs to be mandated, I feel like, to have flex funds available," one respondent expressed. Other gaps had to do with the availability of community services. Many agencies, especially those in rural areas, were deeply affected by a lack of resources in their communities. The most commonly requested services among families—housing, transportation, employment, daycare, and financial assistance—were sometimes simply not available in a community. Homeless families had difficulty making progress on their treatment plans until they found affordable housing, which could take months in some cases. Many families in rural areas struggled to find and maintain employment because there were fewer jobs in the area, an issue compounded by a lack of reliable public transit. Daycare was an issue for many families for a variety of reasons. Sometimes it was because there were no daycares in the area, sometimes it was because a family could not afford to pay for daycare but was not eligible for financial assistance with daycare, and sometimes it was because "the kid's too old to go through the voucher program. But [the child's] definitely not old enough to stay home alone." Finding adequate resources to address the range of families' needs was an ongoing challenge for providers.

Assessment Processes

This domain contains themes related to the process of assessing family needs, strengths, and changes over time. Included within this domain are discussions of specific measures, methods, or assessment tools that FSS providers use, ways in which families are involved in the

assessment process, and indicators or processes that are used to determine when a family is ready to transition out of services.

Family involvement was one of the most prevalent themes that emerged in relation to assessment. Respondents across the focus groups emphasized that families are directly involved as participants in the initial family assessment, and were generally asked to identify their own strengths and needs. Several programs strongly emphasized the concept of family voice and choice, explaining that the purpose of the program was for the family to drive the process and choose their own goals. As one respondent framed it, “In other words, I'm not coming in and telling them what their needs are. I'm simply asking them to, could you tell me your story? Why are we here today?” This was not universally true across all programs, however, with some focus groups describing a more provider-driven process that incorporated feedback from families but was largely informed by the CPI’s referral. Programs that were based on a Wraparound model generally seemed to be more family-driven based on the focus group responses. However, all programs indicated that family perspectives were solicited through the assessment process.

A number of assessment tools and measures were identified, which varied by program. Programs based on the Wraparound model reported use of the Strength and Cultural Discovery tool. Programs operating the STEP model used an actuarial risk assessment tool, similar to the initial risk assessment completed by the CPI. The Boys Town program used a tool called Strengths and Stressors. Finally, a few different programs reported use of the Ages and Stages Questionnaire (ASQ) and the Adult Adolescent Parenting Inventory (AAPI). Overall, responses indicated that there was no universal assessment tool across programs, but each program’s assessment process emphasized family engagement and identification of both strengths and needs. Additionally, respondents in several focus groups mentioned the inclusion of information from collateral sources, such as mental health providers, teachers, neighbors, and relatives, and the use of observation (e.g. of the physical condition of the home, family dynamics, parent-child relationship) to further inform the family assessment.

Assessment was further discussed as an ongoing process, whereby the family’s needs, strengths, and achievements were continually reassessed throughout the case. FSS programs varied in terms of the specific processes in place, but most reviewed the family’s progress on at least a monthly basis. Several programs convened family team meetings, during which they reviewed each of the family’s goals, the progress that had been made, barriers that might be present, and what steps needed to be taken next. Some programs completed formal service plan or assessment updates at set intervals, which ranged from every 30 days to every 90 days, depending on the program, while others simply updated family plans on an as-needed basis. Supervisory reviews were another process noted in several focus groups. A couple programs, furthermore, noted the application of the Transtheoretical Model (“stages of change”) during their progress reviews, focusing on where the family was in the change process and what was needed to get them to the next stage. The common theme across programs was that the family’s goals and needs were revisited and reassessed together with the family on a continual basis.

There was also general consensus across the focus groups regarding how decisions were made about when a case was ready for closure. Respondents described the overall process as being guided by the family’s service plan, the extent to which the family has achieved their goals, and the extent to which the family has been linked to an ongoing support network. In

particular, respondents noted the importance of planning for case closure and building up the family's support system, which might include formal resources, but centered especially on informal supports. For many respondents, the connection of families to long-term supports was a key indicator that a case was ready for closure. Furthermore, several programs developed transition or aftercare plans with families that explicitly laid out the family's ongoing support network and how to access resources when future needs arise. It was also reported that families were directly involved in the decision-making process, and could express to staff when they felt ready to transition from services. Overall, respondents described case closure as a joint decision between families and program staff, and were particularly concerned with ensuring the family had been adequately empowered and prepared to be self-sufficient by case closure.

Program Evaluation

This domain examines the various processes that FSS providers use to monitor and evaluate their programs, including measuring fidelity, quality assurance, and program outcomes. Themes that emerged within this domain include certification processes, supervision, case reviews, observation of workers (e.g. by supervisors or program managers), administration of client surveys to obtain feedback on the services received, and measurement of client functional outcomes (e.g. through standardized assessments) or use of recidivism data to assess program effectiveness. Additionally, a theme that emerged concerns the ways in which participants understood and rationalized cases that were unsuccessful (e.g. cases that ended with an adverse event or in which the family did not complete services).

Programs incorporated a variety of quality assurance and fidelity mechanisms to monitor the extent to which services were provided as intended and with adherence to program requirements. The most commonly reported processes that FSS programs had in place were case file reviews (n = 6 focus groups), case staffings with program supervisors (n = 7 focus groups), structured observations of staff (n = 7 focus groups), and administration of client surveys that solicited feedback on the service provision process (n = 5 focus groups). As described previously, several of the CBC lead agencies (n = 4) had implemented evidence-based programs with their FSS providers, most of which came with prescribed fidelity standards and measures that the programs reported using. Respondents in two focus groups also spoke specifically to certification requirements of the programs they were providing, noting that their agency ensures all staff are certified and stay up-to-date on their certification. Across programs, there was a strong emphasis on the role of supervisors, who regularly staffed cases and reviewed progress with staff, helped to brainstorm solutions to identified barriers, ensured that appropriate follow-up occurred, and determined when a case was ready to close. Overall, each program appeared to have fairly robust and comprehensive monitoring and quality assurance mechanisms in place.

Additionally, each program generally included mechanisms for measuring and tracking program outcomes, although there was variability in the particular outcomes that programs assessed. These included a combination of intermediate and long-term outcomes. In terms of intermediate outcomes, respondents from three focus groups reported that they look at observable behavior changes, such as decreased substance use and demonstration of improved parenting skills. Respondents from four of the focus groups, furthermore, noted that they use standardized assessment instruments that are administered as pre- and post-tests in order to measure changes at the end of services. The use of these intermediate outcome measures generally guided program staff in assessing whether the family's needs had been adequately addressed

through the program, thus informing whether the family had successfully completed services. Some programs also assessed successful service completion based on the extent to which the family completed all the tasks and goals on their care plan. Thus, while service completion was generally documented across all programs, definitions of what constituted "successful" service completion and how it was measured varied somewhat across programs.

There was greater consistency across programs with regard to the assessment of long-term program outcomes, although variability did exist in the timeframes that programs used. Overall, each program measured effectiveness in terms of the proportion of families served that did not have a verified abuse report within a certain prescribed timeframe after the case closed. At a minimum, all programs examined verified reports within six months of case closure. Beyond this, several programs also looked at verified abuse reports within 12 months, and even 18 months of case closure. Across focus groups, staff typically had a sense of their program's success rate, and most respondents indicated that they felt their program was fairly effective in meeting the needs of families and reducing the risk of future maltreatment. Notably, however, the mechanisms for evaluating program outcomes that respondents described lacked any comparative analyses to families who declined or did not complete services. Thus, measures of program effectiveness that were used did not actually assess whether outcomes among families who received FSS were better than outcomes among families who did not receive FSS.

Finally, while respondents did perceive their programs to be effective overall, there was also acknowledgement that services were not successful with every family. Most commonly, unsuccessful cases were described as either families who refused to engage in services from the onset or families for whom there was loss of contact, often due to the transient nature of the population served. Respondents in one focus group noted that lack of success was sometimes due to FSS not being the appropriate type of service for the family's needs, for example, if the caregiver has substantial substance abuse problems and is actively using drugs. These respondents emphasized the importance of assessing the appropriateness of the referrals that are received to ensure that the FSS program is the right fit for the family. In another focus group, respondents noted that a significant factor contributing to families being assessed as "partial" completion rather than "successful" completion was the expectation that a family complete everything on their care plan before they can be successfully discharged. In some cases, these respondents explained, they had families who had made good progress on their plan and decided that they were ready to withdraw from formal services and handle their remaining goals independently, and as a result these cases were counted as only "partially complete," despite the fact that the families clearly felt empowered enough to no longer need assistance. Thus, staff questioned whether some of the performance measures used provided an accurate assessment of their program's success, indicating that there may be a need for more nuance or consideration of additional measures.

Structural Barriers

Themes within this final domain concern the barriers that FSS program staff faced in their efforts to serve families that were imposed by outside structures and largely outside the control of the program. Some of the most notable barriers were limited capacity (e.g., not enough staff to handle the number of referrals that are received), inadequate program funding, delays in the CPI referral process that prevent program staff from initiating services sooner, limited access to community resources, lack of collaboration from other community agencies or providers,

pressure to close out cases to comply with prescribed timeframes, and the lack of long-term solutions to address family economic needs.

While societal structural barriers created a hurdle to family engagement, agencies also found barriers within their own organizations that prevented them from helping families to their full capacity. Limited funding, being understaffed, the ability to undergo quality staff trainings, and having dual or multiple roles placed constraints on fulfilling their purpose and often manifested into short-term solutions. All agencies noted that one of their main focuses was connecting families to community resources to build self-sufficiency, however, they also noted that certain communities had severe shortages in quality community allies, therefore, the ability to make partnerships where they could redirect families in the event the agencies could not provide assistance in-house were limited or non-existent.

Practitioners also expounded on frustrations with the referral process and DCF assessments. Many agencies expressed frustration with the fact that they did not receive referrals until the end of the CPI investigation, which could be up to 60 days after the case opened. This caused a significant delay in the initiation of services, and in some cases families were past the initial crisis that brought them to the attention of DCF and thus less inclined to engage in services. Furthermore, respondents reported that there were frequently issues with the accuracy or appropriateness of CPI assessments and referrals. In some cases, families were referred who really did not require services. In other cases, families were referred for a particular service, but program staff discovered that their needs were actually quite different from what the CPI had requested, as illustrated in the following quote:

> *We may have a issue where a family is referred for one thing, for parenting, but we go in a home and realize that the parent is a good parent, they just have all these other barriers. And then I have to step in and advocate for that parent with DCF or whoever else I need to advocate through for that.*

In addition, the limited duration of FSS programs and pressure to close cases within prescribed time frames, coupled with limited community resources, raised questions about the extent to which these services could adequately address the long-term needs of families. Given the extent to which structural problems of poverty, lack of affordable housing, limited employment opportunities, and economic instability impacted the families served by these programs, there is clearly a need for broader, macro-level interventions targeted at reducing these structural inequalities. While respondents held self-sufficiency as a goal of their programs, they often had to reconcile the limitations to families becoming fully self-sufficient (e.g., in the sense of not being reliant on state or charitable assistance) and set more realistic, short-term goals for families to at least increase their self-sufficiency.

Study 2: Protective Factors Survey

Introduction

The Protective Factors Survey (PFS) was developed to assist child welfare programs measure the degree to which their services increase protective factors, and therefore, minimize the potential for abuse and neglect (Child Welfare Information Gateway, 2014). The PFS has been used by many states to evaluate the ability of prevention programs to develop certain protective

factors in at-risk families. Protective factors have been described as the personal, social, and institutional resources that foster competence and buffer risk factors that might otherwise comprise development (Deković, 1999; Garmezy & Rutter, 1985). The PFS consists of five subscales corresponding to the following protective factors: family functioning, social support, concrete support, nurturing and attachment, and knowledge of parenting and child development.

Family Functioning

Family functioning means "having the adaptive skills to persevere in times of crisis" (Counts, Buffington, Chang-Rios, Rasmussen, & Preacher, 2010, p. 763). Research suggests that one of the most important factors in preventing maltreatment is the ability of family members to communicate with one another about positive and negative experiences, maintain familial cohesiveness, and resolve family conflict (Counts et al., 2010).

Social Support

Social support is "perceived informal support (from family, friends, and neighbors) that helps provide for emotional needs" (Counts et al., 2010, p. 763). Positive social networks benefit families by providing companionship, empathetic support, a vehicle for solving problems, and assistance with childcare (DePanfilis, 1996).

Concrete Support

Concrete support refers to material resources, such as food, money, and clothing. According to Sedlak and Broadhurst (1996), families living in poverty are 22 times more likely to experience maltreatment than families earning over $30,000 annually. Programs that provide assistance with procuring resources are an effective way to prevent maltreatment because they help to moderate financial strain. In terms of the PFS, concrete support was defined as "perceived access to tangible goods and services to help families cope with stress, particularly in times of crisis or intensified need" (Counts et al., 2010; p. 763).

Nurturing and Attachment

Attachment refers to the emotional bond between a child and primary caregiver. Although the quality and strength of this bond, known as "attachment security," varies, research indicates that children subject to maltreatment show lower quality attachment than do their peers (Shonkoff & Phillips, 2000). For the PFS, this construct was defined as "the emotional tie along with a pattern of positive interaction between the parent and child that develops over time" (Counts et al. 2010, p. 763).

Knowledge of Parenting and Child Development

This element of the PFS refers to "understanding and utilizing effective child management techniques and having age-appropriate expectations for children's abilities" (Counts et al., 2010, p. 763). Many parenting programs attempt to increase familiarity with child development in order to improve parenting skills, as it is believed that replacing inaccurate beliefs about parenting with appropriate skills and knowledge will reduce the risk of maltreatment.

The PFS is a self-administered questionnaire that takes approximately 10-15 minutes for participants to complete. It consists of 20 core items in which participants are asked to respond to statements about their families. Each item is scored on a 7-point response scale ranging from

1 (“strongly disagree” or “never”) to 7 (“strongly agree” or “always”). Five items require reverse scoring. The evaluation team included five additional items to measure the quality of prevention services. The team also modified the original demographic items to include additional response categories.

Method

Initially, the evaluation team developed a methodology to administer the PFS to families receiving FSS as well as a matched comparison group of families that declined FSS. However, it was not possible to obtain contact information for families that declined services. Therefore, with the assistance of the CBCs and provider agencies, the PFS was distributed to participating families only. (The team translated the PFS into Spanish and Haitian Creole and provided these versions upon request.) The PFS was completed by a caregiver and mailed to the evaluation team.

Results

The evaluation team assembled and distributed a total of 240 survey packets. Twenty packets were distributed to each provider agency that participated in the focus groups. The packets included a cover letter, the Protective Factors Survey (PFS), a pen, and a self-addressed stamped envelope. Focus group participants were instructed to distribute the survey to families that had completed or almost completed family support services.

As shown in Table 4, the evaluation team received 31 completed surveys from six providers that are affiliated with three of the CBCs. 39% of the surveys came from Families First Network, 23% of the surveys came from Family Support Services of North Florida, and the remaining 39% of the surveys came from Kids Central, Inc. Of the completed surveys received, 16 (52%) were completed in a face-to-face interview between the participant and program staff, 8 (26%) were completed by the participant with assistance from program staff, and 5 (16%) were completed by the participant without staff present. The range of time in the programs was 59 days to 805 days, with a mean of 205 days (*SD* = 174.4).

Table 4 . Completed Surveys Received from the CBC Lead Agencies

CBC Lead Agency	**N**	**%**
Families First	12	38.7
Family Support Services of North Florida	7	22.6
ChildNet	0	0.0
Community Partnership	0	0.0
Kids Central, Inc.	12	38.7
Eckerd Hillsborough	0	0.0
TOTAL	**31**	**100.0**
Note. Percentages do not add to 100 due to rounding.		

Table 5 presents the demographic characteristics of the sample. The majority of the respondents were female (87%) with a mean age of 34 years. 58% of the sample was White, and most of the respondents were not married (78%). Approximately 81% of the respondents reported earning $30,000 or less annually, and only 13% owned their current residence. In addition, most families were receiving supplemental benefits, such as Medicaid (68%), food

assistance (65%), or SSI/SSDI (26%). Most of the respondents had earned a high school diploma (73%), and 71% had more than one child living in the home.

Table 5. Demographic Characteristics of the Sample

	N	%
Gender		
Male	3	10
Female	27	87
Missing	1	3
Age (mean/SD)	*M* = 33.9	*SD* = 8.6
Race/Ethnicity		
African American	9	29
African National/Caribbean Islander	1	3
Hispanic or Latino/a	2	6
White	18	58
Multiracial	1	3
Marital Status		
Married	7	23
Single	17	55
Divorced	3	10
Widowed	1	3
Separated	3	10
Family Housing		
Own	4	13
Rent	23	74
Shared housing with relatives/friends	4	13
In the past month, were you unable to pay for:*		
Rent or mortgage	4	13
Utilities or bills	6	19
Groceries/food	5	16
Child care or daycare	2	6
Medicine, medical expenses, or co-pays	4	13
Basic household or personal hygiene items	3	10
Transportation (e.g., gas, bus passes)	8	26
None of the above	14	45
Total Family Income		
$0 - $10,000	8	26
$10,000 - $20,000	8	26
$20,001 - $30,000	9	29
$30,001 - $40,000	2	6
$40,001 - $50,000	1	3
More than $50,001	2	6
Missing	1	3
Current Benefits*		
Food assistance (SNAP or WIC)	20	65
Medicaid	21	68
Earned Income Tax Credit	3	10

Housing assistance	4	13
Unemployment benefits	0	0
Temporary Assistance for Needy Families (TANF)	1	3
Head Start/Early Head Start	3	10
Social Security Disability or Insurance/Supplemental Security Income	8	26
None of the above	5	16
Highest Level of Education		
Some high school	8	26
High school diploma or GED	10	32
Trade/vocational training	2	6
Some college	9	29
2-year college degree (Associate's)	1	3
PhD or other advanced degree	1	3
Number of Children in Household		
1	9	29
2	13	42
3	8	26
4	1	3
Note. *More than one category may be selected. Percentages may not add to 100 due to rounding.		

Table 6 indicates the number and percentage of families that received specific services as reported on the face sheet of the PFS. The number of services ranged from 1 to 18, with a mean of 4.2 (*SD* = 3.3). The most common services were parenting skills/education, resource and referral, home visiting, and healthy relationships.

Table 6. Services Received by Participating Families

Service Type*	**N**	**% of families receiving service**
Parenting Skills/Education	26	84
Resource and Referral	19	61
Home Visiting	17	55
Healthy Relationships	10	32
Advocacy	9	29
Parent/Child Interaction	7	23
Other	7	23
Family Therapy	5	16
Homeless/Transitional Housing	5	16
Parent Support Group	4	13
Individual Therapy	4	13
Prenatal Class	4	13
Planned and/or Crisis Respite	3	10
Job Skills/Employment Prep	3	10
Family Resource Center	2	6
Skill Building/Ed for Children	2	6

Adult Education (i.e., GED/Ed)	2	6
Fatherhood Program	1	3
Family Literacy	1	3
Note. *More than one category may be selected.		

Table 7 reports the mean scores for the PFS subscales. Although we cannot conclude that scores are attributable to participation in family support services, these results provide important information about the level of protective factors in families that have completed the program. Family functioning/resiliency had the lowest mean score across all of the subscales. This may be an indicator that additional services could be beneficial, such as family therapy in order to build communication skills. As noted above, only 16% of families who completed the PFS indicated that they received family therapy. The mean scores for the remaining subscales indicate that these protective factors are well established in families that have completed FSS. Additionally, families report very high levels of satisfaction with the program.

Table 7. Mean Scores for PFS Subscales

Subscale	N of valid responses	M	SD	Range
Family Functioning/Resiliency	30	5.77	1.07	1.60 – 7.00
Social Support	30	6.23	0.99	3.33 – 7.00
Concrete Support	30	6.19	1.11	3.33 – 7.00
Child Development/Knowledge of Parenting	30	6.29	0.79	4.00 – 7.00
Nurturing and Attachment	30	6.41	0.66	4.25 – 7.00
Program Satisfaction	31	6.61	0.72	4.00 – 7.00
Note. Possible responses are 1 = strongly disagree, 2 = mostly disagree, 3 = slightly disagree, 4 = neutral, 5 = slightly agree, 6 = mostly agree, 7 = strongly agree.				

The evaluation team used multiple linear regression procedures to model the relationship between scores on the PFS subscales with selected demographic and service-related variables (i.e., marital status, race, level of education, income level, and number of children in the household, number of services received, and number of days in the program). None of the variables were statistically significant predictors of scores on the subscales, but this result may be attributable to the small sample size.

Study 3: Outcomes

Introduction

Administrative data from the FSS module of the Florida Safe Families Network was used to examine the relationship between receiving FSS and the likelihood of a family having a new protective investigation during or after the end of FSS. In essence, we focused on determining whether the first goal of FSS, to reduce the incidence of child maltreatment, was achieved. The evaluation team addressed the following research questions:

1. Was the receipt of Family Support Services associated with a lower likelihood of new protective investigations?
2. Did the rate of new investigations differ based on whether Family Support Services were completed or the reason services were not completed?
3. Was the length of Family Support Services associated with the likelihood of a new protective investigation?
4. Among families with new protective investigations, was the receipt of Family Support Services associated with findings from the safety methodology? In particular, did the risk assessment lead to a finding of high risk for future maltreatment, and was the child deemed by the safety determination to be unsafe?
5. Among families with new child welfare investigations, did the rates of mental illness, substance abuse, and domestic violence differ between families that did and did not receive Family Support Services?

Data Sources

The FSS module contained information on each person that received Family Support Services in SFY 2016/17. There were records for 17,994 people in the FSS module. Data were available on the start and end dates for services and the reason that services ended. Potential reasons included: child death (*n* = 2), child relocated (*n* = 277), court obtained jurisdiction (*n* = 402), family fled (*n* = 39), family no longer cooperative (*n* = 1,309), family requests services closed (*n* = 586), new investigation received (*n* = 99), non-judicial in-home (*n* = 356), other (*n* = 2,920), parent/caregiver death (*n* = 15), service provision completed (*n* = 7,361), service provision partially completed (*n* = 1,446), and service refused by family (*n* = 2,938). The remaining families were continuing to receive Family Support Services. For the purposes of this analysis, reasons were combined into five categories: completed services, started FSS-DNF (DNF = did not finish FSS; i.e., family no longer cooperative, family requests services closed, or service provision partially completed), started FSS-ADV (ADV = adverse event led to the end of FSS; i.e., family fled, child death, child relocated, court obtained jurisdiction, new investigation, non-judicial in-home, parent/caregiver death), other, and refused services. Others were continuing to receive services. FSS that ended without services completed were divided into two groups. The first group (i.e., started FSS-DNF) included records where services were not completed without an adverse event. The second group (i.e., started FSS-ADV) included records where services were not completed due to an adverse event.

The investigations module included all investigations initiated in SFY 2016/17 and 2017/18. The file includes all investigations closed as: closing-open ongoing case management service, closing-services, and closing-no services. The file also included an indicator for whether the investigation was completed using the safety methodology.

The safety module reports the safety determination (safe or unsafe). The risk assessment module includes responses to all risk assessment questions for investigations completed using the safety methodology. In addition, the final risk level for the family is reported.

Method

Two different approaches were used to examine whether FSS affect the likelihood of a family having a new investigation. First, we utilized an intent-to-treat approach, where those families that started services were compared to those that refused services. In this case, the new

investigation can occur during or after FSS. The second approach examined differences depending on the reason FSS ended (completed services, started FSS-DNF, started FSS-ADV, other, and refused FSS). In this case, only new investigations that began after FSS ended were included in the analysis.

The analytic approach for this question consisted of logistic regression (0/1 or no/yes) and the analysis of time to a new investigation using proportional hazards models. Statistical differences in the likelihood of a new investigation were assessed using logistic regression. A proportional hazards model is a statistical procedure that allows for analyzing data over time as well as for utilizing information about cases in which the event of interest does not occur during data collection (e.g., children who do not have subsequent investigations).

Results

1. *Was the receipt of Family Support Services associated with a lower likelihood of new child welfare investigations?*

Table 8 reports the proportion of cases that had new investigations after the start of FSS. The rate was similar for families that started FSS (19.9%) and families that refused FSS (20.0%).

Table 8. Rate of New Investigations Based on the Start of FSS

	Number of people	% with new investigation	*p*-value
Refused FSS	2,710	20.0%	.8588
Started FSS	13,843	19.9%	--

The average time to a new investigation was 182 days for those that started FSS, and 196 days for those that refused FSS. Table 8 contains the results from the proportional hazards model, which utilizes data on families that had a new investigation and families that did not have a new investigation. There was no statistical difference in the time to a new investigation for families that started FSS and families that refused FSS.

Table 9. Proportional Hazards Model Results: Time to a New Investigation

	Coefficient	Standard error	Chi square	*p*-value
Intercept	8.486	0.073	13358.00	<.0001
Started FSS	-0.010	0.069	0.02	.8822
Scale	1.463	0.024		
Weibull shape	0.683	0.011		
Observations	16553			
2 Log Likelihood	25875			
AIC	25881			
AICC	25881			
BIC	25904			

2. Did the rate of new investigations differ based on whether Family Support Services were completed or the reason services were not completed?

Table 10 contains the rate of new investigations after the end of Family Support Services. For families that refused services, the end date and start date are the same. Rates are reported based on the reason that Family Support Services ended. Families that were continuing to receive Family Support Services were excluded from this analysis. Families that completed FSS had the lowest rate of new investigations at 15.3%, significantly less than families that refused services ($p < .0001$). Sixteen percent of families that started FSS but did not finish due to adverse events (started FSS-ADV) had new investigations after the end of Family Support Services. These families had a higher rate of new investigations than families that refused services ($p = .0359$). Nearly 17% of families that started FSS but did not finish due to reasons besides an adverse event (FSS-DNF) had new investigations. Finally, nearly 19.3% of families that refused services had new investigations.

Table 10. Rate of New Investigations after FSS

	Number of people	% with new investigation	*p*-value
Finished FSS	6,642	15.3%	<.0001
Started FSS-ADV	881	16.1%	.0359
Started-DNF	2,969	16.9%	.0203
Other	2,586	19.1%	.8947
Refused	2,686	19.3%	--

Among families with a new investigation, the average time between the end of FSS and the start of the new investigation was 236 days for those that completed FSS, 161 days for those that did not complete FSS due to an adverse event, 202 days that did not finish FSS due to other reasons, and 210 days that those that refused services.

Table 11 contains the results from the proportional hazards model. Compared to families that refused services, families that finished FSS had a longer time until a new investigation.

Table 11. Proportional Hazards Model: Time to New Investigation after the End of FSS

	Coefficient	Standard error	Chi square	*p*-value
Intercept	8.392	0.074	12996.40	<.0001
Finished FSS	0.163	0.076	4.65	.0311
Started FSS-DNF	0.093	0.087	1.12	.2898
Started FSS-ADV	0.204	0.132	2.38	.1227
Other	-0.089	0.087	1.05	.3059
Scale	1.395	0.026		
Weibull shape	0.717	0.013		
Observations	15,764			
2 Log Likelihood	21569			
AIC	21581			
AICC	21581			

BIC	21627			

3. Was the length of Family Support Services associated with the likelihood of a new child welfare investigation?

The length of Family Support Services differed considerably across families. Among families that started FSS, the average length of Family Support Services was 80 days with a median of 63 days. Approximately one quarter of families received services for 16 days and another quarter received services for more than 108 days.

Analysis of service duration was limited to new investigations that began after FSS ended. Including investigations that occurred during FSS would introduce potential bias because the length of services could potentially depend on the reason services ended. Families were divided into four groups based on the length of Family Support Services. Preliminary analysis also showed a systematic relationship between the length of treatment and the observation window for new investigations. Cases with shorter treatment durations had much longer time frames to observe a new investigation. Thus, families with a short treatment duration had a higher risk of new investigations, simply because the follow-up period was much longer. Thus, we limited new investigations to those that occurred within 365 days of the end of FSS for the analysis of FSS duration. There was no significant difference in the likelihood of new investigations across quartiles. Thus, duration of services was not associated with the probability of a new investigation in the year after the end of services.

Table 12. Rate of New Investigations Based on Length of FSS

Duration Quartile	Overall		
	Observations	**% with new investigation**	***p*-value**
1 (<16 days)	4,069	15.5%	.4949
2 (16-63 days)	4,053	14.8%	.8567
3 (64-108 days)	3,957	14.4%	.5833
4 (>108 days)	3,685	14.9%	--

Among families with a new investigation in the 365 days after FSS, the average time between the end of FSS and the start of the new investigation was 134 days for families in the bottom quartile, 142 days for the second quartile, 137 days for the third quartile, and 130 days for the top quartile.

Table 13 contains the results from the proportional hazards model. Compared to families who received services for the longest time (quartile 4), families in the second and third quartiles had a longer time until a new investigation.

Table 13. Proportional Hazards Model: Time to New Investigation Based on Duration of FSS

	Overall		
	Coefficient	**Standard error**	***p*-value**
Intercept	8.086	0.073	<.0001
Quartile 1	0.114	0.076	.1327

Quartile 2	0.183	0.077	.0174
Quartile 3	0.194	0.077	.0122
Scale	1.301	0.026	
Weibull shape	0.769	0.016	
Observations	15764		
-2 Log Likelihood	21573		
AIC	21583		
AICC	21583		
BIC	21621		

Table 14 contains the rate of new investigations for the first 365 days after the end of FSS based on the length of FSS and the reason FSS ended. There was no significant relationship between the length of FSS and the likelihood of a new investigation among families that finished services or started but did not finish services.

Table 14. Rate of New Investigations after FSS Based on Duration of FSS

Duration Quartile	Finished			Started-DNF			Started-ADV		
	Obs	% new invest	*p*-value	Obs	% new invest	*p*-value	Obs	% new invest	*p*-value
1	279	12.9%	.358	298	11.4%	.057	198	12.1%	.488
2	1,482	13.3%	.177	1,220	15.8%	.806	411	12.7%	.522
3	2,388	13.4%	.161	923	15.1%	.534	144	15.2%	.920
4	2,493	14.8%	--	528	16.3%	--	128	14.8%	--

Table 15 contains the results from the proportional hazards model. Compared to families who received services for the longest time, families that received services for less time had a longer time until a new investigation. Among families that finished FSS, differences were statistically significant for quartiles 2 and 3. Among families that started but did not finish FSS due to reasons besides adverse events, the difference was significant only for quartile 1.

Table 15. Proportional Hazards Model: Time to New Investigation Based on Duration of FSS

	Finished FSS			Started FSS - DNF			Started FSS - ADV		
	Coef	Std err	*p*-value	Coef	Std err	*p*-value	Coef	Std err	*p*-value
Intercept	7.932	0.095	<.0001	8.100	0.181	<.0001	8.341	0.398	<.0001
Quartile 1	0.342	0.211	.1057	0.640	0.274	.0192	0.408	0.431	.3434
Quartile 2	0.311	0.107	.0036	0.147	0.175	.3990	0.358	0.376	.3405
Quartile 3	0.284	0.092	.0021	0.200	0.185	.2780	0.198	0.438	.9640
Scale	1.210	0.039		1.346	0.062		1.399	0.126	
Weibull shape	0.827	0.026		0.743	0.034		0.715	0.065	
Observations	6642			2969			881		
-2 Log Likelihood	7595			3734			1009		
AIC	7605			3744			1019		
AICC	7605			3744			1019		

BIC	7699			3774			1043		

4. *Among families with new child welfare investigations, was the receipt of Family Support Services associated with findings from the safety methodology? In particular, did the risk assessment lead to a finding of high risk for future maltreatment, and was the child deemed by the safety determination to be unsafe?*

Table 16 contains the proportions of families that had risk assessment findings of high risk, and child safety deemed to be unsafe among families that had a new investigation. Among those with new investigations, starting FSS was unrelated to findings of risk but was related to child safety. Among families that started FSS, 62.5% had a finding of high risk while 61.9% of families that refused FSS had a finding of high risk. Among families that started FSS and had a new investigation, 19.1% of families that started FSS had children deemed unsafe compared to 13.5% of families that refused FSS (*p*=.002).

Table 16. Rate of High Risk and Unsafe Safety Methodology Findings from New Investigations

		High risk		Unsafe	
	Obs	**% High risk**	***p*-value**	**% Unsafe**	***p*-value**
Refused FSS	542	61.9%	.8119	13.5%	.002
Started FSS	2,748	62.5%	--	19.1%	--

Table 17 contains the risk assessment and safety determination findings from new investigations based on the reason FSS ended. There was no significant relationship between the reason for stopping FSS and the likelihood of a future investigation with a high risk assessment. However, nearly 40% of families that ended FSS due to an adverse event had a new investigation where the child was deemed unsafe compared to 14.3% of households that refused FSS. Rates were similar for families that finished services (14.4%) and families that refused services (14.3%).

Table 17. Rate of High Risk and Unsafe Safety Methodology Findings from New Investigations Based on Reasons for Ending FSS

Reason		High risk		Unsafe	
	Obs	**% High risk**	***p*-value**	**% Unsafe**	***p*-value**
Finished FSS	1,017	61.3%	.9509	14.4%	.9704
Started FSS-ADV	142	70.2%	.0575	39.7%	<.0001
Started FSS-DNF	502	63.8%	.4346	16.5%	.3203
Other	495	58.7%	.3676	22.6%	.0007
Refused	518	61.5%		14.3%	

5. *Among families with new child welfare investigations, did the rates of mental illness, substance abuse, and domestic violence differ between families that did and did not receive Family Support Services?*

Table 18 contains several descriptive statistics for families that had new investigations. The research literature consistently finds several characteristics that affect child welfare involvement

and outcomes: substance misuse, mental illness, and domestic violence. Thus, we compared parental characteristics for families that had a new investigation based on whether they received FSS. Families that started FSS and had a new investigation had a higher rate of mental health problems than families that refused FSS (24.4% versus 19.8%). FSS are most likely to be started when a caregiver has a mental health problem. Families that started FSS and had a new investigation also had a higher rate of domestic violence than families that refused FSS (56.6% versus 42.3%). Rates of substance misuse did not differ significantly between families with new investigations that did and did not start FSS.

Table 18. Risk Assessment Variables from New Investigations: Differences between Families that Started and Refused FSS

	% with characteristic	***p*-value**
Mental Illness		
Started FSS	24.4%	
Refused	19.8%	.0246
Substance Misuse		
Started FSS	37.5%	
Refused	38.2%	.7601
Domestic violence		
Started FSS	56.6%	
Refused	42.3%	.0014

Table 19 contains the logistic regression results that examine parental characteristics based on the reason FSS ended. Compared to families that refused FSS, families that started but did not finish due to an adverse event had higher rates of mental illness, substance misuse, and domestic violence. Families that finished FSS had lower rates of substance misuse. Families that did not finish due to reasons besides an adverse event were also more likely to have domestic violence in the household.

Table 19. Risk Assessment Variables from New Investigations: Differences between Families that Started and Refused FSS

	Mental illness			**Substance misuse**			**Domestic violence**		
	OR	**95% CI**		**OR**	**95% CI**		**OR**	**95% CI**	
Finished	1.19	0.93	1.54	0.80*	0.65	0.99	1.12	0.99	1.26
Other	1.64*	1.25	2.17	0.99	0.77	1.25	1.19*	1.04	1.36
Started-ADV	2.28*	1.64	3.17	1.63*	1.21	2.19	1.36*	1.15	1.61
Started-DNF	1.06	0.79	1.41	1.09	0.87	1.33	1.16*	1.01	1.33
Note. * $p < .05$									

Conclusions

FSS programs provide a wide range of in-home services, referrals to community resources, and other critical supports for at-risk families in order to prevent future child maltreatment. Although the programs utilize different models, the incorporation of family team meetings and individualized approaches were common to all programs. In spite of the use of some coercive

tactics to facilitate engagement, program staff utilized a strengths-based approach, demonstrated empathy and respect, and gave the family an opportunity to provide input regarding services. Results of the PFS suggest that participating families were very satisfied with services and had a variety of protective factors in place prior to discharge. Moreover, families that completed FSS had a lower risk of future investigations, which is an explicit goal of the program.

Recommendations

The evaluation team recommends the following:

- Expanding funding and eligibility requirements for FSS programs to allow them to serve low and moderate risk families.
- Modify the current referral process to allow FSS programs to begin working the families sooner, before the CPI has finished their investigation (ideally within 15-20 days of initial CPI contact). If there is greater flexibility to work with families at any risk level, the programs could initiate services with families before the CPI assessment is complete; this will allow for better engagement and is beneficial to families who are in crisis and need assistance quickly.
- Provide additional, comprehensive cultural sensitivity/competency and trauma-informed training to program staff.
- Address the use of coercive practices and ensure that all programs are being honest and forthcoming about the voluntary nature of FSS.
- Identify and implement a common set of assessment tools and procedures for evaluating the impact of the programs.
- Solicit feedback from families that decline services or discontinue services prior to program completion.

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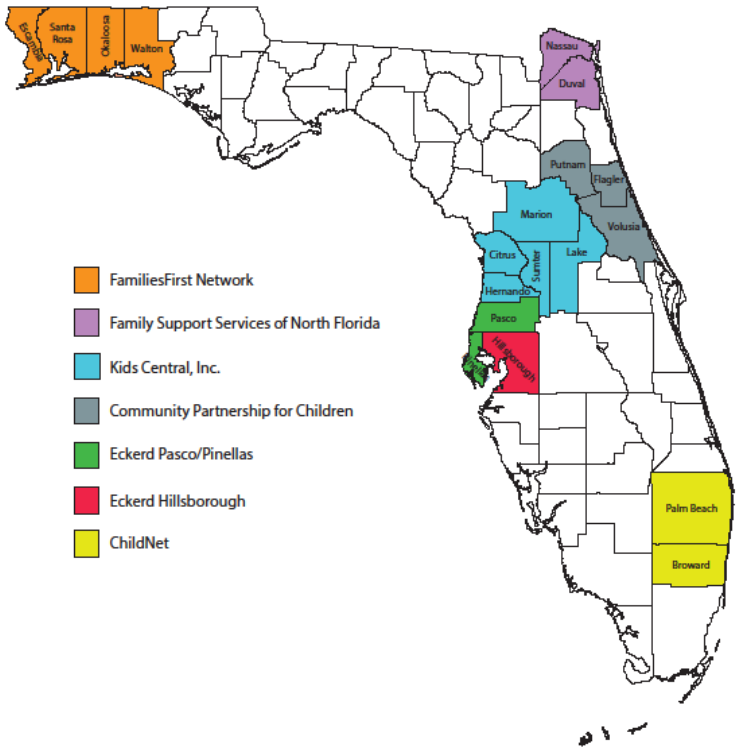
APPENDIX A-1

Community-Based Child Abuse Prevention Program Evaluation

The University of South Florida is collaborating with the Florida Department of Children and Families to evaluate the impact of Family Support Services (FSS) provided by seven CBC lead agencies. We are interested in learning whether voluntary FSS increases family protective factors and prevents future child maltreatment and the subsequent removal of children from their homes. The evaluation will consist of several activities, including focus groups with lead agency and provider staff as well as surveys administered to participating and non-participating families.



Focus group discussions will explore the processes for referring families, expectations for family participation, methods for ensuring quality and effectiveness, strategies for engaging families and procedures for re-engaging families that discontinue participation, and successes and challenges with achieving the specified goals of the program. We anticipate conducting two focus groups with each lead agency.

In addition, the Protective Factors Survey developed by the FRIENDS National Resource Center for Community-Based Child Abuse Prevention will be administered to families. We will work with the lead agencies to determine the best method for distributing the survey. The survey will be completed by participating and non-participating families in order to make comparisons regarding family functioning, social support, and knowledge of parenting and child development.

We look forward to working with you on this important evaluation. If you have questions, please contact Melissa Johnson (mhjohns4@usf.edu; 813-974-0397) or Lodi Rohrer (llrohrer@usf.edu; 813-974-0517).

APPENDIX A-2

USF
UNIVERSITY OF
SOUTH FLORIDA

Community-Based Child Abuse Prevention Program Evaluation

Informed Consent Information

You are being asked to take part in an evaluation study of the family support services component of Florida's Community-Based Child Abuse Prevention (CBCAP) program. This project is not under the oversight of the USF Institutional Review Board (IRB); however, we would like to provide you with information about the study purpose and procedures, risks and benefits, and confidentiality.

The people in charge of this study are Lodi Rohrer (813-974-0517) and Melissa Johnson (813-974-0397). Other study staff are also involved and can act on behalf of the individuals in charge.

Study Purpose: The purpose of this study is to evaluate the impact of family support services. These services are designed to strengthen and support families with the goal of preventing future child maltreatment and the subsequent removal of children from their homes.

Study Procedures: You are being asked to participate in a focus group. Focus group discussions may be audiotaped for accuracy in reporting, if you agree to this. Audio recordings will be professionally transcribed, and the recordings will be erased once the transcriptions are verified for accuracy. You will only be asked to participate in one focus group; however, study staff may want to re-contact you if further information or clarification is needed. Your participation in this study is voluntary.

Benefits: While you may not receive any direct benefit by taking part in this study, the information you provide will help the evaluation team develop a comprehensive understanding and description of how family support services are being implemented. The only cost to you will be the time you take to participate in this focus group. You will not receive compensation for taking part in this study.

Risks: This is a minimal risk study which means that the risks associated with this study are the same as what you face every day. There are no known additional risks to you by taking part in this study.

Privacy and Confidentiality: We will keep study records private and confidential as allowed by law, and your name will not be included in the study report. Study findings will be summarized and reported in aggregate form. We may also publish what we learn from this study, but if we do, we will not include your name or any other personally identifiable information.

APPENDIX A-3

Community-Based Child Abuse Prevention Program Evaluation

Staff Background and Demographics

1. What is your position title? _____

2. How long have you worked in this position? _____

3. What is your typical/average caseload? _____

4. What is your gender? M F Other: _____

5. What is your race/ethnicity? Please circle all that apply.

   Asian Native American/Alaska Native

   Black/African American Pacific Islander/Native Hawaiian

   Hispanic/Latino White/Caucasian

   Other: _____

6. What is your highest level of education attained?

   ___ Bachelor's Degree; Major: _____

   ___ Master's Degree; Major: _____

   ___ Doctorate Degree; Major: _____

   ___ Other (e.g. medical, law): _____

APPENDIX A-4

Community-Based Child Abuse Prevention Program Evaluation

Focus Group Guide

1. How would you describe the purpose/objective of Family Support Services (FSS)?

2. Tell me about your role on FSS cases. What are your typical tasks and responsibilities?

3. How are families referred to your agency for these services? What are the eligibility criteria for families to receive these services? What role, if any, do you have in assessing a family's eligibility?

4. Tell me about the types of cases that are typically referred for FSS. (e.g. What kinds of allegations or family risk factors do you typically see on these cases? Family characteristics? Needs?)

5. Given the voluntary nature of these services, what strategies do you use to engage families? What other factors facilitate family engagement in FSS?

6. What factors hinder or present barriers to family engagement in FSS? How do you address the barriers to family engagement? (e.g. What do you do if a family is reluctant or resistant towards engaging in services?)

7. How are families involved in identifying their needs and strengths? How are family strengths incorporated in the family's service plan?

8. What kinds of services are provided to these families? Are there particular program models or evidence based practices that you use? Do you provide all the services in house or do you refer families out to any other providers?

9. How frequently do you have contact (in person, telephone) with the families on your caseload? What do you do on a typical home visit or appointment?

10. What processes are used to assess a family's progress towards desired goals and outcomes? How are decisions made about when to close a case?

11. What procedures are in place for ensuring the quality of services provided and assessing the effectiveness of the program?

12. In your experience, how effective do you think FSS are in reducing risk and preventing future child maltreatment? Please explain.

13. What do you think are the strengths and challenges to FSS as provided by your agency? What services or programs do you feel are most beneficial to families?

14. Do you have any recommendations about how Family Support Services might be improved?

Thank you!

APPENDIX A-5

CBCAP Code List

Purpose/Goals of Services

Prevention	Prevent future child maltreatment, further involvement with DCF
Family Preservation	Keep families intact, prevent child removals
Parenting skills	Address parenting practices, develop skills/capacities of parents to care for their children
Self-sufficiency	Develop the capacities of families to be independent, e.g. able to meet their own needs and not reliant on state intervention
Linkage	Link families to resources/supports in their community
Root issues	Identify and address the underlying/root causes of child maltreatment
Realistic goals	Focus on setting up realistic goals with families

Family Characteristics

Mental health	Parents suffer from mental health problems/ mental illness
Substance abuse	Parents have problems with substance abuse/misuse
Domestic violence	Issues with domestic/family violence
Physical injury	A child in the home has been physically injured
Sexual abuse	Cases involve allegations of sexual abuse of children
Hazardous conditions	Home has hazardous environmental conditions
Poverty	Families struggle with low economic status/poverty, employment instability or joblessness, trouble meeting basic needs, etc.
Homeless	Families struggle with housing instability or homelessness, unable to find/access affordable housing
Single parents	Families with a single-parent household
Young parents	Parents are young/inexperienced

Child health	Families have children with significant physical or behavioral health problems or developmental disabilities and have trouble meeting the child's special needs
Inadequate supervision	Families have issues with leaving children unsupervised, lack adequate childcare/supervision
Prior history	Parents have prior history with DCF as perpetrators of abuse/neglect
Generational	Families have been involved with DCF over multiple generations; parents were formerly in the system as children.
Unsafe neighborhoods	Families live in neighborhoods with high levels of crime and community violence (gangs, drugs, etc.)
Worker biases	Workers convey negative views/attitudes towards families, use judgmental or stigmatizing language, such as "dysfunctional," "aggressive," "ignorant," "resistant," "crazy," "addict."

Family Engagement

Benefits	Emphasize the potential benefits to the family of engaging in services, such as preventing future involvements with DCF
Strengths-based	Workers identify and build on family strengths
Accessible language	Avoid professional jargon, use language that families can easily understand
Empathy	Demonstrate empathy for the family's situation, approach things from their perspective, avoid blame/shame
Respect	Treating families with respect and dignity
Family input	Soliciting the family's perspective on their needs, strengths, and goals for services and incorporating this into the family's plan
Family driven	Giving the family the authority to choose their services and goals; the family drives the service plan, with help from professionals, as opposed to simply providing input on the plan.
Provider driven	The family's plan and services appear to be largely dictated by the provider's assessment of what the family needs.
Youth involvement	The inclusion of youth in service planning and provision is explicitly noted.

Coercion	Workers manipulate or pressure the family to engage in services, such as by failing to inform the family that services are voluntary or telling the family that participating in services is the only way to get rid of DCF.
Misinformation	Workers take advantage of a family's misinformation to get them engaged in services, such as the belief that DCF won't close their case if they don't engage or fear that their children will be removed.
Distancing	Workers actively distance/separate their agency from DCF, clarify and reinforce to families that they do not work for DCF
Stigma	Families are resistant/hesitant to engage in services because they fear stigma of DCF involvement, don't want others to know.
Disagreement	Family does not agree with the allegations or reason for intervention, does not feel there is a need for services
Intrusive	Families find services to be overly intrusive, too many people in the home, too many requirements and/or too much time commitment.
Further intervention	Families are concerned that cooperation with services will result in increased intervention by DCF and possible removal of their children
Communication	Providing clear and honest information to the family about the program, including the voluntary nature of services and what families can expect.

Program Model

Eligibility – high risk	Program only accepts/serves high/very high risk families.
Eligibility – lower risk	In addition to high risk, program also serves families with lower levels of risk (e.g. moderate or low risk).
Eligibility – in-home	Program only serves families whose child(ren) currently lives in the home (has not been removed).
Eligibility – other	Anything else concerning eligibility that does not fit into the other categories.
Referrals – CPI	Program receives/accepts referrals from CPI (including Sheriff's office).
Referrals – DJJ	Program receives/accepts referrals from DJJ/probation.

Referrals – community	Program receives/accepts referrals from other community partners, such as schools, mental/physical health providers, etc.
Specified model	The program uses a specific, formal, manualized program model.
Frequency of contact	The program has established criteria for how frequently workers must have contact with the family.
Different tracks	Program offers two or more distinct tracks to address families with differing levels of need and service intensity.
Limited duration	Services are intended to be time-limited in their duration, e.g. 3-4 months.
Family team meetings	Program convenes child/family team meetings as part of their program model, in which the family and all their formal and informal supports come together for service planning and/or progress review.
Flexible	There is flexibility in service provision to accommodate family needs, such as workers/providers going to the family's home or other community locations to deliver services, scheduling appointments in the evening or weekends, etc.
Individualized	Services are tailored to the family's particular needs and strengths.
Most beneficial	Specific services or components of the program that are identified as being the most beneficial to families.
Early initiation	Program allows for the agency to begin working with families before CPI finishes the investigation and transfers the case.

Services (in house)

IH-Parenting	Services designed to teach/develop parenting skills.
IH-Counseling	Individual counseling/therapy to address mental health needs.
IH-Family therapy	Family counseling/therapy to address family dynamics, improve communication, etc.
IH-SA counseling	Counseling to address issues with substance use/abuse
IH-Advocacy	Family is provided with an advocate who can assist with various needs (educational, legal, etc.) and help ensure the family has a voice in their services.
IH-Vocational skills	Program provides services to help in development of employment/vocational skills.

IH-Care coordination	Program provides care coordination for the family, including workers who are specifically responsible for care coordination.
IH-Support groups	Program offers support groups for parents and/or youth.
Psychoeducation	Provision of education about mental health, domestic violence, or substance misuse to help the client understand the impact of these issues on their life and functioning
Transport assistance	Provision of transportation for clients, including vouchers or passes for public transit.
Daycare assistance	Provision of daycare subsidies or help with paying for childcare.
EBPs	Program models or practices that are recognized as evidence-based.

Community Services

CS-Basic needs	Assistance for families in meeting basic needs, such as food, housing, clothing, utilities, etc.
CS-SA treatment	Services for substance abuse treatment, such as detox, counseling, etc.
CS-MH treatment	Mental health services (therapy, counseling, psychiatry, etc.) that are not provided in house.
CS-Parenting	Services designed to teach/develop parenting skills.

Service Gaps

Housing	Affordable/low-income housing and/or housing assistance programs.
Transportation	Public transportation options (buses, trolleys, etc.)
Daycare	Affordable childcare options or subsidized programs.
Flex funding	Funds to help with meeting the family's basic needs, e.g. paying an overdue utility bill, down payment for an apartment, etc.

Structural Barriers

Capacity	Insufficient staff capacity to deal with the number of referrals
Funding	Inadequate program funding to support the number of cases and/or provide the amount and quality of services that families need.

DCF assessment	Risk assessments described as "overly cautious", not an accurate assessment of a family's need for services.
Referral process	Time frame of receiving referrals from CPIs towards the end of their investigation, resulting in delay of service initiation.
Family schedules	Difficulty working around families' work and school schedules to provide the intensity of services prescribed.
Access to resources	Families don't know how or are unable to access resources in their community to meet their needs; includes poor availability, lack of flexible hours, lack of insurance coverage, etc.
Community partners	Agencies such as schools, DJJ, DCF, etc. not fully cooperating or collaborating.
Short-term solutions	Lack of long-term solutions to address family economic needs.
Pressure to close	Workers feel pressure to close out cases sooner than they feel ready in order to stick to prescribed timeframes.
Dual roles	Staff have multiple roles that sometimes create conflict, e.g. serving as both safety management and family support provider.

Program Evaluation

Recidivism data	The program uses data such as subsequent/verified reports, child removals, arrests, etc. to assess program effectiveness.
Service completion	The program uses data on service completion rates to assess program effectiveness.
Functional outcomes	The program measures changes in parental and/or child skills, capacities, well-being, functioning, etc. to assess program effectiveness.
Anecdotal	Perceptions of success without supporting data
Unsuccessful	Ways in which participants understand, rationalize, and make sense of unsuccessful cases.
Withdrawal	Procedures for family to terminate services, request case closure prior to agency decision to discharge.

Assessment

Measures	Use of validated measures/tools for assessing family needs and improvement over time
Family involvement	Assessment process includes family's input regarding their needs and how they are progressing towards their goals; family decides when they feel their needs have been met.
Progress reviews	Family's progress is periodically reviewed to re-assess where they are at in achieving their goals.
Observation-family	Use of observation to assess the family's situation and progress (e.g. observation of children, home environment, parent behavior, family dynamics, etc.)
Supports	Extent to which family has been connected to long-term providers and resources used as an indicator of readiness for case closure
Collaterals	Workers interview collaterals such as extended kin, neighbors, school personnel, other providers, etc. to assess the family's needs, behaviors, and change.

Monitoring & QA

Certification	Program has a certification process to ensure all employees are properly trained in the program model.
Case reviews	Periodic case reviews are conducted to assess for quality and adherence to program model.
Observation	Periodic observation of workers is performed (e.g. by a supervisor) to assess for quality and adherence to program model.
Fidelity	Program has formal fidelity tools/processes built in (may include case reviews or observation, or other processes) which are used to monitor adherence to the program model.
Client survey	Program administers a survey or interview to obtain family feedback on the services they received.

APPENDIX B-1

<MM/DD/YYYY>

Dear <NAME>:

My name is Lodi Rohrer, and I am a researcher at the University of South Florida. I am writing to request your help with an important project that is being sponsored by the Florida Department of Children and Families. We are reaching out to caregivers like you to learn more about the factors that help families care for their children so that DCF can better assist families in need.

All of our questions can be found on the enclosed survey. If you would like to participate, please complete the survey and mail it back to me when you have time. I have enclosed a stamped envelope for you and a pen that you can keep.

We cannot pay you for participating in this project, but it also will not cost you anything to participate. There is no known risk to you if you choose to participate. Your participation is strictly voluntary. If you do not wish to participate, you do not have to complete the survey. Please only mail your completed survey to me if you want to participate in this study.

If you decide to participate, all your information will remain confidential. This means that we will not tell anyone outside our study team that you participated, and we will not include your name or any other information that could be used to identify you in any of our reports. To help ensure your confidentiality, please do not write your name on the survey.

Thank you for taking the time to assist us with this project. The data collected will provide useful information about protective factors in families. If you would like more information or have questions, please contact me during business hours at the number listed below.

Sincerely,

Lodi Rohrer

Lodi Rohrer
813-974-0517
llrohrer@usf.edu

APPENDIX B-2

PROTECTIVE FACTORS SURVEY

This page is to be completed by staff to collect program information for participating families.

Agency ID # _____

Family ID # _____

Date survey completed: _____

How was the survey completed?

- ☐ In a face-to-face interview
- ☐ By the participant with assistance available from program staff
- ☐ By the participant without program staff present

Date family began program: _____

Date family completed program: _____

Select the services that most accurately describe what the family received.

- ☐ Parenting Skills/Education
- ☐ Parent Support Group
- ☐ Parent/Child Interaction
- ☐ Individual Therapy
- ☐ Family Therapy
- ☐ Advocacy
- ☐ Fatherhood Program
- ☐ Planned and/or Crisis Respite
- ☐ Homeless/Transitional Housing
- ☐ Resource and Referral
- ☐ Family Resource Center
- ☐ Skill Building/Ed for Children
- ☐ Adult Education (i.e., GED/Ed)
- ☐ Job Skills/Employment Prep
- ☐ Prenatal Class
- ☐ Family Literacy
- ☐ Healthy Relationships
- ☐ Home Visiting
- ☐ Other (*If you are using a specific curriculum, please name it below*):

_____

Did the family meet their treatment goals?

- ☐ Yes
- ☐ No

If no, please explain:

_____

PROTECTIVE FACTORS SURVEY

Agency ID # _____ **Family ID #** _____

Your responses to this survey are confidential. If you need assistance completing the form, please ask a member of the staff or contact the evaluation team at 813-974-0517.

Part I. For each of the following, please circle the response that most closely matches how you feel.

	Never	Very Rarely	Rarely	About Half the Time	Frequently	Very Frequently	Always
1. In my family, we talk about problems.	1	2	3	4	5	6	7
2. When we argue, my family listens to "both sides of the story."	1	2	3	4	5	6	7
3. In my family, we take time to listen to each other.	1	2	3	4	5	6	7
4. My family pulls together when things are stressful.	1	2	3	4	5	6	7
5. My family is able to solve our problems.	1	2	3	4	5	6	7

Part II. Please circle the response that best describes how much you agree or disagree with the statement.

	Strongly Disagree	Mostly Disagree	Slightly Disagree	Neutral	Slightly Agree	Mostly Agree	Strongly Agree
6. I have others who will listen when I need to talk about my problems.	1	2	3	4	5	6	7
7. When I am lonely, there are several people I can talk to.	1	2	3	4	5	6	7
8. I would have no idea where to turn if my family needed food or housing.	1	2	3	4	5	6	7
9. I wouldn't know where to go for help if I had trouble making ends meet.	1	2	3	4	5	6	7
10. If there is a crisis, I have others I can talk to.	1	2	3	4	5	6	7
11. If I needed help finding a job, I wouldn't know where to go for help.	1	2	3	4	5	6	7

Part III. This part of the survey asks about parenting and your relationship with your children.

	Strongly Disagree	Mostly Disagree	Slightly Disagree	Neutral	Slightly Agree	Mostly Agree	Strongly Agree
12. There are many times when I don't know what to do as a parent.	1	2	3	4	5	6	7
13. I know how to help my child learn.	1	2	3	4	5	6	7
14. My child misbehaves just to upset me.	1	2	3	4	5	6	7

Part IV. Please tell us how often each of the following happens in your family.

	Never	Very Rarely	Rarely	About Half the Time	Frequently	Very Frequently	Always
15. I praise my child when he/she behaves well.	1	2	3	4	5	6	7
16. When I discipline my child, I lose control.	1	2	3	4	5	6	7
17. I am happy being with my child.	1	2	3	4	5	6	7
18. My child and I are very close to each other.	1	2	3	4	5	6	7
19. I am able to soothe my child when he/she is upset.	1	2	3	4	5	6	7
20. I spend time with my child doing what he/she likes to do.	1	2	3	4	5	6	7

Part V. The following questions are about your experiences in this program. Your answers to these questions can help staff improve services for you and others like you, so it's important that you answer honestly.

	Strongly Disagree	Mostly Disagree	Slightly Disagree	Neutral	Slightly Agree	Mostly Agree	Strongly Agree
21. I feel like the program staff understand me.	1	2	3	4	5	6	7
22. The staff and I discussed ways to keep my child safe.	1	2	3	4	5	6	7
23. I feel like the program staff expect me to fail.	1	2	3	4	5	6	7
24. I received services that were appropriate for my needs.	1	2	3	4	5	6	7
25. No one in the program believes that I can be a good parent.	1	2	3	4	5	6	7

Part VI. Sometimes it's hard for families to afford everything they need. Please check all that apply.

In the past month, were you unable to pay for:

- ☐ Rent or mortgage
- ☐ Utilities or bills (electricity/water)
- ☐ Groceries/food (including baby formula)
- ☐ Child care/daycare
- ☐ Medicine, medical expenses, or co-pays
- ☐ Basic household or personal hygiene items
- ☐ Transportation (including gas, bus passes, shared rides)
- ☐ None of the above

Part VII. The last few questions are about you and your household. Remember, your responses to this survey are confidential.

Gender: ☐ Male ☐ Female ☐ Other: _____

Age (in years): _____

Race/Ethnicity (select all that apply):

- ☐ Native American or Alaskan Native
- ☐ Asian
- ☐ African American
- ☐ African National/Caribbean Islander
- ☐ Hispanic or Latino
- ☐ Middle Eastern
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Multi-racial
- ☐ Other: _____

Marital Status

- ☐ Married
- ☐ Partnered (living together)
- ☐ Single
- ☐ Divorced
- ☐ Widowed
- ☐ Separated

Family Housing

- ☐ Own
- ☐ Rent
- ☐ Shared housing with relatives/friends
- ☐ Temporary (shelter, temporary with relatives/friends)
- ☐ Homeless

Total Family Income

- ☐ $0 - $10,000
- ☐ $10,001 - $20,000
- ☐ $20,001 - $30,000
- ☐ $30,001 - $40,000
- ☐ $40,001 - $50,000
- ☐ More than $50,001

Highest Level of Education

- ☐ Elementary or junior high school
- ☐ Some high school
- ☐ High school diploma or GED
- ☐ Trade/Vocational Training
- ☐ Some college
- ☐ 2-year college degree (Associate's)
- ☐ 4-year college degree (Bachelor's)
- ☐ Master's degree
- ☐ PhD or other advanced degree

Which, if any, of the following do you currently receive? (Check all that apply.)

- ☐ Food assistance (SNAP or WIC)
- ☐ Medicaid (State Health Insurance)
- ☐ Earned Income Tax Credit
- ☐ Unemployment benefits
- ☐ Housing assistance
- ☐ Temporary Assistance for Needy Families (TANF)
- ☐ Head Start/Early Head Start Services
- ☐ Social Security Disability Insurance/Supplemental Security Income (SSDI/SSI)
- ☐ None of the above

Please tell us about the children living in your household.

	Gender		Birth Date (MM/DD/YY)	Your Relationship to the Child (check one)				
	Male	Female		Birth Parent	Adoptive Parent	Grand-parent	Foster Parent	Other
Child 1								
Child 2								
Child 3								
Child 4								

If more than 4 children, please use the space provided on the back of this sheet.