

Family Preservation and Support Services

A Literature Review and Report on Outcome Measures



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Casey Family Programs, State of Alaska Office of Children's Services,
Tribal State Collaboration Group,
University of Alaska Anchorage School of Social Work





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Report on Outcome
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Susan M. Pope, Ph.D.

Program Manager

Jason R. Williams, M.S.

Research Analyst

Elizabeth A. Sirles, Ph.D.

Director, School of Social Work

Co-Principal Investigator

Eileen M. Lally, Ed. D., L.C.S.W.

Director, Family & Youth Services Training Academy

Co-Principal Investigator

THE UNIVERSITY OF ALASKA ANCHORAGE
Child Welfare Evaluation Program,
School of Social Work

CASEY FAMILY PROGRAMS

TRIBAL STATE COLLABORATION GROUP

STATE OF ALASKA
OFFICE OF CHILDREN'S SERVICES

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Executive Advisory Team:

Dr. Elizabeth A. Sirles - Director, School of Social Work
Co-Principal Investigator, University of Alaska Anchorage

Dr. Eileen M. Lally - Director, Family & Youth Services Training Academy
Co-Principal Investigator, University of Alaska Anchorage

Myra Casey-Field Administrator
State of Alaska Office of Children's Services, Juneau

Theresa Tanoury-Lombardo - Director, Alaska State Strategy
Casey Family Programs Alaska

Francine Eddy-Jones, – Manager, Tribal Family & Youth Services
Central Council of Tlingit and Haida Indian Tribes of Alaska
Co-Chair, Tribal State Collaboration Group

Karen Perdue, – Associate Vice President of Health Programs
University of Alaska Statewide

Special Assistance:

Dr. Tracey Burke, –Assistant Professor
University of Alaska Anchorage, School of Social Work

Project Research Team:

Margie Hunt, Casey Family Programs Seattle
Linda Hendricks-Family Support Services Coordinator, State of Alaska Office of
Children's Services, Juneau
Melissa Taylor-Director, Kawerak Children & Family Services, Nome

Project Advisors:

Dr. Peter J. Pecora and Dr. A. Chris Downs
Casey Family Program Seattle

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University of Alaska Anchorage, School of Social Work

Child Welfare Evaluation Program:

4500 Diplomacy Drive, Suite 430

Anchorage, AK. 99508-5927

(907) 786-6724 or (907) 786-6735 fax

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Presented by

**THE UNIVERSITY OF ALASKA ANCHORAGE
Child Welfare Evaluation Program**

Executive Summary

A partnership of child welfare stakeholders in the state of Alaska sought to examine the efficacy of family preservation and support efforts in their state. This paper is the first step of this investigation, including findings from a review of the national literature, a summary of effective and promising program practices, a compilation of potential program evaluation outcomes and indicators, results from interviews with three Alaskan programs, and recommendations to assist the state of Alaska in making decisions regarding family preservation and support policies, practices, and funding. The desire was to move Alaska towards a more evidence-based system of prevention and intervention with families.

Conclusions from extensive reviews of national evaluation research revealed that these services produce small but significant effects across a range of outcomes for parents and children. No one single program model was identified as the “most effective,” but some program characteristics were highly related to success in preventing child injury and neglect. These included services to teen mothers and/or mothers of young children, as well as programs that offered child activities to improve interactions between parent and child. Services that promote child cognitive development were found to be effective if they were provided directly to children. Programs that offered peer support, as well as those focused on parental self-development, had positive effects on parents themselves and also “trickle down” effects on children. Common elements across programs that were found to be demonstrated effective included being based at a university or elsewhere in the community rather than operated through a child welfare or CPS office, including a cognitive-behavioral component in the intervention, and being involved with schools. The need for longer intervention periods was discussed.

Evaluation of Alaskan family support and preservation programs is scarce. Characteristics of the programs surveyed that respondents nominated as contributing to success included being family-centered and flexible, and focusing on achievable short-term objectives as well as longer service provision. Drawing on the literature, recommendations applicable to Alaskan programs include:

- ensuring that family preservation is defined broadly, and inclusive of kinship care in the child’s own community
- the Office of Children’s Services setting grantee outcome data collection guidelines to synthesize state-wide outcome reports
- providing training on self-evaluation strategies, to improve programs as well as to answer to stakeholders and secure further funding, and including evaluation strategies and feedback as part of program planning
- encouraging and supporting follow-up with families
- encouraging a culturally relevant, strength-based approach to services
- choosing validated or criterion-referenced measures where possible to document process and outcome variables and improve results as well as feedback to stakeholders.

Introduction

The Child Welfare Evaluation Program is a partnership of the State of Alaska Office of Children's Services, the Tribal-State Collaboration Group, Casey Family Programs, and the University of Alaska Anchorage, School of Social Work. The purpose of the partnership is to begin the process of creating and implementing a child welfare research agenda for the state Alaska.

Stakeholders representing each of the partnership entities selected four research topics that all agreed were priorities in the state of Alaska. This paper represents a preliminary investigation into one of those topics—family support and preservation. Under this broad category, child welfare stakeholders identified the following questions they wished to address:

- What are other states doing in this area? What models are they using?
- What outcomes are programs attempting to achieve?
- What constitutes successful programs?
- Are we using the “right” models here?

The final question is ultimately a policy question, but some effort to examine the question of “right” is undertaken in the hopes that it will contribute to answering this question. We have focused on the studies most recent, comprehensive, and relevant to our research questions. The paper is organized into the following sections: definitions, family support studies, family preservation services research, emerging and promising practices (in both family preservation and support), program outcomes and indicators for both areas, Alaskan programs, conclusions, and recommendations.

What Do We Mean by Family Support and Preservation?

Terms and Definitions

Family support and preservation services comprise a continuum of approaches designed to increase the capacity of families to care for their children and therefore minimize or avoid involvement with formal child welfare services. It may be helpful to think of this continuum using a public health framework of three levels of prevention. “Primary” or “universal” prevention of an identified problem/condition focuses on the general public. “Secondary” or “selective” prevention targets individuals and families identified as high-risk. “Tertiary” or “indicated” prevention targets individuals and families in which a disease or problem is already present.

Federal Categories

The State of Alaska bases its classification of family support and preservation on the federal guidelines for Social Security Title IV-B funding. They are:

1. **Family Support**—Preventive Services. Referrals can come from anywhere in the community.
2. **Family Preservation**—Some involvement of the Office of Children's Services, either past or current, with the family. The children are not necessarily in OCS custody.
3. **Time-Limited Family Reunification**—These are families of children currently in OCS custody, may be in foster care or other residential placement. These services involve supervised visitation of the child.

This review will focus primarily on the first two categories of services.

Family Support: Primary and Secondary Prevention

Although “family support” is sometimes used as an umbrella term for an array of child maltreatment interventions which might include “family preservation,” it more often refers to community-based services broadly intended to promote family and child wellness and stability (but not necessarily designed to prevent child maltreatment). Support services which are available to anyone qualify as primary prevention. Family support services that are aimed at families considered challenged or at risk, such as poor families, are considered secondary prevention.

The two levels of prevention within the category “family support” may be difficult to separate in practice. For example, neighborhood-based family support centers might officially be open to all, but in fact serve mostly “at-risk” families because of economic stratification in a particular neighborhood. Funding sources frequently use the presence or absence of eligibility criteria to determine the level of prevention. Thus, for example, a program open only to families receiving public assistance, or to families in which parents have mental illness or developmental disabilities, may be designated secondary prevention. However, a program that serves mostly—but not exclusively—such families may be designated as primary prevention.

Family Preservation: Tertiary Prevention

“Family preservation” as a distinct child welfare intervention is targeted at families who are at relatively high risk of child removal (or at families who need support for reunification with a child removed already). Child maltreatment has been identified in these families and the goal is to prevent its re-occurrence: tertiary prevention. Often these services are characterized as “intensive” and called intensive family preservation services (IFPS).

In practice, one program may offer any or all of these services, particularly in a small community. For example, a village tribal authority may support a family center that offers cultural events and parent support groups to all in the area (primary prevention), drug and alcohol treatment for families experiencing difficulties with parental substance use (secondary prevention), and family-centered wraparound teams involving elders and extended family members for families with reports of child abuse or neglect. Additionally, an individual family may receive all levels of services. Both family preservation and family support are intended to promote “child and family safety as well as family continuity” (Kirk, Reed-Ashcraft, & Pecora, 2002, p. 61). So although we may attempt to distinguish among these categories in this report, in reality it may not be possible to separate them clearly at the program and/or community level. This blurring allows us to seek lessons from past evaluations of both family preservation and family support programs about common elements of successful service models that work well with families regardless of whether they have had CPS interaction or are judged to be at high risk for maltreatment. What works in one arena may also work well with families in the other arena.

National Evaluations of Family Preservation and Family Support Services

Moving towards best practices in any field involves not only individual research projects but also analyses that synthesize the available research. This section summarizes several extensive reviews of family preservation and support evaluations:

- The *National Evaluation of Family Support Programs, Final Report, Volume A: The Meta-Analysis* (Layzer, Goodson, Bernstein, and Price, 2001) describes aspects of successful family support programs, providing a summarizing meta-analysis (a statistical synthesis) of

over 300 evaluations of family support programs conducted within the last 25 years. This report, sponsored by the Administration on Children, Youth, and Families, examines the effect, individually and in combination, of characteristics of family support goals, population targeting, and service delivery on nine outcome areas:

1. child cognitive development and school performance
 2. child socio-emotional development
 3. child health
 4. child safety
 5. parental attitudes and knowledge
 6. parenting behavior and the home environment
 7. family functioning and socio-emotional resources
 8. parent mental health and health risks
 9. family resources and economic self-sufficiency
- *Violence in Families: Assessing Prevention and Treatment Programs*, the report from a project conducted by the National Academy of Science's National Research Council (NRC) Committee on the Assessment of Family Violence Interventions (National Research Council, 1998). The NRC project examines important issues in implementing and in evaluating parenting education and family support programs and intensive family preservation services, among others.
 - Barbara Thomlison's (2003) review of evidence-based child maltreatment interventions. This review arranges nine programs/treatments with varying levels of research support into four levels, ranging from exemplary, well-supported (more than two randomized trials) treatments to promising interventions with anecdotal evidence. The goals of these programs included child safety, family strengthening and stability, enhanced parenting skills and well-being, and improved child functioning.
 - The Office on Child Abuse and Neglect-sponsored report on *Emerging practices in the prevention of child abuse and neglect* (Thomas, Leicht, Hughes, Madigan, and Dowell, 2003). The authors gathered research on programs nominated by practitioners and researchers in the field of prevention and present information on the programs categorized into three levels of evidence, from "demonstrated effective" programs with rigorous experimental evaluation to "innovative programs" that overcome a particular challenge or obstacle or otherwise represent "an exciting new approach to prevention" (p. 19). The OCAN report also describes "programs with noteworthy aspects" (p. 49). Most of the programs are targeted to the general population or to at-risk groups, though a small number include families already involved with CPS.
 - The joint report, *Strengthening America's families* (Alvarado, Kumpfer, Kendall, Beesley, and Lee-Cavaness, 2000), by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) of the US Department of Justice and the Center for Substance Abuse Prevention (CSAP) of the Substance Abuse and Mental Health Services Administration. Although the programs highlighted were nominally aimed at treatment and prevention of youth conduct problems and drug use, such issues are frequently the result of child maltreatment (Briere, 1992; Chalk, Gibbons, and Scarupa, 2002) and family dysfunction (Alvarado et al., 2000)

and are increasingly given as reasons for entering the child welfare system (Barbell and Freundlich, 2001). As such, the programs described either are or have much in common with nominal family support and preservation programs, including a focus on improving parenting skills, socio-emotional functioning of children and adults, family conflict management and problem solving, and social support and self-sufficiency, and reducing conduct problems, injuries, and out-of-home placement. For example, the Homebuilders model is included. As with the above summaries, the programs are categorized on the strength of the empirical evidence supporting them, from exemplary programs with multiple randomized experiments to promising practices with limited and/or non-experimental evaluations.

The first two of these reports will be summarized individually, as they analyze the overall effectiveness of types of programs but not specific programs. Then, based on the other reports, a collection of effective and promising practices will be presented. The focus in this report is on models of delivering family preservation and support services. Agency philosophies or processes for integration of service delivery, such as wraparound services and family group conferencing, will be mentioned peripherally. Similarly, Red Horse et al. (2000), note that mainstream services, specialists, and technical skills can be important in Native communities, but they should be planned and implemented within a Native-based infrastructure. These infrastructures are beyond the scope of the current report and deserve their own separate analysis.

The Family Support Meta-Analysis

For the *National Evaluation of Family Support Programs*, the project team scoured the existing literature and collected over 900 research reports. These were whittled down to 351 eligible short-term follow-up studies and 158 long-term follow-ups providing data for the analysis. The report focused on two primary questions (p. A5-1):

What are the effects of family support programs and services?

What characteristics of programs or the families they serve account for differences in effects?

A “meta-analysis” is a statistical process whereby the results of numerous evaluations can be combined, regardless of the different outcome measures used, to draw general conclusions about the interventions in question. The results are generally expressed as an effect size, a standardized (i.e. independent of the instruments used) measure of average group differences across all the studies¹. Meta-analyses are strongest when limited to studies using experimental designs, but the state of family support research is such that quasi-experiments (studies with control groups thought to be equivalent but not developed via random assignment) were included as well to avoid missing recognized programs. Analysts sought published and unpublished research studies that compared families receiving a variety of family support services.

¹ An effect size is the portion (or multiple) of a standard deviation of change on an outcome measure attributed to the intervention or intervention characteristic in question. For example, most intelligence tests have a standard deviation of 15 points. If a meta-analysis of early childhood education programs finds that they have an overall effect size of .40 on future intelligence testing, this means that, across all the included studies, the IQ of an average child who received the average intervention increased by 6 points (15 X .4) compared to an average child the control group (someone who received no treatment or a different treatment). This is a moderate effect size, as six points could easily make the difference in a child being diagnosed as mentally retarded.

Outcome categories: The researchers explored both child and parent outcomes in their analysis. Across all the studies, four categories of child outcomes emerged: cognitive development and school performance, social and emotional development, health, and safety (including injury, abuse, and neglect). Parent outcomes comprised five categories: parent attitudes and knowledge, parenting behavior, family functioning, parental mental health and health risk behaviors, and economic well-being. Results of the meta-analysis for each of these outcomes are presented in Table 1.

Findings: Short-term effects of FS programs and services

The study reported “small but statistically significant average effects in all nine domain areas” (p. A5-2). Effects were consistently meaningful (.2 or above in the two samples of randomized studies with and without quasi-experimental studies) in three domains, with smaller effect sizes or results that were inconsistent across the two samples of studies in the other six domains. The strongest effects were found in the areas of:

- Child cognitive achievement
- Child social and emotional development
- Parenting behavior

In addition, inconsistent or smaller but still statistically significant effects in favor of family support programs were found in the following areas:

- Child physical health and development
- Child safety
- Parental mental health or risk behaviors
- Parenting attitudes and knowledge
- Family functioning and resources

A major contribution made by the OCAN report was not only to explore the overall effect of family support but to offer evidence as to the relative importance of various program, treatment, and population factors. By capturing this data from those studies that reported it and including these variables in the meta-analysis, the authors could analyze statistically the relative effect of, for example, using home visits as the primary service vehicle versus delivering services via parent groups.

Effect size varied by program characteristics. Table 1 illustrates the level and direction of variation for each characteristic. Statistically significant positive short-term effects are illustrated using plus signs (+) to illustrate the strength of the effect, with more plus signs indicating stronger effects. Small but statistically significant negative effects are indicated by minus signs (-), while conditions that had small positive effects but whose opposites had larger effects are indicated by shaded cells. Where there were enough data and enough variation in differential effects, the authors also examined combinations of characteristics that yielded larger differences in treatment versus comparison groups. Analysis of variation in program effects showed that:

- Programs focusing on children with special biological needs or those that have parent self-help or self-development as a primary goal have larger effects on a variety of outcomes.
- Programs that both work with parents of children with special needs and provide opportunities for peer support have greater effects on parents’ attitudes towards and knowledge of childrearing and child development.

- Programs that use home visiting as a primary method of providing parent education have weaker (but still positive) effects on children’s cognitive and socio-emotional outcomes compared to programs involving parent groups (as indicated in Table 1 by plus signs in red-shaded cells).
- Case management services have a large positive effect on child safety. Programs that do not provide case management, however, appear to have better outcomes in terms of child social development and family functioning than those that do.
- Case management is more effective in preventing maltreatment or injury when targeted towards infants and toddlers. Programs that utilize parent-child activities as well as case management are more effective in protecting children from abuse, neglect, or accidental injury, particularly when targeted at teenage mothers (a large average effect size of 1.1 when not targeted at teen mothers, and a substantially larger 1.4 with young mothers).
- Programs for families with children with developmental delays or behavioral problems that use professional staff to work with parents in group settings rather than through home visits have greater effects on child social-emotional development.
- Programs that use professional staff to provide parent education are more effective in improving parental mental and physical health, while those that provide opportunities for parents to meet in support groups are more effective in producing positive attitudes about parenting, increasing parenting knowledge, and improving overall family functioning.

As illustrated in Table 1, one of the characteristics most associated with positive results is having as a primary goal parent self-help or self-development. The positive effects on parents may “trickle down” to their children, as such programs resulted in improved child social-emotional development. Similarly, programs utilizing peer support groups had positive effects on not only parent and family outcomes but also on child cognitive development and school performance.

In this analysis, variables measuring the amount or intensity of services had no significant effects.

Table 1: Effects of Program Characteristics: A Summary of the National Evaluation of Family Support Programs

Cells indicate smaller of effect sizes given for randomized only versus randomized and quasi-experimental studies. An effect size is the benefit, given as the portion of one standard deviation on any measure of the outcome, that programs with the characteristic achieved on the average. End of treatment: Follow-up:		Outcome domains							
		Child cognitive	Child social/emotional	Child health	Child safety	Parent attitudes	Parent behavior	Family functioning	Parent health
-	<-.1 (negative effect)	□ positive effect							
+	.10 to .24	□ negative effect							
++	.25 to .39								
+++	.40 to .54								
++++	.55 and above								
■	opposite has higher effect								
Program characteristic									
Primary program goals	Social support								
	Parent self-help/self-development		+++			++	+++		
	Prevention of CAN				□				
	Economic self-sufficiency or literacy						■		
	Child mental health/behavior						++++		
	Community participation								
Targeting	Universal								
	Biological or developmental child risk:	++++							-
	biological	+++		++		++++			
	developmental		++						
	Teen parents				++++				
Population served	Mostly low income		+						
	Min. % minority								
	Majority teen parents								
	Infants/toddlers (3 years or less vs. older)		□		++++				
	Child age at end of service (months older)				■				-
		Could not analyze due to lack of variation							

	Program characteristic	Outcome domains								
		Child cognitive	Child social/emotional	Child health	Child safety	Parent attitudes	Parent behavior	Family functioning	Parent health	Economic self-sufficiency
Parent education	Staff all professional (vs. paraprofessional)		++							++
	Home visits (vs. parent groups)	++	+							
Types of services (major focus)	Early childhood education (ECE)	+++								
	Parent-child activities				++++					
	Peer support	+++	+			++		+++		
	Adult education									
	Case management				++++					
	Collaboration with other agencies									
	Health services									
	Community advocacy activities									
Amount of services	Intended length of services									
	Months of services									
	Hours of ECE									
	Intensity of ECE									
	Hours of parent education									
	Intensity of parent education									
	Hours of case management									
	Intensity of case management									
Overall effect	End of treatment	++	+		+	+	+	+		
	Follow-up	++			+	+	+		+	++

Findings: Long-term effects of FS programs and services

Follow-up data ranged from a few months to nine years after end of service, with the average length of follow-up time 31 months. Most notably, the studied programs as a group had the largest effects on child cognitive development and family economic self-sufficiency at follow-up. The latter finding, when compared to the lack of short-term effects, indicates that evaluations concerned with economic self-sufficiency should involve a follow-up data collection some time after the end of the program, allowing the families to put to use their new resources and see the changes in their finances. The results for cognitive, self-sufficiency, and parental health outcomes were all larger at follow-up than at the end of services (both .3 or greater), while the positive effects on child socio-emotional development and family functioning found in the short-term studies were greatly diminished in the follow-up analyses.

Differential effects were found for several characteristics, although the effect sizes were often small. The smaller number of studies limited the researchers' ability to examine combinations of factors. The larger effects included:

- Programs targeting children with biological risk factors had greater results on cognitive development.
- Programs involving younger children had larger effects on parent health.
- Using parent groups rather than home visits resulted in better cognitive outcomes for children.

Case management had a small but statistically significant effect on child cognitive development in the positive direction, further adding to the mixed results of case management services. Home visitation, on the other hand, had inferior results compared to programs using parent groups in the follow-up studies as well as the short-term studies. In contrast to the short-term analyses, programs with CAN prevention as a goal appeared to be somewhat successful in the long-term.

Relevant Conclusions

This study provides several conclusions relevant to the current research questions regarding family support (pp. A5-42-43):

1. Family support services produce small but significant effects across a range of outcomes for parents and children. Many of these effects are evident months or years after receiving services.
2. There is no single effective model.
3. The positive effects of family support are not consistent across programs. Almost two-thirds of the programs studied had very small or no effects on changing parental behavior or increasing parents' knowledge of child development.
4. Several programmatic characteristics were highly related to success in preventing child injury and neglect. Programs that targeted services to teen mothers and/or mothers of young children, programs that offer parent-child activities to improve interactions, and programs that offered support through case management had large effects. Combining some or all of these characteristics in a new program may have very large positive effects.

5. Family support services promote children's cognitive development and school readiness if they provide those services directly to children. There was evidence, however, of a trickle down effect, as programs that offered parent groups and peer support for parents had relatively large effects on cognitive development as well.
6. Family support services are effective with some vulnerable populations (specifically, teen mothers and families with a special needs child or one with behavior problems).
7. Programs were generally more effective with younger children. Early intervention and support, before parents have settled into habitual practices and before children are put too far off proper developmental pathways, appear to be key.

Note that the meta-analysis was not able to examine issues related to culture. Few individual studies have examined the effects of cultural reintegration, the use of natural helping networks, or the involvement of spiritual leaders in family support efforts.

Family Violence and Family Support Services

The National Research Council Committee on the Assessment of Family Violence Interventions (National Research Council, 1998) examined critical factors in developing or evaluating intervention and prevention programs in the area of family violence, which includes child maltreatment, domestic violence, and elder abuse. The project examined available evaluations (with comparison groups) of a vast array of parenting education and family support programs, maltreatment prevention services, health services for victims of abuse and children who witness domestic violence, other domestic violence-related services and interventions, treatment programs for abuse perpetrators, child placement, and intensive family preservation services, among others. The services of the programs included in the study ranged from pre-and post-partum support to weekly parenting classes and support groups to multisystemic therapy to home visiting. Similar to the programs in the meta-analysis described above, targeted outcomes for family support, family preservation, and maltreatment prevention were grouped into five categories: *parental mental health, social support, reduced reported maltreatment, parental competence and skills, and home environments.*

Similar Conclusions

As with the findings from the meta-analysis, the Committee came to the following conclusions:

- While some interventions showed a short-term improvement in parenting practices in certain areas (such as stress, anger control, empathy, etc.), there was little evidence that these changes were maintained over time.
- There was mixed evidence on the effectiveness of intensive family preservation services (IFPS), with some studies reporting no effect, some only a short-term effect, and a small number finding sustained improvement six months or one year post-services. Many of the studies found no effect on placement incidence, but some found that IFPS services shortened placement duration. Finally, only 2 out of 10 studies in one review showed a reduction in the risk of placement.
- No clear evidence existed to support the claim that expansion of social networks and greater use of community resources leads to better parenting practices.
- There was no body of evidence to provide clear indications of which families could benefit from support services and parent education as opposed to mental health services.

- The majority of acceptable studies on home visitation programs evaluated the Nurse Family Partnership (formerly the Nurse Home Visitor Program, developed in Elmira NY and since replicated elsewhere), which has been shown to have significant positive effects. This program has one of the few long-term follow-up studies, which found positive results 15 years after program completion. The results for other programs were promising but not as positive as in the Elmira project, largely due to incomplete evaluations or the lack of long-term follow-up. Despite methodological difficulties, the Committee concluded, “home visitation remains one of the most promising interventions for prevention of child abuse or neglect” (p. 222).

The researchers concluded that short-term interventions and services, with brief periods of support, may be insufficient to “deal with problems that are pervasive, multiple, and chronic” (p. 102) and which are often structural or otherwise well out of the influence of a social service office. Furthermore, most of the evaluations in family support and preservation have numerous methodological flaws, and further suffer from great variability in the services rendered, the characteristics of the parents and children, the ability of the families to “reestablish their equilibrium” (p. 106) and handle crisis without outside intervention, and the nature of the risk or the maltreatment, as applicable. The Committee further recommended that more research be done on the efficacy of matching individual families with specific interventions and on delineating the pathways between parent and child characteristics and future maltreatment.

Evidence-based Practices in Family Support and Preservation

Evaluations come in various forms, with different levels of rigor and different ability to make valid statements about effects in a population. The most rigorous studies involve random assignment of subjects to treatment (intervention, program, etc.) and control (comparison) groups, with careful monitoring of services received as well as controls for contextual factors that may affect the outcomes. Such randomized experiments may, however, not be very generalizable to other populations because the control and restrictiveness result in an unnatural setting. Quasi-experiments have non-randomized comparison groups, and generally attempt to measure differences between the groups before treatment. Non-experimental evaluations do not have matched comparison groups within the study, although the authors may compare their results with those of other studies. Quasi- and non-experimental studies more often involve interventions that operate in their normal, everyday fashion, and therefore are more comparable (generalizable) to other situations utilizing the same treatment.

All of these evaluations have value. When it comes to answering the question, “Does this program work (better than another program or no program)?”, randomized experiments provide the strongest answers. Table 2 summarizes programs meeting various standards for how well the body of research on that program has demonstrated that they are effective. Programs are divided into three levels of evidence:

1. Demonstrated effective or exemplary programs: These are programs that have undergone extensive evaluation demonstrating positive results. Among the evaluations is at least one randomized experiment. More study is always appropriate, but there appears to be definitive evidence for the program’s effectiveness in at least the tested population(s).
2. Reported effective or model programs: Programs in this category have several studies, including quasi-experimental evaluations, clearly demonstrating positive effects for participants. None of the evaluations are randomized experiments.

3. Innovative or promising programs: The programs at this level of evidence meet at least one of two criteria: there are positive results from a single group pre- and post-test or other non-experimental study, or the program addresses a particular challenge or difficulty in strengthening families and preventing maltreatment that has been identified in research or practice.

The program summaries in Table 2 are drawn from the reviews listed above, with three exceptions. These exceptions appear at the end of level 3. The sources for these entries, tribal family support and family preservation and Casey Family Program's new Powerful Families initiative, are cited in the table and listed in the references. These programs were sought out for inclusion in Table 2 because they address unique challenges and issues in family preservation and because they may be particularly applicable to Alaska.

In synthesizing the reviews, eight programs met the criteria for demonstrated effective. These interventions, Dare to be You, Family Connections, Incredible Years, Michigan Families First, the Nurse Family Partnership, Parenting Wisely, Strengthening Families, and trauma-focused cognitive-behavioral therapy, offer a mix of secondary and tertiary prevention. Most offer some form of parent education and/or social support and connection to the community. Interestingly, all may be provided by medical or psychological clinics and/or universities (Parenting Wisely is used by many state or county government child welfare agencies, but not exclusively). The same holds true for many of the reported effective (level 2) programs. To some extent this frequent finding is due to the fact that universities and hospitals do more research than social service agencies in general. It may also be due to the commonly adversarial or invasive relationships families and communities perceive themselves to have with child welfare agencies. There may be less fear of child removal when working with a university clinic or a home visit nurse. Communities may have less of a history of imposition by and lack of support from such entities compared to child welfare authorities.

The issues of the adversarial relationship with child welfare and the fear of child removal are especially pertinent in Native communities which have experienced racism and trauma in their interactions with state and federal government agencies (Red Horse et al., 2000; Halverson, Puig, & Byers, 2002; Peregoy, n.d.). Although concerns about family unity and child maltreatment appear to be similar in Western and Native cultures (Alaska Native Health Board, 2002), there are some differences in the root causes of family disruption—i.e. the historical trauma associated with Native groups due to their treatment by the mainstream society (Red Horse et al., 2000; Halverson, Puig, & Byers, 2002; Peregoy, n.d.). “Issues of identity, family dysfunction, and community disintegration are all interrelated, and unless family preservation efforts acknowledge and incorporate this fact, they will remain ineffective for American Indians” and Alaskan Natives (Red Horse et al., 2000, p. 64). Native groups thus may be wary of home visitation programs, depending on how they are presented. On the other hand, the focus among many of the effective programs on building connections with the community and developing formal and informal supports appears to be in line with traditional Native values of community interdependence.

Table 2: Evidence-based proven and promising practices in family support and preservation

Level 1: Demonstrated effective/exemplary programs (body of positive evaluation research includes at least one random assignment experimental design)

Program	Primary	Secondary	Tertiary	Target population				Setting/ service medium	Format/essential components	Primary intended outcome of program	
				Who	Risk	CPS status	Urban/ rural				Particular ethnic group? (cultural competence)
Dare to be You (Colorado State University Cooperative Extension)	X			Parents of children 2-5, inc. extended family; also training for teachers, community workers			both	Evaluated with diverse groups, inc. 2 Native American tribes	Parent and child workshops follow brief parent-child activity; With trained facilitator	20 hours (12+ weeks) 8 hours of follow-up events; parent learn: communication & social skills, problem-solving & negotiating skills, child development, healthy behavior attributions; incentives to promote program completion	Promote parent self-efficacy and self-esteem, teach effective child- rearing techniques, understand child development, increase social support & problem-solving skills
Incredible Years (Carolyn Webster- Stratton, University of Washington; incredibleyears. com)		X	X	Parent, child (3-10) & teacher	Maltreated children or children with or at risk of conduct problems. Families with: depression, marital discord, poor coping skills, or lack of support in home, preschool/Head Start, school			Multicultural focus, inc. materials in Spanish	Parent training groups; children receive services at school	Contingency management (behavioral): interactive play, reinforcement skills Cognitive/social learning techniques: parent training, classroom discussions and practice activities stimulated by videotaped vignettes	Strengthen parent and teacher competencies (communication, play, limit setting, discipline) Child: strengthen social & academic competence, reduce behavior problems, increase positive interactions with peers and adults

Program	Primary	Secondary	Tertiary	Target population			Particular ethnic group? (cultural competence)	Setting/ service medium	Format/essential components	Primary intended outcome of program	
				Who	Risk	CPS status					Urban/ rural
Family Connections (University of Maryland School of Social Work)		X		Families with children 5-11, inc. extended family	Exhibited risk for 1 or more neglect subtypes and at least 2 other risk factors for CAN	No current involvement	urban	No completed replication beyond Baltimore; replications currently under way	Community-based psychosocial intervention: coordination of services & supports, some in-home services	Emergency assistance and crisis intervention, family assessment, social support, increase connection with community and access to services, problem-solving, cognitive and behavioral strategies	Promote safety & well-being, by improving parenting & support, reducing risk factors
Michigan Families First (www.michigan.gov/dhs/0,1607,7-124-5439-21887--,00.html)			X	Families referred by Mich. Court system or Dept. of Social Services	Imminent risk of removal	Referred by CPS	Urban	Services in Michigan include 10 Indian reservations	Intensive face-to-face services offered 24 hours a day.	Intensive services for 4-6 weeks include parenting education, financial management, transportation, job skills. Caseworkers assigned two cases at a time.	Prevent out-of-home placement
Nurse Family Partnership (formerly Nurse Home Visitor Program; Olds et al.; contact Ruth O'Brien, Kempe Prevention Research Center for Family and Child Health, Denver)		X		At risk young mothers-to-be	Low income, 1 st birth, communities with risk factors such as high poverty & maltreatment rates	Probably none	urban	'culturally relevant'	Home visits prenatal through 2 nd birthday; weekly for 1 st 6 weeks, every other week through 21 st month, monthly during final 3 months	Professional nurse visits focus on personal & environmental health, maternal role & life course development, & social support. Consistent nurse for each mother for 3 years.	Reduce incidence of CAN, subsequent pregnancies, medical treatment, increase employment

Program	Primary	Secondary	Tertiary	Target population				Setting/ service medium	Format/essential components	Primary intended outcome of program	
				Who	Risk	CPS status	Urban/ rural				Particular ethnic group? (cultural competence)
Parenting Wisely (Gordon and colleagues, Ohio University; familyworksinc. com)	X	X		Families with children 6- 18, also teen parents	Low income, illiteracy, resistance to other training programs & interventions		both	Unspecified; used in Anchorage, Conway, and Wrangell AK and at Native institutions in the lower 48	Self-paced CD-ROM program with extensive video, can be completed independently even by illiterate parents; at center or in home (agency laptop), parents and children together; one study showed larger effect when used in context of parent support group versus individually	Requires little if any staff training (just turn on the computer and get the program started), although recommend availability of experienced family therapist or parent trainer; 3 to 6 hours over (1 to 2 sessions) to complete, covers communication & problem solving skills, discipline, step-family problems, etc.	Enhance family relationships, decrease conflict, improve parental confidence in parenting skills

Program	Primary	Secondary	Tertiary	Target population					Setting/ service medium	Format/essential components	Primary intended outcome of program
				Who	Risk	CPS status	Urban/ rural	Particular ethnic group? (cultural competence)			
Strengthening Families (Kumpfer & colleagues, University of Utah) (more focused on child behavior but exemplary evidence regarding parenting outcomes)	X	X		Children 6-12 & their parents	Children at risk of substance abuse, depression, aggression & delinquency, school failure	Probably none	both	Evaluated versions for African American, Hispanic, Asian/Pacific Islander, & Native American populations; also a rural modification	Center-based 14-session family skills training with up to 14 families per cohort; parents & children separate for first hour, together for second for practice	Parent training includes discipline, communication; child training includes communication, emotional development, coping skills, resisting peer pressure; incentives for attendance, participation, homework completion, & graduation	Improve family relations; parenting skills, stress level, & emotional functioning; youth social & life skills
Trauma-focused cognitive-behavioral therapy (Cohen & Mannarino; Deblinger, Steer, & Loppmann)			X	Children 7-13 & their parents	Children sexually abused				Community building, office, or school. 12-16 individual child, family, or group sessions	Cognitive-behavioral therapy/education for managing child's reaction to abuse; including support to parent(s) as well as child	Reduce negative behavioral, developmental, & emotional consequences of abuse

Level 2: Reported effective/model programs (body of positive evaluation research includes quasi-experimental [non-randomized] designs)

Program	Primary	Secondary	Tertiary	Target population					Setting/service medium	Format/essential components	Primary intended outcome of program
				Who	Risk	CPS status	Urban/rural	Particular ethnic group? (cultural competence)			
Early intervention foster care (Fisher & Chamberlain, Oregon Social Learning Center) (adaptation of treatment foster care for maltreated younger children)			X	Abused/neglected 3 to 7 year-olds, & their parents & foster parents	CAN allegation/substantiation and removal of child	removed			Child-focused social learning and behavioral management to avoid harsh, ineffective responses to challenging child behaviors; in treatment foster home, school, birth home	Foster parents: intensive child behavior management, with daily telephone contact (with birth parents, supervisor), clinical supervision, weekly visits with parents, group support for foster parents. Birth parents: behavior management training in office then home. Intense supervision of children, rewards for prosocial behaviors, & behavioral reinforcement. Alliance-building with parents. Team delivers permanence support services; contact with family up to 3 mo. post-reunification.	Protect children, then improve parental discipline/reinforcement and monitoring (reduce coercive practices)

Program	Primary	Secondary	Tertiary	Target population				Setting/service medium	Format/essential components	Primary intended outcome of program	
				Who	Risk	CPS status	Urban/rural				Particular ethnic group? (cultural competence)
Effective Black Parenting (Kerby Alvy, Center for the Improvement of Child Caring, ciccparenting.org)	X	X		Parents of children 2-12			primarily urban	African American, "appropriate for all socio-economic status levels"	Interactive workshops (15 3-hour classes) w/ trained Black facilitator; held in schools, agencies, churches/mosques, Urban League affiliates; large group 1 day seminar also available	Discuss respectful & rule-breaking behavior, traditional & modern discipline, Black pride, Black self-disparagement, coping with racism, African-origin family values, drug use prevention, single parenting. Role playing and home behavior change projects	Foster identity, communication, identity, growth & development; help combat child abuse, substance abuse, juvenile delinquency & gang violence, learning, emotional, & behavior problems
Families and Centers Empowered Together (FACET; Delaware Office of Prevention & Early Intervention)		X		Families in high-risk neighborhoods	Low income and other CAN risk factors		urban		Family support & empowerment at neighborhood child care center	Family support/building activities, services, & training opportunities, Parent Council leadership group, lending library Based on national Parent Services Project	Develop & sustain environment of family support & empowerment, increasing social support, connection, family strength/resiliency, self-advocacy

Program	Primary	Secondary	Tertiary	Target population					Setting/service medium	Format/essential components	Primary intended outcome of program
				Who	Risk	CPS status	Urban/rural	Particular ethnic group? (cultural competence)			
Families & Schools Together (FAST; Lynn McDonald, www.wcer.wisc.edu/fast)	X	X		Parents of children 3-14					Group skills and social network development; school- or community-based; with parent/professional teams	8-10 weekly sessions including orchestrated family activities, with monthly parent-directed support group meetings for 2 years; emphasis on parenting via meals, play & games, time for couples, self-help parenting group	Build support networks, prevent school failure, enhance family functioning, prevent familial substance abuse, reduce stress
Focus on Families (Social Development Research Group, Seattle)		X		Addicted parents of children 3-14, particularly those in methadone treatment	Parents are addicted		urban		Group parent training, with trained Master's level therapist, center-based with home-based care management & follow-up	5 hour family retreat followed by 32 sessions; topics: family goal setting, relapse prevention, communication skills, management skills, family expectations about substance use, teaching skills to children, helping kids succeed in school	Increase skills (e.g., family management, anger management, refusal and problem-solving), self-efficacy, and ability to teach children and help them with school

Program	Primary	Secondary	Tertiary	Target population				Setting/service medium	Format/essential components	Primary intended outcome of program	
				Who	Risk	CPS status	Urban/rural				Particular ethnic group? (cultural competence)
Homebuilders (Institute for Family Development, Federal Way WA, www.institute family. org) (more discussion beginning p. 26)			X	Highly troubled families with children (newborn to 18) at imminent risk of or recently placed in out-of-home placement	Report of harm	open case	both	Evaluated with groups with high proportions of non-white families	Intensive in-home (or setting of client's choice) services from single practitioner: counseling, concrete services, developing community support; on call 24/7 for crisis support	4-6 weeks, 8-10 hours per week of direct contact; therapeutic: cognitive-behavioral strategies, including rational-emotive therapy and motivational interviewing; teaching: didactic, modeling, and role-playing, with video & audio-tapes, workbooks & handouts team back-up for consultation	Strengthen families, maximize safety of children, & prevent out-of-home placement by improving motivation for change, parenting skills, social support, self-esteem, & living conditions, decreasing conflict, and establishing healthy family routines
MELD (Joyce Hoelting, Meld.org)	X	X		Parents of children 0-5	Low income; versions for young, single, and/or first time parents, parents of special needs children		varies with program version	9 tailored versions of program for different populations, e.g. young moms, Hmong families, parents with low literacy	Interactive group workshops led by trained parent-facilitators, held in community	2 years for entire program; segments on: health, child development, child guidance, family management, use of community resources, home & community safety, balancing work & family	Reduce family isolation, increase parent knowledge of child development, increase parental problem-solving & decision-making, nurture parent personal growth

Program	Primary	Secondary	Tertiary	Target population					Setting/service medium	Format/essential components	Primary intended outcome of program
				Who	Risk	CPS status	Urban/rural	Particular ethnic group? (cultural competence)			
Multisystemic family treatment (MST; Henggeler & colleagues; MST Services Inc.) (usually for juvenile delinquency, adapted for maltreatment)			X	Families with maltreated school-age children	Maltreated children	Some involvement		'culturally relevant'	Comprehensive, community-based interventions, w/ cognitive-behavioral & behavioral parent training & other methods In homes or school/ community, professional service providers	Home-based or family preservation model of individualized services drawing on 'empirically validated' interventions (cognitive-behavioral, pragmatic therapy, etc.), also inc. parent education, marital therapy, coaching, support (group) Several hours of contact/week for 4-6 mo.	Improved parental and family functioning, prevention of further CAN
Nurturing Parenting Program (Bavolek & colleagues; familydev.com)		X		Families with children 1-19	Some CAN risk but level unspecified			Adapted for Hmong, Hispanic, African American families	Group skills training, parents and children in separate groups (can be done in home); includes parent handbooks, videos, games	12-45 weekly sessions (2-3 hours); self-awareness, alternatives to abusive behaviors, communication, healthy development	Build nurturing skills as alternative to abusive parenting & attitudes

Program	Primary	Secondary	Tertiary	Target population					Setting/service medium	Format/essential components	Primary intended outcome of program
				Who	Risk	CPS status	Urban/rural	Particular ethnic group? (cultural competence)			
Parent-Child Education Program for Physically Abusive Parents (Wolfe et al.)			X	Parents of preschool children who use power-assertive discipline	Physically abusive parents	Some involvement			Child-focused behavioral parent training, in home or clinic	Weekly parent enhancement sessions for 4 to 12 months, w/ follow-up for up to 2 years	Reduced abuse. Enhanced sensitivity to child's social & emotional needs, reasonable expectations for children, effective discipline, know how to access community resources
Resilient Peer Training (RPT; Fantuzzo et al.)			X	Physically abused, withdrawn, & neglected, high-risk, preschoolers Some focus on parents and school staff	High risk, including high levels of CAN, low-income family, children demonstrating emotional dysfunction	probably		'culturally relevant'	Child-focused social-developmental, behavior, & social skills training using peers, in therapeutic preschool/day treatment or Head Start	20 play sessions over 8 weeks, with a resilient or prosocial peer guided by trained parent helpers	Reduce effects of CAN: improved social functioning at home & school, reduced aggression; improved cognitive development

Program	Primary	Secondary	Tertiary	Target population					Setting/service medium	Format/essential components	Primary intended outcome of program
				Who	Risk	CPS status	Urban/rural	Particular ethnic group? (cultural competence)			
Social Support Network (Social Network Intervention Project; Gaudin & colleagues, University of Georgia School of Social Work)			X	High-risk families w/ chronic neglect	Chronic neglect, limited or no family or informal social support	Open case			Multiple components: ecological interventions, social support, parenting enhancement; individual or group	Family support networking, mutual aid group, social skills training, assistance from volunteers & neighbors; 10 weeks to 23 months	Improve social support and parenting adequacy

Level 3: Innovative/promising programs (positive results from single group post-test-only outcome or other non-experimental studies, or solves a particular problem/challenge noted in the literature)

Program	Primary	Secondary	Tertiary	Target population			Setting/service medium	Format/essential components	Primary intended outcome of program		
				Who	Risk	CPS status				Urban/rural	Particular ethnic group? (cultural competence)
Acupuncture Initiative to Improve Retention in a Parenting Class (Parent Child Health Unit, SW WA Health District)	Depends on program used in conjunction with			Participants in parenting classes	At-risk of dropping out of program and/or abusing due to high level of stress, anxiety, depression, addictions				Acupuncture provided in health care center before regular parenting class	Acupuncture is introduced and demonstrated on a staff member in 3 rd week of parent curriculum. Participants are invited to receive treatment before each class for all subsequent weeks.	Increase effectiveness of CAN prevention parenting classes: increase attendance, receptivity, connection with other participants, reduce stress
Building Leadership for Community Development, Free to Grow				unspecified	Unspecified though given goals, some risk is implicit		urban	Multi-ethnic	Unspecified	10 sessions with trained facilitator; includes sessions on group facilitation and community development skills-building	Prevent child abuse & substance abuse as intertwined problems

Program	Primary	Secondary	Tertiary	Target population				Setting/service medium	Format/essential components	Primary intended outcome of program	
				Who	Risk	CPS status	Urban/rural				Particular ethnic group? (cultural competence)
Circle of Security (Ctr. for Clinical Intervention, Spokane)		X		High-risk child-caregiver dyads	Demonstrate disorders or insecure attachment (IDed by Head Start staff, university-based assessment team, and program therapists)				Parent education at Head Start/Early Head Start centers	Education groups Parent feedback via edited videotapes	Shift patterns of interaction to appropriate developmental pathway: Increase sensitive/responsive interaction, reflection on behavior, and reflection on experiences that may effect parenting
Fathers and Children Together (FACT; Prevent Child Abuse Kentucky)		X		Incarcerated fathers					Parent education/support in prison, though some follow-up work can be done	Father-oriented parent education groups, practicing of skills during visits, and tape recording of father reading a story given to children weekly.	Increase effective parenting skills, reduce isolation, increase child-oriented focus in fathers, reduce recidivism
Financial Literacy & Justice (part of Neighborhood Economic Development Advocacy Project; nedap.org/financial_lit.html)		X		Low-income adults	Low income		urban	“designed as template and can be tailored to meet the needs of any group;” multi-ethnic potential	Trained facilitator, can include peer	Classroom-based curriculum “designed to address practical financial skills, individual economic rights, and community economic justice issues”	Increase knowledge about: banking basics, budgeting, credit topics including predatory lending, credit reporting & repair, building & protecting assets

Program	Primary	Secondary	Tertiary	Target population			Setting/service medium	Format/essential components	Primary intended outcome of program	
				Who	Risk	CPS status Urban/ rural				Particular ethnic group? (cultural competence)
Fussy Baby Program (Oakland Family Services, Pontiac MI)		X		Children 0-3 with regulatory or behavioral disorders	Infant/ toddler behavior problems			Home visits weekly	Parent support & stress management with Infant Mental Health Specialist, plus Family Service Plan with team of medical, mental health, & educational professionals	Reduce stress and risk of CAN
Hui Makuakane (Hana Like Home Visitor Program, Hawaii)		X		Fathers				In-home (or jail, as appropriate) or on phone with Father Facilitator (24 hour access), some group activities	Broad support and crisis intervention, including career and education help, referrals, in addition to family-focused education & experiences; includes infant massage instruction	Increase engagement & competence of fathers
Parenting Partnership (Mary Bridge Children's Hospital, Tacoma WA)		X		Unprepared, isolated parents of medically fragile children	Parents have own history of abuse, endorse high levels of stress related to the care of their infant			1 hour weekly home visits by clinician for 1 st 3 years of child's life; nurse accompanies for 1 st 2 visits; also monthly psycho-educational/ support groups	Therapeutic activities for enhancing parenting skills & resolving issues from parent's own difficult childhood	Reduction of CAN for medically fragile children through increasing protective factors

Program	Primary	Secondary	Tertiary	Target population				Setting/service medium	Format/essential components	Primary intended outcome of program	
				Who	Risk	CPS status	Urban/rural				Particular ethnic group? (cultural competence)
Parents Anonymous (www.parentsanonymous-natl.org)	X	X		Parents					Weekly peer support groups with trained facilitator, parent group leader as co-facilitator	Group decides topics to be discussed, but always address basic parenting skills; group members offer 24 hour support to each other; simultaneous children's activities foster social development. Requires training and accreditation from national organization	Prevention of child abuse, increase parenting competency and coping skills
Parents Encouraging Parents (Grangeville ID; parentingonline.org)	X	X		Rural parents		May include parents required/ mandated to attend parenting classes	rural		On-line family strengthening & support; 14 90-minute interactive classes. In-person groups, home visits, and phone/e-mail consultation also available.	Classes inc. audio lectures, slide presentations, questions via microphone or chat. General family strengthening, inc. communication, discipline, divorce/separation issues, preventing & dealing with problem behaviors, parenting while recovering from substance abuse.	Use technology to bring parent education & family support to rural/isolated families; prevent CAN by strengthening families through giving parents education, skills, support.

Program	Primary	Secondary	Tertiary	Target population			Setting/service medium	Format/essential components	Primary intended outcome of program		
				Who	Risk	CPS status Urban/ rural				Particular ethnic group? (cultural competence)	
Powerful Families (formerly Parent to Parent; Casey Family Programs, 2004, 2005; see www.casey.org/OurWork/PreventionAndFamilySupport and www.powerfulfamilies.org)		X		Population targeted by local partner agency, but generally low-income parents & families	Families who may experience stress due to low financial resources and limited access to financial or other services		both	Pilot studies involved urban and rural groups, many with high proportion of minority attendees. Future expansion to include additional rural areas (inc. Alaska); attention to cultural competence	Interactive group workshops with trained group leader and (paid) parent facilitators; support to local staff provided by community specialist	Each curriculum, focusing on financial literacy, advocacy and system navigation, and community leadership, includes 9 weekly 2 hour sessions, plus 1 extra hour before each for networking; meals provided. Focus on skill-building, peer support & empowerment.	Improved financial functioning and more successful service navigation: focus on “parents as financial managers and as navigators of public services,” areas not covered by most family support programs. Maintenance of gains through establishment of ongoing social support with other parents.
Project 12 Ways/Project SafeCare (John Lutzker, Centers for Disease Control)			X	Families with chronic neglect	Chronic neglect, poor parenting practices; environments w/ risk factors for child health & safety, parent-child interaction issues; social isolation	Open file, substantiated neglect			Multiple interventions provided by paraprofessionals: ecological, parent education, social support, parent-child training; in home	Individualized, pragmatic approach, inc. family education & support, training, stress reduction, self-control therapy, health & nutrition info, job placement	Reduce incidence of further neglect & abuse, improve family functioning, health, safety

Program	Primary	Secondary	Tertiary	Target population					Setting/service medium	Format/essential components	Primary intended outcome of program
				Who	Risk	CPS status	Urban/rural	Particular ethnic group? (cultural competence)			
Strengthening Multi-Ethnic Families and Communities (Marilyn Steele)	X	X		Parents of children 3-18	unspecified		both	Multi-ethnic; materials in English, Spanish, Vietnamese, Korean, Cambodian, Russian, also implemented with Native groups	Interactive group workshops w/ trained facilitator in churches, schools, community agencies	12 3-hour sessions; five areas: culture, rites of passage, positive discipline, enhancing relationships, community involvement	Improve parental sense of competence, family interactions, connection with community; reduce drug/alcohol use, teen suicide, juvenile delinquency
Tribal family preservation (NICWA curriculum, Module IV: Family-Centered Services for Indian Children, nicwa.org/resources/catalog/curriculum/index.asp .)		X	X	Native (extended) families with reports of abuse/neglect	Risk of out-of-home placement	yes	primarily rural	American Indian/Alaska Native	Particular attention paid to in-home services; also to importance of extended family, cultural traditions and reconnection; implicitly, services (i.e., ICWA worker involvement) are not time-limited	Relationship-based, small caseloads, team approach including family and community resources, availability in emergencies, family decision-making; family rather than individual focus	Child safety, strengthen families, prevent family breakup, prevent further removal of reunified children, reduce dependence on social services

	Primary	Secondary	Tertiary	Target population				Setting/service medium	Format/essential components	Primary intended outcome of program	
				Who	Risk	CPS status	Urban/rural				Particular ethnic group? (cultural competence)
ily , but mmend- an rts: al.,	X	X		Potentially all community members	Risks such as substance abuse and family violence recognized but not targeted	any	primarily rural	American Indian, including Ojibwe (MN, WI) and 3 tribes of Ft. Berthold reservation (ND) (some Alaska Native survey respondents)	Culturally-grounded and community focused (and family; emphasizing that there is much more overlap between the two among Native peoples and mainstream child welfare does not always recognize this)	Must address historical trauma; Native non-professionals more important than non-Native professionals; infrastructure must support both “internal” (adhering to traditional values and ways) and “external” (government) sovereignty Emphasis on way of life, not program or strategy	Family/ community w being with emphasis on cultural integrity and revitalization

Evaluation of Family Preservation and Reunification Programs: The Federal Study

Most family preservation programs possess common elements: crisis-oriented, short-term treatment generally involving in-home services, with a child at imminent risk for removal. The Homebuilders model, often considered the prototype FPS program, developed specific protocols for delivering services (National Family Preservation Services Network, 2001, p. 8):

- Staff are available 24 hours a day, seven days a week
- Staff have caseloads of 2-4 families
- The family is seen within 24 hours of referral
- Five to 20 hours of services are provided each week
- Services are available on weekends and evenings
- Services are limited to 4-8 weeks total

As it is often regarded as the first family preservation model, Homebuilders has undergone much scrutiny, evaluation, and criticism. It is possibly the most controversial family preservation and support program. This is largely due to the mixed findings regarding its effectiveness interacting with the often fervent support of those dedicated to the model. Because of its place in the family preservation and support field, Homebuilders will be examined separately.

The most extensive evaluation of FPS, funded by the Administration for Children and Families of the U.S. Department of Health and Social Services (Westat, Inc., Chapin Hall Center for Children, & James Bell Associates, 2001) examined the impact of FPS on the following areas: *reducing foster care placement, maintaining child safety, and improving family functioning*. The study included programs in four states—Kentucky, New Jersey, Tennessee, and Pennsylvania (Philadelphia). Three of the sites used the Homebuilders model, while Philadelphia used a broader but similar family preservation service model.

The findings in each of the areas were the following:

Placement: None of the sites showed statistically significant differences between experimental and control groups in placement rates of children.

Child Safety: Maltreatment after beginning of treatment was not related to experimental group membership, except in one Tennessee sub-group. For this group of families, who had allegations of abuse within 30 days prior to random assignment, children in the experimental group experienced fewer substantiated allegations than children in the control group did.

Family Functioning: Family functioning appeared to improve in some families in some areas. These improvements, however, were not maintained at the end of a year. One result proved to be an exception: Caregivers in the experimental groups in Kentucky and New Jersey reported that they saw “great improvement” in their lives at post-treatment.

Although it was intended to move the field towards a definitive conclusion about Homebuilders, more discussion ensued. Kirk (2001), with the National Family Preservation Network, provided the following criticisms to the Federal FPS study:

- The programs studied strayed from the Homebuilders treatment model in a variety of ways, including number of hours of service to families, availability of counselors, etc.

- “Random” assignment of cases to “traditional” services and the Homebuilders model was not truly random. CPS workers were reluctant to assign cases randomly. In addition, there was a “blurring” of differences between traditional services and Homebuilders.
- Many of the families served by the Homebuilders programs were not appropriate to that treatment model. Their children were not at “imminent risk of child placement.”

In a later article, Kirk, Reed-Ashcraft, and Pecora (2002) identified “treatment fidelity,” or adherence to the treatment model, as a major issue in the family preservation movement as a whole. A lack of fidelity in an evaluated program produces an evaluation with little validity and little ability to find differences between treatment and control groups: What program is being studied? If differences between the groups in services received are small, why would we expect large differences between them in outcomes? The authors provide examples of ways to assess the treatment fidelity of any FPS program that is being evaluated.

Kirk and Griffith (2004) were subsequently able to develop a large quasi-experimental study that addressed many of these criticism and weaknesses. The project involved retrospective review of records regarding 542 children along with their families who had received services via a six-week intensive family preservation services (IFPS) model and a comparison group of 25,722 families who had received typical services in 51 counties in North Carolina. The research design was strengthened by standard measures and extensive use of service data. Risk was measured for all cases using a standardized risk assessment with early indications of reliability and validity, thus allowing the researchers to include only cases with high risk as assessed in their CPS reports. Case data was mined to assess and control for other factors. Several of these have been identified as risk factors for child removal, such as race, prior substantiated report, and prior removal, most of which were more frequent in the IFPS sample than in the control group. Case data also allowed for maximizing treatment fidelity, as cases that did not meet the IFPS definitions of minimum (or maximum) quickness of response, service level, and time to case closure were eliminated from the analysis.

Without these controls, Kirk and Griffith (2004) found, as in other research, that there was no difference in placement rates one year after receiving services. This may explain some of the lack of findings in previous research and validates the criticisms of that research. When risk factors and time were controlled for, significant differences emerged illustrating the positive effects of IFPS in this sample. Greater treatment effects were found with higher risk cases. The analysis did find some diminishing of effect over time, which the authors discuss as illustrating anecdotal practice findings of the need for a “booster shot” of IFPS services to ameliorate vulnerability four to seven months after the initial intervention.

Evaluating Family Preservation and Support Services

Since the passage of the 1980 Adoption Assistance and Child Welfare Act states have been required to take steps to prevent children from entering foster care and reunify those who were placed outside of their parents’ homes. More recently, the 1993 Family Preservation and Support provision of the Omnibus Budget and Reconciliation Act encouraged states to institute or further develop family preservation and support programs. The intent of these federal mandates seemed simple: prevent children at risk of abuse and neglect from being placed outside their homes, and/or reduce the length of placement in out-of-home care.

Challenges

In reality, the goals of family preservation and support programs are more complex than simply to prevent removal from the home, and treatment protocols are rarely carried out consistently. As discussed previously regarding Homebuilders, this makes evaluating these protocols and detecting true treatment effects difficult. Jacobs (2001) summarized several challenges in evaluating Family Preservation Services (FPS). Two of the most prominent problems she encountered in her review of the most recent broad-scale FPS evaluation efforts were the lack of difference in kinds of services provided to the experimental and control groups and heterogeneity in and poor definition of “imminent risk of harm” to the children. She also identified other difficulties listed below:

- FPS takes a variety of shapes and addresses many purposes.
 - Goals of FPS services have expanded beyond placement prevention to include enhancing child development, improving parenting, enhancing agency collaboration, etc.
 - These goals, particularly placement prevention, often have different definitions in different programs.
- The field lacks a coherent “theory of change” that encompasses the multitude of program and client goals.
 - Most intensive family services model have roots in crisis intervention theory, more specifically predicated on the “disequilibrium” model of intervention: A system (family) is most open to change when confronted with a disorienting crisis, a break-down in the usual functioning. The rationale is that the system can be changed with brief intensive services during this period of period of disequilibrium.
 - However, long-term supports are precisely what many of these families need. There is little attention paid to the developmental readiness of the adults in the family, or the family as a system, or the fact that the issues these families face are often chronic rather than acute.
- Replicating FPS models across systems and communities may not be possible.
 - As discussed previously, one of the most repeated complaints about evaluation of FPS programs is the lack of fidelity to the espoused treatment model. Considering the intensity of the services, the staffing and resource requirements, and the need for the families’ cooperation in participating in treatment, Jacobs noted that treatment fidelity may be an unattainable goal. (See also the previous discussion regarding the adversarial, authority-based nature of mainstream child welfare vis-à-vis Native communities.)
- Evaluation efforts have suffered from lack of access to data, appropriate measures, expertise, money, or political will.
 - State MIS systems may be inadequate and instruments to measure outcome areas may be scarce, expensive, or difficult to administer. Measures used for years in practice may not be valid and effective for use in evaluation.
 - The expansion of the goals of family preservation has resulted in attempts to answer questions using evaluations not designed to address those issues.
 - Limited resources have left evaluations unable to analyze mediating variables, such as improvement in family functioning.

Family support programs have many of the same issues. As described above, the NRC (1998) project examined critical factors in implementing and evaluating parenting education, family support programs, and intensive family preservation services. Noting that most evaluations in these areas have been of poor quality, largely because they “were not planned as part of the introduction of a program and...[their] evaluation designs were too weak to reach a conclusion as to” program effects (p. 60), the Committee offered a variety of methods and advice for improving evaluations. For example, the authors strongly advocated for the use of multiple outcome measures collected at multiple points in time that should include long-term follow-up. Most studies have not incorporated these design strengths, have not utilized standard measures of outcomes and explanatory variables, and have not included appropriate comparison groups. Because of these weaknesses, only one program (the University of Maryland’s Family Connections) in the Office on Child Abuse and Neglect-sponsored report (Thomas et al., 2003) was deemed to be “demonstrated effective”.

Implications

The findings from the NRC (1998) review and the recent more rigorous study by Kirk and Griffith (2004) exemplify the limitations Kirk (2001; Kirk et al., 2002) and Jacobs (2001) discussed regarding past evaluations of family preservation programs. Inconsistent program models have been aimed with incomplete implementation at a myriad of outcomes. Placement of children may be delayed in the short term, but few evaluations have indicated that short-term services deliver long-term impacts. The findings from the family support and preservation evaluations suggest that longer term interventions may be needed to sustain short-term improvements. Other difficulties arise from how variables are defined: because the definition of “imminent risk” is too often based on the subjective judgment of a caseworker, it will be difficult to compare this criterion across studies. Similarly, “placement” often has different definitions in different studies (Jacobs, 2001; NRC, 1998).

Finally, whether FPS works or not depends on complex interactions among many systems, including:

Characteristics of *the enrolled families*—their particular strengths, needs, hopes, and life circumstances; *their contexts and “or holding environments”*—their neighborhoods, informal support systems, the network of accessible community-based services; and the *FPS program itself*—its duration, intensity, quality, and the nature of the relationship established between FPS caseworker and family (Jacobs, 2001, p. 11).

This complexity results in an irony of FPS (and family support) evaluation: The services are developed to reduce placement in foster care, but placement rate may not be the best outcome to use in an evaluation. Whether a child is removed depends on innumerable forces, most of which are outside the influence of the state CPS authority. In focusing primarily on reduction of placement outside of the home, other important outcomes may be overlooked (NRC, 1998). To further aid those planning to implement and evaluate a family preservation and support program, the next section will discuss outcomes that should be considered.

Selecting Outcomes for Family Preservation and Support Programs

As Jacobs (2001) noted, the goals of family preservation and support have greatly expanded beyond family stability and preventing maltreatment and child placement. As in any service field, the family preservation and support community should agree upon its goals in order to further discussion and refinement. One step in this process is to review what outcomes have been pursued most often in the literature. In this section, we present such a review, compiling outcomes and potential ways to measure

those outcomes, to help program planners and evaluators develop services and evaluations. Sources for this compilation of outcomes were:

- Thomlison’s (2003) review of evidence-based child maltreatment interventions. These programs had the following goals:
 - Decrease the need for out-of-home placements
 - Change child or parent behavior
 - Improve the health and socio-emotional functioning of children and families
 - Enhance parent management skills
 - Enrich parents’ personal and social resources
 - Prevent the recurrence of child maltreatment
- OCAN’s *Emerging practices in the prevention of child abuse and neglect* (Thomas, Leicht, Hughes, Madigan, and Dowell, 2003). The programs reviewed address all three levels of prevention and had numerous goals beyond child safety.
- The CSAP-OJJDP joint report, *Strengthening America’s families* (Alvarado, Kumpfer, Kendall, Beesley, and Lee-Cavaness, 2000). The highlighted programs included in the current survey of outcomes were focused on improving parenting skills, socio-emotional functioning of children and adults, family conflict management and problem solving, and social support and self-sufficiency, and reducing conduct problems, injuries, and out-of-home placement.
- The ACYF meta-analysis of family support programs (Layzer, Goodson, Bernstein, and Price, 2001). This report reviewed hundreds of evaluations gathered through an exhaustive search for published and unpublished studies.
- The National Research Council (NRC) review of family violence interventions (National Research Council, 1998). As noted above, the authors considered the important issues and difficulties in implementing and evaluating family support and preservation services. The Committee also discussed outcome measures for evaluations of family-based or parent-focused child maltreatment and family support interventions (upon which this section will focus).

By highlighting specific outcomes from the myriad evaluations examined, these sources help bring the field towards consensus on the appropriate outcomes for family preservation and support (and most child welfare services). Table 3 below provides a summary of the outcomes mentioned in these five sources. Checkmarks (✓) denote the use of that outcome in the specific source, with double checks (✓✓) indicating repeated mentions.

Once an outcome is chosen, the evaluation planning team must develop the specific methods that will be used to measure them—what scientists call the “operational definition.” Potential indicators for the outcomes noted in Table 3 include administrative data, criterion-referenced measures (easily gathered items, often resulting in a “yes” or “no” answer, directly related to the goals of the intervention), and standardized instruments. The latter are described in some detail in appendix A, with sources for obtaining them indicated.

Choosing appropriate outcome indicators is very important and somewhat difficult. This choice must be considered with an eye towards ease of data collection, cost, whether the indicator can serve clinical or administrative purposes in addition to meeting an evaluation need, the meaning and utility for program

staff and policy makers, cultural relevance and reading level, and the ability to compare results with other evaluations. The National Research Council notes that “until standardized definitions and objective assessment tools are adopted to measure services, placement, and risk, tests of the efficacy of an intervention strategy using [placement and placement risk as outcomes] will remain difficult” (National Research Council, 1998, p. 106). The National Study of Outcome Measurement in Public Child Welfare Services (Johnson & Wells, 2000) discusses standardized measures that meet all or some of the following requirements:

1. addresses specific domains relevant to child welfare
2. easy to administer and interpret (minimal training required)
3. can be administered in less than 20 minutes
4. sensitive to clinically significant change

The report, available at <http://cfrwww.social.uiuc.edu/pubs/Natl.Surv/susmain.htm>, also lists administrative and criterion measures that may be of use.

Other resources for finding appropriate measurement instruments include:

- Bickman, L., Nurcombe, B., Townsend, C., Belle, M., Schut, J., & Karver, M. (1998). *Consumer measurement systems in child and adolescent mental health*. Canberra, Australia: Australia Department of Health and Family Services.
- Corcoran, K., & Fischer, J. (2000). *Measures for clinical practice: A sourcebook* (3rd edition). New York: The Free Press.
- Touliatos, J., Perlmutter, B.F., & Straus, M.A. (Eds.). (1990). *Handbook of family measurement techniques*. Thousand Oaks CA: Sage.

The administrative data, criterion indicators, and measures below are presented here as suggestions. There may be other indicators that programs are already using or that are unique to that community, and other assessment measures that are useful or more readily available. The instruments chosen were included because they appear to measure constructs useful in evaluating family preservation and support programs and because they have exhibited good psychometric properties (reliability and validity). Many of the instruments can be used not only to assess outcomes but also to control for risk factors, such as parental depression or social isolation, and protective factors, such as parental sense of competence or child psychosocial development, which may be associated with other outcomes. Appendix A provides detailed descriptions of the measures included in Table 3, as well as information on where to obtain them.

Table 3: Outcomes for evaluating family support and preservation interventions, as mentioned in five major reviews, with suggested indicators

Outcome area	Potential indicators	Thomlison	OCCAN	ACYF meta-analysis	CSAP-OJJDP	NRC
Reduce/prevent child abuse and neglect (CAN), or risk of CAN	CPS reports, Child Abuse Potential Inventory, Index of Family Relations (IFR), Index of Parental Attitudes (IPA), SUNY Parenting Scale (PS), Child Well-Being Scales	✓✓	✓✓	✓	✓✓	✓✓
Reduce/prevent behavior problems secondary to CAN	Adolescent drug and alcohol screens (such as CRAFFT); see behavior indicators below	✓				✓
Reduce aggression, conduct problems	Child Behavior Checklist (CBCL), arrest records, school discipline records, runaways, Adolescent Concerns Evaluation (runaway risk index), juvenile arrest/incarceration rates	✓	✓✓	✓	✓✓	✓
Improve peer interactions and prosocial behavior	Vineland Adaptive Behavior Scales or Socio-Emotional Early Childhood Scales (VABS, V-SEEC)	✓		✓	✓✓	
Reduce child social isolation, improve social skills	VABS or V-SEEC, Child and Adolescent Functional Assessment Scale (CAFAS), Social Development domain of the Ansell-Casey Life Skills Assessment (ACLSA)	✓		✓	✓✓	✓
Improve cognitive development, academic skills	Cognitive functioning tests (Wechsler Intelligence Scale for Children, Wechsler Preschool and Primary Scales of Intelligence, Kaufman Assessment Battery for Children, Kaufman Brief Intelligence Test, Wide Range Intelligence Test, etc.), language skills tests (e.g., the Peabody Picture Vocabulary Test), grades, grade retention/promotion, use of special education services, Bayley Scales of Infant Development, VABS, CAFAS, Home Observation for Measurement of the Environment (HOME)	✓	✓	✓	✓✓	✓

Outcome area	Potential indicators	Thomlison	OCCAN	ACYF meta-analysis	CSAP-OJJDP	NRC
Parents: improve positive affect, reduce criticism and negative comments, improve empathy and responsiveness to child's emotional needs, improve parent-child interactions	Adult-Adolescent Parenting Inventory (AAPI), observation, Panel Study of Income Dynamics (PSID) Child Development Supplement, Family Emotional Involvement and Criticism Scale, Parental Bonding Instrument (PBI)	✓	✓✓	✓	✓✓	✓✓
Decrease negative parenting: spanking and harsh discipline	AAPI, PBI	✓✓	✓✓	✓	✓✓	✓✓
Increase monitoring of children	Home visits, random phone calls or visits	✓	✓✓		✓	✓
Improve family communication, coping, and problem solving	Self-Report Family Inventory (SFI), Family Adaptability and Cohesion Evaluation Scale (FACES), etc.	✓	✓	✓	✓✓	
Improve child conflict management with peers and family	CBCL, VABS or V-SEEC	✓		✓	✓	
Increase/improve parent-teacher communication, school involvement	Number of conversations per month, attendance at parent-teacher conferences, self report	✓			✓✓	
Decrease incidence of subsequent pregnancies	Count later pregnancies, use of birth control	✓	✓		✓	✓
Increase maternal employment	Part- or full-time employment status	✓			✓	✓
Home safety: decrease injuries and ER visits	ER visits, CPS reports of neglect	✓	✓✓	✓✓	✓✓	✓✓
Decrease negative parental beliefs about child rearing, improve parental expectations, satisfaction, and positive attitudes toward parenting	AAPI, CAPI, IPA	✓	✓✓	✓	✓✓	✓
Increase consistent discipline, positive reinforcement	Observation, Daily Discipline Interview, PS	✓	✓✓		✓✓	✓✓

Outcome area	Potential indicators	Thomlison	OCCAN	ACYF meta-analysis	CSAP-OJJDP	NRC
Child emotional regulation, positive responses to stress; decrease psychological symptoms	Depression and PTSD diagnoses, CBCL, Child Well-being Scales, CAFAS, VABS or V-SEEC, Children’s Depression Inventory	✓	✓✓	✓	✓✓	✓✓
Decrease passive compliance by child	AAPI Children’s Power and Independence subscale	✓				
Increase child safety and protections skills (e.g., appropriate vs. inappropriate touching)	Self-Care domain of the ACLSA		✓			✓
Child life-skills development	ACLSA		✓			
Strengthen parental support—formal and informal (see also parent-teacher communication, access to services)	Family Support Scale, frequency of interaction, Social Support Index	✓✓	✓✓	✓	✓✓	✓
Improve parent access to services	Service usage (survey parents or survey services for # of new cases), reports of knowledge of and barriers to services		✓		✓	✓✓
Decrease parent stress and psychological symptoms	Parenting Stress Index, CAPI distress and unhappiness subscales, Beck Depression and Anxiety Inventories, General Health Questionnaire	✓	✓✓	✓	✓	✓✓
Increase parental self-confidence, self-efficacy	Parenting Sense of Competence Scale, Rosenberg Self-Esteem Scale, PSI sense of competence scale		✓	✓	✓	
Decrease out-of-home placement (incidence, length of stay)	Agency records, follow-up surveys (include formal and informal placement in all systems)	✓		✓	✓	✓✓
Decrease maternal criminality	Arrest records		✓			✓
Increase self-sufficiency (see also maternal employment above)	Welfare use, income, literacy, percent of eligible families using Earned Income Tax Credit, homelessness rate		✓	✓	✓✓	✓

Outcome area	Potential indicators	Thomlison	OCCAN	ACYF meta-analysis	CSAP-OJDDP	NRC
Decrease pregnancy risk status, birth complications	Rate of complications (low birth weight, etc.), use of supplements (vitamins, folic acid, etc.), compliance with/attendance at family planning, mother's last use of substances, use of substances by others in home		✓	✓	✓✓	✓
Child health and physical development	Height and weight percentiles, illnesses, immunizations up-to-date (direct) or National Immunization Survey (state-wide, 19 to 35 months old, see www.cdc.gov/nis/), VABS, Bayley Scales		✓		✓✓	✓
Improved parental knowledge of child development	AAPI developmental expectations subscale		✓✓	✓	✓✓	✓
Increase appropriate stimulation in home environment (see also cognitive development above)	Home observation (may include standardized instrument, such as the HOME or the Environmental Assessment Index), parent reads to child		✓			✓
Decrease role reversal	AAPI		✓			
Positive attachment	Strange Situation procedure, Emotional Availability Scales		✓			✓
Parental alcohol, tobacco, or drug use	Use as indicated in case records, drug and alcohol screens (Michigan Alcohol Screening Test, Alcohol Use Disorder Identification Test, CRAFFT, Drug Abuse Screening Test, etc.), ER and police encounters for drug and alcohol reasons			✓	✓✓	✓
Parent motivation to change parenting practices	Attendance at and participation in parent education or treatment sessions, Stages of Change Scale					✓
Parent impulsivity (see also parental distress/mental health, consistent discipline)	Functional-Dysfunctional Impulsivity Scale, the Maturity/Modeling scales from the 3 older child versions of the HOME					✓

Summary

The field of family preservation and support has set out for itself a rather complex and lofty set of goals. These goals extend from the identified child to the very fabric of society. Any growing field requires time to build a consensus on what outcomes and what variables are important to measure. By compiling the outcomes mentioned in four major reviews of family preservation and support programs, we hope to help the field move towards agreement on what such programs should try to accomplish and what evaluations of those programs should measure.

Some of the most frequently mentioned outcomes, of course, are indications of maltreatment and parenting. They appear to reflect two continua of parenting practices within the home. One of these continua is psychological, involving:

- Affect, criticism versus positive comments and praise, and attitudes towards parenting
- Beliefs and expectations about parenting
- Knowledge of child development
- Empathy, responsiveness, and attachment
- Parental self-confidence

The other continuum is behavioral, ranging from consistent, constructive discipline and positive reinforcement to monitoring and stimulation to home safety and injury to child maltreatment. Child removal and placement in foster care may also be added to the negative end of that continuum. Preventing child abuse and neglect is an obvious goal of family preservation and support. Families, however, operate in a complex context that involves many more actors and factors than simply the social service agency, all of which influence the probability of maltreatment. Furthermore, to truly measure child maltreatment, an evaluator would need to collect data until the children reach 18 (or some older age), comprising a follow-up period that may not be favorable to funders. So many program designers and evaluators turn to more proximal outcomes, such as indications of discipline practices, emotional responsiveness, parental attitudes and knowledge, and short-term assessments of the home environment (physical and interactional).

Several other commonly-mentioned outcomes focus on the parents or the family in general. Several evaluations have focused on family communication patterns and coping strategies. Parent mental health, including substance use, is a frequently measured outcome. Many family support programs target mothers-to-be or young mothers, in which the prevention of birth complications and minimizing future pregnancies are common program goals. Other risk factors, such as formal and informal support and self-sufficiency, are frequently assessed in evaluations of family preservation and support. It should be noted, however, that the NRC Committee on the Assessment of Family Violence Interventions (National Research Council, 1998) found no conclusive evidence to date indicating that improving social networks and access to resources results in better parenting practices.

Another major focus of family support programs are child outcomes. Many evaluations include measures of child development—physical, psychological, and social. Other measures of child well-being, such as mental health, are common. Although they may have ameliorative effects on the risk of child maltreatment, many family support programs arise from a youth behavior or juvenile justice context, and so assessments of child conduct are common. Many behavior problems, from running away to substance use, may be at least partly the result of victimization, and may in turn lead to further family

breakdowns resulting in further maltreatment. Thus, measures of child aggression and conduct problems are appropriate for evaluations of tertiary prevention (or treatment) programs.

Whatever the outcomes chosen, careful planning is necessary. Evaluators should address validity issues, including reactions to the evaluation itself rather than the intervention, such as the common bias of participants to respond as they think the evaluator wants them to respond (e.g., “Sure I’m satisfied” or “Yes, I have been using the behaviors we were taught.”). Consideration of outcome measurement should begin very early in the program planning process. Similarly, planning for the evaluation itself should be integrated into program development. In this way, outcomes that are meaningful to all stakeholders, feasible, and valid may be chosen and incorporated. As evaluations begin to utilize common outcomes, this will result in ease of implementation (learning from previous efforts), comparisons across evaluations, agreement on impact of services and programs, and the readiness of the field to move from global evaluations to begin teasing out the interconnections among program characteristics and service levels, child and family factors, and future maltreatment.

Survey of Success in Family Preservation Programs within Alaska

Introduction

A brief snapshot of the state of the State in terms of successes of family preservations programs was conducted. The purpose of this survey was to obtain information about outcomes in selected programs. This early discussion of in-state programs can then be compared to a synthesis of national literature to begin to examine where the state stands in terms of evidence base and outcomes in family preservation and support services.

The cursory, snapshot nature of the examination of state programs should be noted. Three agency programs were surveyed in a non-random sample. One program each was surveyed from Anchorage, Fairbanks and Juneau. All surveys were performed by phone. Three open-ended questions were used to illicit information from respondents. They included:

- How do you define success in your program?
- How do you measure it?
- What do you think contributes to this success?

A standard script was used for each survey interview and is attached to this report. (See Appendix B.) In keeping with human subjects research guidelines, as reviewed by the UAA Institutional Review Board, subject were guaranteed that identifying information would not appear in any report. The insights provided by participating agencies are much appreciated. The purpose of this investigation was to get a beginning picture of the state of family preservation and support in Alaska, not to single out any particular agency. Recommendations will be given in general terms, applicable to all Alaska programs supporting families.

Results of Qualitative Data

Participants provided rich responses to the questions. In this section, these responses are organized around themes that collectively represent the participants’ insights. Each question will be discussed separately.

Question 1: How do you define success in your program?

- By client involvement
 - Amount of family participation
 - Completion of services
- Community support for client
- Developing and implementing case plans
- Work on relationships, parenting and concrete issues
- Improved family functioning skills
 - Coping
 - Self-confidence

Definitions of success for these programs seemed to rely more on process-related results (outputs) than outcome measures describing family changes. Grant requirements often dictate definitions of success in programs. One program was just converting from measuring staff productivity to measuring client outcomes, so outcomes being newly implemented in that program were discussed. In this discussion of success, there was one mention of using a standardized tool to assess improvement in functioning skills from before to after the intervention. One program mentioned the success of reunification of three families, but did not place this statistic in context with a time line or total number of families served.

Question 2: How do you measure it?

- Self-report client surveys
 - Satisfaction
- Community surveys
- Functional outcome measures
 - How many children remain in home, extended family or community
 - How many children stay out of state custody
- Pre- and post-assessment using self-developed or standardized tools
 - CWLA Family Assessment Form
 - North Carolina Family Assessment Scale
 - Improvement in coping skills
 - Increased confidence in skills
- Follow up visits
- Observations of family
- Referrals of children for early intervention
- Provide services to kids in school once problems are identified

- Progress on case plan

While responses to the first question indicated that little data was being gathered, these programs are in fact using a variety of means to gather process and outcome data. Two programs use standardized tests in a pre- and post-assessment to quantify their families' improvements. Success was measured in at least four different methods: standardized assessments conducted by or with staff, observation of the family, parental self-reporting, and follow-up visits with the family. Some of these measures are more long-term than others. For example, one measure of success was the extent to which children remained either with extended family, or at least in the community, when the parents were not able to have the children placed with them. Like staying out of state custody, this is a long-term outcome that may be affected by multiple factors beyond the family preservation or support program.

Question 3: What do you think contributes to this success?

- Outcomes-based data
- Focus on family
 - Buy-in from the client and family
 - Partner with the client to identify their needs
 - Clients will choose what they want to work on
 - Involve family in planning
 - Meet the parents where they are, in terms of their culture, community values, etc.
 - Also assist with housing, employment, childcare, etc.
 - Treat families with respect
 - Families are assessed fairly
- Clear expectations for families
- They are there of their own free will—they have choices
- Uses a needs assessment developed for American Indians in the lower 48 that identifies their strengths
- Design family service plans with Medicaid format (seeking reimbursement)
- Collaboration of family therapist and clinical associate
- Holistic approach with family
- Develop treatment plans with short-term goals that can be achieved
- Longer service time frame:
 - Provide therapeutic booster for families that slide back into bad behavior
 - One year follow up for reunified families

The programs attributed success to their family-centered focus. All programs valued the inclusion of the family and its support system in a treatment or intervention plan as necessary to achieve success.

Meeting the clients “where they are”, providing choices on the treatment plan, and actively seeking client involvement were identified as important to success. Two programs identified seeking resources outside the family—within the community—as important in holistically assessing and addressing the family’s needs for employment, housing, etc. Use of a culturally-sensitive strengths assessment by one program was identified as a key. One program is converting to a Medicaid model to seek reimbursement of services, and hopefully expand capacity with increased funds.

Discussion

This was a limited, focused review of three programs in the three largest cities in Alaska. No conclusions can be drawn from these results regarding urban versus rural issues, or comparison of programs. This review serves as a starting point to generate discussion of family preservation programs within Alaska.

There is no one model being used in the three programs surveyed, but similarities are evident. Each program values the inclusion of family and the community in working toward keeping families together. Each program seeks to strengthen family skills and provide supportive services to achieve equilibrium and provide a safe environment for children.

None of the programs provided quantitative data in defining their success, yet they all collect data in the form of client assessments or surveys. Some also seek feedback from the community. Standardized measurement tools are used in two programs to measure outcomes. The third program is just addressing client outcomes measurement. Follow-up is provided in one program following families for up to a year after reunification.

Further research should include a more in-depth review of program attributes and quantified outcomes to further define how each program achieves success. Any further study should be expanded to include more family preservation programs, or agencies that perform similar services with the goal of family reunification. Program managers and evaluators should be flexible in measuring success, as success may be defined as other than reunification with parents, especially in communities where extended families are normal and valued.

Conclusions and Recommendations

Conclusions

This report has attempted to review the implementation and evaluation of family preservation and support programs. These programs may be thought of as lying along a continuum of prevention, from primary prevention intended for the general population, to secondary prevention targeted at specific risk groups, to tertiary prevention or treatment for families with child protective service involvement who are at high risk of or have already experienced child removal. The focus has been on identifiable programs, packages of services that might be transported to individual communities in Alaska for replication by state government, tribal groups, or private agencies. In reality, it may not be possible to separate these levels of prevention at the community level, particularly in small communities. This blurring of preservation and support provides a broader evidence base from which to gather information on effectiveness of particular strategies and characteristics. As such, the terms family preservation and family support are often intermixed, with the understanding that what works well in family preservation may also work well with families who could be defined as being in need of family support, and vice versa. The current focus on particular programs also leaves infrastructure and service delivery

integration issues, such as family group conferencing or wraparound services, for consideration in other reports.

When discussing family preservation and support programs, there is something of an elephant in the room: the Homebuilders program. As perhaps the first established program of family preservation services, Homebuilders is beloved by some. As perhaps the most studied program, it is criticized by many. This single program illustrates the difficulties and intricacies of implementing and evaluating a family preservation and support program. Below are the highlights of the evaluation issues portrayed in this report relevant to Homebuilders and other kinds of family preservation and support programs.

Program focus: The goals of family preservation and support have increasingly grown beyond the issues of family stability and prevention of child maltreatment and placement. From enhancing child development to enhancing agency collaboration to improving family self-sufficiency, this expansion of promises may have served to help make these programs attractive to everyone, thus maintaining political support (Jacobs, 2001). It may also stretch resources, extending staff into areas in which they have little training and promising success with issues that might be better served by a more focused and experienced program. The lack of an explicit theory of change makes proving success difficult, and inconsistent attempts to address myriad outcomes makes comparisons among programs difficult (Jacobs, 2001; Kirk et al., 2002; NRC, 1998). Issues of program fidelity have often been cited to explain the mixed research findings regarding Homebuilders (Jacobs, 2001; Kirk, 2001; Kirk & Griffith, 2004; Kirk et al., 2002). Homebuilders aims to improve family functioning on the way to preventing maltreatment and child placement, and while mixed results have been found with the latter outcomes, positive findings have resulted in evaluations of the former (Alvarado et al., 2000; Westat et al., 2001).

Choice of outcomes to target: On the other hand, focusing on and, in particular, evaluating a single outcome can be detrimental. This single outcome is often child placement. Child removal depends on a variety of issues, including family characteristics, family context and support systems, community priorities, service quality and the family's relationship with service providers, policy changes, and political and media pressures, few of which may be under the control of the child welfare agency. Furthermore, program developers, managers, and evaluators often overlook short-term or mediating outcomes that might affect placement status in the long term (Jacobs, 2001; NRC, 1998). For each major population and intervention there needs to be a coherent theory of change to identify short-term outcomes known to affect long-term child outcomes. Most of the demonstrated effective programs in Table 2, and many of the others, focus on short-term outcomes in addition to child safety. Similarly, the programs in Alaska that contributed information for this report all focused on strengthening family skills thought to, over time, create and support a healthier environment for children.

At the same time, family preservation and support programs should set realistic expectations. Broad and lofty goals can lead to deep disappointment. In discussing Intensive Family Preservation Services such as Homebuilders, Kirk and colleagues (Kirk et al., 2002) noted the "need to be clear about the limitations of this intervention approach to addressing human needs and problems that have their roots in family poverty and other larger societal deficits" (p. 66). Few programs will have the resources to truly address and evaluate too many outcomes (Jacobs, 2001), thus necessitating careful and informed choices regarding short- and long-term outcomes.

Treatment time frames: Given that maltreatment and child placement are multiply determined, it should be no surprise that positive short-term treatment effects have been rarely found to sustain over time in the few evaluations that have conducted long-term follow-ups (Jacobs, 2001; Layzer et al., 2001; NRC, 1998). Kirk and Griffith (2004) associated this diminished effect over time with anecdotal practice

findings of the need for a “booster shot” of follow-up services. If we expect family services to have long-term effects on “problems that are pervasive, multiple, and chronic” (NRC, 1998, p. 102), it may be unreasonable to apply short-term interventions and brief periods of support with many families.

Lack of access to resources and support: Long-term follow-ups in treatment and evaluation cost money. Money is often connected with political support, and political support can vary for reasons that have little to do with informed decisions (Jacobs, 2001; see also Bjork’s [2000] discussion of the need to protect “the independence and integrity of scientific inquiry and publication” [p. 983]). The Homebuilders model dictates intensive services available at all times from staff with caseloads of two to four families. A social service agency facing budget shortfalls may be hard-pressed to dedicate such resources, and may choose to water down Homebuilders into a model that differs little from other family preservation service offerings.

The NRC (1998) noted that past evaluations of family preservation and support were often of poor quality. A major reason for this was that the evaluations “were not planned as part of the introduction of [the] program” (p. 60). Having an evaluation team involved from the beginning helps ensure that a competent evaluation can occur. Arriving later and trying to conduct an evaluation using existing data, often collected in inadequate management information systems (Jacobs, 2001), can be very difficult if not impossible. Competent evaluation should involve multiple measures collected at multiple points in time, including follow-up; standard measures of outcomes and explanatory variables; and appropriate comparison groups truly receiving different services (NRC, 1998), which may not be possible using 10% of a grant’s funding.

Treatment fidelity: Much has been made of the need for adhering to a program model in evaluations of that program (Jacobs, 2001; Kirk, 2001; Kirk et al., 2002; Kirk & Griffith, 2004). Many aspects of programs, however, must be adapted to particular communities and families, making absolute fidelity to current models difficult (Jacobs, 2001; Kirk et al., 2002). The interviews with three Alaska programs illustrated this flexibility and adaptation, as well as a limited focus on outcomes and evaluation. The field of family preservation and support research is young enough that little has been done to “unpack” the black box of services—to understand exactly what has been provided to whom, in what intensity over what duration” (Jacobs, 2001, p. 9; see also Kirk et al., 2002). While the family support meta-analysis (Layzer et al., 2001) is a notable exception, the field has not identified which characteristics are essential and which can be adapted to the particular situation. Evaluations documenting and validly measuring these program applications, population targeting, and contextual issues have been relatively rare (Kirk et al., 2002). For example, the family support meta-analysis (Layzer et al., 2001) started with over 900 research studies but could conduct the analyses on only 351 studies in the end-of-service outcomes dataset and 158 studies in the follow-up dataset. The small number of appropriate studies made analysis of differential treatment effects difficult or impossible for some outcome domains (e.g., economic self-sufficiency).

The meta-analysis and the NRC (1998) review both found short-term improvements in certain areas, sometimes with diminished long-term effects. Most effects, however, were not consistent across all programs, which varied widely in implementation, population targeting, and likely program fidelity. The meta-analysis found positive effects in the long- and short-term in the areas of child cognitive development, child safety, parent attitudes, and parent behavior. Interestingly, relatively strong positive effects were found only in the follow-up studies in the area of family economic self-sufficiency, indicating that evaluations of programs focusing on this area, such as Casey Family Program’s Powerful Families, should include a long-term follow-up component to allow families time to put their new skills to work in improving their financial situation.

No single effective model was identified: Individual program characteristics were not found to be linked to positive effects in all outcome areas. Some of the strongest effects noted in the meta-analysis were for programs with a focus on parent self-help or self-development, and programs that targeted specific populations, such as younger children or teen mothers. Programs that offer peer support, as well as those focused on parental self-development, appear to have positive effects on parents themselves and also “trickle down” effects on children.

The effects of providing case management services were not consistent, with programs that did not offer case management performing better as a group in the areas of child socio-emotional development and parent behavior. Case management was highly effective in promoting child safety, as were programs that offered opportunities for parent-child interactions to practice skills, programs serving mothers with young children, and those targeting teen mothers. Early intervention and support, before parents solidify bad parenting practices, appears to be key in promoting positive parenting and optimal child development.

While the meta-analysis found some positive effect for home visit programs, larger effects were found for programs that worked on a parent group model. The NRC (1998), in contrast, found that home visitation remained a promising intervention. This conclusion, however, was based largely on the extensive evaluation, including long-term follow-up, of the Nurse Family Partnership program developed in Elmira NY. As noted in Table 4, this was one of only eight programs that met criteria for demonstrated effectiveness in family preservation and support.

Common Components of Effective Programs

Although the demonstrated effective programs vary greatly in their targeted populations, settings, and service media, there are a great many similarities. In keeping with the results of the meta-analysis (Layzer et al., 2001), which found better results for programs not built around home visitation, many of the validated programs are primarily center-based. Many of them are conducted by universities or other agencies besides the governmental child welfare authority. Such agencies may provide more support for evaluation, thus explaining in part the validation of these interventions. Universities, medical or psychological clinics, and child advocacy agencies have historically had less of an adversarial relationship with families, as opposed to the often more invasive public CPS authority that can remove children from homes. This less adversarial relationship may in part explain the positive findings regarding these programs.

Each of the eight validated programs has some cognitive-behavioral component. For some, this involves basic education regarding child development or available resources, but many also focus on contingency management and other disciplining skills, cognitive reframing efforts, and modeling of positive parenting. Opportunities for parents to practice new skills with children are common, in keeping with the strong positive effect of parent-child activities noted in the meta-analysis. The Strengthening Families and Dare to be You programs specifically include incentives for compliance with the program.

Table 4: Guide to demonstrated effective family support and preservation programs

Program	Prevention level^a	Cultural competence	Home- or center/ community-based	Contact information
Dare to be You	1	Multicultural focus; tested with Native American, Asian and Pacific Islander, Hispanic, and African-American groups	Community-based: developed at university center, designed to be portable to any agency	Jan Miller-Heyl, Dare to be You Program, Colorado State University Cooperative Extension
Family Connections	2	Replications outside of Baltimore currently under way	Community-based, with some in-home services	University of Maryland School of Social Work
Incredible Years	2 & 3	Multicultural focus, including materials in Spanish	University center; children receive some services at school	Carolyn Webster-Stratton, University of Washington; incredibleyears.com
Michigan Families First	3	Previous applications in primarily urban/suburban settings, although 10 Indian reservations are served	In home or by telephone; state-contracted private providers	http://www.michigan.gov/dhs/0,1607,7-124-5439-15373--,00.html
Nurse Family Partnership (formerly Nurse Home Visitor Program)	2	'Culturally relevant'; previous applications in urban setting	Home visitation	Ruth O'Brien, Kempe Prevention Research Center for Family and Child Health, Denver
Parenting Wisely	1 & 2		Computer-based, in center or at home	Donald Gordon and colleagues, Ohio University; familyworksinc.com
Strengthening Families	1 & 2	Evaluated versions for African American, Hispanic, Asian/Pacific Islander, & Native American populations; also a rural modification	Center	K.L. Kumpfer, University of Utah
Trauma-focused cognitive-behavioral therapy for sexually abused children	3		Center, office, or school	

^a 1 = primary, universal, 2 = secondary, selective, 3 = tertiary, indicated

Three of the eight, Incredible Years, Family Connections, and Strengthening Families, specifically include a peer or social support component. (Trauma-focused cognitive-behavioral therapy may also be conducted in a group setting.) The NRC (1998) found no clear evidence that expanding social networks and use of community resources results in better parenting, and the meta-analysis (Layzer et al., 2001) found no positive effects associated with having social support as a primary program goal. In contrast, the meta-analysis did find many positive effects for programs providing peer support. These programs often have parent self-development and/or child safety as a goal.

Review of the entries in Table 2 reveals that little evaluation research has been conducted with rural populations, even less with Alaskan Native or American Indian populations. The Strengthening Families program is unique in that it has version that has undergone validation for Native American populations, and a rural modification. Dare to be You has also been evaluated in rural areas and with Native families, but specific validation is not clear. Parenting Wisely is unique in that it is the only demonstrated effective program built specifically for distance delivery. It has also been shown to be effective with families with limited skills in reading English. Some programs, including Incredible Years and Nurse Family Partnership, are noted to have some unspecified level of cultural competence. Details regarding use with Native groups were not found. Strengthening Multi-Ethnic Families and Communities appears promising in that it has been implemented with Native groups (and has materials in several Asian languages as well as Spanish and Russian), but little evaluation of that program has been completed. Similarly, NICWA's development of family support and family preservation materials offers obvious benefits for implementing culturally sensitive services, including incorporation of extended families, cultural traditions and reconnection, and longer service provision, but these efforts have not been tested scientifically. This is one area where Alaska programs may be ahead of the curve, as the three programs discussed all make efforts to incorporate and reach out to extended families and the community.

Finally, many of the programs in Table 2 focus on or are involved with schools. Often, the school is an ideal setting for such programs, as the child is familiar with the building, the parent knows where it is, and there are rooms available. Interventions including trauma-focused cognitive-behavioral therapy, multisystemic family treatment (MST), and Effective Black Parenting may take place in a school. Incredible Years and Resilient Peer Training (RPT) reach children directly in schools, while Circle of Security and Families & Schools Together (FAST) serve parents in the school setting. Incredible Years, FAST, and Dare to be You focus specifically on improving parent-teacher interactions.

Recommendations

The family preservation and support literature indicates that, under certain conditions, services can have positive short-term outcomes that sustain for years, producing healthy families. Considering the financial costs to the public of foster care and the psychological and developmental costs to children of child maltreatment and placement, such programs are a worthy pursuit. But in a context of limited funding, careful choices must be made regarding program choice and allocation of resources. At times, personal preference and media pressures work against evidence-based programming decisions. Families exist amid myriad influences that impinge upon their ability to remain healthy and functional, including the sociopolitical context, poverty, addiction and mental health, and the coordination, availability, variability, and brevity of services (Jacobs, 2001; NRC, 1998).

Some of the impetus for over-promising results from family preservation, or home visiting, or family support, or even community-based child protection initiatives is that, as a society, we care so little for poor children that we refuse to invest in them without the "hype." We want to yield extraordinary benefits at a bargain

price, and we want scientists to validate that we got a good value. We don't want to confront poverty directly—that would require fundamental, structural changes— so we approach it weakly and obliquely—through social services of one type or another. But all these programs are sorely constrained in their bids for effectiveness until we make a decision truly to invest in these families and children (Jacobs, 2001, p. 15).

This report has attempted to compile and summarize the literature regarding family preservation and support programs to help guide investments in such interventions. Although more effort is necessary to describe and delineate the characteristics and successes of Alaskan programs, some comparisons have been made. While little is known about the success of Alaskan programs, they appear to have good characteristics that are linked with success, including being family-centered and flexible, with a focus on achievable short-term objectives as well as longer service provision. Some of the national interventions appear to be quite applicable to Alaska, and at least one validated program, Parenting Wisely, is already in use. Further recommendations (with supporting pages in the text referenced in brackets) include:

- For Alaskan communities, the “family” in family preservation needs to be broad and inclusive of kinship care as well as care within a child's own community, not strictly in the sense of traditional nuclear families. {pp. 13, 45-47}
- Encourage all family preservation and support programs to include the “family” (broadly defined) and community in planning and decision making from the beginning of case referral and throughout case management efforts. {pp. 12-13, 35-36, 47-48}
- The Nurse Family Partnership may be effective in large part due to the relationship that is established between service provider and family. Efforts should be made to work with families in an effort to counteract the traditionally adversarial relationship that agencies, particularly state CPS agencies, may have with families. This is especially important in native communities. To that end, further investigation into the philosophical and infrastructural practices specifically not covered in this paper, such as family group conferencing, as well as public relations and outreach efforts, is warranted. {pp. 5, 11-13, 15, 46-47}
- Encourage and support follow-up services for families beyond the typical treatment episode. Chronic problems may not be alleviated with six weeks of intervention, no matter how intensive, and any short-term behavioral changes may be overwhelmed by the on-going context of the family. Consider implementing automatic “booster shots” to support families in their new-found skills and to further their success. {pp. 11-12, 34-36}
- Encourage a culturally relevant, strength-based approach to services, and at the same time, define what each program means by these terms, how they are measuring presence of these attributes, and what results they are achieving. This will boost legitimacy of these approaches and provide information that may be helpful across agencies and communities. {pp. 12-13, 34-47}
- Agencies need to find ways to capture, synthesize, share, and feed back the evaluative data that they are collecting haphazardly or anecdotally. Also, the state of Alaska Office of Children's Services needs to set guidelines for the kind of outcome data they wish their grantees to collect so that there can be a synthesis of state-wide outcome reports. This would assist the state in documenting progress toward achieving the goals set in their Federal Performance Improvement Plan. {pp. 34-47; see also Appendix A}

- Provide training on evaluation strategies, including setting realistic outcomes and accurate indicators of those outcomes, as well as how to track progress to those outcomes and analyze data collected. One road to helping ease and standardize this process may be to use the Family to Family self-evaluation tools that are being developed for use in the Anchorage Office of Children’s Services to capture data in local communities (Family to Family Self-Evaluation Committee, personal communication, Travis Erickson, Children’s Services Manager, Anchorage Region, 9/30/04). Use this as a possible model to measure community-based aspects of community support and/or preservation. {pp. 12, 33-45; see also Appendix A}
- Ideally, the goals of family preservation and support—family stability and child safety—will hold over the long-term. Traditionally, however, programs only seek out results for the funding cycle or during the first six months of treatment. Family preservation and support research shows that the impact of services may not be apparent until a year or more after treatment. This is especially pertinent when a program is attempting to impact child safety as well as family economic self-sufficiency, as in the Powerful Families program being implemented in Alaska. {pp. 10-12, 43, 45-46}
- Choose validated or criterion-referenced measures, where possible, to document process and outcome variables. This strengthens the evaluation and the combined research base, provides improved feedback to funders, and improves communication and program transfer, and may inherently improve clinical decision-making through incorporating better information. Table 3 (pp. 40-43) lists suggested outcomes and indicators, which are further described in Appendix A. {pp. 56-70}

References

- Alaska Native Health Board (with the Southcentral Foundation Wellness Warriors Initiative). (2002). *Tribal definitions of domestic violence and child abuse*. Anchorage AK: Authors.
- Alvarado, R., Kumpfer, K.L., Kendall, K., Beesley, S., & Lee-Cavaness, C. (Eds.). (2000). *Strengthening America's families: Model programs for substance abuse and delinquency prevention*. Washington DC and Rockville MD: Office of Juvenile Justice and Delinquency Prevention and Center for Substance Abuse Prevention.
- Barbell, K., & Freundlich, M. (2001). *Foster care today*. Washington DC: Casey Family Programs.
- Bjork, R.A. (2000). Independence of scientific publishing: Reaffirming the principle. *American Psychologist*, 55, 981-984.
- Blythe, B., & Jayaratne, S. (1999). *Michigan Families First Effectiveness Study*. Retrieved 15 September 2004. <http://www.michigan.gov/dhs/0,1607,7-124-5439-21887--,00.html>
- Bor, W., Sanders, M.R., & Markie-Dadds, C. (2002). The effects of the Triple P-Positive Parenting Program on preschool children with co-occurring disruptive behavior and attentional/hyperactive difficulties. *Journal of Abnormal Child Psychology*, 30, 571-587.
- Briere, J.N. (1992). *Child abuse trauma: Theory and treatment of the lasting effects*. Newbury Park CA: Sage.
- Casey Family Programs. (2004). *Parent to Parent evaluation summary: Pilot run report*. Seattle: Author.
- Casey Family Programs. (2005). *Powerful Families pilot report update: Summary of Evaluation Results from Cycles 1 (April through June 2004) and 2 (July 2004 through January 2005)*. Seattle: Author.
- Chalk, R., Gibbons, A., & Scarupa, H.J. (2002, May). The multiple dimensions of child abuse and neglect: New insights into an old problem. *Child Trends Research Brief*.
- Committee on the Assessment of Family Violence Interventions, National Research Council and Institute of Medicine. (1998). *Violence in families: Assessing prevention and treatment programs* (R.A. Chalk & P.A. King, Eds.). Washington DC: National Academy Press. Retrieved 20-28 May 2004 from <http://books.nap.edu/books/0309054966/html/1.html>
- Halverson, K., Puig, M.E., & Byers, S.R. (2002). Culture loss: American Indian family disruption, urbanization, and the Indian Child Welfare Act. *Child Welfare*, 81, 319-336.
- Johnson, M., & Wells, S. (2000). *Measuring success in child welfare: A National Study of Outcome Measurement in Public Child Welfare Services: Results and recommendations: Measuring child and family functioning*. Urbana: University of Illinois at Urbana-Champaign Children and Family Research Center. Retrieved 3 May 2004 from <http://cfcrcwww.social.uiuc.edu/pubs/Natl.Surv/pdfs/func.pdf>
- Kirk, R.S. (2001). *A critique of the Evaluation of Family Preservation and Reunification Programs: Interim Report*. Buhl ID: The National Family Preservation Network, Inc. Retrieved 1 September 2004 from <http://www.nfpn.org/tools/articles/critique.php>
- Kirk, R.S., Reed-Ashcraft, K., Pecora, P.J. (2002) Implementing intensive family preservation services: A case of infidelity. *Family Preservation Journal*, 6(2), 59-81.

- Kirk, R.S., & Griffith, D.P. (2004). Intensive family preservation services: Demonstrating placement prevention using event history analysis. *Social Work Research, 28*, 5-16.
- Layzer, J.I., Goodson, B.D., Bernstein, L., & Price, C. (2001). *National evaluation of family support programs: Final report volume A: The meta-analysis*. Cambridge MA: Abt Associates.
- National Indian Child Welfare Association. (no date). *Module IV: Family-centered services for Indian children* (Curriculum Materials, No. 09). Retrieved 9 September 2004 from <http://www.nicwa.org/resources/catalog/curriculum/index.asp>
- Peregoy, J.J. (n.d.). Working with American Indian/Alaskan Native clients: Perspectives for practitioners to start with. In Wellfeld, E. (Ed.), *The handbook of counseling: A desk reference*. Upper Saddle River NJ: Merrill. Manuscript submitted for publication.
- Red Horse, J.G., Martinez, C., Day, P., Day, D., Poupart, J., & Scharnberg, D. (2000). *Family preservation: Concepts in American Indian communities*. Seattle: Casey Family Programs.
- Thomas, D., Leicht, C., Hughes, C., Madigan, A., & Dowell, K. (2003). *Emerging practices in the prevention of child abuse and neglect*. Washington DC: US Department of Health and Human Services Office on Child Abuse and Neglect.
- Thomlison, B. (2003). Characteristics of evidence-based child maltreatment interventions. *Child Welfare, 82*, 541-569.
- Westat, Inc., Chapin Hall Center for Children, & James Bell Associates. (2001). *Evaluation of family preservation and reunification programs: Interim report*. Washington DC: US Department of Health and Human Services. Retrieved 25 May 2004 from <http://www.aspe.hhs.gov/hsp/fampres94/>

Appendix A: Summaries of Measures Included in Table 3

Adolescent Concerns Evaluation (ACE): The ACE assesses the relative risk of running away, reportedly with very good reliability and validity. Few, if any, other instruments measure this construct. The ACE has 40 items completed by the youth in question.

Original source: Springer, D.W. (1998). Validation of the adolescent concerns evaluation (ACE): Detecting indicators of runaway behavior in adolescence. *Social Work Research*, 22, 241-250.

Available from David Springer, University of Texas at Austin, School of Social Work, Austin TX 78712-1203.

Adult-Adolescent Parenting Inventory (AAPI-2): The AAPI assesses parenting and child-rearing strategies to indicate risk of maltreatment. Subscales in the AAPI are 1) inappropriate developmental expectation, 2) lack of empathy toward child, 3) beliefs about corporal punishment, 4) reversing parent-child roles, and 5) oppressing children's power and independence. It is a short instrument, now comprising 40 statements (after a recent revision) to which the parent indicates his or her level of agreement. This generally takes approximately 20 minutes. The instrument is written at a 5th grade level, or can be read to non-readers. Reliability is much improved in the new version and can be considered good to very good for all subscales. Validity is reported to be very good. There are alternate versions to reduce practice effects in pre-post evaluations. It is frequently used in evaluations of family support and preservation programs, including the current national replication of the Family Connections program (see nccanch.acf.hhs.gov/topics/prevention/emerging/family.cfm).

Original reference: Bavolek, S.J., Kline, D., & McLaughlin, J. (1979). Primary prevention of child abuse: Identification of high risk adolescents. *Child Abuse and Neglect*, 3, 1071-1080.

Computer administration and scoring available.

Available from Family Development Associates at www.nurturingparenting.com/aapi/aapi2.htm.

Alcohol Use Disorders Identification Test (AUDIT): The AUDIT is a newer, shorter, self-administered alcohol problems screen, with 10 items that measure current (past 12 months) drinking behavior. Some of the items do ask about lifetime issues. It was developed by the World Health Organization, based on the International Classification of Diseases, and has undergone a recent revision. Some research suggests that the AUDIT performs better than the MAST (at least the BMAST), including across different cultures, although some adjustment of cut-off scores may be necessary with different groups. It has two scales, called the Core Instrument (for early detection of harmful drinking) and the Clinical Instrument (for identification of dependency). Some research has suggested that the first three items, together called AUDIT-Consumption (AUDIT-C), may actually have slightly better validity in detecting hazardous drinking and/or abuse or dependence among women.

Original reference: Saunders, J.B., Aasland, O.G., Babor, T.F., de la Fuente, J.R. and Grant, M. (1993). Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption II. *Addiction*, 88, 791-804.

Available in the manual at whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf, or separately at www.projectcork.org/clinical_tools/pdf/AUDIT.pdf.

Ansell-Casey Life Skills Assessment (ACLSA): The ACLSA is a free tool for assessing youth readiness for independent living, developed with input from foster parents and youth in foster care. There are versions for different age groups, plus a 20-item short form, each available in youth and caregiver report form (except for the young adult version). Acquired knowledge of life skills is assessed across four to six domains, depending on the age level of the child (and thus the form used): daily living tasks (food storage, washing clothes, etc.), housing and community resources (obtaining housing, knowledge of social service agencies, etc.), money management (bills, budgeting, etc.), self-care (health and safety skills), social development (positive interactions, assertiveness, etc.), and work and study habits (job interviews, double-checking work, etc.). The long versions of the ACLSA take approximately 20 to 40 minutes to complete, depending on the reading ability of the person completing it, and their Internet connection—it is possible to print out the assessment for non-computer administration, but the results must be entered on-line to obtain scoring. All but the youngest child version include multiple choice “performance” items, which act as something of a reliability check against the reported knowledge/ability items that make up the bulk of the assessment. Reliability is moderate to very good for the individual domains, and good to very good for the total scores, particularly in the older versions. The manual includes benchmark comparison groups divided by age and gender, the latter being important because females tend to score higher than males. Better norms are currently under development. Preliminary validity work is promising, with more studies currently under way.

Original reference: Nollan, K.A., Pecora, P.J., Downs, A.C., Wolf, M., Horn, M., Martine, L., & Lamont, E. (1997). Assessing life skills of adolescents in out-of-home care. *International Journal of Child and Family Welfare*, 2, 113-126.

Available for free at www.caseylifeskills.org.

Bayley Scales of Infant Development: Often used in both research and clinical settings (including evaluations of family preservation and support programs), the Bayley Scales assess the mental and psychomotor development and behavior of young children. New version extends the age range from 1 to 42 months (versus 25 months with the original). Unlike many intelligence tests for preschool age children, the Bayley works well even at the lower end of the range of recommended ages. Reliability and validity are very good. The Bayley Scales have norms for various risk groups (Down’s Syndrome, premature, etc.). Administration takes approximately 15 to 25 minutes for children under 15 months, and up to 60 minutes for children 15 months and older, depending on the child’s level of attention and/or impairment. A newer version that will add more domains to the assessment and extend the age range down to 15 days is under development.

Available from Psychological Assessment Resources at www.parinc.com/product.cfm?ProductID=396.

Also available from PsychCorp at marketplace.psychcorp.com.

Beck Anxiety Inventory (BAI): Although a more recently developed instrument than the Beck Depression Inventory, the BAI has also been used with great frequency in clinical and research settings. It has displayed very good reliability and validity, including the ability to differentiate anxiety from depression. Its 21 items assess the physiological and cognitive components of anxiety, covering subjective, somatic, or panic-related symptoms. It has been used with Native Americans, but no reports of validation with Alaskan Native samples could be found. Although designed for ages 17 and above, the BAI has exhibited preliminary evidence of good reliability and validity in younger adolescents.

Original reference: Beck, A.T., Epstein, N., Brown, G., Steer, R.S. (1988). An inventory for measuring clinical anxiety: Psychometric properties. *Journal of Consulting and Clinical Psychology*, 56, 893-897.

Available from PsychCorp at marketplace.psychcorp.com.

Computer and scannable scoring available.

Beck Depression Inventory (BDI-II): The BDI is one of the most widely used assessments of depressive symptoms, having been validated with groups ranging from unemployed Finns to sufferers of chronic lower back pain to Egyptian depressive inpatients to Native Americans. The current version, the BDI-II, has 21 items that were adjusted to correspond more closely with the *Diagnostic and Statistical Manual of Mental Health Disorders—Fourth Edition* (the DSM-IV) and to address some earlier criticism of individual items. It has very good reliability and validity. It takes 5 to 10 minutes to complete, by self-report or by a trained administrator. Although the instrument is written at a 5th grade reading level and the age range is given as low as 13, the CDI may be a better choice for children under 15. There is also a short form, the BDI-FastScreen for Medical Patients, that focuses on the affective and cognitive symptoms of depression (i.e. it does not include somatic and behavioral items from the BDI).

Available from PsychCorp at marketplace.psychcorp.com.

An older version of the BDI can be reviewed at www.health.umd.edu/mentalhealth/Beck.pdf. (Note that, due to copyright laws, the linked file cannot be used.)

Computer and scannable scoring available.

Child Abuse Potential Inventory (CAPI): Oft-used instrument designed to discriminate between potentially abusive parents and non-abusive, on the basis of personality and other characteristics of known abusers. Many examples of validation across cultures, although scores reportedly vary by nationality, SES, and other characteristics. The 160-item instrument takes 12 to 20 minutes to complete, and is written at a 3rd grade level. The CAPI has very good reliability and validity, and includes a validity scale to detect response distortion.

Original source: Milner, J.S., & Wimberley, R.C. (1979). An inventory for the identification of child abusers. *Journal of Clinical Psychology*, 35, 95-100

Published by Psytec, Inc., P.O. Box 564, DeKalb, IL 60115.

Computer scoring available.

Child and Adolescent Functional Assessment Scale (CAFAS): Assesses role performance, cognitions, behavior toward others and self, moods and emotions, and substance use of children in grades one through 12, as well as caregiver needs and support. There is a separate version for younger children. The basic instrument is completed in approximately 10 minutes by a case worker who rates the youth's level of difficulty/disruption. If further information is needed, there is a supplemental 30 minute phone interview (presumably conducted with the family). It is sensitive to improvements in poor functioning, but not to changes above average functioning. Some studies report no differences across ethnic groups, though one study noted slightly higher (more severe) scores for Caucasians and children from low income families. Research has demonstrated acceptable reliability and good validity, particularly in the updated version.

Original source: Hodges, K., Kline, J., Stern, L., Cytryn, L., & McKnew, D. (1982). The development of a child assessment interview for research and clinical use. *Journal of Abnormal Child Psychology*, 10, 173-189.

Published by Kay Hodges, Functional Assessment Systems LCC, 2140 Old Earhart Rd, Ann Arbor MI 48105.

Computer scoring available.

Child Behavior Check-List (CBCL): Widely used screener for behavioral and emotional problems, in parent (including a version for young children, ages two to three), teacher, and child and young adult self-report forms. The multiple variations take approximately 15 to 20 minutes to complete. Although they generally show good to very good reliability and validity, this is less true of the individual problem scales, and most clinicians and researchers use only the Internalizing Problems, Externalizing Problems, and Total Problems scores. Many also use the Social Competence scale. The tremendous volume of research utilizing the CBCL includes many studies of family support programs, including the Family Connections replication.

Published by the ASEBA Research Center for Children, Youth, and Families, 1 S Prospect St, Burlington VT 05401-3456.

Information on obtaining forms and computer and Web-based administration and scoring is available at www.ASEBA.org.

Children's Depression Inventory (CDI): Widely used in both research and practice, the CDI is a short (15 minutes or less) screener to assess the severity of depressive symptoms, that can be administered individually, in group, or via self-report. It has five empirically-validated factors, normed by gender and age: negative mood, interpersonal problems, ineffectiveness, anhedonia (enjoyment), and negative self-esteem. There is also an empirically-derived Short Form that uses 10 of the original 27 items. The CDI can be used with children ages 7 to 17, and has a reported first grade reading level. There is a parent version, the P-CDI, in which the parent indicates how he or she thinks the child feels. The 17 items on the P-CDI result in two factors, emotional problems and functional problems. There is a new teacher report version that is similar to the P-CDI but shorter (12 items).

Original source, CDI: Kovacs, M. (1980/1981). Rating scales to assess depression in school-aged children. *Acta Paedopsychiatrica*, 46, 305-315.

Original source, P-CDI: Garber, J. (1984). The developmental progression of depression in female children. In D. Cicchetti & K. Schneider-Rosen (Eds.), *New directions for child development* (pp. 29-58). San Francisco: Jossey-Bass.

Available from Multi-Health Symptoms, www.mhs.com.

Computer scoring available.

Child Well-Being Scales: Originally developed in 1986 for the Child Welfare League of America, these scales assess 43 dimensions (in 43 items) of the unmet physical, psychological, and social needs of the child, as rated by the social worker. The scales garnered criticism in their original form. Gaudin, Polansky, and Kilpatrick (1992) demonstrate good reliability and validity for their subset of 23 items, with good ability to differentiate between families with verified neglect and SES-matched control families. The scales are being used in the national Family Connections project, although it is not known whether the researchers are using the original version or the 23-item version.

Original source: Magura, S., & Moses, B.S. (1986). *Outcome measures for child welfare service*. Washington DC: Child Welfare League of America

Available from the CWLA at www.cwla.org/pubs/pubdetails.asp?PUBID=3062

Use items designated in Gaudin, J.M., Jr., Polansky, N., and Kilpatrick, A.C. (1992). The Child Well-Being Scales: A field trial. *Child Welfare, 71*, 319-328.

CRAFFT: Constructed from parts of a variety of previous measures, the CRAFFT (the name refers to the subject matter of the six items: Car, Relax, Alone, Forget, Family/Friends, and Trouble) is a screen for both alcohol and drug use. Typically used with adolescents, it may be appropriate for use with young parents in Alaska. The CRAFFT has demonstrated good to very good reliability and validity in a variety of samples, particularly American Indian and Alaskan Native groups.

Original reference: Knight, J. R., Shrier, L. A., Bra Vender, T. D., Farrell, M., Vander Bilt, J., & Shaffer, H. J. (1999). A new brief screen for adolescent substance abuse. *Archives of Pediatrics & Adolescent Medicine, 153*, 591-596.

Available at www.projectcork.org/clinical_tools/html/CRAFFT.html.

Daily Discipline Interview (DDI): A telephone interview regarding discipline practices, the DDI was born out of Carolyn Webster-Stratton's lengthy work on parent education and support. It has exhibited moderate to good reliability and good validity.

Original reference: Webster-Stratton, C., & Spitzer, A. (1991). Development, reliability, and validity of the daily telephone discipline interview. *Behavioral Assessment, 13*, 221-239.

Available from the University of Washington Parenting Clinic at www.son.washington.edu/centers/parenting-clinic/forms.asp.

Drug Abuse Screening Test (DAST): Designed to parallel the items in the MAST, the DAST is a widely-used measure of the severity of problems related to drug misuse. Originally a 28-item scale, it now appears to be most often used in a 20-item version. There is also a 10-item short version. The DAST (including the DAST-10) has exhibited very good reliability and good validity in a variety of contexts. It does, however, appear to be more susceptible to denial/lying, so gathering data in absolute confidentiality (if not anonymity) is paramount. Adding to the measure's validity, the DAST has been found to measure a different underlying construct than the MAST (i.e. they do not merely measure tendencies towards addiction).

Original reference: Skinner, H.A. (1983). The Drug Abuse Screening Test. *Journal of Addictive Behaviors, 7*, 363-371.

The 20-item DAST is available in *Measures for clinical practice* (Corcoran & Fischer, 2000).

DAST-10 also available in Corcoran and Fischer (2000), who list items from the larger instrument that should be used in the short form.

Emotional Availability Scales: Given the complexity of assessing attachment using the Strange Situation (see below), researchers (and clinicians) have turned to other measures that may assess closely related constructs. The Emotional Availability Scales measure emotional openness and communication between the parent and the child through observation of their interaction. They have exhibited excellent correlation with Strange Situation results in different cultural contexts. The current revision (the 3rd) has four parent scales (Maternal Sensitivity, Structuring, Nonintrusiveness, and Nonhostility) and two child scales (Child Responsiveness and Child Involvement).

Primary reference: Biringen, Z., Robinson, J. L., & Emde, R. N. (2000). Appendix B: The Emotional Availability Scales (3rd ed; an abridged Infancy/Early Childhood Version). *Attachment and Human Development*, 2, 256-270.

Manual: Biringen, Z., Robinson, J., & Emde, R. N. (1998). Emotional Availability Scales (3rd ed.). Unpublished manual, Department of Human Development and Family Studies. Colorado State University, Fort Collins, CO.

A modification of the EAS has been implemented by the National Center for American Indian and Alaska Native Mental Health Research. See www.uchsc.edu/ai/ncaianmhr/pastrsch/cmstnprj.htm.

Environmental Assessment Index (EAI): Partially based on the original Home Observation for Measurement of the Environment (see below), the EAI is a structured home observation instrument comprised of 44 yes/no questions, 26 of which can be completed via interview or observation. When the 26 items are done as an interview, the entire EAI takes approximately 60 minutes to complete. It is designed for use regarding children ages 3 to 11. Like the HOME, it assesses developmental and educational support for the target child in the physical and social home environment. It has shown good reliability and very good validity, with early psychometric tests (the primary reference below) conducted with 62 rural homes with children.

Primary reference: Poresky, R.H. (1987). Environmental Assessment Index: Reliability, stability, and validity of the long and short forms. *Educational & Psychological Measurement*, 47, 969-975.

Available in the primary reference above or in *Measures for clinical practice* (Corcoran and Fischer, 2000).

Family Adaptability and Cohesion Evaluation Scale (FACES): The Circumplex Model of family functioning holds that there are three dimensions of family functioning: cohesion, adaptability, and communication. The three versions of FACES are designed to measure two of these dimensions. The first version displayed good reliability but relatively weak validity, and the reading level of its 111 items precluded use with younger children. FACES-II lowered the reading level (targeted for ages 10 and above) and the burden (30 items), with good reliability and fairly good validity. FACES-II was normed with a large, randomly drawn national survey and has been used with diverse populations (although no report of use or research on native populations). The development of FACES-III was undertaken to improve one aspect of the validity of the instrument. FACES-III has 20 items that are responded to twice, for the perceived and the ideal family. By reducing the number of items, the internal consistency reliability was also unfortunately reduced. It was normed on a large sample of varied families, and has cutting scores to categorize families into four levels on each of the two dimensions (producing 16 family types). There has been some indication that FACES-III affected by ethnic factors, gender, poverty, and education. It is recommended that researchers use FACES-II due to its better overall reliability and validity, while clinicians should use the shorter FACES-III.

Original reference, FACES-I: Olson, D.H., Bell, R., & Portner, J. (1978). *FACES: Family Adaptability and Cohesion Evaluation Scales* (manual). St. Paul MN: University of Minnesota Department of Family Social Science.

Original reference, FACES-II: Olson, D.H., Russell, C.S., Sprenkle, D.H. (1983). Circumplex Model of marital and family systems: VI. Theoretical update. *Family Process*, 22, 69-83.

Original reference, FACES-III: Olson, D.H., Portner, J., & Lavee, Y. (1985). *FACES III*. St. Paul MN: University of Minnesota Department of Family Social Science.

Available from David Olson, Family and Social Science, University of Minnesota, 290 McNeal Hall, 1985 Buford Ave, St. Paul MN 55108.

Family Emotional Involvement and Criticism Scale (FEICS): A 14-item measure that assesses emotional involvement and perceived criticism, two aspect of expressed emotion (EE). EE is a construct involved with mental illness, particularly found in the schizophrenia spectrum disorders literature. Higher criticism scores, for example, are associated with increased health care visits. Reported reliability and validity are good.

Original source: Shields, C.G., Franks, P., Harp, J.J., McDaniel, S.H., & Campbell, T.C. (1992). Development of the Family Emotional Involvement and Criticism Scale (FEICS): A self-report scale to measure expressed emotions. *Journal of Marital and Family Therapy*, 18, 395-407.

Available from Cleveland Shields, Family Medicine Center, 885 South Ave, Rochester NY 14620.

Family Support Scale (FSS): Originally developed (and normed) on families of children experiencing or at risk of developmental delay, with 60% of the families from low SES, the FSS measures the number of social supports, the satisfaction with existing support, and the degree of helpfulness perceived by the parent(s). Further psychometric analysis has been conducted with similar samples. The FSS is a short instrument whose 18 items demonstrate good to very good reliability. There are indications of good validity.

Original source: Dunst, C.J., Trivette, C. M., & Cross, A.H. (1986). Mediating influences of social support: Personal, family, and child outcomes. *American Journal of Mental Deficiency*, 90, 403-417.

Available: Dunst, C.J., Trivette, C.M., & Hamby, D.W. (1994). Measuring social support in families with young children with disabilities. In C.J. Dunst, C.M. Trivette, & A.G. Deal (Eds.), *Supporting & strengthening families, Vol. 1: Methods, strategies and practices* (pp. 152-160). Cambridge, MA: Brookline Books; or from Carl Dunst, Family, Infant, and Preschool Program, Western Carolina Center, 300 Enola Rd, Morganton NC 28655.

Functional-Dysfunctional Impulsivity Scale: This scale, also known as the Dickman Impulsivity Inventory, measures two types of impulsivity with moderately good reliability and validity. The instrument has shown great stability in its functioning in different countries and different languages, although to date this has been limited to European countries, Australia, and the US. It is a short assessment, with 23 true-false (or “like me/not like me”) items, and is written at approximately a 6th grade reading level.

Primary reference: Dickman, S. J. (1990). Functional and dysfunctional impulsivity: Personality and cognitive correlates. *Journal of Personality and Social Psychology*, 58, 95-102.

Available from the reference above.

General Health Questionnaire (GHQ): The GHQ is a self-administered screener for general psychological distress. It has been studied extensively, with some research showing it to be better than the BDI in screening for major depression. There are 60-item, 30-item, 28-item, and 12-item versions.

The 60-item GHQ is the full version, screening for non-psychotic mental health diagnoses in full detail and with the most precision of the GHQ versions. The 30-item version eliminates items relating to physical illness. The 28-item version has four empirically-validated subscales: anxiety/insomnia, social dysfunction, severe depression, and somatic complaints. Finally, the 12-item screener is good for researchers wanting a single measure of overall distress. All have been translated into several languages. The User's Guide provides guidance for researchers intending to set up their own localized validation studies. Although designed for adults, several studies have used the GHQ with adolescents. Results of validity studies with adolescents, however, have been mixed.

Available from nferNelson at www.nfer-nelson.co.uk/catalogue/catalogue_detail.asp?catid=98&id=1124.

The GHQ-12 can be reviewed at [www.workhealth.org/UCLA OHP class 2004/GHQ and scoring.pdf](http://www.workhealth.org/UCLA_OHP_class_2004/GHQ_and_scoring.pdf).

Home Observation for Measurement of the Environment (HOME): The HOME is a structured instrument for gathering useful data via home observation about sources of cognitive stimulation, and has been used in a variety of research and clinical settings. It is completed by the visiting observer in 45 to 90 minutes, including the parent interview at the beginning that helps to put the primary caregiver at ease before the observation begins. The HOME has exhibited good sensitivity to change from parent education and early intervention programs, is being used in the national Family Connections replication, and has been incorporated into the National Longitudinal Survey of Youth. It has also been shown to be predictive of developmental delay and performance on intelligence tests, and thus can be used as a short-term marker of a long-term outcome. There are four major versions:

The infant-toddler HOME-IT, the first version developed, has 45 items in six subscales (Parental Responsivity, Acceptance of Child, Organization of the Environment, Learning Materials, Parental Involvement, and Variety in Experience).

Original reference: Caldwell, B., Heider, J., & Kaplan, B. (1966, September). *Inventory of Home Stimulation*. Paper presented at the annual meeting of the American Psychological Association, New York.

The early childhood HOME-EC, for ages three to six, has 55 items in eight subscales (Learning Materials, Language Stimulation, Physical Environment, Parental Responsivity, Learning Stimulation, Modeling of Social Maturity, Variety in Experience, and Acceptance of Child).

Original reference: Bradley, R.H., & Caldwell, B.M. (1979). Home observation for measurement of the environment: A revision of the preschool scale. *American Journal of Mental Deficiency, 84*, 235-244.

The HOME-MC for families with a child between 6 and 10 years of age, has 59 items in eight subscales (Parental Responsivity, Physical Environment, Learning Materials, Active Stimulation, Encouraging Maturity, Emotional Climate, Parental Involvement, and Family Participation).

Original reference: Bradley, R.H., Caldwell, B.M., Rock, S.L., Hamrick, H.M., & Harris, P. (1988). Home observation for measurement of the environment: Development of a HOME inventory for use with families having children 6 to 10 years old. *Contemporary Educational Psychology, 13*, 58-71.

The pre-adolescent version, the HOME-EA, for ages 10 to 15, contains 60 items in seven subscales (Physical Environment, Learning Materials, Modeling, Instructional Activities, Regulatory Activities, Variety of Experience, and Acceptance & Responsivity).

Original reference: Bradley, R. H., Corwyn, R. F., Caldwell, B. M., Whiteside-Mansell, L., Wasserman, G. A., Walker, T. B., & Mink, I. T. (2000). Measuring the home environments of children in early adolescence. *Journal of Research on Adolescence, 10*, 247-289.

There is also a short form, as well as administration modifications for use with children with orthopedic disabilities or hearing impairments. All of the forms have been shown to exhibit good reliability and good to very good validity across various ethnic groups in various countries (including native groups in the continental US and Central and South America), particularly in the total score. As with most measures, some of the subscales have not exhibited good reliability.

Available from: The Center for Applied Studies in Education at the University of Arkansas-Little Rock. A request form can be submitted at www.ualr.edu/~crtldept/home3.html.

Index of Family Relations (IFR): The IFR is a 25-item measure of the severity and magnitude of relationship problems among family members. The index has very good reliability and validity, and has two cutting scores, one indicating clinically significant problems and one indicating severe distress with a strong possibility of future violence. The respondent should be at least 12 years old. The IFR is one of many similar scales of family functioning developed by Walter W. Hudson and colleagues.

Original reference: Hudson, W.W. (1982). A measurement package for clinical workers. *Journal of Applied Behavioral Science, 18*, 229-238.

Published by WALMYR Publishing Company, PO Box 12217, Tallahassee FL 32317-2217; 850.383.0045.

Index of Parental Attitudes (IPA): Another Walter Hudson (WALMYR) instrument, assessing the magnitude of a parent's relationship problem with the identified child.

Original reference: Hudson, W.W. (1982). A measurement package for clinical workers. *Journal of Applied Behavioral Science, 18*, 229-238.

Available from WALMYR Publishing Company, PO Box 12217, Tallahassee FL 32317-2217; 850.383.0045. Also from the Educational Testing Service, Princeton, NJ 08541.

Kaufman Assessment Battery for Children (KABC-II): Capitalizing on cultural-competency criticism of the Wechsler scales, the Kaufman scales were developed to be more valid in different ethnic groups and to rely less on majority-culture knowledge and skills. Now in its second edition, the KABC minimizes verbal instruction and content and maximizes engagement with the child, regardless of cultural background and English ability. It is a comprehensive battery of tests assessing intelligence and some aspects of academic achievement (though not a full achievement test). The new edition expands the applicable age range to ages 3 to 18, takes 25 to 70 minutes, and is administered individually. It was developed and normed with a sample conforming to 2001 Census data, and has been subsequently tested with a variety of groups, including Native American children. It has good to very good reliability and validity, particularly in the scales and composite indices (Mental Processing, Fluid-Crystallized, and Nonverbal). The KABC-II includes tests of short-term and long-term memory, the latter requiring administration of some of the supplementary subtests.

Available from AGS Publishing at www.agsnet.com/group.asp?nGroupInfoID=a21000.

Computer scoring available.

Kaufman Brief Intelligence Test (KBIT-2): The Kaufman scales include a short assessment of verbal (crystallized) and nonverbal (fluid) intelligence that can be completed in approximately 20 minutes with children and adults ages 4 through 90. Its two subtests together have good reliability and validity.

Available from AGS at www.agsnet.com/Group.asp?nGroupInfoID=a32300.

Michigan Alcoholism Screening Test (MAST): One of the most well-known quick screens for lifetime alcoholism and alcohol-related problems, the MAST is a 25-item questionnaire (paper-and-pencil or interview) that is completed in approximately 10 minutes. It is written at about a 7th grade reading level, and can be modified to assess past-year symptoms. Usually only the total score is used, although there has been some work done to develop specific subscales. There are several versions of the MAST, including the 10-item Brief MAST (the BMAST), the 13-item Short edition (SMAST), and versions specifically for the fathers and mothers of the respondent (the F-MAST and M-MAST). The different versions of the MAST generally have very good reliability and validity. The MAST was designed to overcome a lack of candor, and has even exhibited very high validity when respondents were instructed to lie about their drinking problems. The shorter versions, however, appear to be better at identifying people who have recognized their drinking problems and labeled themselves accordingly. There is some concern that the MAST (at least the BMAST) does not work comparably across ethnicity and gender groups, necessitating differing cut points for different groups.

Original reference: Selzer, M.L. (1971). The Michigan Alcoholism Screening Test: The quest for a new diagnostic instrument. *American Journal of Psychiatry*, 127, 1653-1658.

Primary reference for the BMAST: Pokorny, A. D., Miller, B. A., & Kaplan, H. B. (1972). The brief MAST: A shortened version of the Michigan Alcoholism Screening Test. *American Journal of Psychiatry*, 129, 342-345.

Primary reference for the SMAST: Selzer, M.L., Vinokur, A., & van Rooijen, L. (1975). A self-administered Short Michigan Alcoholism Screening Test. *Journal of Studies on Alcohol*, 36, 117-126.

Primary reference for the F-MAST and M-MAST: Crews, T.M., & Sher, K.J. (1992). Using adapted short MASTs for assessing parental alcoholism: Reliability and validity. *Alcoholism: Clinical and Experimental Research*, 16, 576-584.

Long version available from the original reference above, in *Measures for clinical practice* (Corcoran & Fischer, 2000), or at www.projectcork.org/clinical_tools/html/MAST.html.

BMAST available at www.projectcork.org/clinical_tools/html/BriefMAST.html.

SMAST available from the reference above, in Corcoran and Fischer (2000), who identify the 13 short-form items among the original 24, or at www.projectcork.org/clinical_tools/html/ShortMAST.html.

Panel Study of Income Dynamics Child Development Supplement (PSID-CDS): Part of the University of Michigan Survey Research Center's on-going national, representative study of income, including in this case how economic and social differences affect child development. The supplement assesses cognitive, behavioral, and health status of infants; time use of caregivers (e.g., monitoring of child), children and adolescents, and teachers; and resources available to the family. Many items were taken from previous studies. Relevant parts of the supplement may be used in other studies, and data are

available for secondary analysis and comparison group purposes. Very good reliability was reported for the behavior problems scale.

Available at psidonline.isr.umich.edu/CDS/.

Parental Bonding Instrument (PBI): Often-used retrospective measure of perceived parenting on two dimensions: caring versus indifference/rejection, and overprotection versus encouragement of autonomy. The two dimensions result in quadrants to which parents can be assigned, such as “optimal parenting/bonding” (high care and low protection) and “affectionless control” (low care and high protection). Reliability and validity have been established. Among the volumes of research on the PBI are efforts to produce a version shorter than the original 25 items, with the most successful being that of Pederson.

Original source: Parker, G., Tupling, H., & Brown, L.B. (1979). A Parental Bonding Instrument. *British Journal of Medical Psychology*, 52, 1-10.

Ten-item version: Pederson, W. (1994). Parental relations, mental health, and delinquency in adolescents. *Adolescence*, 29, 975-990.

Parenting Sense of Competence Scale (PSOC): The PSOC measures two aspects of parental self-esteem: Efficacy (frustration, anxiety, and motivation) and Satisfaction (competence, problem-solving ability, and capability). Originally developed for parents of infants, the instrument was revised for use with parents of older children as well as infants and tested with such a population. This and further analyses have revealed good reliability and fairly good to good validity. The PSOC is a short instrument, with 17 items (parent interview or self-report), that has been used in previous evaluations of family support, including the Family Connections replication. A shorter version, called the Being a Parent scale, comprises 12 items measuring the same two factors, efficacy and satisfaction, with fairly good reliability and preliminary evidence of construct validity.

Original reference for current PSOC: Johnston, C., & Mash, E.J. (1989). A measure of parenting satisfaction and efficacy. *Journal of Clinical Child Psychology*, 18, 167-175.

Reference for the Being a Parent scale: McCarty, C.A., & Doyle, S.R. (2001). *Being A Parent* (Conduct Problems Prevention Research Group Technical Report). Retrieved 20 May 2004 from www.fasttrackproject.org/techrept/b/bpr/bpr1tech.pdf.

Parenting Stress Index (PSI): Perhaps the most frequently used measure of parental stress, the PSI is a 101-item questionnaire (plus an optional 19-item life stress scale) that has been shown to exhibit good to very good reliability and validity across diverse groups of respondents. It is available in eight languages, and written (at least in the English version) at a 5th grade reading level. Designed for parents of children ages one month to 11 years, it takes approximately 20 to 30 minutes to complete. Although the measure has 13 subscales divided among child (distractibility/hyperactivity, adaptability, reinforces parent, demandingness, mood, and acceptability) and parent domains (depression, attachment, role restriction, sense of competence, social isolation, spousal relationship, and health), some research suggests that the instrument has three main factors: parental distress, child difficulties, and parent-child interaction dysfunction factors. The PSI has undergone a number of adjustments to improve it. There is a 36-item short form that has been shown to exhibit very good reliability and validity. The PSI-SF measures three scales corresponding with the three factors of the larger PSI listed above, and takes approximately 10 minutes. A version of the PSI is among the outcome measures for the national Family Connections replication.

Earliest journal reference: Loyd, B.H.; Abidin, R.R. (1985). Revision of the Parenting Stress Index. *Journal of Pediatric Psychology, 10*, 169-177.

Available from Psychological Assessment Resources,
www.parinc.com/product.cfm?ProductID=127.

Computer scoring and administration available.

Peabody Picture Vocabulary Test (PPVT-III): The PPVT is an oft-used assessment of receptive vocabulary and verbal ability. It is an untimed test in which the subject identifies the pictures that illustrate the words read by the administrator, generally completed in less than 15 minutes. No reading or writing is involved. Training items help make the test widely applicable for subjects ages 2½ to 90 or more. It has exhibited good to excellent reliability and validity, both much improved in the new version. The third edition comes in parallel forms, which is useful for minimizing practice effects in pre-test/post-test evaluations.

Available from AGS at
www.agsnet.com/Group.asp?nMarketInfoID=31&nCategoryInfoID=2590&nGroupInfoID=a12010.

Rosenberg Self-Esteem Scale (RSE): One of the most frequently used instruments in social research, the Rosenberg Self-Esteem Scale is a short instrument that exhibits good reliability and validity. Generally the total score is used to indicate current level of self-esteem, although there is some evidence that self-esteem as measured by the Rosenberg can be divided into self-worth/liking and self-efficacy or competence. The RSE has been used with a variety of ethnic groups, with mixed results on whether there are inherent ethnic differences in the instrument.

Primary reference: Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton, NJ: Princeton University Press.

Available at www.bsos.umd.edu/socy/grad/socpsy_rosenberg.html.

Self-Report Family Inventory (SFI): The SFI measures family functioning and competence along five empirically-derived subscales: conflict, communication, cohesion, directive leadership, and family health. It was developed and normed with diverse families, although this diversity was not reported to include American Indian/Alaskan Native people. Moderate to good reliability and preliminary indications of good validity have been shown in studies using this 36-item instrument. The SFI is being used in the national replication of Family Connections.

Original reference: Beavers, W.R., Hampson, R.B., & Hulgus, Y.F. (1985). Commentary: The Beavers systems approach to family assessment. *Family Process, 24*, 398-405.

Available from W. Robert Beavers, Southwest Family Institute, 12532 Nuestra, Dallas TX 75230.

Social Support Index (SSI): A fairly well-established measure of community-based social support (not just relatives and friends), the SSI has exhibited good reliability and validity. It is a short instrument, with only 17 items (rated strongly disagree to strongly agree). It has been used with a variety of families, including Native Hawaiian, Asian, and rural.

Primary source: McCubbin, H.I., Patterson, J., & Glynn, T. (1996). Social Support Index (SSI). In H.I. McCubbin, A.I. Thompson, & M.A. McCubbin (Eds.), *Family assessment:*

Resiliency, coping and adaptation. Inventories for research and practice (pp. 357-389).
Madison: University of Wisconsin.

Available in the book cited above, then by registering with the publisher. Although the book is currently listed as in print, the authors were unable to locate a copy on the Internet.

Stages of Change Scale (SOCS): The Stages of Change Scale was developed out of the prominent Transtheoretical Model of Change of Prochaska, DiClemente, and colleagues. This model holds that people undergoing any sort of psychological change go through five stages: *Precontemplation* (unawareness), *Contemplation* (aware but not committed to action), *Preparation* (making small changes in advance of anticipated larger changes), *Action* (larger changes), and *Maintenance* (relapse prevention). The SOCS, also called the University of Rhode Island Change Assessment (URICA), measures four of the five stages, leaving out Preparation. It is a quickly-completed assessment that is widely used in the addiction, psychotherapy, and health behavior change fields, and starting to appear in the social work and juvenile justice literatures as well. It is adaptable to a variety of problems, although there is one question that mentions “all this talk about psychology,” which may create reactivity in participants not involved in a mental health or substance use intervention. Reliability is generally fairly good to good. Scoring seems to vary by use and by study, and between the mixed uses and the mixed scoring methods, the overall validity of the assessment appears to be generally but inconsistently good. It is probably most useful to use the instrument to put respondents into two motivational clusters, Precontemplation or Contemplation/Action, or to develop a Readiness score (Readiness = [Contemplation + Action + Maintenance] – Precontemplation). The Readiness score has exhibited very good reliability and good to very good validity.

Primary reference: McConaughy, E.A., Prochaska, J.O., & Velicer, W.F. (1983). Stages of change in psychotherapy: Measurement and sample profiles. *Psychotherapy: Theory, Research, and Practice*, 20, 368-375.

The URICA is available at www.uri.edu/research/cprc/Measures/urica.htm or at www.vcu.edu/vattc/urica.html. It is copyrighted by James Prochaska, who has granted free use of the instrument for research purposes.

Strange Situation procedure (SSP): Infant attachment is a difficult construct to assess. The classic assessment of the young child’s attachment to the mother was developed by Mary Ainsworth in her seminal work on attachment. The Strange Situation involves standardized presentation and observation of child behavior when faced with a unique and mildly stressful situation, involving an unfamiliar room filled with toys. The situation is designed to elicit both the motivation to explore and the urge to seek security, with the resulting behaviors observed over a period of about 20 minutes, including several separations from and reunions with the mother and entries and exits of a stranger. The SSP has been used in countless research projects. Some of these projects have produced results which lead the researchers to question the validity of the procedure in different cultures (particularly Asian). Other researchers have concluded that most if not all of the cultural differences can be accounted for by assessing infant behavior before beginning the procedure or by procedural differences, and that the cross-cultural differences are smaller than intra-cultural differences. Much of the (particularly earlier) research with the SSP has found that infants vary in their attachment on a so-called “standard distribution”: 20% are found to be avoidant, 70% to have secure attachment, and 10% to have resistant attachment to their mothers. Variations in this distribution in some countries and cultures have been the source of much of the criticism. Conducting the SSP requires highly trained administrators and observers who exhibit maximum inter-judge correlation, which maximizes the overall reliability of the

procedure. Rigorous laboratory testing has found physiological functioning differences, which greatly validates the categorizations. The procedure can also produce assessment of child temperament. Originally used with infants, coding systems for using the SSP with older children have been developed.

Primary reference: Ainsworth, M. D., Blehar, M., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the Strange Situation*. Hillsdale NJ: Erlbaum.

Coding system used in the National Institute of Child Health and Development Study of Early Child Care is available at secc.rti.org/display.cfm?t=m&i=Chapter_17_3_1.

Coding system for use with preschoolers, the Preschool Assessment of Attachment: Crittenden, P.M. (1992). Quality of attachment in the preschool years. *Development and Psychopathology*, 4, 209-241. A two-week training course is offered by Patricia Crittenden (pmcrittenden@worldnet.att.net). Dr. Crittenden also trains on the infant version of the SSP.

Coding system for use with six-year-olds: Cassidy, J. (1988). Child-mother attachment and the self in six-year-olds. *Child Development*, 59, 121-134.

Review of coding systems: Goldberg, S. (2001). Attachment assessment in the Strange Situation. In L.T. Singer & P.S. Zeskind (Eds.), *Biobehavioral assessment of the infant* (pp. 209-229). New York: Guilford Press.

SUNY Parenting Scale (PS): Designed specifically to identify dysfunctional discipline, this instrument has 30 items resulting in a total score and subscale scores for laxness, overreactivity, and verbosity. It has demonstrated good reliability and very good validity, and has been used in at least one study of family support programs (Triple P-Positive Parenting Program for child behavior management; Bor, Sanders, and Markie-Dadds, 2002).

Original source: Arnold, D.S., O'Leary, S.G., Wolff, L.S., & Acker, M.M. (1993). The parenting scale: A measure of dysfunctional parenting in discipline situations. *Psychological Assessment*, 5, 137-144.

Available from Susan G. O'Leary and colleagues in the Psychology Department of the State University of New York at Stony Brook, Stony Brook, NY 11794.

Vineland Adaptive Behavior Scales (VABS): Often used to diagnose mental retardation (paired with an intelligence test), the Vineland measures adaptive behavior in four areas, communication, daily living skills, socialization, and motor skills. There are three versions, including a 45-item screener that takes 30 to 60 minutes, conducted by a trained psychologist or social worker, and a classroom edition completed by a teacher in about 20 minutes. The Vineland has some cross-cultural evidence, and has been translated into many languages. It is accepted as valid, with good reliability (particularly the overall Composite score).

Published by AGS Publishing, Circle Pines MN 55014-1796.

Available at www.agsnet.com.

Computer scoring program available.

Vineland Socio-Emotional Early Childhood Scales (V-SEEC): Basically the Socialization scale of the VABS, the SEEC offers a fairly quick (15 to 25 minutes) assessment of socio-emotional development of children up to age 11. Reliability is moderately good, with fair validity results. It is a semi-structured interview conducted by a psychologist or social worker.

See availability information for VABS above.

Wechsler Intelligence Scale for Children (WISC-IV): One of the most prominent intelligence tests for children, the WISC is now in its fourth edition. The assessment produces an overall intelligence score indicating the child's level of intellectual functioning, and four other composite scores: verbal comprehension, perceptual reasoning, working memory, and processing speed. The latest edition improved the assessment of non-verbal functioning in particular, which is important for use with children from homes in which English is not the primary language. The various WISC editions have been tested with children of various ethnicities, including Inuit and other Native groups, and standardized on nationally representative samples. Past research with Native samples and groups with limited English skills have found Verbal IQ scores significantly lower than Performance IQ scores. The WISC is administered individually with children ages 6 to 16. Adaptive testing allows for limiting the number of items necessary for each scale, thus keeping the assessment as short as possible. The recent versions of the WISC have also added limited assessment of academic achievement/knowledge via supplemental subtests. Administration takes 50 to 90 minutes, depending upon the choice of supplementary subtests and the child's abilities. Various short forms of the Wechsler scales have been developed, which lead PsychCorp to publish an "official" Wechsler Abbreviated Scale of Intelligence. Unfortunately, this official assessment has not demonstrated good reliability and validity, particularly compared to the many other short forms discussed in the assessment literature.

Available from PsychCorp at marketplace.psychcorp.com.

Computer scoring available.

Wechsler Preschool and Primary Scales of Intelligence (WPPSI-III): Now in its third edition, the young children's version of the Wechsler scales (for ages two years six months through seven years three months) has also improved its assessment of non-verbal and not culture-bound skills. Some of the development and validity work was done with samples of children with limited English proficiency.

Available from PsychCorp at marketplace.psychcorp.com.

Computer scoring available.

Wide Range Intelligence Test (WRIT): While not as widely used as some other psycho-educational test, the Wide Range products are very popular with some assessment professionals, school psychologists, and researchers. Recently revised, the WRIT produces Verbal (crystallized) and Visual (fluid) composites and a General IQ score with an administration time of only 20 to 30 minutes, with individuals ages 4 to 85. It has good reliability and validity, with high correlation with the much longer Wechsler scales of intelligence.

Available from Wide Range at www.widerange.com/writ.html

Appendix B: Interviewer Script for Child Welfare Agency Questions

Parental Substance Abuse and Child Welfare And Family Support and Preservation Programs Child Welfare Evaluation Program

Hello, my name is _____. I am calling you on behalf of the Child Welfare Evaluation Program, a part of the University of Alaska Anchorage School of Social Work. We have been conducting a literature review of best and promising practices in the field of parental substance abuse and child welfare [or family support and preservation] and now are seeking information from Alaskan programs which provide services in this area. I would like to ask you a few questions about your program. This should take approximately 5-15 minutes of your time and is completely voluntary and will not affect your job in any way.

Our study has the following purposes:

To review the literature on the outcomes, as well as best and promising practices, of programs across the country which provide services in the area of substance abuse and child welfare [or family support and preservation],

To summarize the findings from the literature, highlighting common elements of successful programs,

To identify and summarize Alaskan programs which provide services in the areas just mentioned,

To gather further information from specific Alaskan programs, identifying how they define success and measure outcomes,

To produce a report summarizing all of the above information, highlighting best practices, outcomes of successful programs, with possible indicators and measurements.

The intent of the study is to inform policy-making and assist with program development by state agencies and non-profit organizations.

I will be asking you the following questions:

How do you define success in your program?

How do you measure it?

What do you think contributes to this success?

We will not use your name in our report, or the name of your agency.

If you have any questions about anything covered in this interview, about our study, or the Child Welfare Evaluation Program, please contact Dr. Susan Pope, program manager, at the University of Alaska—907-786-6724.

Thank you for your time.