

Final Report  
Children's Bureau Demonstration Grants

**Valley Youth House**  
**Family Intervention Project**

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**Submitted on:**  
**December 30, 2001**

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**VALLEY YOUTH HOUSE**  
**FAMILY INTERVENTION PROJECT**

**I. INTRODUCTION: BRIEF DESCRIPTION OF PROJECT**

**A. Background Information**

**1. Pinpoint the Child Neglect Problems and Issues To be Addressed and Demonstrate the Need**

The proposed program addresses six issues of importance to those concerned with child neglect. The first two issues are related to decreasing the personal and social problems of neglecting parents, and neglected children: 1) What strategies will be effective in reducing the most prominent precursors to neglectful parenting - substance abuse, emotional problems, poverty, inadequate education, and unsatisfactory childhood experiences, and 2) What strategies will be effective in ameliorating the most prominent effects of neglect on the child - developmental and neurological deficits, poor health, interactional, emotional and academic problems?

The applicant is especially encouraged by OCAN's focus in the Request for Proposal on models that "incorporate mental health, substance abuse, parenting education, and substance abuse services." Between 1992 and 1996 the applicant established and operated the Family Intervention Program (FIP), funded by OCAN, which is maintained and strengthened in this proposal. The purpose of FIP was to provide emergency and long-term assistance to abusive and neglectful families headed by substance abusing parents. The project evaluation (Woodhouse and Livingood, 1996) documented the major program successes of strengthening parenting skills, reducing child abuse and neglect, and preventing public child welfare involvement and placement among the 440 project families served. The strategy that led to these successes involved many of the OCAN identified services including outreach, counseling, parenting skill education, substance abuse interventions, family support services and child health services. The evaluators and project staff agreed that the lack of parent and child mental health services limited the match between the client population, which presented with a very high rate of mental health problems, and the program design.

The observations of FIP clinical staff confirm the social statistics and research literature, but perhaps more vividly document the connection between parental problems, neglectful behavior and the interventions needed to allow for improvements in parenting and the positive development of children. It was all too common for staff to observe single mothers involved in substance abuse leave their very young children unsupervised for long periods of time in order to engage in illegal activities to obtain drug money. The cost of maintaining drug habits often leads to a lack of adequate food and clothing for children, and sometimes leads to selling furniture to get drug money. Parents with mental health problems, particularly depression, are often too inactive and self-involved to assure that their children get adequate medical care or are ready to attend school in the morning. The extremely impoverished families often cannot even provide basic shelter for their families.

The proposed program also seeks to provide insight into three issues of concern in the field of child neglect research: 1) Will providing services that address the personal and social

problems of neglectful parents be related to a decrease in child neglect behaviors, 2) Will providing services to address the personal and social problems of neglected children be related to improved child health and improved child functioning in the home and school, and 3) Will a wider range of core services offered by professional staff, paraprofessionals, and volunteers result in superior outcomes as compared with a smaller core service program provided only by professional staff? A historical study of the research efforts of OCAN recommends that increased resources be devoted to outcome research (Thompson and Wilcox 1995). The need to document the effectiveness of child neglect treatment programs is especially important in light of limited success among many formerly evaluated programs (Daro et. al. 1993). Testing the efficacy of different sets of core services is a particular research interest of OCAN cited in the Request for Proposal under which this application is submitted. The proposed research plan will have the special distinction of building upon the previous project evaluation by using instruments and data from the first evaluation effort.

## **2. Goals**

Goal 1: To identify and offer long term in-home assistance to families at risk of neglect, and chronically neglectful families including those who have children that have returned from placement.

Goal 2: To add to the community supply of services by providing an in-home program of mental health, substance abuse, and family support services, as well as parenting education, to meet the prevention, intervention, and treatment needs of project children and parents.

Goal 3: To reduce the substance abuse, emotional, and economic problems of project parents, and increase parental skills.

Goal 4: To reduce the health, academic, behavioral, social and emotional problems of project children.

Goal 5: To keep the family unit intact and to minimize the involvement of high-risk project families with public child welfare services and chronically neglectful families with public child welfare placement services.

Goal 6: To test the overall efficacy of the program, and the efficacy of a core service package that consists of professionally provided services only (Group 1) as compared to a core service package that includes volunteer provided prevention and intervention services in *addition to* the professionally provided services (Group 2).

## **B PROGRAM MODEL**

### **1. Chronological Workplan**

#### **a. Referral**

A primary source for referrals continued to be the two area public child welfare agencies: the Lehigh County and Northampton County Offices of Children, Youth and Family Services. Referrals from these sources included children at risk of neglect and open public child welfare cases involving neglectful families who have had children in out-of-home placement who have returned to the family home, as well as other open neglect cases. The following is a profile of referral sources for 1995: child welfare agencies - 63%; schools, 12%; hospital and other community agencies - 25%. Referral information requested included the nature of the presenting problem, the person/organization making the request for service, the family name, address and phone number. The referral source was responsible for informing the family that the referral was being made and for obtaining their consent to refer to the project.

During normal business hours referrals were accepted by the Project Supervisor. Each project staff member was required on a rotating basis to provide emergency assessment and emergency services. The project counselor providing on-call duty was accessible to hotline staff through a pager.

## **b. Assessment Services**

### **b1 Initial Project Assessment**

Project staff made an assessment of each family to determine their service needs and their eligibility for project services, and to develop an action plan in partnership with the family.

The eligibility criteria for project services were that the referred family contained at least one child between birth and 11 years of age who was at risk of child neglect or who had been neglected; that the referred family contained at least one parent figure who was involved in substance abuse or had a mental health problem; that the family resided in either Lehigh or Northampton County; and that the child was not in immediate danger of life threatening harm.

The assessment included an evaluation using materials designed to plan service delivery as well as to conduct the project evaluation. The actual information gathered was in a fixed as well as open-ended format. The assessment used the following evaluation instruments:

- (a). An intake form
- (b). A child health survey
- (c). A substance abuse and drug treatment history
- (d). A family stress survey
- (e). A parenting skills survey

The counselor conducting the assessment was responsible for preparing a written assessment report which includes a summary of the information obtained, their diagnostic impressions of the family, and an individualized service plan for family, parent, and child services that is sensitive to the sociological and cultural needs of each family and that is jointly constructed by the parent and counselor. Assignment to one of the two service groups (Group 1 or Group 2) was made at this time.

The plan included the services to be provided including their frequency and duration. The plan specified service providers, both internal and external to the project. The initial plan was reviewed and approved in writing by the parents and project director. The project director had the responsibility of convening an initial team planning meeting and quarterly team meetings, including the parent and all service providers for each family. At the conclusion of each meeting, updates of changes to the action plan were noted by the counselor carrying primary responsibility for services to the family involved.

with that provider to achieve the results described above.

### **b2. Outreach to Resistant Families**

Traditionally, child welfare service populations have been known as "semi-voluntary" clients. They often begin their contact with child welfare agencies by being accused of being "bad" parents and are drawn into a legally mandated process which they experience as intrusive. This project therefore anticipated that many of the parents would be resistant to services because of these experiences as well as personal problems including addiction, anxiety, and denial issues related to their parenting. Therefore, with these resistant families an "intervention" approach was used. The

other family members, referral source, school, etc., were used to involve the substance abusing and emotionally troubled parents with project services and ultimately in drug and mental health treatment. Outreach efforts with resistant families lasted for one month. During that time at least two home visits, two school visits, one intervention meeting and three telephone contacts were used to involve the resistant family with project services. In situations where parents refused to participate after these efforts, the case was either closed, or referred to the child welfare agency, whichever was appropriate.

### **c. Ongoing Project Services**

#### **c1. Prevention Services**

##### **(a) Parenting Skills Education**

Professional staff provided parenting skills education for parents. Professional staff used individual parent sessions to provide parenting skills education within a counseling context. The program goals were to help develop and enhance positive parenting skills and to assist parents in experiencing their child's development in a positive manner.

##### **(b) Food, Clothing, and Furniture Linking Services**

This referral and linkage service was utilized to assist all families in obtaining basic life necessities, particularly food, clothing, furniture, and appliances through community food banks, thrift stores, and church programs, and in developing skills in establishing and maintaining social network linkages with helping resources. The program maintained a directory of these services, including hours and eligibility requirements, and kept current on new programs and program changes through participation in a community coalition and utilization of the area's centralized information and referral service, Valley Wide Help. This family support service linked families with resources and taught service linking skills, as well as life skills such as budgeting.

##### **(c) Housing Assistance Services**

Housing assistance services had the goals of 1) assisting all families at risk of homelessness to retain their housing, and 2) to locate long term housing for homeless families residing in emergency shelters or who are doubled up with relatives or friends. A number of strategies were utilized including negotiating payment schedules with landlords and utility companies, both directly and through the local Consumer Credit Council, obtaining FEMA grants for families, obtaining Section 8 housing, and having families participate in special HUD housing programs such as Bridge Housing and Transitional Housing programs.

Again, the focus was on obtaining a vital family resource, connecting the parent with an important network resource, and teaching the parent housing location and maintenance skills.

##### **(d) Transportation Services.**

Transportation services had the goal of assuring that all clients without transportation participate in program provided and community activities. This service involved providing transportation to appointments with service providers that do not offer home based services, or in connection with a housing or job search. Also, parents were linked with the community bus system by teaching parents to obtain and use bus scheduling information. In some situations, bus passes were purchased for parents and carpooling was facilitated.

**(e) Employment and Training Services**

Employment and Training Services had the goal of linking all unemployed or underemployed parents with appropriate community based job training and job search services. These programs included the Private Industry Council of the Lehigh Valley, The Literacy Council, specialized community college programs, and services offered through Neighborhood Centers.

**(f) Program Graduate Peer Mentor Program**

This program component was based on the work of Dore and Harnett (1995), Hornick and Clark, (1986) and Lines (1987). Volunteers were recruited from among the 300 successful parent program graduates served by the Family Intervention Program during its 4 1/2 years of operation. Acting as mentors, they visited with families at least once a week and provided nurturance, emotional support, understanding, friendship, and modeling in the areas of interpersonal relationships, problem solving, self-advocacy and networking.

**(g) Home Based Child Medical Care and Medical Care Linkage**

While the provision of medical care for all neglected children may be an issue, it is of particular importance for the infants and young children who had been prenatally exposed to drugs due to their risk of developing a number of problems described in the psycho-social model literature review. Program professional staff had the responsibility of assuring that all children were receiving well baby and well child care in addition to treatment for medical problems

**c2. Intervention Services**

**(a) Substance Abuse Interventions**

The program counselor with the goals of having the substance abuser commit to abstinence and enter a substance abuse treatment program staged substance abuse interventions. Some interventions were of the more formal type in which other family members, employers, public child welfare staff, helping agents, school counselors etc. met to persuade the substance abuser to seek help and explained the consequences of not seeking help, some were done on a more informal basis by program staff and one or more of the people in the substance abuser's network, depending on what was thought to be most effective in each situation.

**(b) Linkages with Drug Treatment Programs**

The counselor was responsible for linking substance abusers with drug treatment programs. A variety of programs were used depending upon the situation and need of the substance-abusing parents. Programs used included hospital based detoxification programs, thirty day residential programs, outpatient counseling, and day treatment programs. During the previous 4 1/2 years of program operations, the director and staff gained the commitment of the county Single Authority agencies, which often made the financial authorizations to pay for these services as well as treatment programs, to arrange for speedy admissions for service, a factor which is often a critical component in treatment success. Respite foster care was used for children when there was no family resource and a parent was participating in a residential program.

**(c) Linkages with 12 Step Programs**

Both project counselors and volunteers were committed to linking substance-abusing families to local twelve step programs, and a current directory of group meetings and sponsor linkage telephone numbers was used to link parents with such programs.

**(d) Emergency Residential Services**

Parents involved in substance abuse or having serious mental health problems are often unemployed or underemployed and family homelessness was often an issue. Also, these families presented with acute parent-child conflict sometimes necessitating emergency shelter for the child. The issue of homelessness can often lead to placement of a child. Therefore, the project offered emergency housing services for both the family and child.

The counselor, who arranged for emergency shelter or respite services for a child, was responsible for learning from the parents whether an alternative shelter situation existed within the extended family. As was appropriate, the counselor contacted aunts, uncles and grandparents to obtain emergency shelter for children through a family source when this was available.

**(e) Emergency and Respite Foster Care**

Emergency foster care homes were available to receive children between the ages of birth and 11 on a 24-hour basis. The service was provided by Pinebrook Services for Children and Youth, a state licensed foster care agency, and included the provision of food, shelter and emergency clothing as was necessary for a period of time between 1 and 30 days.

**(f) Family Homeless Shelter Services**

Emergency shelter for families was provided in a transitional housing program through New Bethany Ministries. The facility can accommodate up to eight families at any one time. Twenty-four-hour staff coverage was provided. The service included temporary shelter, food and a children's program. Alcoholic's Anonymous groups and GED instruction were available. The program also offered assistance in locating long-term housing primarily through the Federal Section 8 Program. The average length of stay was 68 days.

**(g) Emergency Financial Assistance**

Emergency Financial Assistance was provided if a family emergency existed that: a) placed the child at risk for out of home care or posed an immediate risk to the health and safety to the child, b) was non-reoccurring in nature, and c) could not be resolved using existing community resources. In no case was financial assistance given without the approval of the project director or exceeded \$500.00. Examples of emergencies include provision of food for a family over a weekend when food banks were closed, or the provision of diapers for a child.

**(h) Counseling Services**

**(h1) Family Counseling Services**

Family counseling services were included, as appropriate and needed, parent, marital, and family counseling. The service focused on developing positive interactional patterns between family members using identified family strengths and developed problem solving and coping skills for family members.

**(h2) Individual Parent Counseling**

Individual parent counseling was used to teach parenting skills and, as needed, to develop life, social and coping skills and offered empathy and support to parents who were not involved in individual mental health services.

**(h3) Individual Child Counseling**

Individual child counseling was used as needed to assist the child in developing daily living, coping, and social skills as well as to offer empathy, support, and nurturance when the child was not involved in enhanced mental health services.

### **c3. Treatment Services**

#### **(a) Adult Mental Health Services**

##### **(a1) Individual Psychotherapy**

Home based individual psychotherapy was provided at least once per week, with additional in-home and telephone crisis services delivered as needed to seriously emotionally troubled parents. Treatment modalities employed were based on the results of the project assessment and psychiatric evaluation and included psychodynamic, cognitive, social and behavioral approaches that were interwoven with an individual empowerment approach.

##### **(a2) Medication Monitoring**

For parents using psychotropic medication, monitoring, including blood level evaluation, was conducted by the community mental health resources to which the parent was linked.

##### **(a3) Linkage and Coordination Services**

In situations where specialized services were required, such as acute hospitalization, respite, extended hospitalization, or mental health residential service, the project took responsibility for assisting the parent in obtaining the service and coordinating family work and after care with the service provider.

#### **(b) Child Mental Health Services**

Child mental health services were provided to avoid the out of home placement of a child with serious emotional problems through the amelioration of the problem and the provision of child and family support services. The broad goals were to change child behaviors, and strengthen the ability of family members and community institutions to manage these behaviors, through the identification and utilization of child strengths and the provision of behavioral and other therapeutic services.

### **C. Collaborative Efforts**

This was a multi-agency effort involving two county children and youth agencies, two county drug and alcohol agencies, a family emergency shelter, a tutoring and mentoring program, psychiatric and psychological services, a foster care program, and a community health organization.

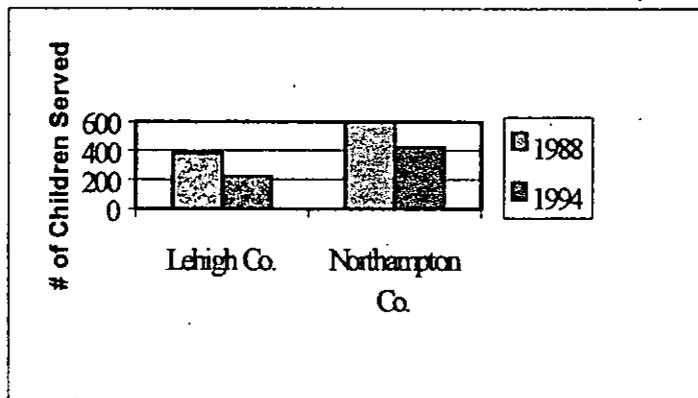
Both the county children and youth agencies and the drug and alcohol agencies referred clients to the program, provided a cash match to the Federal funds, and participated in treatment team meetings. New Bethany Ministries provided emergency residential services when homelessness was an issue. Pinebrook Services for Children and Youth is a state licensed foster care agency that provided emergency and respite foster care, including food, shelter, and emergency clothing as needed. The Visiting Nurse Association of Bethlehem and Vicinity has provided a wide range of health care services for over 75 years. They provided home based medical care and medical care linkage.

In addition to the collaboration described above, East Stroudsburg University, a member of the state university system, conducted program evaluation through its Center for Community Health Research and Development. The evaluation process included review and revision of evaluation instruments, clarification of evaluation outcomes and process, management of data collection, and data analysis.

### D. Special Issues

This proposal also addressed the issue of the inadequate supply of services for neglected children in this community through the public child welfare agencies. There are two components to this issue. First, in light of increasing reports of neglect and abuse (see Graph 1), the decreasing number of cases served by the public child welfare agency (see Graph 2) is especially alarming. Second, Pennsylvania law does not provide for the protection of children who have been neglected (OCAN, 1996). As the state child abuse law does not cover neglected children, they are an underserved child welfare population.

Graph 1  
Child Abuse Reports by County, 1988 and 1994



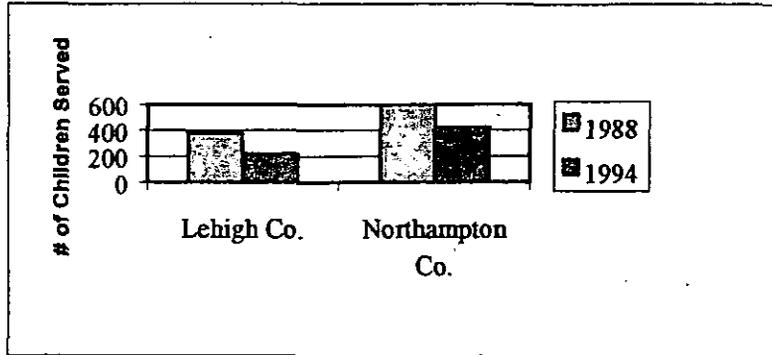
Source: 1995 PA County Data Planning Kit

Table 1  
Social Problem by County, 1988 and 1994

	Lehigh County			Northampton County		
	1988	1994	% Change	1988	1994	% change
AFCDCases	5,275	7,579	43.7%	3,482	4,226	21.4%
Medical Assistance Cases	7,603	13,881	82.6%	5,446	9,763	79.3%
Drug Arrests	788	997	26.5%	626	635	1.4%
# of Alcoholics	10,176	14,071	38.3%	6,520	6,933	6.3%

Source: 1995 PA County Data Planning Kit

Graph 2



Number of Children Served by County Public Child Welfare Agencies, 1988 and 1994

Source: 1995 PA County Data Planning Kit

## E. Funding

Year 1

A. EXPENSES		Total Budget	HHS	Match	Non-Grant Related Income
<b>I. PERSONNEL</b>					
Executive Director	4%	3,375	3,375	0	0
Assoc. Exec. Dir.	4%	2,293	2,293	0	0
Finance Director	4%	1,390	1,390	0	0
Administrative Assist.	4%	1,134	1,134	0	0
Finance Assist.	4%	680	680	0	0
Billing Clerk	4%	591	591	0	0
Grant Writer	4%	1,274	1,274	0	0
Program Director	50%	20,695	20,695	0	0
Mental Health/D&A Counselor	100%	30,805	25,805	0	5,000
Mental Health/D&A Counselor	100%	24,688	19,688	0	5,000
Family Support Worker	100%	24,000	24,000	0	0
Secretary	25%	6,033	6,033	0	0
Maintenance	4%	802	802	0	0
		117,760	107,760	0	10,000
<b>II. BENEFITS</b>					
Medical		5,838	0	5,838	0
Dental		1,774	0	1,774	0
Disability		480	0	480	0
Life		205	0	205	0
Worker's Comp.		624	0	624	0
Unemployment		834	0	834	0
FICA		9,009	0	9,009	0
Retirement		3,515	0	3,515	0
		22,279	0	22,279	0
<b>III. TRAVEL</b>					
D.C. Conf. Transportation		114	0	114	0
D.C. Conf. Per Diem		570	0	570	0
		684	0	684	0
<b>IV. EQUIPMENT</b>					
		0	0	0	0
<b>V. SUPPLIES</b>					
Office		2,657	0	2,657	0
Building & grounds		1,061	0	1,061	0
		3,718	0	3,718	0

Non-Grant

	<b>Total Budget</b>	<b>HHS</b>	<b>Match</b>	<b>Related Income</b>
<b>VI. CONTRACTUAL</b>				
Behavior Specialist	10,000	0	0	10,000
Therapeutic Staff Support	30,000	0	0	30,000
Payroll	1,610	0	0	1,610
Audit	1,310	0	0	1,310
Visiting Nurse Association	4,056	4,056	0	0
Pine brook Services	4,280	4,280	0	0
New Bethany Ministries	3,770	3,770	0	0
Psychiatric Services	4,000	4,000	0	0
East Stroudsburg University	27,392	26,134	0	1,258
	<u>86,418</u>	<u>42,240</u>	<u>0</u>	<u>44,178</u>
<b>VII. CONSTRUCTION</b>				
	0	0	0	0
<b>VIII. OTHER</b>				
Office rent	5,400	0	5,400	0
Insurance	2,000	0	2,000	0
Telephone	2,700	0	0	2,700
Postage	1,565	0	1,565	0
Printing	552	0	552	0
Staff training	1,122	0	0	1,122
Local travel	4,500	0	0	4,500
Care of bldgs/grounds	600	0	600	0
Office equip. maint.	370	0	370	0
Subscriptions/publications	332	0	332	0
	<u>19,141</u>	<u>0</u>	<u>10,819</u>	<u>8,322</u>
<b>PROGRAM TOTAL.</b>	<u>250,000</u>	<u>150,000</u>	<u>37,500</u>	<u>62,500</u>

**B. INCOME**

Lehigh County Children & Youth	12,500	7,500
Lehigh County Drug & Alcohol	6,250	3,750
Northampton County Children & Youth	12,500	7,500
Northampton County Drug & Alcohol	6,250	3,750
Medical Assistance Reimbursements	0	40,000
	<u>37,500</u>	<u>62,500</u>

Federal Share	150,000
Required Match	37,500
Proposed Match	37,500

Year 2      Year 3      Year 4      Year 5

**A. EXPENSES****I. PERSONNEL**

		<b>Total Budget</b>	<b>Total Budget</b>	<b>Total Budget</b>	<b>Total Budget</b>
Executive Director	4%	3,476	3,580	3,687	3,798
Assoc. Exec. Dir.	4%	2,362	2,433	2,506	2,581
Finance Director	4%	1,432	1,475	1,519	1,565
Administrative Assist.	4%	1,168	1,203	1,239	1,276
Finance Assist.	4%	701	722	744	766
Billing Clerk	4%	608	626	645	664
Grant Writer	4%	1,313	1,352	1,393	1,435
Program Director	50%	21,315	21,954	22,613	23,291
Mental Health/D&A Counselor	100%	31,729	32,681	33,661	34,671
Mental Health/D&A Counselor	100%	25,429	26,192	26,978	27,787
Family Support Worker	100%	24,720	25,462	26,226	27,013
Secretary	25%	6,214	6,400	6,592	6,790
Maintenance	4%	826	851	877	903
		121,293	124,931	128,680	132,540

**II. BENEFITS**

Medical		6,013	6,193	6,379	6,570
Dental		1,827	1,882	1,938	1,996
Disability		494	509	524	540
Life		211	217	224	231
Worker's Comp.		643	662	682	702
Unemployment		859	885	912	939
FICA		9,279	9,557	9,844	10,139
Retirement		3,621	3,730	3,842	3,957
		22,947	23,635	24,345	25,074

**III. TRAVEL**

D.C. Conf. Transportation		117	121	125	129
D.C. Conf. Per Diem		587	605	623	642
		704	726	748	771

**IV. EQUIPMENT**

		0	0	0	0
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**V. SUPPLIES**

Office		2,737	2,818	2,903	2,990
Building & grounds		1,093	1,126	1,160	1,195
		3,830	3,944	4,063	4,185

	<b>Year 2 Total Budget</b>	<b>Year 3 Total Budget</b>	<b>Year 4 Total Budget</b>	<b>Year 5 Total Budget</b>
<b>VI. CONTRACTUAL</b>				
Payroll	1,658	1,708	1,759	1,812
Audit	1,349	1,389	1,431	1,474
Visiting Nurse Association	4,178	4,303	4,432	4,565
Pinebrook Services	4,408	4,540	4,676	4,816
New Bethany Ministries	3,883	3,999	4,119	4,243
East Stroudsburg University	28,214	29,060	29,932	30,830
	<u>43,690</u>	<u>44,999</u>	<u>46,349</u>	<u>47,740</u>
<b>VII. CONSTRUCTION</b>				
	0	0	0	0
<b>VIII. OTHER</b>				
Office rent	5,562	5,729	5,901	6,087
Insurance	2,060	2,122	2,186	2,252
Telephone	2,819	2,904	2,991	3,081
Postage	1,612	1,660	1,710	1,761
Printing	569	586	604	622
Staff training	1,164	1,199	1,235	1,272
Local travel	4,635	4,774	4,917	5,065
Care of bldgs/grounds	572	589	607	625
Office equip. maint.	381	392	404	416
Subscriptions/publications	342	352	364	375
	<u>19,716</u>	<u>20,307</u>	<u>20,919</u>	<u>21,556</u>
<b>PROGRAM TOTAL</b>	<u>212,180</u>	<u>218,542</u>	<u>225,104</u>	<u>231,866</u>
<b>B. INCOME</b>				
Lehigh County Child/Youth	20,726	22,847	25,034	27,289
Lehigh County D & A	10,364	11,424	12,518	13,644
Northampton County Child/Youth	20,726	22,847	25,034	27,289
Northampton County D & A	10,364	11,424	12,518	13,644
	<u>62,180</u>	<u>68,542</u>	<u>75,104</u>	<u>81,866</u>
Proposed Match (25%)	37,500	37,500	37,500	37,500
Non-Grant Related Income	24,680	31,042	37,604	44,366
	<u>62,180</u>	<u>68,542</u>	<u>75,104</u>	<u>81,866</u>

### **F. Evaluation Information**

The evaluation for this project was conducted by a team of third party evaluators. Dr. Lynn Woodhouse, Professor and Coordinator of the accredited MPH Program at East Stroudsburg University, PA, served as the Principal Investigator for the Evaluation of this Project. The

evaluation team included Dr. William Livingood, Professor at East Stroudsburg University, Angela Herrlinger, Research Associate, and Dr. Harold Jacobs, Professor of Math at East Stroudsburg University and the statistician for this project, and Tonya Williams, secretary. This team served as the evaluators for the previously funded FIP cycles. The team has extensive experience providing evaluation services to several regional, state and national projects over many years.

Throughout the duration of the project, the evaluation team was actively involved in providing evaluation feedback. Involvement included attending multiple staff member meetings each year, providing yearly evaluation reports (even though the grant contract only required two evaluation updates), and providing support and problem solving expertise in a collaborative fashion.

Because of the goals of the evaluation (listed below), the evaluation design was both consistent and emerging. The data collection measures were consistently applied throughout the length of the project, though input from project staff allowed for improvement in data collection methods over the course of the project. In addition, additional new measures were implemented to capture the changing concerns and realities that the project staff reported over time. Because of the longitudinal nature of this project, and because of the varying realities of the context in which the project was implemented and the varying realities experienced by families it served, the need for flexibility and adaptability was paramount.

**Goals of the Evaluation:** There are three major goals of the evaluation which have driven this evaluation since October 1996:

1. The evaluation methods are designed to give feedback on processes, impacts and outcomes based on the goals and objectives of the project. The emphasis is on triangulation. Triangulation means that each of the goals and objectives of the evaluation has multiple data sources from which information on processes impacts and outcomes can be assessed.
2. The evaluation is based on the emerging concept that evaluation should be empowering to the participants, staff, project coordinators, evaluator and funders. The methods of this evaluation are designed to enhance the project's effectiveness, capture the staff concerns and wisdom and facilitate effective interactions for the participants. It is designed to let us "learn while doing" from the many perspectives of the staff and participants rather than just "learning what we did."
3. The evaluation data generated in this evaluation has consistency with and allows for some comparison with the data from earlier OCAN funded projects.

**Sources of Data for the Evaluation:** The multiple data sources allow for triangulation of data and provide increased meaning and understanding about the project. Cumulatively they facilitate a better understanding of how FIP works and how it supports change within the context of the families' lives.

1. Referral sheets
2. Discharge Forms
3. Family Survey - Exit interview for Families
4. Services Documentation sheets
5. Presenting Problems Survey - Measures types and severity of 3 presenting problems – Added to evaluation to capture additional data
6. Parent pack - measures child health, substance use and abuse, family stress, etc. This is pre and post.

7. Parenting Skills Inventory/Primary Care Giver - a pre and post measure assessing parenting skills, conflict resolution, communication and parental problem solving
8. Family Risk Scales - Seven scales modified from the Child Welfare League scales. Pre and post measures taken.
9. School Interviews - Teacher/counselor interviews at closing of school age children – added to evaluation to capture additional evaluation data
10. Verification with Children's Protective Services at end of project to determine rate of re-entry into the system of a sample of served clients.
11. Meetings with parents involved in Mentoring program - Life History Research
12. Focus Groups/informal meetings with staff
13. Exit Interviews with staff to determine issues related to working on the project-added to evaluation to capture additional information for evaluation.

**II. Was the project successful in attaining its Implementation Objectives? (Process Evaluation)**

**A. Statement of the Project's implementation objectives as provided in the grant application.**

Goal. 1: Identify and Offer long term in home assistance to families at risk of neglect and chronically neglectful families including those who have children that have returned from placement

1.a. Receive Referrals from hospitals and schools for children who are at risk of neglect	-8 referrals were from other Valley Youth House programs -4 referrals were from schools -3 referrals were from hospitals -7 were self referrals
1.b. Receive Referrals from two county public welfare agencies of chronically neglected children and children who have returned home from placement	-107 of the families were referred by Children and Youth (child protection) -23 referrals were from other outside agencies including mental health (4 cases re-opened)
1.c. To provide Services only to families that meet project criteria : Child, 0 to 11 years old at risk of neglect or being neglected, at least one parent with a substance abuse problem, and/or diagnosed with a mental health problem	All identified clients were between the ages of 0 to 11 years old. It is important to note that the identified child was between these ages, however the whole family benefited from these services. (See Chart Section II D.)
1.d. Provide services to 150 families in 5 years	The project served 156 families. Of these families we have complete evaluation data on 22 families. We have incomplete evaluation data on 77 families. Twenty-six families refused to participate in the evaluation. No data was collected on 28 cases because they closed early. Three or four cases were closed and then re-opened (depending on the definition). Therefore we have some or all data on 102 families.
1.e. To provide 75% of services for project families on an in-home basis	All clients received in home services – 100%
1.f. To provide services to families for up to 18 months	See Chart section II D.

**Goal II: To add to the community supply of services by providing an in-home program of mental health, substance abuse, and family support services ,as well as parenting education, to meet the prevention, intervention and treatment needs of project children and parents.**

<p>2.a.(1a) Prevention - Professional Staff</p> <ul style="list-style-type: none"> <li>i. Parenting skills</li> <li>ii. parent network groups</li> <li>iii. linkages to life necessities (food, etc.)</li> <li>iv. linkages – formal, informal housing</li> <li>v. linkages – education, job training</li> <li>vi. transportation</li> <li>vii. child medical care</li> </ul>	<ul style="list-style-type: none"> <li>i. 100%</li> <li>ii. 100% referral to this support</li> <li>iii. 100%</li> <li>iv. 100% referral as needed</li> <li>v. NA</li> <li>vi. 100%</li> <li>vii. 60% added to Medical Assistance or received medical care</li> </ul>
<p>2.a.(1b) Prevention - Volunteer &amp; Para Prof</p> <ul style="list-style-type: none"> <li>i. parenting skills education</li> <li>ii. academic tutoring &amp; mentoring for school age children</li> <li>iii. peer mentoring (program grads)</li> </ul>	<p>(1b) 17 possible mentors identified, 10 completed training, 6 saw clients</p> <ul style="list-style-type: none"> <li>i. parenting skills – 100% of those trained</li> <li>ii. academic tutoring - this activity did not work out as planned</li> <li>iii. peer mentoring - 60% completed</li> </ul>
<p>2.b. Intervention</p> <ul style="list-style-type: none"> <li>(2a) substance abuse intervention</li> <li>(2b) linkage - in&amp;out patient drug test</li> <li>(2c) emergency shelter &amp; respite care</li> <li>(2d) emergency financial assistance</li> <li>(2e) linkage - AA &amp; NA</li> <li>(2f) indiv parent counseling</li> <li>(2g) indiv child counseling</li> <li>(2f) family counseling</li> </ul>	<ul style="list-style-type: none"> <li>(2a) 100 % referral, compliance inconsistent</li> <li>(2b) 100% referred when appropriate, 25% compliance</li> <li>(2c) 30% of clients received as needed</li> <li>(2d) food bank, clothes, etc., 60%</li> <li>(2e) 25% compliance</li> <li>(2f) 100%</li> <li>(2g) 100% when age appropriate</li> <li>(2f) 100% when age appropriate</li> </ul>
<p>2.c. Treatment</p> <ul style="list-style-type: none"> <li>(3a) outpatient psych evaluation &amp; medication of parents</li> <li>(3b) individual psychotherapy- other than counselor</li> <li>(3c) psychological evaluation of children</li> <li>(3d) comprehensive mental health services</li> </ul>	<ul style="list-style-type: none"> <li>(3a) referral 55%, compliance consistent 25%</li> <li>(3b) 15% (severely limited by emerging managed care requirements)</li> <li>(3c) 30% if old enough (eval and medication available/early intervention of preschool/developmental delays)</li> <li>(3d) 50% referral, compliance low</li> </ul>

**Definitions:**

1. A substance abuser is defined as an alcoholic or a person addicted to crack, cocaine, heroin, barbiturates, hallucinogens, amphetamines, depressants or other mind or behavioral altering substances.
2. Negligence is defined as the negligent treatment or maltreatment of a child including physical neglect (refusal to seek health care, abandonment, inadequate supervision, expulsion), educational neglect (permitting truancy, failure to enroll a school age child, inattention to special education needs), and emotional neglect

(spouse abuse in child's presence, permission for child to use drugs, refusal to provide psychological care) by a parent responsible for the child's welfare, under circumstances which indicate that the child's health or welfare is harmed or threatened (NCCAN, 1992).

## **B.Statement of Questions related to assessing the implementation Objectives.**

1. Were the individual project implementation objectives attained for Goal 1 and Goal 2? If not, what contributed to this process?
  - a. Did the project serve the expected number of families?
  - b. Did the project receive the required types of referrals?
  - c. Did the project provide the expected amount of in-home services?
  - d. Did the project provide the services for up to 18 months?
  - e. Did the project provide the required types of prevention services through the professional staff?
  - f. Did the project provide the anticipated types of prevention services through the volunteers/paraprofessionals?
  - g. Did the project provide the anticipated types of substance abuse and mental health as well as life support services to clients?
  - h. Did the project provide the anticipated types of mental health treatment services to clients?
2. What, if any, changes were made to Goal 1 and/or Goal 2 implementation objectives during the course of the project? What contributed to these changes?
3. What specific barriers or facilitators could be illuminated regarding attainment of Goal 1 and 2, and the specific implementation objectives, while examining the data that pertains to each or all of the implementation objectives?

## **C.Methods used to answer each implementation-related question.**

1. Data collected to answer each question:
  - a. Referral or Face sheets, Intake and Discharge summaries provided the information for measuring objectives 1.a. to 1.f.
  - b. Interviews/focus groups with staff and directors, project documentation materials, Family Survey data and Discharge Summaries provided information for measuring objectives 2.a. to 2.c.
  - c. Participant observation, focus group at mentor training, life history research and record keeping by mentor trainer for 2.a.
2. Methods of data collection and data sources:
  - a. Referral and Face sheets were collected at referral by project staff or directors, Intake and Discharge summaries were prepared by the counselor for the family, Interviews/focus groups with staff were conducted periodically during staff meetings and follow up interviews of staff and directors were used to provide clarification.
  - b. Triangulation was used to verify accuracy of information. Multiple data sources provided support for validity of information provided here, especially when inconsistencies or missing data problems emerged.
3. Description of sampling procedures, if relevant: When possible, data was collected on all families/clients. There were no sampling procedures for any of the data collected. Inconsistencies in available data are not due to sampling procedures.

4. Description of data analysis procedures, if relevant: All data analyzed for Goals 1 and 2 are analyzed through frequency counts and other descriptive techniques.

**D. Findings regarding each of the implementation-related questions.**

**1. Findings for each implementation-related question.**

1. A. Were the individual project implementation objectives attained for Goal 1 and Goal 2? If not, what contributed to this process?
- a. Did the project serve the expected number of families? MET
  - b. Did the project receive the required types of referrals? MET
  - c. Did the project provide the expected amount of in-home services? MET
  - d. Did the project provide the services for up to 18 months? MET
  - e. Did the project provide the required types of prevention services through the professional staff? MET (except for tutoring)
  - f. Did the project provide the anticipated types of prevention services through the volunteers/paraprofessionals? UNMET
  - g. Did the project provide the anticipated types of substance abuse and mental health as well as life support services to clients? MET
  - h. Did the project provide the anticipated types of mental health treatment services to clients? MET
2. B. What, if any, changes were made to Goal 1 and/or Goal 2 implementation objectives during the course of the project? What contributed to these changes? *See Below*
3. C. What specific barriers or facilitators could be illuminated regarding attainment of Goal 1 and 2, and the specific implementation objectives, while examining the data that pertains to each or all of the implementation objectives? *See Below*

The summary of the findings is provided in the charts in section II A. These charts provide a review of the quantitative results of the Goals I and II and the respective objectives. The following information supplements the findings provided earlier in these charts.

Demographic information in the following chart indicates that the clients came from families displaying the prerequisites for service.

**Table 1**

Demographic Issues Identified Prior to Involvement With FIP (at Intake) as Assessed by Counselor:	Yes	No
History of Abuse or Neglect	96%	4%
Prior reported Neglect or Abuse	79%	21%
Prior Welfare Caseload	58%	42%
Previous Placement Outside Home	35%	65%
Past Health Problem for Child	38%	62%
Medical Insurance before FIP	87%	13%
Child mental health problem	32%	68%
Parent mental health problem	82%	18%
Parent substance abuse problem	82%	18%
Adult smoking in household	77%	23%
Housing or Neighborhood safety concerns at intake	48%	52%
History of past arrest of adult in home	74%	26%
Past probation	26%	74%
Child has developmental problems diagnosed by agency or provider	33%	67%

Information on the ages of children served is derived from several data sources. One data source is the Discharge summaries. These summaries are completed by the counselor at the time of the closing of the case. Because the clients may have been in the project for up to 18 months, the ages of the clients (on the discharge summaries) may exceed the limits set for the program. The second data source is the parenting inventory filled out by the primary caregiver (only one per client child). These two sources corroborate that there is data for approximately 90-100 clients. Data documenting the remaining 50 subjects (described in the charts above) is from the FIP staff record keeping materials.

Table 2

<b>Age of child in years - from discharge summaries</b>				
<b>age</b>	<b>Frequency</b>	<b>Percent</b>	<b>Cumulative Frequency</b>	<b>Cumulative Percent</b>
<b>1</b>	2	3.23	2	3.23
<b>2</b>	7	11.29	9	14.52
<b>3</b>	4	6.45	13	20.97
<b>4</b>	3	4.84	16	25.81
<b>5</b>	5	8.06	21	33.87
<b>6</b>	9	14.52	30	48.39
<b>7</b>	4	6.45	34	54.84
<b>8</b>	6	9.68	40	64.52
<b>9</b>	5	8.06	45	72.58
<b>10</b>	8	12.90	53	85.48
<b>11</b>	7	11.29	60	96.77
<b>12</b>	1	1.61	61	98.39
<b>13</b>	1	1.61	62	100.00

*Frequency Missing = 24*

<b>Age in years- from parenting inventory for primary caregivers</b>				
<b>age</b>	<b>Frequency</b>	<b>Percent</b>	<b>Cumulative Frequency</b>	<b>Cumulative Percent</b>
<b>under 1</b>	4	4.40	4	4.40
<b>1</b>	11	12.09	15	16.48
<b>2</b>	8	8.79	23	25.27
<b>3</b>	5	5.49	28	30.77
<b>4</b>	10	10.99	38	41.76

5	11	12.09	49	53.85
6	5	5.49	54	59.34
7	6	6.59	60	65.93
8	10	10.99	70	76.92
9	7	7.69	77	84.62
10	8	8.79	85	93.41
11	5	5.49	90	98.90
12	1	1.10	91	100.00

**Frequency Missing = 3**

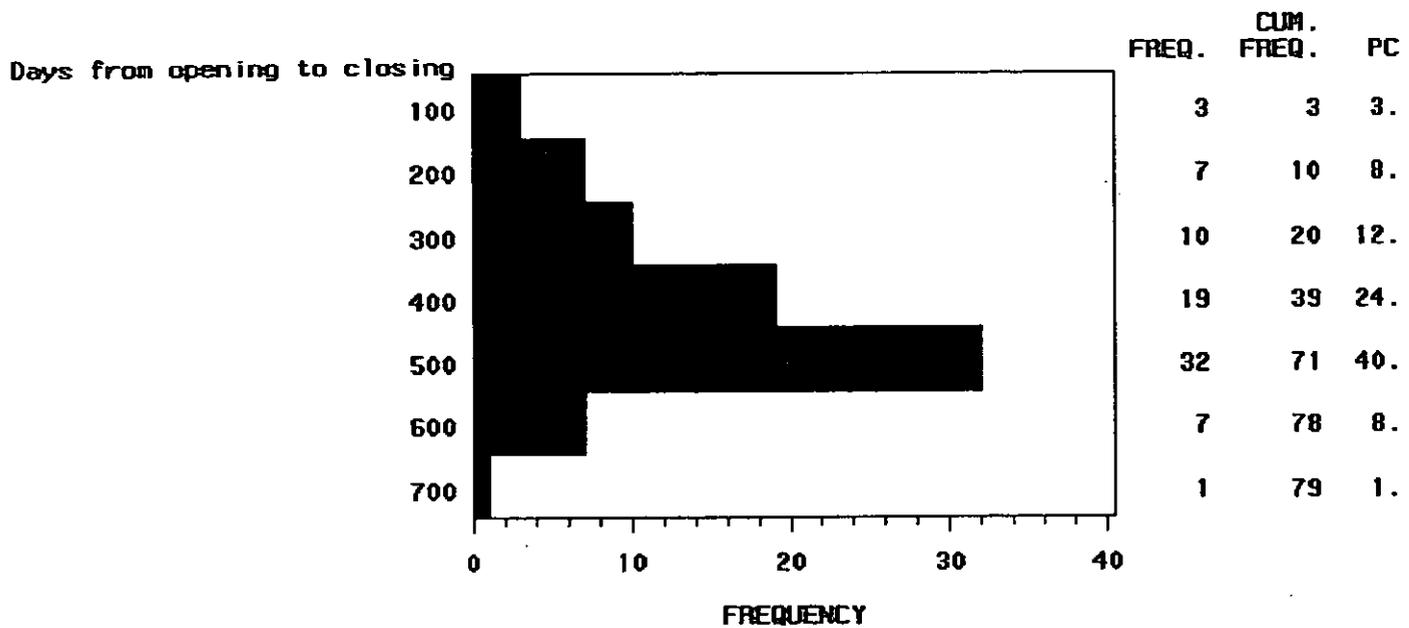
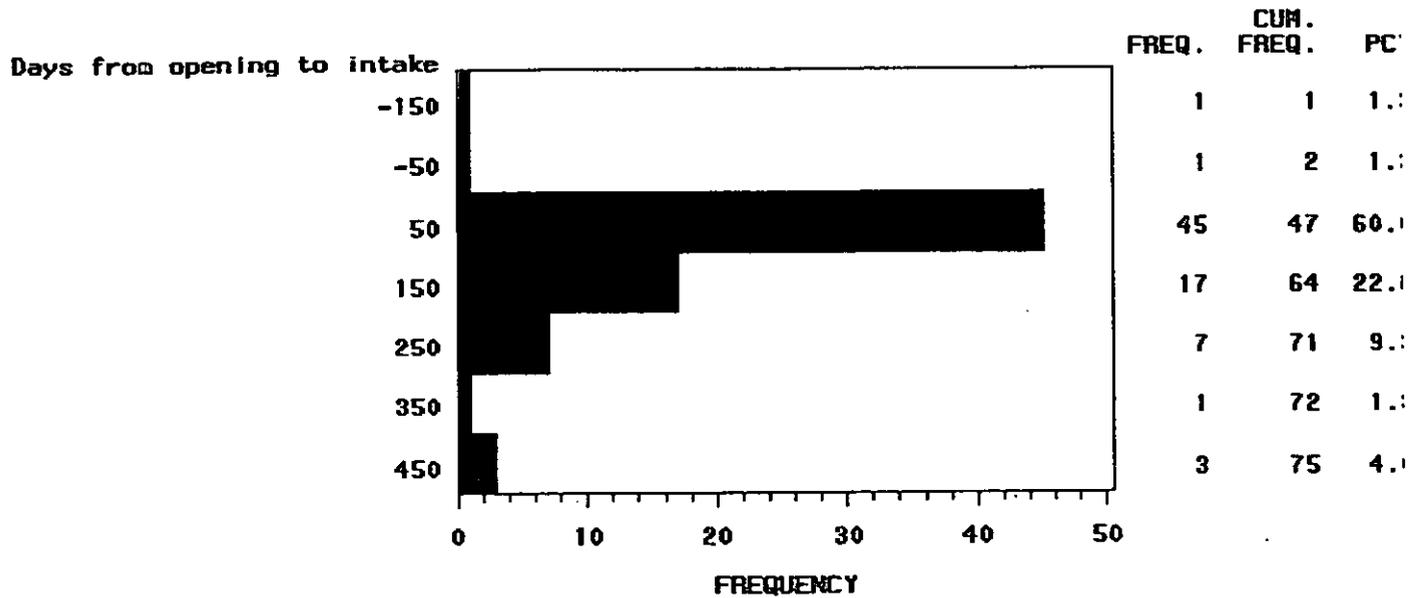
Data documenting the length of service for clients and the numbers of clients receiving these services (for whom there is evaluation data) are displayed in the following graphs. These graphs are prepared from data on the intake and Discharge summaries. Additional information is provided from family member responses on the Family Survey.

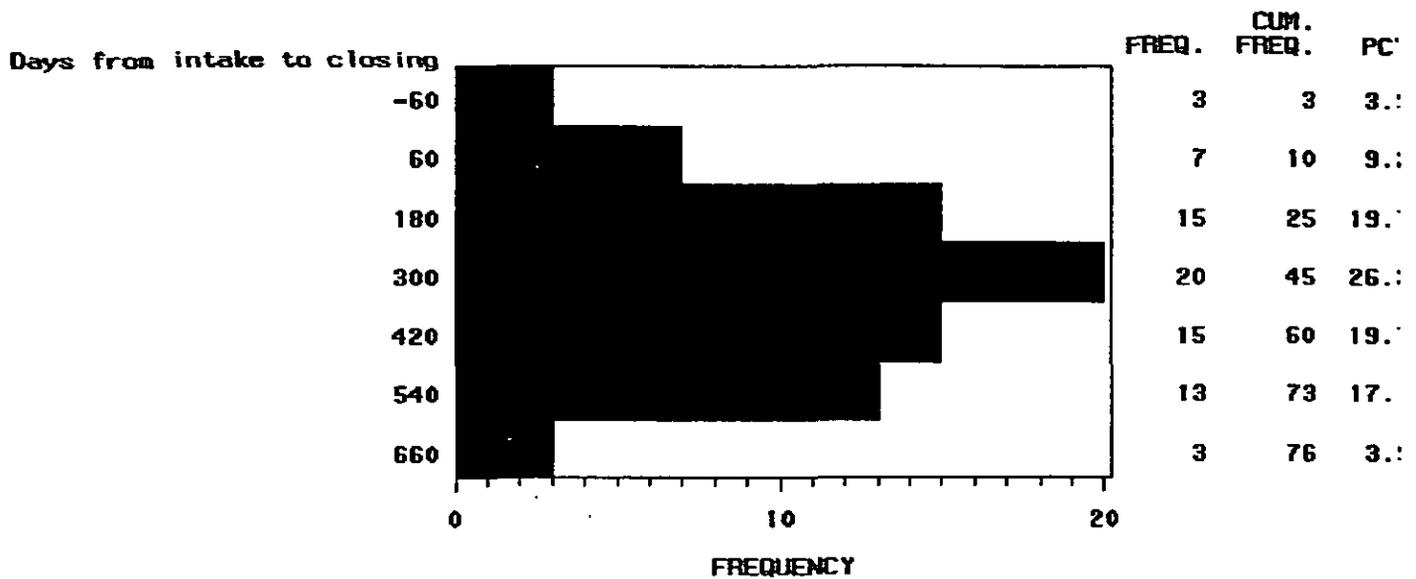
The time of service frequencies are developed by documenting the intake date and the discharge date. This information is then used to determine the length of service. The number of clients is reduced because the graphs could only be developed from data recorded by the counselors. In some cases a Discharge summary was not available and in some cases the date of discharge was incomplete.

The first graph, days from opening to intake, displays the average for the length of time it took for the counselor to complete intake once a case was opened. Though the graph is confusing due to some erroneous data (reversed dates, etc.) recorded by a few counselors, the graph shows that the most frequent average for the days from opening to intake is around 50-100 days, followed by the average of 100 - 150 days. Clearly this is a potentially lengthy process. In fact, this was the discussion of many staff focus group and training sessions. The discussion is described in the next paragraph.

At the beginning of this project, as the evaluation processes were being developed and implemented, the staff reported that they were having great difficulty accurately evaluating the status of families. They discovered that it took several weeks or even months to accurately create a total understanding of the situation of each family. They negotiated a process they would follow to complete intake. The goal was that each counselor would complete the intake process for each family in approximately six weeks. In other words, all intake data for the evaluation should be completed by six weeks into the client family's involvement with the project. Though there were many things that impacted the counselor's ability to accurately complete the intake process, the most important concern was the extreme crisis situation in which the families existed. The project evaluation data collection needed to wait until the crisis was supported. It would be unethical to do otherwise. The agreed upon time frame was 42 days, but, in reality, sometimes the process took

longer. It is not clear if this intake process took increasingly longer in the later years of the project. What is clear is that the counselors reported that the level of crisis experienced by the clients became exponentially greater over the five years of the project. The following graphs demonstrate:





The most frequently reported number of days from opening (when case was referred) to closing was 400 - 600. The most frequently reported number of days from intake (when intake and evaluation data were completed) to closing was 180 - 540. Since the project was designed to serve the families for up to approximately 18 months, and 18 months is approximately 540 days, the project met this objective.

Additional data on the amount of time spent in FIP comes from the Family Survey. This survey is mailed to and returned voluntarily by family members after they were discharged from the project. The respondents to this survey reported their perceptions that they were involved in the project the following lengths of time: 0-1 months 27%, 1-2 months 5%, 2-6 months 5% and 6 or more months 63%.

Additional data on services provided comes from the Family Survey. The following tables represent the responses by the families returning this survey which indicate the types of help they received from FIP. The respondents (caregivers) to this survey were: Mother (81%), Father (12%) and other (7%).

**Table 3**  
**Family Survey Data**  
**Assistance Provided by FIP as Reported by Caregiver**

Type of assistance	Percent	n
Overall: FIP help to your family	90%	56
Transportation	61%	38
Health Care	50%	31
Housing	27%	17
Drug & Alcohol services	48%	30
Employment / Education	18%	11
Other	31%	19
Counseling services	77%	48
Parenting skills	73%	45
Violence or abuse reduction	44%	27
Caseworker visit in home useful	89%	40

Missing 17

**Table 4**  
**Caregiver Reported use of D&A services**

Type of Drug & Alcohol Service	Percent	N
Received any D & A services	45%	23
Received Inpatient D & A services	13%	8
Received Outpatient D & A services	23%	14
Received Aftercare D & A services	8%	5
Received Assessment D & A services	19%	12
Received AA or NA services	19%	12
Received Coping services	6%	4
Received Other D & A services	13%	8

Missing 11

**Table 5**  
**Caregiver reported use of Mental Health Services**

Type of Mental Health Service	percent	N
Received any MH services	53%	19
Inpatient MH services	3%	2
Outpatient MH services	21%	13
Assessment MH services	13%	8
Medication	13%	8
MH support services	22%	11
Other MH services	4%	2

Ninety percent of the respondents reported that FIP was helpful to them. Eighty-nine percent responded that the home visits were helpful to them. Transportation (61%), counseling services (77%), parenting skills (73%), mental health services (53%), drug and alcohol services (48%) and health care (50%) were most consistently reported as being of help by the families.

The level of success of the paraprofessional/volunteer objective needs some explanation. The process was conceptualized to be the matching of successful graduates of FIP with people currently in the program. These graduates would receive training including: networking, relationship skills, communication skills, problem solving, parenting skills, child safety and advanced parenting training. Three attempts were made to recruit and train these mentors. Two of the scheduled recruiting efforts were successful. In these two attempts a total of 9 mentors were successfully trained. These mentors had varying levels of involvement with clients. Most mentors were successful at engaging one family and met with this family between 4 and 19 times. Many of the 9 mentors worked with the family until this family's case was closed by FIP. However, many of the mentors were not able to continue to be involved with families. The most common reason for this was that their own personal problems were too great to allow them the flexibility they would need to take care of others. The observations of the mentors and life history research with the mentors documented that while serving as mentors the women gained a great deal of confidence and felt they were very helpful to the clients. The FIP staff member responsible for recruiting and training the mentors went to great lengths to facilitate the success of this project. She attempted to recruit mentors from other programs within the agency. Ultimately it became too time consuming and it was decided her time was better spent working directly with clients.

## 2. Lessons Learned

A. The obvious difference in time from opening to intake needs some clarification. The problem (the need for many weeks to do an accurate intake) was articulated by the counselors as the project was evolving. Because of the multiple crises experienced by the families and because it took a great deal of time to break down resistance and engage the families at a level where they could be accurately assessed, the line between a pre measure and a post measure became blurred. This was one of the most important barriers to the effectiveness of the project (as conceptualized) and for the evaluation. In essence, the concept of a project that engages a family, treats a family, then discharges a family is too linear. Engaging a family is blurred with treatment. In fact, counselors reported that the process of assessing and breaking down resistance is continual. Families are more like a slowly opening flower that closes back up at night. The resistance comes and goes, the crises lessen and worsen. There is not really a beginning and end. Even some families that are discharged need to reenter the project. In addition, the context in which the family attempts to recover or change is a moving target and this has a tremendous impact on the effectiveness of their change efforts and the services provided.

B. The established criteria for entry into the program was not strictly followed by the referring agencies. Since the majority of referrals came from the child welfare agency, the critical nature of the problems experienced by the families was exponentially worse than the project was originally conceptualized to serve. The criteria for entry should have been more carefully communicated and more strictly enforced. However, because there is such a heavy caseload for child welfare workers,

because the community resources to support families are not plentiful and because the legal definition of abuse and neglect in PA does not allow for effective early intervention, this project has continually had to attempt to serve families with multiple and very severe problems. For the project to be implemented as designed the level of the problems experienced by the families served should have been much less severe. Examination of Table about Demographic Issues clearly documents the very critical situations in which these families lived prior to involvement with FIP, including very high rates of child abuse.

C. An objective for documenting and minimizing staff turnover would be helpful. A second objective to decrease the impact of staff turnover on the effectiveness of the project would also be helpful, specifically to provide a team of counselors (perhaps a case manager and a therapist) for each client. It was not until about ½ way through the 5 years that the staff turnover problem became apparent. At that time we implemented an evaluation process to conduct exit interviews with the staff to better understand the issues involved in their departure. (This data will be summarized in a later section of this report.) If this process had been in place prior to the staff turnover problem beginning, perhaps we could have provided feedback into the project that could have reduced this turnover or at least minimized the impact of the turnover on the effectiveness of the project.

D. The types of services provided were both life-sustaining services, with clear and easily understandable benefits, and services that require the client to engage in change processes. Based on the evaluation information available (and interviews with staff and directors) it is clear that the clients are much more likely to follow up on referrals for life sustaining services like shelter, clothes and food and are least likely to follow up on referrals that require their personal efforts to work for change. Staff reported that they would make referrals and then provide transportation, help clients learn to schedule appointments and help them navigate the system. They would do whatever it takes to help clients get over their resistance to the needed change. However, because of the greater resistance to personal change types of referrals, a greater emphasis on implementing change in these areas would have been helpful in program design.

Along this line, client resistance should be a greater focus of the project, especially resistance to personal behavior change. Because there was not a planned emphasis on reducing this type of client resistance, and because the resistance complicated the project plans, a greater emphasis on reducing resistance should be an objective of future projects.

E. The concept of pre and post measures is predicated on the linear model of research. As with many other projects evaluated by this team, this concept has proved less valuable in application than it is in conceptualizing research. Typically researchers believe understanding the value of a treatment requires knowing the accurate status of a client when they begin involvement with a project (at some ostensibly measurable point in time) and then measuring their progress at discharge. The experiences with this project evaluation demonstrate that the value of the treatment cannot be understood in this fashion. The lines between opening, intake and discharge are too blurred. What should be done differently, and what we built into the evaluation over time, is the utilization of multiple data collection strategies that are designed to illuminate the perceptions of the many stakeholders throughout the project implementation process. If we were able to rely more heavily on these types of measures from implementation, and could have de-emphasized the need for pre and post measures, we would have additional valuable data to report.

F. Re-conceptualize the paraprofessional/volunteer approach. The clients served are too vulnerable to be the primary volunteers for this process. Because of the critical nature of the families, with most being referred to FIP by the child protective agency, the level of crisis was too great for them to transition easily from client to mentor. The types of problem solving and organization necessary to be successful as a mentor may be more than these clients can continually display. Future attempts at mentoring should concentrate more on finding mentors without such crisis-laden histories. It is true that the idea of having a mentor who has succeeded is very important, but when they are so recently recovering this may be more than they can successfully handle. It might also be important to consider teams of mentors or group mentoring if the desire is to use this type of program graduate. The critical nature of the clients referred to this program made the success of this aspect of FIP less likely.

**III. Was the project successful in Attaining its Participant Outcome Objectives?**

**A. Statement of the project's participant outcome objectives as stated in the grant application.**

Goal 3: Reduce substance abuse (SA), emotional and economic problems of project parents and increase parenting skills

Objective	Data Collected
3.a. Reduce SA in 50% of Parents who report SA as a problem through interventions and linkages to treatment	Intake/Discharge Parent SA Survey Problem/Severity Measure Family Risk Scale Family Stress Inventory Parent Focus Group
3.b. Reduce emotional problems through mental health services in 65% of parents with emotion problems at entry	Intake/Discharge Problem/Severity Measure Family Risk Scale Family Stress Inventory Parent Focus Group Life History Research
3.c. Improve economic viability of 65% of parents with problems at entry through linkages with resources providing basic life necessities, housing assistance, training and employment and emergency services.	Intake/Discharge Family Stress Inventory Parent Focus Group
3.d. Increase parenting skills in 65% of parents through parenting skills education	Intake/Discharge Family Stress Inventory Parent Skills Inventory Parent Focus Group Family Risk Scales Life History Research
3.e. Increase parent empowerment, network building, interactional and social skills of 65% of parents having skill deficits by providing social network groups, peer mentors and individual counseling	Family Stress Inventory Family Risk Scales Parent Skills Inventory Discharge Inventory Parent Focus Group Life History Research

**Goal 4: Reduce health, academic, behavioral, social and emotional problems in project children**

Objective	Data Collected
4.a. Improve the health and developmental status of 65% of children with problems at entry by providing health services	Intake/Discharge Child Health Survey Family Stress Inventory Family Risk Scales Problem/Severity Measure
4.b. To improve the academic and interactional functioning of 65% of children with less than "C" average at entry through participation in a program of academic tutoring and mentoring.	School/teacher survey - Family Stress Inventory Intake/Discharge Life History Research
4.c. To reduce the in emotional and behavioral problems of 65% of school age children with emotional problems at project entry through the provision of enhanced mental health services and individual counseling services	Intake/Discharge Family Stress Inventory School/teacher survey Child Mental Health Scale Question - I&D* Family Risk Scale Problem/Severity Measure

**Goal 5: Keep family unit intact and minimize the involvement of high risk project families with the child welfare services and the chronically neglectful families with child welfare placement services**

Objective	Data Collected
5.a. Prevent 75% of cases at risk for neglect at time of entry from becoming child welfare agency cases through the provision of project services	Intake/Discharge Verification at CPS
5.b. To prevent out of home placement of 80% of chronically neglected children, including the previously placed children who have been open cases with the two county child welfare agencies at program entry, through the provision of project services	Intake/Discharge Verification at CPS - if necessary

**Goal 6: To test the overall efficacy of the program, and the efficacy of a core service package that consists of professionally provided services only (Group 1) as compared to a core service package that includes volunteer provided prevention and intervention services in addition to the professionally provided services.**

Objective	Data Collected
6.a. Document project services by measuring the extent to which the services in goals 1 and 2 are implemented	Services Documentation Family Survey
6.b. Document outcomes by measuring the extent to which goals 3-5 are achieved	
6.c. Comparison with theoretical for: per unit cost per family cost overall cost	Data to be generated by VYH
6.d. Assign 50% of cases to professional care only and 50% of cases to care by volunteers and compare outcomes for both groups	Cases from years 2,3 and 4 that are assigned to the two different treatments will be compared for outcomes on specified variables. Demographic variables will be used to document similarity of families. A matching process will be developed to insure similarity of groups due to the potential ethical problems associated with randomly assigning families to the two treatments

**B. Questions related to assessing participant outcome objectives, expectations for change and definitions. Through participation in FIP:**

1. Was substance abuse (or the impact of substance abuse on the family) decreased in 50% of parents/families for whom this was a problem?
2. Were emotional problems decreased in 65% of parents with emotional problems at entry through mental health services?
3. Was economic viability increased for 65% of parents with problems at entry?
4. Were parenting skills increased for 65% of all parents?
5. Were the networking, interaction, social skills and empowerment increased for 65% of parents?

6. Did the project help increase the health of 65% of children for whom health was a problem at intake?
7. Did the project help increase or improve the academic functioning of school age children with less than a C average?
8. Did the project help decrease the emotional and behavioral problems of 65% of the children for whom these problems were reported at entry?
9. Did the project help prevent 75% of the cases from becoming a child welfare agency case?
10. Did the project help prevent out of home placement of 80% of children?
11. Did the paraprofessionals/mentors enhance the effectiveness of FIP in efforts to meet goals 3 to 5?
12. Did the paraprofessionals/mentors provide cost effective services?
13. Did the clinical trial concept, assigning 50% of cases to professional care only and 50% of cases to care from volunteers, change the types of outcomes for the families?

(B. Continued – Specific Project Components and their relationship to project successes):

1. Was substance abuse (or the impact of substance abuse on the family) decreased in 50% of parents/families for whom this was a problem through linkages with substance abuse interventions and treatment?
2. Were emotional problems decreased in 65% of parents with emotional problems at entry through mental health services through provision of parent mental health services?
3. Was economic viability increased for 65% of parents with problems at entry services through linkages with resources providing basic life necessities, housing assistance, training and employment services, and the provision of emergency family housing and financial assistance?
4. Were parenting skills increased for 65% of all parents through parenting skills education ?
5. Were the networking, interaction, social skills and empowerment increased for 65% of parents by providing social network groups, peer mentors and individual counseling?
6. Did the project help increase the health of 65% of children for whom health was a problem at intake through the provision of child health services?
7. Did the project help increase or improve the academic functioning of school age children with less than a C average through participation in academic tutoring and mentoring ?
8. Did the project help decrease the emotional and behavioral problems of 65% of the children for whom these problems were reported at entry through provision of advanced mental health services and individual counseling?

**C. The data collection methods, listed in Section B, were used to answer each outcome-related question. The charts in section A (column 2 for each Goal) clearly display the multiple sources of data used to answer each outcome question. In this section the data source and the process of collection of the data will be described in more detail.**

**Summary of data source and analysis process used:**

- Adult Consent Forms for all adults involved in the evaluation, Child Consent forms signed by the guardian specifically for the child (included interaction with child's school).

- Referral sheets – This data source was completed by the director or counselor. This information documented the issues presented to Valley Youth House as the reason for the referral at intake. Analysis: Frequency counts/percentages

- Discharge Forms – This data source provided both the discharge information for the agency and the data for the evaluation. This extensive measure was completed within a few weeks of the final discharge of the family from the program. This measure described the types of problems experienced by the family and ranks the levels of improvement as seen by the therapist/counselor. Analysis completed included frequencies and changes in ordinal improvement scales.

- Family Survey – The family survey was mailed to the family after discharge from the program. It measures the types of help the family perceives they received while a client of FIP. The family caregiver completed it and returned it in a self-addressed stamped envelope. Analysis completed included frequency counts and percentages on yes no measures and percentages.

- Services Documentation sheets – provided the data to document the types of services and referrals for each client. Frequencies.

- Type of Problem/Presenting Problems Severity Survey - Measures types and severity of the top 3 presenting problems through narrative descriptions rather than selecting predetermined categories. This method was added to the evaluation about midway into the project. Measure is completed at pre and post in an effort to capture the multiple levels of issues and interactive types of change in these issues that could occur in the families. It was also designed to capture additional data on the complexity of the life situations of the families. This measure was completed by the therapist. Extensive analysis on this set of measures included: Frequency counts on types of problems, ordinal measures of severity changes discharge minus intake differences and t-tests on severity differences within problem types and across all severity changes.

- Parent pack - measures include child health issues, substance use and abuse, including the Family Stress Inventory, etc. This is pre and post measure completed by all parents involved in the project. The Family Stress Inventory was also completed by the therapist, pre and post. In many cases this data was also collected for different primary caregivers over time. This was added because the caregiver may change if the child entered the project while in placement or if a relative cared for the child and then the child returned to the parent. Analysis: Frequency counts and mean difference changes

- Parenting Skills Inventory/Primary Care Giver Inventory - a pre and post measure assessing parenting skills, conflict resolution, communication and parental problem solving that was

completed by the therapist or counselor. Analysis: Frequency counts, changes on improvement on ordinal scale discharge minus intake mean differences for matched cases – then aggregated

**-Family Risk Scales** - Seven scales, significantly modified from the Child Welfare League scales. Pre and post measures completed by the therapist/counselor. The processes used to collect this data changed during the course of this project due to multiple trainings required by the staff. These scales assessed various levels of risk for families at pre and post. Analysis: Frequency counts, changes on improvement on ordinal scale (based on mean differences at discharge minus intake for matched cases then aggregated)

**- School Interviews** - Teacher/counselor interviews at closing of school age children – This process was added to evaluation to capture additional data on the changes on school age children and to better understand the school/project/family relationship. Analysis: Qualitative thematic analysis.

**- Verification with Children's Protective Services** at end of project to determine rate of re-entry into the system or placement of a sample of served clients. Analysis: Case names provided to the agency by Valley Youth House. The Protective Service workers documented the status of involvement of that particular client with the agency. Valley Youth House provided the evaluators with the numbers of reopened cases or placements.

**- Participant observations** at meetings with parents involved in Mentoring program. Analysis: Qualitative thematic analysis.

**- Life History Research** with three mothers who became mentors. Analysis: Qualitative thematic/content analysis.

**- Ongoing focus groups and informal meetings with staff** held at least quarterly throughout the 5 years of the project. Analysis: Qualitative thematic/content analysis.

**- Exit Interviews with staff** leaving the project to learn about issues related to working on the project and determine the types of concerns they had about working on the project. This measure was added to evaluation about mid project as the turnover of staff began to increase. Analysis: Qualitative thematic/content analysis.

Definitions developed prior to the project implementation:

3. A substance abuser is defined as an alcoholic or a person addicted to crack, cocaine, heroin, barbiturates, hallucinogens, amphetamines, depressants or other mind or behavioral altering substances.
4. Negligence is defined as the negligent treatment or maltreatment of a child including physical neglect (refusal to seek health care, abandonment, inadequate supervision, expulsion), educational neglect (permitting truancy, failure to enroll a school age child, inattention to special education needs), and emotional neglect (spouse abuse in child's presence, permission for child to use drugs, refusal to provide psychological care) by a parent responsible for the child's welfare, under circumstances which indicate that the child's health or welfare is harmed or threatened (NCCAN, 1992).

## D. Findings regarding each of the outcome questions:

1. Outcome evaluation questions and the effectiveness of FIP as determined by multiple data sources:

1. Was substance abuse (or the impact of substance abuse on the family) decreased in 50% of parents/families for whom this was a problem?

This objective was met. The **Problem Type and Severity Scale** indicated that substance abuse of the parent was the # 1, most frequently cited problem type (by all counselors across all clients). The severity change for all substance abuse problems noted was statistically **significant (p value was .0227)**. Additional data sources verify this finding: the Family Risk scale indicated a mean difference of -.41 for parent substance abuse change (indicating an improvement for 38% of families) and the Family Stress Inventory indicated improvement as perceived by both parents (at 15%) and therapist (at 61%). Additional data on this question collected from the Discharge Summary was unavailable for analysis at this time.

2. Were emotional problems decreased in 65% of parents with emotional problems at entry through mental health services?

This objective was met. The **Problem Type and Severity Scale** indicated that mental health of the parent was the # 2, most frequently cited problem type (by all counselors across all clients). The severity change for all mental health problems noted was statistically **significant (p value was .0008)**. Additional data sources verify this finding: the Family Risk scale indicated a mean difference of -.09 for parent mental health (indicating an improvement for 34% of families) and the Family Stress Inventory indicated improvement in parent mental health as perceived by both parents (at 35%) and therapist (at 47%). Additional information from the discharge summary indicated that the therapists documented a 64% improvement in parent mental health for families for whom this was a problem at intake.

3. Was economic viability increased for 65% of parents with problems at entry?

Progress was made on this objective, but the economic situation of many of these families was too severe for rapid change in long-term economic viability. A summary of information about the potential for economic viability of parents includes the following statistics: Percent of families experiencing hard times since the conception of the client child (mean 50%), percent parents with less than a high school diploma is 37%, percent parents with reported income of less than \$1000 per month is 65%. On the Family Stress Inventory parents reported a 43% improvement in money problems and therapists reported a 33% improvement in money problems. In addition, on this inventory the parents reported a 31% increase in employment and the therapists reported a 33% increase. *Economic problems were the most frequently reported problem in the category of "other" on the Problems and Severity Scale. The improvement of other was statistically significant (p = .0068).*

4. Were parenting skills increased for 65% of all parents?

This objective was met. The **Problem and Severity Scale** indicated that poor parenting skills was the # 3 problem cited by all counselors across all clients. The severity change for all parent skills problems noted was statistically **significant (p value was .0482)**. The Parenting Inventory, developed to measure a total change in parenting skills across several important aspects of parenting, was not significant. However the mean differences on the items were in the desired direction. The parenting inventory did indicate that the percent of parent improvement across each of the 12 measured skill areas was between 29% and 48%. It is important to note that on the

parenting inventory the percent of parents who stayed the same on each item ranged from 19% to 46%. This is important to note because, in the severe situations of many of these families, staying the same may be a major achievement.

5. Were the networking, interaction, social skills and empowerment increased for 65% of parents?

Several types of data help to create a picture of progress on this objective. Though it is not specifically clear that this objective was met, due to the multiple types of issues included in this objective, it is clear that the data indicates that it may have been met. The Discharge Summary indicated that for families for whom neighborhood safety issues were a concern, 76% of these problems were improved during involvement with FIP. On the Family Risk Scale "family social support" showed a mean change of  $-.04$  (discharge minus intake). On this scale 32% of families improved for social support and 42% stayed the same. On the Family Stress Inventory neighborhood problems improved for 24% as rated by the parents and 33% as rated by the therapist. On this scale, isolation problems improved for 30% as reported by parents and 56% as reported by the therapist. On the Problem and Severity Scale, poor coping systems and lack of social support systems were frequently reported in the "other" category. The change in the "other" category was statistically significant,  $p = .0068$ .

6. Did the project help increase the health of 65% of children for whom health was a problem at intake?

This objective was met. On the Discharge Summary the counselor rated the improvement of child medical health issues at 70% improved. On the Family Stress Inventory the parents reported a 29% improvement in child health and the therapist reported a 33% improvement in child health. Transportation to health care was reported as a benefit of the project. Most children had access to health insurance when they entered the project (according to self-report of parents). However, there was a slight increase in children covered by health insurance at discharge.

7. Did the project help increase or improve the academic functioning of school age children with less than a C average?

It is important to note that many of the children were not at school age when they entered the project. For school aged children, the average grades reported by the parents at intake indicated that the majority of students had average grades of C or better. Approximately 10% of children for whom grades were available had average grades below C. Therefore this objective could not be accurately assessed as written. However, several data sources provide insights into this area of concern. On the Family Stress Inventory school problems (if noted at intake) were reportedly improved by 17% of parents and 22% of therapists. An additional data source was the School Survey. Thirty-three surveys were returned by school personnel. This data source indicated that there was some positive change over time for some of the school age students, however attendance and behavior problems were noted as the areas of concern for those students with school problems.

8. Did the project help decrease the emotional and behavioral problems of 65% of the children for whom these problems were reported at entry?

This objective was met. On the Discharge Survey the counselors rated two issues of importance to this objective. One issue, improvement in violent and acting out behavior of child, showed a 78% improvement. The second issue, child mental health, showed a 72% improvement. Both of these were improvements for children/families for whom this was an issue at intake. The school personnel survey indicated that there was some improvement for children who originally displayed behavior problems.

9. Did the project help prevent 75% of the cases from becoming a child welfare agency case?

This objective was met, though there is conflicting information. This objective was measured in three ways. The first process of measurement involved sending a sample list of client names to the child welfare agency serving the county in which the child was located. The agency then checked the names against their master list of children who had become a caseload or had been placed since discharge from FIP. Of the two counties (for cases that had been closed for at least one year as of 8-7-01) for the 61 case names provided, 32 children had become part of the "caseload." This represents about 50% of the cases. Because this was a one to three year follow up measure, and did not involve all the children, this finding needs to be considered within that context. Another measure for this objective is from the Discharge Summary. All discharge summaries, for all discharged clients, required the counselor to indicate if the case had become a caseload for the public welfare agency during any time the child was as a client of the project. Twenty-four percent (24%) of the surveys indicated that the client had become a caseload since involvement with the project (or at discharge). However, this does not mean that the child remained a caseload after discharge. The child could have been referred by the counselor (if perceived to be at risk) and then the child may have been removed from the list during service by FIP. The third type of data used to understand progress on this objective is the Problem and Severity measure. For all the children reported to be experiencing neglect as a problem at intake (one of the top three problems), the severity change measure (pre and post) was significant,  $p = .03$ . It is important to note that the number of children for whom neglect was considered one of the top three problems was only 10. The number of children reported to be experiencing child abuse as one of the top three problems was only 4. This measure was not significant.

10. Did the project help prevent out of home placement of 80% of children?

This objective was Met. This objective was measured in two ways. First the discharge data was used to determine the number of children who were put into placement during or immediately following their involvement in FIP. The counselors noted that only 18% of client children were put into placement. The second source of data for this objective was the follow up study conducted with the child welfare agencies (described in Objective 9 above). The same process was used as in Objective 9. Of the children's names provided, 11 cases of the sample of 51 provided had been placed outside the home. This represents 22% of the cases.

11. Did the paraprofessionals/mentors enhance the effectiveness of FIP in efforts to meet goals 3 to 5?

The efforts to meet this objective were discontinued. Available data from the Life History Research indicates, for the mothers involved in this mentoring training and project, the process was very helpful and their efforts were appreciated.

12. Did the paraprofessionals/mentors provide cost effective services?

There is no data to measure this outcome. However, the effort to continue training mentors/paraprofessionals was discontinued because the process was too expensive and labor intensive for the staff member assigned. Her support was needed on the project in other ways.

13. Did the clinical trial concept, assigning 50% of cases to professional care only and 50% of cases to care from volunteers, change the types of outcomes for the families?

There is no data to measure this outcome as a large enough number of paraprofessionals/mentors was not trained and the number of clients impacted by those who were trained was too small to conduct any analysis on this from a clinical trial perspective.

Specific components and the effectiveness of the outcome objectives:

1. Was substance abuse (or the impact of substance abuse on the family) decreased in 50% of parents/families for whom this was a problem through linkages with substance abuse interventions and treatment?

**All clients who experienced substance abuse problems were provided linkages with substance abuse interventions and treatment as well as individual counseling. Not all clients followed up on the referrals. The outcome on this specific component objective would be the same as Objective #1 above.**

2. Were emotional problems decreased in 65% of parents with emotional problems at entry through provision of parent mental health services?

**All clients who experienced emotional problems at entry were provided mental health services, referrals and individual counseling. The changing behavioral health system, including the managed care changes, had an impact on the access to care and altered the processes through which the project functioned. The outcome on this specific component objective would be the same as Objective # 2 above.**

3. Was economic viability increased for 65% of parents with problems at entry services through linkages with resources providing basic life necessities, housing assistance, training and employment services, and the provision of emergency family housing and financial assistance?

**The outcome on this objective would be the same as that described for Objective # 3 above.**

4. Were parenting skills increased for 65% of all parents through parenting skills education ?  
The outcome on this objective would be the same as that described for Objective # 4 above.

5. Were the networking, interaction, social skills and empowerment increased for 65% of parents by providing social network groups, peer mentors and individual counseling?

**Peer mentors were not a part of the intervention on this objective. Individual counseling made up the majority of the impact on this objective.**

6. Did the project help increase the health of 65% of children for whom health was a problem at intake through the provision of child health services?

**Because of the changing health care system requirement, and because transportation to health appointments may have been the most important component of success on this objective, it is unclear how much the "provision of child health services" had to do with the improved health of the children.**

7. Did the project help increase or improve the academic functioning of school age children with less than a C average through participation in academic tutoring and mentoring ?

**Academic tutoring and mentoring was never really implemented. The planned involvement of Lehigh University did not come to fruition. There was only sporadic involvement of any tutors. The basic involvement of the families in the whole project seemed to have a positive impact on the perception of the child's academic functioning.**

8. Did the project help decrease the emotional and behavioral problems of 65% of the children for whom these problems were reported at entry through provision of advanced mental health services and individual counseling?

**All children received individual counseling if needed. In addition, they received family counseling when needed. Provision of advanced mental health services was somewhat complicated by the changing requirement for behavioral health services in emerging managed care programs. Accessing these services was continually noted to be a problem by the staff.**

## **E.Lessons learned relevant to participant outcome objectives**

1. There was a significant amount of counselor/therapist burn out and staff departure. The rate of departure of staff became so high that we implemented a process for interviewing the staff as they resigned (or were removed from service). The departure of staff had major impact on the project AND the evaluation. The following is the report of the analysis of the 12 exit interviews conducted between March 2000 and September 2001:

### **COUNSELOR INTERVIEWING PROCESS FINDINGS:**

One of the most critical issues facing FIP and other similar programs is staff turnover. The last few years FIP has experienced very frequent staff turnover. The turnover rate can impact the project in several ways:

1. When counselors leave they are leaving the clients and the agency. The clients have slowly begun to trust and drop some of their resistance to treatment and support. The clients have great difficulty developing this trust and this change in counselors may greatly impact their potential success with FIP.
2. When Counselors leave they leave with all the acquired knowledge and attitudes about the clients. Though there are copious notes in the records, it is clear that the acquired perceptions and subtle behaviors that have been successful with clients leave with the staff member as they depart.
3. As counselors prepared to leave, many have not completed their required paperwork. This has greatly impacted the capacity of the next counselor to serve the client.
4. The evaluation suffers tremendously as many of the measures rely on counselor pre/post assessments. Clearly, the impact of having 2 or 3 different counselors complete assessment creates a low reliability factor in these assessments. In spite of multiple efforts to train new staff in how to complete the evaluation tools, rapid turnover of staff has had a strong impact. In an effort to increase the value of the data, the Program Supervisor has reviewed most evaluation data for cases where 2 or more counselors have been involved in a case.

To examine strengths and weakness of the program, the process of interviewing counselors (working with clients in the Family Intervention Program) who leave the agency for other employment or except a new position within the agency has been implemented. A twelve-question survey was developed with initial broad questions focusing on national, state and local comparisons as well as program/agency functioning. Questions narrow to the more specific relating to counselor training, team functioning, program utilization and client/counselor expectations.

The following reflects the major themes of 12 personal interviews conducted at Valley Youth House during March 2000-September 2001.

### **POSITIVE ASPECTS**

- Cooperation and support on the part of other counselors and supervisor was evident
- In-home therapy was beneficial to the clients who otherwise would not receive therapy

- Eighteen month duration of program very beneficial with client trust improving because of long-term therapy. Many similar programs are only 6 months to a year in length.
- Training was somewhat adequate for therapeutic component
- Peer group supervision
- Services not based on socioeconomic conditions of family
- Latitude to use modalities and therapeutic approaches deemed appropriate by the therapist

## **NEGITIVE ASPECTS**

- Safety was an issue in doing therapy in someone's home without a "partner"
- Direct service time is 50% -this does not include transportation, cancellations, phone time, paperwork, etc.
- Crisis management is required on a regular basis-few cases exist where therapy is exclusive
- Expectations s by administrators do not seem realistic to some interviewees
- Workload is more than costmary for this type of position
- Paperwork is excessive
- Additional training in Drug and Alcohol would be beneficial
- Low salaries in relation to professional degrees and experience
- Other social services agencies understaffed and in crisis which effects the program
- Some Client resistance
- In-home therapy can be distracting

2. Understanding change in project children through interaction with schools is a complicated process that requires a context sensitive method of data collection. In order to understand the interaction between schools and project families a survey process, using open-ended questions, was implemented. The following report, developed from the qualitative analysis of these open-ended interviews, illuminates some of the concerns and comments communicated by the school personnel.

### **SCHOOL/TEACHER SURVEY**

In addition to the existing measures implemented for evaluating the outcome related goals and objectives of the FIP, a school component was added. The purpose of this evaluation component was developed to ascertain the school perspective on the school-aged child's progress since becoming involved with FIP. Various factors have complicated this process including: the short duration of time some children spend in school (due to absences) and the rapid and frequent transfer process between schools. In some cases there is a frequent turnover of school staff so that no one knows a child.

A ten-question survey was developed to measure academic progress and school adjustment including emotional and behavioral problems. The process of data collection is by telephone interview or a survey mailed to the teacher or guidance counselor, and/or appropriated school personnel. The release form, signed by the parent or caregiver, is provided in advance of the interview/survey. Valley Youth House provides a list of clients, as well as schools and school contacts to a research associate on the evaluation team. This is used to determine the sample for

this interview process. A matrix was developed to document all contact information. The Research Associate describes interviews and all members of the evaluation team, using qualitative methods, analyze data. Confidentiality is strictly enforced. Although this process is in the early stages, with approximately 22 surveys having been completed to date, the main early themes are emerging:

### **ACADEMIC PERFORMANCE**

About 40% of the students showed improvement or stayed the same in both grades and performance, one remained unchanged and about 60% were “struggling” due to either poor attendance or the inability to follow directions. The impact of poor attendance was clear and consistent. The impact of homework not being completed or not having support for homework or learning at home was mentioned. Two to 3 students were frequently suspended.

### **ATTENDANCE**

Attendance is rated about 50% poor and 30% average and 20% good. Multiple reasons are given for the attendance problem, but it is clear it has a major impact on the school performance of the child.

### **BEHAVIOR**

About 50% of the students were reported to have improved or good behavior. Most of the children did not have behavior problems when they began the FIP project. Many other children were exhibiting inappropriate behavior in the classrooms. This included behavior problems that were simply disruptive to behavior problems that indicated aggressive or violent behaviors at school.

### **SELF-CARE**

Most students had either good or improving hygiene. However, there were some students who clearly were not washed or dressed in cleaning. A minority of students were indicated to need specific intervention.

3.Emphasis on Pre and Post Tests in Evaluation design may have impacted the findings of the analysis of this data. This emphasis interacted with the consistent departure of staff counselors/therapists causing a possible impact on the validity of the findings. Any measure requiring a normative assessment on a pre measure (a subjective process) and then requiring a normative assessment on a post measure is uniquely vulnerable to a change in staff. This is highlighted in the analysis of the staff exit interviews above.

**Table 6**

**Changes in Adapted Family Risk Scales  
Information Provided by Therapist**

	Better % (n)	Same % (n)	Worse % (n)	Mean change	SE
Meeting Child's physical needs	29% (22)	57% (43)	14% (11)	-0.20	0.09
Emotional care & Infant stimulation	25% (3)	42% (5)	33% (4)	0.08	0.23
Emotional care and stimulation for child & older	29% (19)	48% (31)	23% (15)	-0.18	0.12
Child's mental health	27% (17)	53% (39)	10% (6)	-0.26	0.10
Parent's mental health	34% (26)	38% (29)	28% (21)	-0.09	0.12
Families social support	32% (25)	42% (32)	26% (20)	-0.04	0.10
Parent's substance abuse	38% (27)	46% (33)	15% (11)	-0.41	0.19

**Table 7**

**Type of Problem  
Ranked # 1 by Type at Intake & Discharge**

Type of problem	Intake % (n)	Discharge % (n)
Child Abuse	2% (2)	1% (1)
Child Neglect	7% (6)	7% (5)
Mental Health	29% (27)	27% (20)
Parenting Skills	9% (8)	12% (9)
Substance Abuse	51% (47)	47% (35)
Other	2% (2)	7% (5)

**Ranked # 2 by Type at Intake & Discharge**

Type of problem	Intake % (n)	Discharge % (n)
Child Abuse	5% (5)	5% (4)
Child Neglect	21% (19)	12% (9)
Mental Health	20% (18)	28% (21)
Parenting Skills	20% (18)	15% (11)
Substance Abuse	18% (16)	20% (15)
Other	16% (15)	20% (15)

**Ranked # 3 at Intake & Discharge**

<b>Type of problem</b>	<b>Intake % (n)</b>	<b>Discharge % (n)</b>
<b>Child Abuse</b>	<b>4% (3)</b>	<b>7% (4)</b>
<b>Child Neglect</b>	<b>4% (3)</b>	<b>8% (5)</b>
<b>Mental Health</b>	<b>19% (14)</b>	<b>10% (6)</b>
<b>Parenting Skills</b>	<b>18% (13)</b>	<b>25% (15)</b>
<b>Substance Abuse</b>	<b>11% (8)</b>	<b>10% (6)</b>
<b>Other</b>	<b>45% (33)</b>	<b>39% (23)</b>

Other: A review of the narratives that were categorized into the term “other” shows that the most frequently reported issues under the term other were (in order of frequency): financial struggles, anger management and poor coping skills. Additional problems were non-compliance, lack of social support system, low-self esteem, etc.

**Table 9**

**Rated Level of Severity for Type of Problem Ranked # 1 at Intake & Discharge**

<b>Level of Severity</b>	<b>Intake % (n)</b>	<b>Discharge % (n)</b>
1 Least Severe		7% (5)
2	3% (3)	17% (13)
3	26% (24)	25% (19)
4	46% (42)	33% (25)
5	25% (23)	17% (13)

**Level of Severity for Type of Problem Ranked #2 at Intake & Discharge**

<b>Level of Severity</b>	<b>Intake % (n)</b>	<b>Discharge % (n)</b>
1 Least Severe		7% (5)
2	4% (4)	21% (16)
3	28% (26)	25% (19)
4	52% (48)	32% (24)
5	12% (11)	12% (9)

**Level of Severity for Type of Problem Ranked # 3 at Intake & Discharge**

<b>Level of severity</b>	<b>Intake % (n)</b>	<b>Discharge % (n)</b>
1 Least Severe		8% (6)
2	4% (4)	23% (17)
3	24% (22)	23% (17)
4	41% (38)	16% (12)
5	8% (7)	5% (4)

**TABLE 10**  
**Changes in Rated Severity for each Type of Problem**  
**Recorded at Intake & Discharge**

	<b>n</b>	<b>Diff in Mean</b>	<b>Lower CL Mean</b>	<b>Upper CL Mean</b>	<b>p value (&lt;.05)</b>
<b>Substance Abuse</b>	<b>48</b>	<b>-0.438</b>	<b>-0.811</b>	<b>-0.064</b>	<b>.0227</b>
<b>Mental Health</b>	<b>32</b>	<b>-0.813</b>	<b>-1.256</b>	<b>-0.369</b>	<b>.0008</b>
<b>Parenting Skills</b>	<b>18</b>	<b>-0.667</b>	<b>-1.327</b>	<b>-0.006</b>	<b>.0482</b>
<b>Child Neglect</b>	<b>10</b>	<b>-1.7</b>	<b>-2.657</b>	<b>-0.743</b>	<b>.0300</b>
<b>Child Abuse</b>	<b>4</b>	<b>-1.5</b>	<b>-4.547</b>	<b>1.547</b>	<b>.2152</b>
<b>Other</b>	<b>26</b>	<b>-2.95</b>	<b>-1.11</b>	<b>-1.198</b>	<b>.0068</b>

**Table 11**  
**Discharge Data**  
**Miscellaneous Issues**

<b>Issues Identified During Involvement with FIP (at discharge) as assessed by Counselor:</b>	<b>Yes</b>	<b>No</b>
<b>Became a Welfare Caseload During FIP</b>	<b>24%</b>	<b>76%</b>
<b>Currently Placed Outside of Home</b>	<b>18%</b>	<b>82%</b>
<b>Outreach provided in the home during FIP</b>	<b>99%</b>	<b>1%</b>
<b>Currently Enrolled in School</b>	<b>93%</b>	<b>7%</b>
<b>Currently in Special Education (if school age)</b>	<b>25%</b>	<b>75%</b>
<b>Present Medical Insurance</b>	<b>93%</b>	<b>7%</b>
<b>Health Transportation Provided during FIP</b>	<b>41%</b>	<b>59%</b>
<b>Present involvement with law enforcement of adult in home</b>	<b>25%</b>	

**Family Income at Discharge**

INCOME	Frequency	Percent
Less than \$600 per month	21	24%
\$601 to \$1000	35	41%
\$1001 to \$1500	16	19%
\$1501 to \$2000	9	10%
\$2001 or more	5	6%

**Employment History of Caregiver at Discharge**

Employment Status	Yes	No
Are you currently employed?	44 (48%)	47 (52%)
Is someone else in the home currently employed?	56 (64%)	31 (36%)

**Highest Year of School Completed by Caregiver**

Year of School	Frequency	Percent
Less than 10 <sup>th</sup> grade	15	16%
10 <sup>th</sup> grade to some high school	19	21%
High school graduate	27	30%
Some college or special training	28	31%
College graduate	2	2%

**Table 12**  
**Percent of Hard Times Since Conception of Client Child**

<b>Percent of Hard Times</b>	<b>Frequency</b>	<b>Percent</b>	<b>Cumulative Frequency</b>	<b>Cumulative Percent</b>
0	10	11.63	10	11.63
3	2	2.33	12	13.95
5	2	2.33	14	16.28
8	2	2.33	16	18.60
10	8	9.30	24	27.91
13	1	1.16	25	29.07
20	5	5.81	30	34.88
25	3	3.49	33	38.37
30	2	2.33	35	40.70
33	1	1.16	36	41.86
40	2	2.33	38	44.19
50	13	15.12	51	59.30
60	3	3.49	54	62.79
70	4	4.65	58	67.44
75	6	6.98	64	74.42
80	2	2.33	66	76.74
85	2	2.33	68	79.07
90	1	1.16	69	80.23
100	17	19.77	86	100.00

Frequency Missing = 12

**Table 13**  
**Levels of Improvement**  
**Issues of Concern from Discharge Data**

<b>Improvement demonstrated (during involvement in FIP) IF reported as a problem at intake :</b>	<b>(1) Much Worse</b>	<b>(2) Worse</b>	<b>(3) No Change</b>	<b>(4) Better</b>	<b>(5) Much Better</b>	<b>Percent Improved during FIP</b>
Violent Acting Out Behavior of Child		2%	20%	51%	27%	78%
Child Medical Health Problem		8%	30%	42%	28%	70%
Client Mental Health Problem		8%	31%	50%	12%	72%
Parent Mental Health Problem		6%	30%	51%	13%	64%
Housing/Safety of Neighborhood Problem		4%	29%	40%	27%	76%
Parent Substance Abuse Problem – Data Incomplete						

**Table 14**  
**Parenting Skills Inventory**  
**Change in Caregivers Skills**

<b>Skill</b>	<b>% (n) better</b>	<b>% (n) worse</b>	<b>% (n) same</b>	<b>n missing</b>
Stimulation of the Child	42% (30)	39% (28)	19% (14)	16
Listening to the Child	36% (28)	22% (17)	42% (32)	11
Expressing Feeling to Child	36% (27)	28% (21)	35% (26)	14
Use of Child Services	40% (30)	21% (16)	39% (29)	13
Appropriate Child Discipline	48% (33)	22% (15)	30% (21)	19
Child Supervision	29% (22)	27% (21)	44% (34)	11
Emphasis on Positive Approaches	35% (23)	21% (14)	44% (29)	22
Dealing at appropriate developmental level	41% (32)	23% (18)	36% (28)	10
Enabling responsibility	41% (26)	16% (10)	44% (28)	24
Problem Solving /Decision Making	35% (25)	18% (13)	46% (33)	17
Organizing, Managing & Scheduling	36% (28)	21% (16)	44% (34)	10
Providing Basic Nutrition	40% (28)	17% (12)	43% (30)	18

% = percent of responses excluding missing data (may exceed 100% due to rounding)

**TABLE 15**  
**Comparison of Family Stress at Intake & Discharge**  
**Assessed by Parent/Caretaker at Intake and Discharge**

Family Stress type (reported by)	Intake			Discharge			% Imp
	n	mean	SE	n	mean	SE	
FAMILY STRESS: Money problem (parent)	85	3.80	0.14	56	3.21	0.16	43%
FAMILY STRESS: Housing problem (parent)	48	3.63	0.20	22	2.82	0.32	34%
FAMILY STRESS: Transportation problem (parent)	52	3.75	0.17	31	3.48	0.26	31%
FAMILY STRESS: Child care problem (parent)	42	3.86	0.20	19	3.05	0.31	38%
FAMILY STRESS: Health care problem (parent)	40	3.23	0.22	23	3.04	0.31	29%
FAMILY STRESS: Employment problem (parent)	43	3.56	0.23	24	3.04	0.31	31%
FAMILY STRESS: Neighborhood problem (parent)	26	3.15	0.31	17	3.00	0.31	24%
FAMILY STRESS: Legal problem (parent)	35	3.17	0.26	22	3.27	0.27	19%
FAMILY STRESS: Family problem (parent)	43	3.58	0.23	25	3.20	0.29	19%
FAMILY STRESS: Friend problem (parent)	24	2.71	0.29	9	2.78	0.46	25%
FAMILY STRESS: Household problem (parent)	35	3.17	0.24	11	3.18	0.30	33%
FAMILY STRESS: Mental health problem (parent)	52	3.19	0.18	26	3.23	0.30	35%
FAMILY STRESS: School problem (parent)	18	3.78	0.31	15	2.93	0.38	17%
FAMILY STRESS: Drug and alcohol problem (parent)	26	3.65	0.26	14	2.93	0.35	15%
FAMILY STRESS: Isolation problem (parent)	44	3.11	0.21	24	2.79	0.25	30%
FAMILY STRESS: Money problem (therapist)	39	3.85	0.17	35	3.40	0.17	33%
FAMILY STRESS: Housing problem (therapist)	21	3.71	0.30	12	3.00	0.30	36%
FAMILY STRESS: Transportation problem (therapist)	26	3.88	0.25	16	3.13	0.33	28%
FAMILY STRESS: Child care problem (therapist)	27	3.48	0.22	18	2.61	0.27	39%
FAMILY STRESS: Health care problem (therapist)	26	3.69	0.21	11	3.09	0.34	33%
FAMILY STRESS: Employment problem (therapist)	25	4.08	0.19	19	2.95	0.31	33%
FAMILY STRESS: Neighborhood problem (therapist)	17	3.18	0.26	17	2.47	0.27	33%
FAMILY STRESS: Legal problem (therapist)	18	3.50	0.29	15	3.60	0.31	28%
FAMILY STRESS: Family problem (therapist)	35	3.86	0.17	32	3.34	0.20	39%
FAMILY STRESS: Friend problem (therapist)	23	3.43	0.15	18	3.22	0.24	28%
FAMILY STRESS: Household problem (therapist)	24	3.79	0.21	19	2.79	0.24	50%
FAMILY STRESS: Mental health problem (therapist)	37	4.16	0.13	32	3.38	0.22	17%
FAMILY STRESS: School problem (therapist)	16	3.38	0.29	15	3.13	0.36	22%
FAMILY STRESS: Drug and alcohol problem(therapist)	31	4.16	0.19	20	3.40	0.28	31%
FAMILY STRESS: Isolation problem (therapist)	36	3.97	0.15	29	3.17	0.18	36%

#### **IV. Discussion of Relationships Between Program Implementation and Participant Outcome Evaluation Results.**

- A. In reviewing notes from observations at focus groups with staff members, conducted throughout the duration of the project, it was clear that project staff benefited from the evaluation feedback provided about the types of successes they were supporting through their efforts. *It was this finding that facilitated the addition of an evaluation method for capturing the life histories of the most successful mentors. Being able to report back to the staff about the changes experienced and the benefits realized by a few successful clients made the evaluation information very real for the staff. Telling the stories of successes had a powerful motivating effect on staff and the evaluators.*
- B. Reviewing notes from the observations and focus groups with staff members conducted throughout the duration of the project, it is clear that staff enjoyed and benefited from learning about the evaluation findings. They also benefited from learning how their participation in the data collection supported the process of learning about the impact of the project as a whole. Because there seemed to be only a few staff members who had participated in evaluation in the past, it is important to note that *this may have had an impact on the evaluation. Clearly social workers and counselors need to learn more about evaluation in their training programs so that they can be more effective in their project implementation roles. During the early evaluation trainings, where decisions were being made about how to implement the use of some scales, the lack of staff members' knowledge about evaluation had a negative impact on implementation of evaluation strategies.*
- C. It is clear that the caregivers respond most effectively to a counselor whom they believe is committed to their well-being. The findings on the family survey indicate that the counselors perceived to be the most dedicated and best able to "understand my situation" were able to facilitate the greatest amount of change.
- D. It is clear that home based services are a very important aspect of this project. Why this is so is less clear, but is consistently reported.
- E. The multifaceted and flexible nature of this project makes it possible for the counselors to respond to the ever changing problems presented by the client families. However, it might be possible to institute some required or consistent benchmarks, types of services that must be accessed if a referral is made or milestones that must be reached, so that progress toward change can be more effectively measured.
- F. Clearly staff turnover is a major problem. Using a team approach for the provision of counseling/intervention staff could help minimize the negative impact of staff turnover.

## **V. Recommendations to Program Administrators or Funders Regarding Future Program or**

### **Evaluation Initiatives – developed by Program Director, Anne Adams, M.Ed.**

More federal funding needs to be invested in servicing the needs of families in which children are being neglected and otherwise maltreated due to addicted and/or mentally ill parents. The home-based delivery, of both clinical and casemanagement services, is the most effective approach to utilize with these families; yet, there is limited local funding available to sustain a home-based model.

Recruiting and retaining staff to work with these families has been a challenge. Coupled with health and safety concerns are the low salaries and discouragement that staff experience working in a field with a population that is not highly motivated. Moreover, master's level staff became overwhelmed dealing with the myriad concrete needs of the families, in addition to, the chaos and crisis nature of the situations, which were frequently normalized within the families. In the future, a more useful staffing pattern should comprise a team approach of a bachelor's level casemanager and a master's level therapist. The cost, however, becomes a consideration which is why this project was never able to consistently employ a team approach.

Managed behavioral health care has also proven to be a detriment to both parents and children in terms of their ability to access mental health treatment. There is a tremendous shortage of resources for adults, in general, and managed care in behavioral health has turned an already troublesome situation into a worse one. There need to be more innovations in the mental health field, and not exclusively pharmaceutical in nature.

Additional Recommendations provided by Project Director developed collaboratively with the Lehigh Valley Child Welfare System workers:

1. More opportunities are needed for advanced training and employment for clients.
2. More understanding is needed about subsidized child care and how to best access this for clients.
5. More effort needs to be made to provide outreach to families regarding food and nutrition resources.
6. More training needs to be conducted on welfare reform and the implications of this reform on case management.
7. More training is needed on behavioral health program availability as it pertains to welfare reform.
8. More training needs to be conducted to help staff learn about best practices related to case management, especially management across several agencies.
9. More training is needed to update staff on best practices on filling transportation needs and filling gaps in child care.

1/29/02  
78 N. 24th

Recd. 1/29/02  
(Priority mail)

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Valley Youth House*  
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December 31, 2001

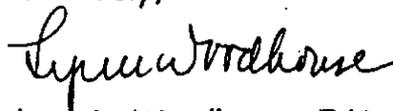
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Hello:

Enclosed is a completed copy of the Valley Youth House Family Intervention Project final grant report. The report has been provided to the agency for their review. Any concerns they have will be addressed and an amended report will be forwarded along with the evaluation instruments. Happy New Year.

Sincerely,



Lynn D. Woodhouse, Ed.D., MPH, CHES