Children’s Institute, Inc. was awarded the Abandoned Infants Assistance (AIA) grant for the period of October 2008 to September 2012. Project Stable Home (PSH) has been implementing a randomized service study comparing two treatment conditions. Blended funding and the use of evidence-based treatment approaches are key components of the program. Regardless of condition, all clients receive the core PSH services including weekly in-home parenting education via the Growing Great Kids curriculum and case management support as needed. This is a 12-month program, with in-home sessions weekly for the first six months and on average bi-weekly thereafter. In addition to the core home services, Condition A clients receive referrals to community resources and mental health consultations on an as needed basis, initially identified in a Strengths and Needs Service Plan meeting. Condition B clients are eligible to receive additional services through PSH; available services include: Baby and Me Group, Parenting Education Group, Domestic Violence and Anger Management Group, Enriched Play, Child-Parent Psychotherapy, and Individual Adult Psychotherapy.

**PROGRAM INDICATORS**

**B-01(4) Major activities and accomplishments:**

_Services provided:_ To date, we have started services with 47 clients and their families. Of these, 21 clients have been assigned to Condition A (Home and Community) and 26 clients have been assigned to Condition B (Home and Center). Thirty-six clients have been randomly assigned to their respective conditions, but exceptions have been made for 11 clients who have been non-randomly assigned to Condition B either because a) the clients were high risk clients that called for
immediate, intensive services to preserve family safety or b) the client and the client’s mother were residing at the Flossie Lewis Center; all clients residing in the Flossie Lewis Center are assigned to the same condition (Condition B) to facilitate transportation to center-based services as well as to eliminate potential confusion amongst residents.

Evidence-based treatment implementation:

Growing Great Kids (GGK) home visitation curriculum: To date, each of our In-Home Service Workers (IHSW), two sets of MSW interns, the research assistant, the clinical supervisor, and the program coordinator have successfully completed the intensive forty hour GGK training on the in-home interactive parenting and child development curriculum and have received their TIER I certification as GGK in-home facilitators. During this reporting period, staff and interns continued to receive weekly supervision from the program coordinator on implementing and tailoring the curriculum to their client families. The Program coordinator also continued to receive a total of six telephone consultations with one of the developers of the GGK curriculum, Kathy Flanagan, MSW, on a once bimonthly basis. Each of these telephone consultations lasted about an hour and was centered on advancing the program coordinator’s capacity to continue facilitating staff and intern development as well as to support IHSW efforts in promoting change and growth in parenting behaviors. Each IHSW is on her way to Tier-2 certification and has completed the “Six Competencies Self-Assessment Tool” to evaluate their strengths in relating to families, cultivating nurturing parent-child relationships, facilitating and creating learning opportunities, using activities to anchor learning, and weaving family enhancement modules into the parent and child development modules.

Child-Parent Psychotherapy (CPP): In the Home/Center service condition, we began to provide CPP as proposed to selected parent-child dyads whose attachment relationships had been significantly disrupted by the experience of trauma, including domestic violence, drug abuse, and/or child maltreatment. Based in attachment and psychoanalytic theory, CPP works directly with the parent and child interactions, helping the caregiver protect the child and maintain a safe environment, understand the impact of trauma on the child’s emotional wellbeing and behavior, attend to the
child’s needs as they emerge in the moment, and help both partners make sense of their experience and improve their mutual relationship. These services are funded through our department of mental health contract. During this reporting period we developed a sustainability plan, identified additional therapists, and began to train them in Child-Parent Psychotherapy.

**Recruitment and orientation of MSW interns:** We successfully continued our collaboration with the California State University of Long Beach and the University of California Los Angeles, recruiting a new rotation of MSW interns for PSH. The three MSW interns underwent a rigorous orientation that was both didactic and experiential. The orientation was conducted over a period of four weeks and included a general introduction of the agency, the PSH grant proposal, and the PSH research design; training in the administration and interpretation of PSH research measures; training in children’s developmental milestones and social-emotional development; informing about the basics of home visitation and IHSW safety; and participating in the aforementioned Growing Great Kids in-home facilitator training with the certified GGK trainer. The interns also conducted guided observations in our infant/toddler and preschool units as well as the intensive day treatment program for preschool children with severe internalizing or externalizing behavioral problems. In final preparation for our interns to conduct their own in-home visits, the interns shadowed several in-home visits conducted by our experienced IHSW staff.

**Integrating research and practice:** A comprehensive assessment battery is administered to all clients at the intake, 6-month, and 12-month (termination) time points. In order to translate the information we receive from these assessment batteries into practical information that our in-home staff can use in their service planning, the evaluation team developed a Summary Score Sheet (see Appendix A) and a corresponding Summary Score Sheet Guide for IHSWs, in which we consolidate family assessment results into four broad domains: child well-being, caregiver well-being, child-caregiver relationship, and other supports. This summary is given to the IHSW to use along with her own observations as service planning begins. To further facilitate the successful integration of research and practice, the program coordinator, IHSWs, and research assistant collaborate about each individual
family’s apparent strengths and needs in group supervision settings before the IHSW meets with the family for their individual Strengths and Needs Service Plan meeting (detailed below). The program evaluator meets periodically with all PSH staff to discuss evaluation measures, outcomes, and related matters.

**Treatment planning:** To facilitate family-focused, strengths-based treatment planning, we have enlisted a “Strengths and Needs” method of treatment planning. The Strengths and Needs Meeting provides a formal opportunity for the staff and family members to meet, share information, and collectively develop a service plan. It is a family-driven process where decisions about the service plan are made by the family with the recommendations and support of staff.

The IHSW typically begins the Strengths and Needs meetings by viewing with the mother a portion of the videotaped Functional Emotional Assessment Scale (FEAS) play interaction and using it as a gateway for discussion about the family’s immediate reactions, self-identified strengths, and self-identified needs. Thereafter, the IHSW indicates the strengths staff have identified in the FEAS interaction and uses these to segue into other strengths we have identified about the family (via IHSW observation as well as the evaluation assessments). From there, the IHSW identified a few needs the family has indicated they’d be interested to address, and finally the family and IHSW decide upon goals to work towards over the next six months as well as the services the family will receive in order to work toward those goals.

Following the Strengths and Needs Meeting, the IHSW considers family input derived from the Strengths and Needs Service Plan Meeting, IHSW observation, and empirical evidence from the Summary Score Sheet as s/he creates a *Goal Attainment Scale* for the family—a plan with three to six goals individualized for that family, with criteria that would indicate progress towards each goal, and a weighting of the importance of each goal (adding to 100%). This provides the IHSW a way to set a clear intention for the services s/he will deliver over the course of the next six months, a chance to include goals s/he deems important for the family but that the family may not have identified (e.g., sobriety goals, child safety goals, etc.), as well
as a chance to document the fulfillment of those goals whose progress might not otherwise be captured by the evaluation battery of assessments.

**Mental health consultation in Home/Community condition (Condition A):** Although Condition A does not include mental health services, we do provide the possibility of mental health consultation via brief individual adult psychotherapy if results on the intake assessment or if the IHSW observes that the caregiver’s psychological well being is interfering with the caregiver’s capacity to provide adequate care for his or her child or children. With the caregiver’s request and consent, the program coordinator, a licensed psychologist, will provide at least four sessions to help stabilize the caregiver’s psychological well being. If longer term mental health services are deemed necessary or are desired, the caregiver will receive community referrals to address that need. No mental health consultations were provided during this reporting period.

**Quality assurance:** The Program Coordinator, In-Home Staff, and Research Assistant participate in weekly AIA Group Supervision meetings to collaborate about clients, progress with clients, obstacles that have arisen in working with clients as well as to collaborate in the process of service planning for new clients. In addition to the AIA group supervision meetings, all PSH staff participate in weekly Staff Meetings to discuss administrative needs as well as to discuss and to delegate new program referrals. All in-home staff receive one hour of individual clinical supervision with the program coordinator each week, and all MSW interns receive one additional hour of reflective supervision with the intern supervisor each week. Too, our external evaluator, Dr. Bruce Baker (Professor of Psychology, UCLA) is closely involved and collaborates with the program director and the research assistant on a regular basis.

**Electronic data collections:** Data are recorded electronically throughout the course of services for each family. Following each home visit or family interaction, IHSWs write progress notes documenting main points of the interactions including time spent, crisis management, GGK topics covered, case management delivered, family’s response, and the like. These are uploaded to TIER, an agency-wide network containing client information, client enrollment in services, and client progress notes.
Also, all of the data from the research measures collected during the intake, 6 month, and 12-month assessments are entered by the research assistant and research interns into SPSS shells (version 17). The AIA Interview and Parenting Stress Inventory are entered separately into the template provided.

**B-02(4) Problems**

Loss of funding for Individual Adult Psychotherapy: The center-based services were diminished by CII’s loss of funding for adult psychotherapy from another source. We continue to provide this service, but it is available to fewer clients.

Attrition: To date, 47 clients have entered the PSH program. Of these, 35 are continuing (from early in the program to over six months or completed at least 6 months and at least 14 visits). Of the remaining 12, three (6.3% of the entering sample) terminated because they had moved outside of the catchment area, so we would not consider them as “dropouts” in the usual sense of the term. Thus there have been 9 “dropout” cases who have stopped attending and, in most cases, became unreachable. These represent 19% of the entering sample.

The PSH team (including the Regional Director, the external evaluator, and the research assistant) convened in January 2010 to discuss the issue of attrition. We made a distinction between cases closed because the client could no longer participate (e.g. moved out of the area, or was not available for some other non-preventable reason such as being hospitalized, incarcerated, or now employed full-time) vs. cases closed because the client would no longer participate. We identified a number of potential factors contributing to dropouts as well as possible ways to reduce them. We discussed factors including mismatch between our services and some clients’ needs, histories of poor attendance, emergence of unforeseen crises, and abrupt relocations. An additional factor contributing to client pre-mature termination is our mode of service delivery to some clients -- through one of the local drug treatment facilities. This sometimes results in automatic dropouts for mothers who are expelled from the drug treatment program. We acknowledged that while some of the reasons underlying the dropouts were simply results of the unstable lifestyles many of our
high-risk and high-stress families lead, there were still some steps we could take to reduce the numbers of unplanned terminations. We are currently building stronger relations with the local drug treatment program and delineating a contract to further encourage open communication between our client families and our IHSWs.

**B-03(4) Significant findings and events: Program Evaluation**

To date, 47 client families have begun our AIA program and completed the intake assessment; however, to date only 19 have completed the six-month assessment. We will report here on the demographic characteristics of our clients, their initial status on several key measures, and a preliminary examination of progress over the first six months.

**Client demographics.** Overall, the PSH clients are, for the most part, living in poverty, with little employment and a host of risk factors in their histories. They are relatively young (M = 26.3 years), unmarried (about 5 in 6), and limited in their education (no mother graduated from college). While over half (61%) of clients live in their own apartments or home, 37% at intake lived in some kind of residential program. They presented with a wide variety of risk factors in their histories, including domestic violence (62%), substance abuse (53%), having a child removed from the home (45%), physical abuse as a child (38%), sexual abuse as a child (36%), and criminal conviction (32%). About a quarter had a history of psychiatric illness and/or selling drugs, while about 1 in 6 had a history of prostitution. Overall, the median number of these risk factors was 3.7, indicating a clientele with high and varied risk history. Despite the high risk history, it is encouraging that fully 71% of mothers began prenatal care in the first trimester of pregnancy and all but 4% began prenatal care at some time during pregnancy.

Despite the high substance abuse in their history, a much lower percent of mothers reported using toxic substances during pregnancy; overall, fully 62% reported no substance use during pregnancy. This seems like a high percentage given the admission criteria to our AIA program, and we will explore this further.

The average child was just over a year old at program entry (13.7 months), with a range from not yet born to just short of 3 years old. Boys and girls are equally
represented. The birth weight and gestational age do not represent risk status for most of the children. While toxicology screens were conducted with two thirds of the clients, they were rarely positive; the number of days in the hospital for newborns was not remarkable.

Thus far we have enrolled 21 clients in Intervention Condition A (Home + community referrals) and 26 clients in Condition B (Home + Center programs). Fortunately the two conditions do not differ significantly on any of the intake variables considered above.

We administer the Parenting Stress Index to our clients to assess their overall levels of parenting stress as well as some related domains. The total mean score (80.6) is in the 78th percentile of this measure’s norms, indicating a highly stressed group. The Parent Distress subscale mean score (31.6) was in the 80th percentile; this score is the most relevant as an indicator of parenting stress. The subscales indicating Difficult Child (M=26.8) and Parent-Child Dysfunctional Interaction (M=22.3) were both at the 62nd percentile. Mothers are, thus, reporting very high stress for themselves, but report less heightened difficulties for their children and their relationship with them. We should note, though, that on the Defensive Responding scale, indicating clients who are not forthcoming about their problems, our mothers scored very high (M=19.2), at the 87th percentile!

Progress indicators at 6 months

We have begun to examine intake to 6 month changes, although the sample with these two sets of measures only includes 19 clients to date. We have indicated in this section a sampling of changes examined on some of the primary progress indicators.

Consumer Satisfaction. To date 17 clients (of the 19 families at 6 months) have returned the anonymous Client Satisfaction Survey. On the key item “I would recommend Project Stable Home to other parents” 100% agreed, and of these 65% said “strongly agree.”

Overall benefits to family from PSH. The Progress Evaluation Form is completed at six months by the IHSW in consultation with the entire staff. The analysis of overall benefits included n=16 of the 19 families who had completed the
6-month assessment (the other 3 PEFs are not yet completed) as well as 5 dropouts who met our criterion of having had at least 12 visits. Of these, one (4.8%) was judged to have had no benefit, 6 (28.6%) had some benefit, 9 (42.9%) had moderate benefits, and 5 (23.1%) had high benefits. No family was scored as having had very high benefits. Thus 2 of 3 families with 12 or more visits, whether they completed the six month assessment or discontinued, had moderate or high benefits from PSH.

Parent needs. On the Parent Needs Questionnaire, mothers expressed significantly reduced needs at six months. The total score dropped from 33 to 21 (p<.001) and all three subscales (need for information, support, community resources) dropped significantly (each p=.003).

Mother well-being. On the Parenting Stress Inventory, mothers indicated slightly reduced total stress (84 to 80), but the change was not statistically significant. On the Symptom Checklist, mothers decreased in anxiety and depression, each nearly significant (p = .065), and decreased significantly in somatic symptoms (p=.01) and in the overall SCL symptom score (p=.02).

Parenting knowledge. On the AAPI, there was a slight increase (122 to 129) but the difference was not statistically significant. The corporal punishment scale was unchanged.

Parent-child interaction and home environment. The Infant-Toddler version of the HOME, completed by IHSWs, was only available for 10 clients. Yet there was improvement in every category. This was statistically significant for organization of the environment (p=.02), providing learning and play materials (p<.01), and the total score (p <.05).

Goal Attainment Scaling. The GAS is our most sensitive measure, as it is an individualized evaluation of each client’s success in the areas targeted for her particular program. As noted above, at intake the staff and client determine 3 to 6 primary goals for the client’s program, with at least one related to the child’s well-being, one to the mother’s well-being, and one to the mother-child relationship. For each goal the present level is described and given a value of 0. Indicators of some (1), much (2) and very much (3) progress are determined, as well as an indicator of worsening (-1). The indicators are as objective as possible, utilizing the range of
measures available. Each goal is then assigned a weight, so that the weights add to 100. At 6 months, the client is assigned a score (-1 to 3) on each goal and each goal score is multiplied by the weight for that goal. The final score can range from -1.00 (worsening on every goal) to 3.00 (maximum improvement on every goal). Our present 6-month sample of clients ranged from 0 (an early dropout who showed no progress) to 3, with a mean of 1.91 (almost 2, which means an average of “much progress” on every goal). This individualized GAS score correlated $r=0.57$ ($p=0.005$) with the staff’s evaluation of the family’s overall progress (Progress Evaluation Form, above).

**Predictors of outcome**

One hypothesis in our proposal was that birth order would relate to gains from intervention – that there would be greater improvement when the target child was the first born vs. later born. One supportive finding is that when total parenting stress was examined by birthorder, mothers of firstborns showed a 16 point decrease in stress while mothers of laterborns showed a 1 point increase, a significant difference ($F=6.04$, $p = 0.025$). A second hypothesis was that parent engagement with the intervention program would relate positively to improvement. Our Progress Evaluation Form, completed as the 6 month assessment, showed a significant correlation between engagement and family benefits ($r = 0.58$, $p=0.006$). In future reports, with a larger sample of clients who have completed the six month assessment, we will present a more comprehensive report of overall outcome, as well as the relationship of treatment condition and other predictors to outcome.

**B-04(4) Dissemination activities**

None to date.

**B-05(4) Other activities**

**Staffing:** We were fully staffed over this reporting period, except for the Parent Partner position. We had 5 In-home workers (2 employees and 3 MSW interns), a project director, program coordinator, clinical supervisor, research assistant, external evaluator, and administrative assistant.
Staff Training: Twelve of our staff attended a one-day seminar on *Trauma, Resiliency and Recovery in Infancy and Early Childhood* by Alicia Lieberman and Barbara Bowman, two national leaders in the field of early childhood development and mental health.

**B-06(4) Activities planned for next reporting period**

**Deliver services per grant proposal and at full capacity:** We do not anticipate any major changes for the upcoming reporting period. We do anticipate an increase in the number of new clients and, hopefully, a reduction in attrition as a result of changes now being implemented.

**Hire a third staff IHSW:** In order to help us meet our proposed caseload as discussed above, we will be hiring a third staff IHSW. We anticipate that this IHSW will be a bilingual Spanish-English individual with experience working with children ages zero to five.

**Training:** In late summer we will begin training new MSW’s in the Growing Great Kids (GGK) approach, and increase the skill level of current staff. We will also continue training for all staff in assessment and recording procedures. The GGK TIER 2 certification process includes helping IHSW and interns to build skills in effectively supporting growth and change in families incrementally and progressively by developing IHSW motivation for learning a new skill, creating many opportunities for practice, acknowledging and accentuating skills that are demonstrated, providing time for staff to reflect, and providing feedback for enhancements. IHSWs will be videotaping their sessions in the home for review and feedback from GGK curriculum developer, Kathy Flanagan, and from our program coordinator. We will continue monthly meetings with the program coordinator and all staff to hone key concepts of GGK curriculum and to develop depth in using the curriculum. We are also planning to collaborate with a community partner to provide occupational therapy and speech therapy consultation as needed; we have already scheduled with an OT to consult bi-monthly.

**Outreach:** We will conduct extensive outreach activities such as presentations and mailings to increase community agencies’ awareness of new services and reach
additional families. Our efforts will focus particularly on the recruitment of pregnant 
women, and first-borns, and newborn children, a population that historically has not 
received services due to the need of other funding sources eligibility requirements 
such as mental health diagnosis, medical necessity, and Medi-Cal insurance.

**Evaluation**: At the end of the next reporting period, we should have a 
sufficient caseload to conduct more complete program evaluation analyses. These 
will include examining: (a) retention rates overall and in the two conditions, (b) 
process indicators related to the child’s placement, health, and safety; (c) intake to six 
month changes for the caseload as a whole and by treatment condition, and (d) 
prediction of changes in parents, children, and parent-child relationships from intake 
variables (e.g. child birthorder, parent housing, parent risk history) and treatment 
process variables (e.g. parent engagement).