



Child Welfare Information Gateway

PROTECTING CHILDREN ■ STRENGTHENING FAMILIES

Program Evaluation

Synthesis of lessons learned by
child neglect demonstration projects

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U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau



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In 1996 and 1997, the Children's Bureau funded 10 demonstration projects to address the prevention, intervention, and treatment needs of neglected children and their families. These projects implemented and evaluated a wide variety of service strategies with large numbers of high-risk children and families. The programs varied considerably in terms of theoretical model (psychosocial or ecological), target population, location (in-home or out-of-home), duration, and intensity. The projects provided a great variety of services, including parent education and support, home visits, and referrals to other resources or services in the community. (For information about the programmatic aspects of these projects, see the companion synthesis, *Child Neglect Demonstration Projects: Synthesis of Lessons Learned*, published by Child Welfare Information Gateway.) Throughout the course of their 5-year projects, grantees faced a number of common challenges in combining service delivery with a rigorous program evaluation methodology. Despite these challenges, several of the programs conducted very thorough evaluations, and they all reported positive outcomes.

In recent years, there has been a growing interest in the evaluation of social service programs. Funders and other stakeholders want evidence that programs are achieving their intended outcomes. Practitioners want to develop more effective services by documenting interventions and measuring results, and they want to establish stronger connections between services and outcomes. Therefore, this program evaluation synthesis summarizes the grantees' challenges, strategies, and lessons learned regarding program evaluation, so that these lessons may help future projects develop and implement effective evaluation

plans. While some of the lessons learned will be most useful to other programs addressing child neglect, many are applicable to a broader range of social service programs.

Contact information for each program discussed, and information about evaluation designs, instruments, and outcomes, are included in the appendices for readers interested in learning more about individual projects.

Challenges and Successful Strategies for Evaluation Design and Methodology

All 10 grantees encountered challenges related to design and methodology. These challenges, and the strategies grantees reported to be successful in addressing them, are summarized below. They relate specifically to the processes of:

- Selecting instruments
- Establishing comparison groups
- Collecting data
- Analyzing the impact of individualized services

Selecting Instruments

All 10 programs used standardized instruments, and many used the same ones. The table in Appendix B shows which instruments each program used. The most commonly used were:

- Child Well-Being Scales (6 programs)
- Adult Adolescent Parenting Inventory (4)
- Child Behavior Checklist (4)

- Home Observation for Measurement of the Environment (4)
- Family Support Scale (2)
- Maternal Social Support Index (2)
- Parenting Stress Index (2)

Grantees did not recommend using standardized instruments alone for the evaluation of these programs. One grantee felt that these commonly used standardized instruments were designed for individual therapy sessions or for populations with less pervasive problems and therefore did not work well for measuring outcomes with the grantee's target population. The majority of projects found the Child Well-Being Scales to be the most appropriate and useful instruments, but one program found that these scales were not sensitive to detecting risk and were more appropriate for higher functioning clients.¹ Another grantee reported that its interventions simply did not address some of the domains that the standardized instruments assessed and, thus, these instruments would not detect change.

Administering the instruments also proved challenging. One program reported that participants' low literacy levels, test anxiety, absenteeism, and hostility made it difficult to obtain valid and reliable pre- and posttest scores. Another grantee reported that in-home assessments were difficult to administer (these were not CPS-mandated cases, so home access was voluntary). Some participants were afraid to allow clinicians into their homes due to substandard living conditions, overcrowding, domestic violence, or drug dealing. Those who

¹ Magura, S., and Moses, B. S. (1987). *Outcome measures for child welfare services: The Child Well-Being Scales and rating form*. Washington, DC: Child Welfare League of America. Available online at www.cwla.org/pubs/pubdetails.asp?PUBID=3062.

did allow home visits were self-selected and may have had fewer of these concerns. Many young mothers lived with family members and were not free to invite clinicians into the home without the owner's permission. When access was possible, some grantees' staff also encountered scheduling and safety issues.

Some of the strategies suggested by grantees to address these challenges include:

- **Modify existing instruments to meet your needs.** For example, recommendations for use of the Child Well-Being Scales included clustering items to match program objectives and adding a seriousness scale to make the findings more interpretable.²
- **Develop your own instrument.** The Parent Empowerment Program believed its own instrument, the Personal Goal Achievement Measure (PGAM), assessed outcomes more accurately and meaningfully than the available standardized instruments. When program participants and program staff worked together to develop this instrument, participants were empowered by selecting their own goals and working toward meeting established criteria for successful achievement.³
- **Use multiple strategies to collect data.** All programs collected qualitative data to help them interpret and clarify the results of the standardized instruments. These data collection tools and techniques included:
 - » Referral and discharge forms

² There is a risk, in adapting standardized tests, of nullifying the reliability and validity of the instruments. However, creating or modifying a risk assessment instrument to use in the interpretation of the results can have merit.

³ Data from site-specific instruments should be interpreted with caution. If reliability and validity have not been established, the ability to generalize their results is limited.

- » Mentors' pre- and post-intervention surveys, weekly reports, and in-service meeting notes
- » Surveys of presenting problems (types and severity), focus groups, life history research, and satisfaction surveys
- » Staff notes, service documentation sheets, family case logs, activities notes, meeting minutes
- » School interviews
- » CPS verification
- » Exit interviews with families and staff

Establishing Comparison Groups

Six of the 10 projects reported program evaluation challenges related to the establishment of treatment and comparison groups. A number of factors affecting the use of comparison groups may have compromised evaluation results, including voluntary participation, statutory requirements that made a "no-treatment" group impossible in at least one site, inappropriate referrals from community partners, difficulties achieving random assignment to groups, and unintended variations in service intensity.

In one program, only a few families were able to successfully engage and graduate, so it was not possible to compare treatment and comparison group service outcomes as planned. At least one grantee felt that the process of assigning some families to a comparison group and the fact that some families could not receive full services competed with the program's goals. While not denying the value of experimental design for determining program effectiveness, they noted that without this constraint their services would

have reached and benefited more families, resulting in better outcomes overall.

Strategies used or suggested by grantees include:

- **Use service enhancements.** Several programs avoided having to deny services to families in their comparison groups by providing core services to these families and adding service enhancements (such as a mentoring component) or longer-term services (such as 9 months rather than 3 months) for treatment group families.
- **Establish and communicate clear participation criteria.** Several grantees recommended establishing clear eligibility criteria for entry into the program to screen out families whose needs were greater than the program was designed to address. It was also recommended that care be taken during the process of assigning families to treatment and comparison groups to ensure that eventual outcomes will not be biased because of initial differences between groups in their risk of future neglect.

Collecting Data

At least seven grantees reported difficulties related to data collection. Challenges in this area varied widely, and related to:

- **Establishing baselines.** Several grantees reported difficulty accurately evaluating families at intake. One program reported that this intake process took 6 weeks, often due to family crises. Families drifted in and out of the program and moved in and out of crises, so their progress could not be represented as a straight line from intake to exit. Another program indicated that intake scores were unrealistically high,

probably because families were not comfortable telling a stranger how bad things were or because their chaotic lives seemed normal to them. While thorough assessments were considered essential, the intake process was often found to be burdensome for large families. It sometimes took them 4 to 6 hours to complete the numerous standardized measures and provide demographic data.

- **Collecting follow-up data.** Grantees found many of the families were difficult to locate or contact. Follow-up interviews with caretakers sometimes were delayed due to scheduling difficulties. One program reported that posttest data were more difficult to collect simply because clients were reluctant to exit the program.
- **Involving children.** Children presented unique data collection challenges, because they often were unavailable or too tired to complete the process. One program found screening preschool-aged children nearly impossible, as parents were reluctant to risk having their children labeled at an early age.
- **Using self-report measures.** One program reported differences in findings from observational versus self-report measures. In several instances, self-report measures identified significant depression and child behavior concerns that were not observed by student interns.
- **Generating large enough samples.** One program reported that use of assessment instruments by the various intake workers was inconsistent, resulting in significant gaps in data. Another grantee reported that due to project extensions to maximize sample size, the 12-month follow-up period was not reached for all families at the time

of the final report, so findings for some of their evaluation questions could not be included at that time. A third program reported that their sample size was only half of the projected size. Another program reported a high attrition rate: 438 families were referred, 250 enrolled, 195 started the program, and only 87 graduated.

Strategies used or suggested by grantees included:

- **Streamline data collection.** Programs recommended striving for a balance between the need to conduct an in-depth initial assessment and the need to streamline initial demographic data collection. One recommendation was to use Bavolek's Adult-Adolescent Parenting Inventory (AAPI) as a clinical tool to initiate conversation while gathering baseline data. The AAPI is a brief agree/disagree survey designed to assess parenting attitudes. Staff reported that using this tool was an efficient and effective way to gather data while engaging the family. (See Appendix C for more information on the AAPI.) Another program found it helpful to limit the amount of information families were asked to provide during initial meetings with agency staff.
- **Use multiple data collection methods.** Programs recommended using many sources of qualitative and quantitative data and gathering data more often than just when they enter and exit the program. One grantee recommended getting releases from families for access to Department of Social Services data to track what happens to families once they exit the program.
- **Offer incentives.** Providing incentives, such as cash or "graduation" parties, to families

for participating in baseline and follow-up interviews was recommended.

- **Gather child data.** Most of the programs collected data on children as well as families. One program had success assessing children while in child care during parent group meetings.

Analyzing the Impact of Individualized Services

Programs frequently customized services, provided resources tailored to individual needs, changed plans when families were in crisis, and varied the level of service to meet families' unique needs. At least 8 of the 10 grantees agreed that providing multifaceted and flexible services was good for meeting families' needs. However, this strategy also makes comparisons across families more difficult and makes it very challenging to describe a replicable service model.

Strategies employed by grantees to address this challenge included:

- **Document service variations.** Several grantees opted to closely monitor the intervention to ensure it was being implemented as planned and to document variations as they occurred.
- **Work closely with the program evaluator.** Several grantees believed that having the program evaluator participate in program activities and attend staff meetings deepened their understanding and helped ensure that the evaluation evolved along with the program.

Lessons Learned for Evaluation Management

Several factors related to management of the evaluation process contributed to these grantees' ability to overcome numerous challenges and produce high quality program evaluations:

- Detailed evaluation plans
- Sufficient evaluation budget and project duration
- Strategies to address staff turnover
- Strong evaluation teams
- Federal evaluation supports: Grantee cluster and technical assistance

Detailed Evaluation Plans

In its fiscal year 1996 funding announcement, the Children's Bureau made its expectations clear. Applicants were asked to provide a logic model and propose an evaluation plan for their projects, including methods, data, and criteria that would be used to evaluate the proposed project's processes and outcomes. As a result, all of the programs established clearly defined and measurable implementation and outcome objectives as they started their program planning. These objectives, along with operational definitions and specific measures for each outcome, helped programs assess their progress accurately and objectively. (For more information about how individual programs structured their evaluations, see Appendix B. For a sample logic model, see Appendix D.)

Sufficient Evaluation Budget and Project Duration

Grantees were expected to invest 10 to 15 percent of their budgets (or approximately \$15,000 to \$22,500 per year) in program evaluation. This helped the programs leverage the resources needed to support an in-house evaluation or contract with an external evaluator. (See Strong Evaluation Teams, below.) Many of these evaluators were able to invest sufficient time to become very familiar with the project. In several cases the evaluator also supported graduate students who assisted in data collection and processing.

These grantees had 5 years to implement and evaluate their projects. This allowed sufficient time to develop and implement strong program evaluation plans.

Strategies to Address Staff Turnover

Eight of the 10 programs reported that addressing staff turnover was a crucial part of managing the program evaluation. Staff turnover sometimes resulted in uneven data collection and analysis. One program found that its pre- and posttest evaluation design did not work well, because high staff turnover resulted in missing discharge data and inconsistency from pre- to posttesting. Another found that clients with a consistent caseworker had higher posttest scores and showed greater improvement than clients who experienced caseworker turnover.

Several programs minimized the impact of staff turnover on the evaluation process by focusing on training. Some projects provided their staff with evaluation training and manuals to ensure consistency despite staffing changes. Others used videotape training to reduce errors. One program found that an

intervention manual, weekly seminars, and supervision were helpful in keeping the evaluation on track. One program found using the evaluation itself as a learning opportunity helped minimize the impact of turnover. They designed their evaluation to be empowering for staff so they could learn while doing their work. Project staff reported that they enjoyed and benefited from the evaluation feedback provided about the types of success their efforts were supporting.

Strong Evaluation Teams

All 10 projects assigned program evaluation responsibilities to qualified individuals or organizations. Universities operated five of the projects, and a medical center operated one. Four of these projects used their own in-house program evaluators. All but one of the remaining programs used nonuniversity outside evaluators. Several of the evaluation teams also performed or assisted with data collection and entry. In several instances, the evaluation team also assisted with providing training and developing manuals.

Most of the program evaluators stayed with the program for the full 5 years, although one of the grantee programs changed its lead evaluator three times in 5 years and two projects using graduate student data collectors experienced schedule conflicts and high turnover due to graduation. All the evaluators maintained close regular contact with the programs. Grantees reported that having evaluators with in-depth knowledge of the program and its participants, and having staff willing to implement a program with an extensive evaluation component, were key components in the evaluation's success. In particular, one program reported that placing research staff in the agency during the delivery of services

to monitor recruitment of families, random assignment to treatment groups, timely completion of data packets, and service parameters (such as length) may have improved targeting, sample size, and adherence to the intervention's original definitions.

Federal Evaluation Supports: Grantee Cluster and Technical Assistance

From the beginning, these projects were intended to operate cooperatively as a grantee cluster. The Children's Bureau facilitates this cooperation within clusters of discretionary grantees by providing technical assistance and by encouraging the development of common evaluation criteria, data elements, and measures to maximize comparability of evaluation findings. Grantees reported that operating as a cluster led to stronger and more credible results. Project staff were able to refine their evaluation plans and implementation processes at annual grantee meetings and by keeping in touch via a listserv. Together with their Federal Project Officer and the evaluation technical assistance provider, grantees developed a uniform final report format that emphasized implementation and outcome evaluation strategies and results and, most importantly, helped them think through the relationship between program implementation and participant outcomes.

included reductions in child behavior problems, parenting issues, foster care placements, and CPS reports; improvements in child and family health and well-being; and increased parenting skills. (See companion synthesis, *Child Neglect Demonstration Projects Synthesis of Lessons Learned*, for further information on program outcomes.)

Along the way, however, all of the grantees experienced some challenges in implementing their program evaluation plans. The difficulties they faced in selecting instruments, staffing their evaluations, establishing comparison groups, conducting sound evaluations of individualized and flexible services, and collecting data are similar to those any program manager will likely face when conducting an evaluation in the field. Starting with a detailed evaluation plan, committing substantial funds to program evaluation, developing strategies to minimize the impact of staff turnover on evaluation implementation, forming strong evaluation teams, working together as a cluster, and receiving evaluation technical assistance all contributed to the success of these grantees. These successful strategies, and the lessons learned throughout the grant cycle, will be helpful to other programs wishing to establish effective program evaluation designs and methods.

Conclusion

Several of the grantees in this cluster conducted very thorough evaluations, and they were all able to report positive outcomes for children and families. These outcomes

Appendix A: Children's Bureau Child Neglect Demonstration Projects

Family Intervention Program

Valley Youth House Committee, Inc.
531 Main Street, 2nd Floor
Bethlehem, PA 18018
Anne Adams
(610) 954-9561 extension 24

Family Network Project

Joan A. Male Family Support Center (formerly Parents Anonymous of Buffalo and Erie County)
60 Dingens Street
Buffalo, NY 14206
Joan A. Male
(716) 822-0919

Family Preservation Services for African American Families at Risk of Neglect

Portland State University
P.O. Box 751
Portland, OR 97207-0751
Kristine Nelson, D.S.W.
(503) 725-5012

Family Reclaim: A Community-based Collaborative to Strengthen Families with Substance Abuse and Neglect Issues

Family Support Services of the Bay Area
554 Grand Avenue
Oakland, CA 94610
Patricia Chambers, Ph.D.
(415) 861-4060 extension 3024

Family Support and Intervention for Neglected Preschool Children

University of Rochester
Mt. Hope Family Center
187 Edinburgh Street
Rochester, NY 14608
Jody Todd Manly, Ph.D.
(585) 275-2991
www.psych.rochester.edu/research/mhfc

Healthy Families D.C.

Mary's Center for Maternal and Child Care, Inc.
2333 Ontario Road, NW
Washington, DC 20009
Joan Yengo
(202) 483-8196

Helping Families Prevent Child Neglect

University of Maryland, Baltimore
School of Social Work
525 West Redwood Street
Baltimore, MD 21201
Diane DePanfilis, Ph.D., M.S.W.
(410) 706-3609
www.family.umaryland.edu

Homefriends

Temple University
Center for Intergenerational Learning (CIL)
1601 North Broad Street, USB206
Philadelphia, PA 19122
Adam Brunner, Ph.D., former Program Director
Nancy Henkin, Executive Director CIL
(215) 204-6970
www.temple.edu/cil/Homefriendshome.htm

Neglected Children in Intergenerational Kinship Care

Georgia State University
College of Health and Human Sciences
University Plaza
Atlanta, GA 30303-3083
Susan J. Kelley, Ph.D.
(404) 651-3043
www.gsu.edu/~wwwalh/index.html

Parent Empowerment Program: Neglect Prevention Education for Pregnant and Parenting Teens

Montefiore Medical Center
Child Protection Center
3314 Steuben Avenue
Bronx, NY 10467
Karel Amaranth
(718) 920-6429
www.Montekids.org/programs/cpc

To order copies of any of these projects' final reports, contact Child Welfare Information Gateway at info@childwelfare.gov or 800.394.3366.

Appendix B: Project Evaluation Information

	Program Evaluation	Desired Outcomes	Evaluation Tools and Instruments	Reported Outcomes
Family Intervention Program	<ul style="list-style-type: none"> • Outside evaluator • Comparison group • No random assignment reported • Three standardized scales • Pre- and postintervention • Statistical analysis of data 	<ul style="list-style-type: none"> • Reduce substance abuse, reduce emotional and economic problems, and increase parenting skills • Reduce health, academic, behavioral, social, and emotional problems in project children • Keep family unit intact and minimize the involvement of high-risk project families with child welfare services • Test overall efficacy of the program and compare efficacy with two groups 	<ul style="list-style-type: none"> • Family Stress Inventory (Orkow, 1985) • Parenting Skills Inventory • Family Risk Scales (seven scales modified from Magura, Moses, & Jones, 1987) 	<ul style="list-style-type: none"> • Substance abuse impact reduced in 50% of families where it was a problem • Decrease in caregiver emotional problems • Increase in parenting skills for 65% of parents • Improved health of children • Decreased behavior problems of children • Some reduction in social isolation of caregivers
Family Network Project	<ul style="list-style-type: none"> • Outside evaluator • Comparison group • No random assignment • Two standardized scales • Intake, 6 months, 1 year, 18 months, at closing, and at 6-month follow-up • Statistical analysis of data 	<ul style="list-style-type: none"> • Maintain safe housing • Master the skills necessary to ensure appropriate activities of daily living • Ensure adequate health care • Master the skills necessary to ensure the psycho-emotional needs of family members • Master the skills necessary to ensure appropriate discipline 	<ul style="list-style-type: none"> • Adult-Adolescent Parenting Inventory (Bavolek, 1984) • Family Profile • Eco-Map (Hartman, 1979) • Intake Packets (designed for program) • Child Well-Being Scales (Magura & Moses, 1987) 	<ul style="list-style-type: none"> • Families maintained adequate housing • Families achieved adequate health care • Caregivers developed skills to meet children's psycho-emotional needs • Caregivers showed improvement in using appropriate discipline
Family Preservation Services	<ul style="list-style-type: none"> • Outside evaluator • Comparison group • Some random assignment • Seven standardized scales • CPS data - 12 months prior and 12 months postintervention; child and family data at intake, after intensive service and after care • Statistical analysis of data 	<ul style="list-style-type: none"> • Reduce out-of-home placement of target children • Reduce re-referrals for neglect • Prevent referral for neglect for Outreach families 	<ul style="list-style-type: none"> • Child Behavioral Checklist (Achenbach, 1991) • Battelle Developmental Inventory (Newborg, Stock, & Wnek, 1984) • Child Well-Being Scales (Magura & Moses, 1987) • Family Support Scale (Dunst, Jenkins, & Trivette, 1984) • Resource Scale for Teen Mothers (Dunst, Leet, Vance, & Cooper, 1988) • Strengthening Multi-Ethnic Families & Communities: A Violence Prevention Parent Training Program (Steele, Marigna, Tello, & Johnson, 1999) • Alaska Assessment for the Risk of Continued Neglect (used at intake) (Baird, 1988) 	<ul style="list-style-type: none"> • Decrease in founded neglect reports and out-of-home placement • Child well-being increased from intake to the end of the intensive phase of services • Increases in family support and family resources
Family Reclaim	<ul style="list-style-type: none"> • Outside evaluator • No comparison group • Two standardized scales • Baseline and closure • No statistical analysis of data 	<ul style="list-style-type: none"> • Improve the quality of parenting • Improve the quality home life • Improve the overall healthy development of children in areas of self-esteem and self respect • Provide services that are as or more effective than routine services at an acceptable cost, relative to benefit • Determine client/family characteristics that appear to respond best to the Family Reclaim model 	<ul style="list-style-type: none"> • Child Well-Being Scales (Magura & Moses, 1987) • Family Well-Being Scale (developed for program) 	<ul style="list-style-type: none"> • Improvement in child well-being scores • Improvement in family functioning for a significant number of families • 97.5% of children at risk for removal were able to remain with their families • Improvement in children's academic performance and school attendance • Cost effective

	Program Evaluation	Desired Outcomes	Evaluation Tools and Instruments	Reported Outcomes
Family Support and Intervention for Neglected Preschool Children	<ul style="list-style-type: none"> In-house evaluators Comparison group No random assignment reported 14 standardized scales Intake, conclusion, 1-year follow-up Statistical analysis of data not completed yet 	<ul style="list-style-type: none"> Improve functioning for children and parents For children: improve cognitive and pre-academic skills, language and communication skills, gross and fine motor skills, and socioemotional development For families: improve skills in parenting, coping with stress, development of social networks, knowledge of appropriate developmental expectations, effective behavior management, positive interactions with children, lower rates of CPS reports, reductions in stress, and improvements in social supports 	<ul style="list-style-type: none"> Demographics Interview (Carlson & Cicchetti, 1979) Home Observation for Measurement of the Environment (preschool version, Caldwell & Bradley, 1984) Parenting Dimensions Inventory (Slater & Power, 1987) Adult Adolescent Parenting Inventory (Bavolek, 1984) Childhood Trauma Questionnaire (Bernstein, Fink, Handelsman, & Foote, 1994) Interpersonal Support Evaluation List (Cohen & Hoberman, 1983) Perceived Stress Scale (Cohen, Kamarck, & Mermelstein, 1983) Daily Hassles Scale of Parenting Events (Crcic & Greenberg, 1990) Semi-Structured Free Play (Beeghly & Cicchetti, 1994) Wechsler Preschool and Primary Scale of Intelligence-Revised (Wechsler, 1989) Child Behavior Checklist (Achenbach, 1991) Developmental Indicators for the Assessment of Learning-Revised (Mardel-Czudnowski & Goldenberg, 1983) Preschool Symptom Self-Report (Martini, Strayhorn, & Puig-Antich, 1989) Maltreatment Classification and Rating System (Barnett, Manly, & Cicchetti, 1993) 	<ul style="list-style-type: none"> 94% of families made progress on treatment goals 99% of children achieved at least one developmental goal Improved parenting skills and increased social support for caregivers Increased knowledge of child development and positive behavior management Children's developmental adaptation exceeded that of control group
Healthy Families D.C.	<ul style="list-style-type: none"> A series of three different outside evaluators No comparison group Eight standardized scales Baseline and at developmental intervals No statistical analysis of data 	<ul style="list-style-type: none"> Promote optimal birth outcomes, child health, child development, and school readiness Foster positive parenting and successful parent-child interaction Promote optimal family functioning and life outcomes Prevent child abuse and neglect 	<ul style="list-style-type: none"> Knowledge of Infant Development Inventory, Short Form (MacPhee, 1981) Home Observation for Measurement of the Environment (Caldwell & Bradley, 1984) Home Screening Questionnaire (Coons, Gay, Fandal, Ker, & Frankenburg, 1981) Adult-Adolescent Parenting Inventory (Bavolek, 1984) Maternal Social Support Index (Pascoe, lalongo, Horn, Reinhart, & Perradatto, 1988) Carolina Parent Support Scale (Bristol, 1983) Maternal Health Beliefs Questionnaire (based on Hochbaum, 1958, & Rosenstock, 1974) Participant Satisfaction Survey (developed for program) 	<p>Met objectives with regard to:</p> <ul style="list-style-type: none"> Healthy birth weights Immunizations and well-care visits Developmental screenings Progress toward self-sufficiency goals No cases of CA/N
Helping Families Prevent Child Neglect	<ul style="list-style-type: none"> In-house evaluators Random assignment to four different intervention groups 12 standardized scales Baseline, case closure, and 6-month follow-up Statistical analysis of data 	<ul style="list-style-type: none"> Decrease risk factors for neglect: caregiver depressive symptoms, alcohol use, drug use, functioning, everyday stress, and parent stress Increase protective factors: attitudes toward change, parenting attitudes, parenting competence, social support and family functioning Increase child safety: reduce child maltreatment, meet basic needs, improve quality of physical home environment Improve child well-being: improve behavior and functioning 	<ul style="list-style-type: none"> Center for Epidemiologic Studies-Depressed Mood Scale (Radloff, 1977) CAGE Questionnaire (Ewing, 1984) NIMH Diagnostic Interview Schedule Version III (DIS-III-R) (Robins, Helzer, Cottler, & Goldring, 1989) Family Risk Scales (Magura, Moses, & Jones, 1987) Child Well-Being Subscale (Magura & Moses, 1987) Everyday Stressors Index (Hall, Williams, & Greenberg, 1985) Parenting Stress Index- Short Form (Abidin, 1995) Child Well-Being Scales (Magura & Moses, 1987) Adult-Adolescent Parenting Inventory (Bavolek, 1984) Parenting Sense of Competence Scale (Gibaud-Wallston & Wandersman, 1978) Social Provisions Scale (Russell & Cutrona, 1984) Self-Report Family Inventory (Beavers, Hampson, & Hulgus, 1985) Home Observation for Measure of the Environment (Caldwell & Bradley, 1984) DHR CIS database Child Behavior Checklist (Achenbach, 1991) 	<ul style="list-style-type: none"> Reduced caregiver depressive symptoms, drug use, life stress, parenting stress Increased appropriate parenting attitudes, satisfaction with parenting, perceived social support Fewer CPS reports on participants following than prior to intervention Enhanced physical and psychological care of children Decreased caregiver perceptions of child behavior problems

	Program Evaluation	Desired Outcomes	Evaluation Tools and Instruments	Reported Outcomes
Homefriends	<ul style="list-style-type: none"> • Outside evaluator • Random assignment to comparison and treatment groups • Five standardized scales • Baseline and at 9 months • Statistical analysis of data 	<ul style="list-style-type: none"> • Improved caregiver parenting skills • Increased caregiver knowledge and access to community resources • Decreased social isolation • Decreased parent stress • Improved caregiver attitudes and response to children with disabilities/chronic illness 	<ul style="list-style-type: none"> • Parenting Stress Index (Abidin,1995) • Social Support Network Inventory (Flaherty, 1983) • Index of knowledge and use of community resources (developed for this program) • Child Well-Being Scales (Magura & Moses, 1987) • Parent-Child Dysfunction Scale of the Parenting Stress Index (Abidin, 1995) 	<ul style="list-style-type: none"> • No families in intervention group had child placed in foster care • Some improvement found in parental teaching and stimulation of children • Parents experienced an improvement in their feelings and perceptions of themselves as parents
Neglected Children in Intergenerational Kinship Care	<ul style="list-style-type: none"> • Outside evaluator • No comparison group • 10 standardized scales • Intake, 1-year exit, and 6-month follow-up • Statistical analysis of data 	<ul style="list-style-type: none"> • Identify the negative effects of prior neglect and provide resources tailored to children's needs • Prevent subsequent neglect • Decrease grandparents' social isolation • Maximize quality of life for grandparent caregivers 	<ul style="list-style-type: none"> • Child Behavior Checklist (Achenbach, 1991) • Teacher's Report Form (Achenbach, 1991) • Child Well-being Scale (Magura & Moses, 1987) • Denver II (Frankenburg, Dodds, Archer, Bresnick, Maschka, et al., 1992) • Grandparent Interview (developed for this program) • Child Neglect Index (Trocmé, 1996) • Home Observation for Measurement of the Environment (Caldwell & Bradley, 1984) • Family Resource Scale (Dunst & Leet, 1987) • Family Empowerment Scale (Koren, DeChillo, & Friesen, 1992) • Family Support Scale (Dunst, Jenkins, & Trivette, 1984) • Health Risk Appraisal (Hutchins, 1991) • SF-36 (Ware, 1992) • Brief Symptom Inventory (Derogatis, 1993) 	<ul style="list-style-type: none"> • Decreased child behavior problems • Reduced risk for child neglect • Improved caregiver health • Caregiver empowerment • Increase in caregiver social support • Decrease in caregiver stress
Parent Empowerment Program	<ul style="list-style-type: none"> • In-house evaluator • No comparison group • Five standardized scales • At enrollment and at graduation • No statistical analysis of data reported 	<ul style="list-style-type: none"> • Empower parents to create nurturing homes for their children • Improve participants' self-esteem and trust in their parenting skills • Reduce neglect and abuse • Increase maternal social support • Decrease child abuse potential • Increase knowledge of infant development • Improve home environment safety 	<ul style="list-style-type: none"> • Child Abuse Potential Inventory (Milner, 1994) • Knowledge Inventory of Child Development and Behavior (Fulton, 1995) • Maternal Social Support Index (Pascoe, lalongo, Horn, Reinhart, & Perradatto, 1988) • Personal Goal Achievement Measure (developed for program) • Child Well-Being Check List (CWBCL) 	<ul style="list-style-type: none"> • Slight increase in child well-being scores • Slight increase in knowledge of infant development • Slight downward trend in child abuse potential • Significant percentage of family-identified goals partially achieved or achieved

Appendix C: References for Evaluation Tools and Instruments

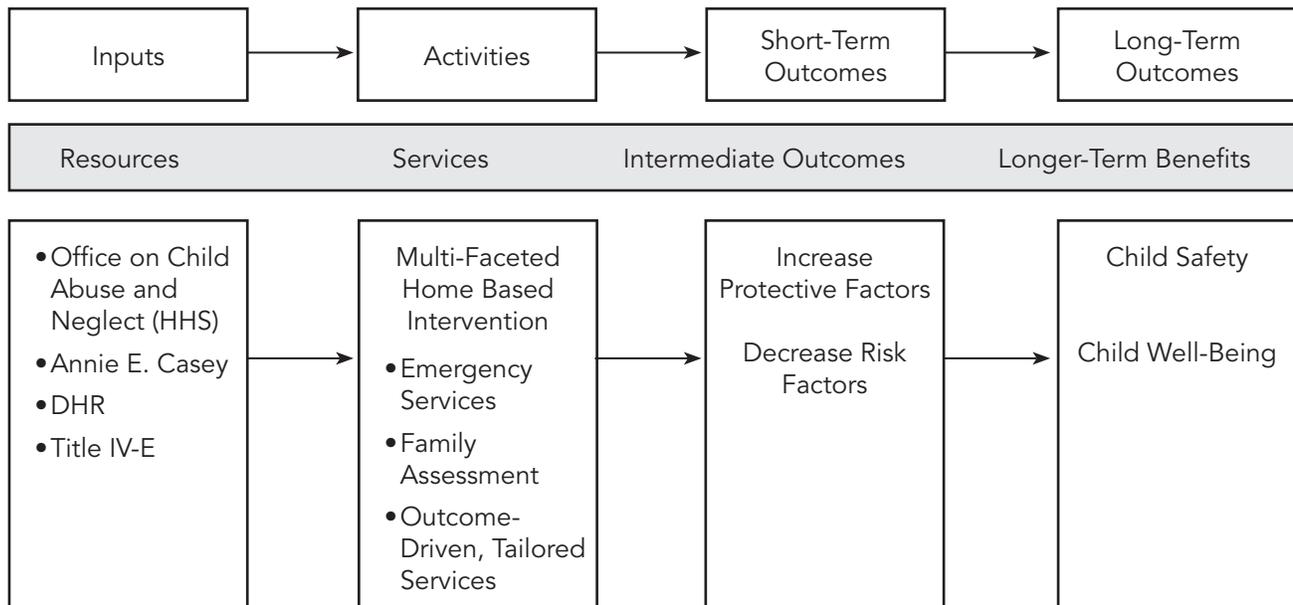
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Appendix D: Sample Logic Model



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