Title

Preventing Child Maltreatment and Neglect: New Directions for Successful Engagement and Retention of At-Risk Families

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Publication Date

2013

Peer reviewed|Thesis/dissertation

UNIVERSITY OF CALIFORNIA

Los Angeles

Preventing Child Maltreatment and Neglect:

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A dissertation submitted in partial satisfaction of the

requirements for the degree Doctor of Philosophy

in Social Welfare

by

Andrea Leigh Witkin

2013

ABSTRACT OF THE DISSERTATION

Preventing Child Maltreatment and Neglect:

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Andrea Leigh Witkin

Doctor of Philosophy in Social Work

University of California, Los Angeles, 2013

Professor Todd M. Franke, Chair

Child maltreatment continues to be a growing and a serious problem in the United States. Early prevention efforts are a cornerstone of inquiry among researchers across the country. Using secondary data analysis, this dissertation evaluates the effectiveness of a community-based, child maltreatment prevention program that emphasized parental collaboration (working as partner with agency worker) and parental empowerment (focusing on parenting strengths) in achieving successful rates of engagement and retention working with families at-risk for child maltreatment. Specifically, it is hypothesized that programs that utilize strategies focusing on parent strengths, community engagement, and available community resources in service planning and decision-making will have successful (met program goals/requirements) rates of family retention and engagement in child maltreatment and neglect prevention services. Further, the ability to achieve long term engagement and retention was hypothesized to be more related to the way the agency worker empowers the family to be self- sufficient rather than whether families were targeted for being at risk or universally selected to receive services. Data were collected from 170 families, who completed focus groups and surveys regarding their experiences in the Partnership for Families Program. Results from the surveys using a varimax factor analysis

revealed three key components for successful engagement and retention of families receiving services in the prevention program: (a) a focus on parental strengths, (b) a focus on community engagement and (c) a focus on resource availability and awareness. Matched paired t-tests were conducted on each of the factors, with a resulting $p<.001$ for each. Findings from qualitative content analysis were consistent with quantitative results and suggest that parents' participation in services shapes the ways in which they engage their families and others. Based on this study, successful engagement of at-risk families and reduction of risk for child maltreatment may depend on emphasizing parental empowerment and well-being. The findings from this sample may not be representative of the larger population as participation was based on parent attendance, availability, and logistics. Future research should examine the roles of engagement, empowerment, and parental well-being with different sub-populations yielding greater diversity among participants with a random selection process.

The dissertation of Andrea Leigh Witkin is approved.

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2013

This dissertation is dedicated in loving memory of my mother Francine Witkin who always believed in me and who would be so very proud of this accomplishment.

To my father Melvin Witkin who continually encouraged me, provided unwavering support and told me I could achieve this! Without my father, this would not have been possible. I love you daddy.

I also wish to dedicate this dissertation to Mireya Guadalupe Garcia Briones who reminds me every day how to turn struggle into triumph.

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ACKNOWLEDGEMENTS

This research was supported by people whose dedication and generosity of spirit were invaluable to me both personally and professionally. I express my sincere appreciation to the members of my doctoral committee: Dr. Todd M. Franke and Dr. Diane de Anda, Dr. Aurora Jackson, and Dr. Mary Jane Rotheram-Borus. I am most fortunate to have had their kind and patient guidance not only on this research project, but throughout my doctoral education as well.

To Dr. Todd M. Franke, I express my deepest gratitude and admiration. As the chair of my dissertation committee, and as my mentor, he has always been caring, challenging, and expecting me to do my best, and then some. As my doctoral advisor, his unwavering encouragement, attentiveness, and faith ensured that I would conclude this research with the same commitment, effort, and integrity as I have with all my work both professional and educational. His wisdom and guidance have left me with an incomparably rich experience.

To Dr. Aurora Jackson and Dr. Diane de Anda, I am deeply indebted to your expertise and guidance in completing this dissertation with the highest standards of expectations and continual feedback which was invaluable to me at every step. Thank you for your guidance and wisdom.

To Dr. Mary Jane Rotheram-Borus I owe my love of all things research and my commitment to excellence. She has been my mentor, advisor, teacher, and staunch supporter, for the past 15 years and without her continued support and guidance, I would have not attempted this accomplishment. Through my work with her in the field of adolescent risk behaviors and family wellness, I have become the person I am today. Her brilliance as a leading pioneer in her field has inspired me to do my best work at all times, and has provided me with the tools and skills needed to pursue a doctoral degree. She has and continues to be someone I admire and

aspire to emulate in all my future professional endeavors. She is a true visionary whose work to improve the lives of families across the world has inspired me more than she will ever know. Thank you Mary Jane!

I would be remiss not to acknowledge numerous people involved with the Partnership For Families Initiative who worked side by side with me on this project. Specifically the PFF Evaluation Team which included but not limited to Dr. Ashaki Jackson, Dr. Todd Franke, Dr. Stephen Budde, Dr. Devon Brooks, Dr. Jan Nissly, Dr. Ericka Rosenthal, Lauren Dods, and Alice Kim.

In addition, a special acknowledgement to my Australian counterpart and supporter Dr. Philip Batterham who provided me with much needed support exactly when I needed it. Thank you, Dr. Batterham!

Last but certainly not least, I would like to acknowledge my sister Cynthia Witkin who has always been on my side and who continues to be my number one cheerleader. She has continually provided me with the emotional support needed to complete this tenuous process and is my best friend. She reminds me every day that I am worthy of anything I choose to accomplish. I love you, Cindy. A final thank you goes out to all my family and friends who never stopped believing in me. I appreciate their support and relentless belief in my abilities.

Finally, thank you to the entire UCLA Department of Social Welfare – staff, professors, and administrators. Each has contributed to the success of this dissertation and I thank you for your patience and guidance.

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CHAPTER 1

INTRODUCTION

Interest in promoting parent and family involvement in interventions designed to help children and families at-risk of child maltreatment or other poor outcomes has expanded exponentially in recent years, spurred on by the utility of ecological theories of development (Bronfenbenner, 1979) and a greater understanding of the role of parental nurture in early childhood development (Buofard & Weiss, 2008). The costs of preventing child maltreatment are minuscule in comparison to the cost incurred as a result of child maltreatment, which include foster care, child healthcare, special education services, and the expenses associated with the increased likelihood of criminal behavior (McCurdy & Daro, 2001). Despite the cost-benefit ratio of child maltreatment prevention, state and local governments facing budget shortfalls will seek funding cuts to social programs that address maltreatment. At the state level, California's recently enacted budget includes $2 billion in cuts to mental health care and early childhood programs as well as a reduction of $1.7 billion to Medi-Cal spending (Johnson, Oliff, & Williams, 2011). Agencies seeking to protect vulnerable children and families must demonstrate sustained and widespread program efficacy, something that can be difficult when a significant number of families do not initially engage or remain in interventions (Lowe, 2006; Budde, Sessoms, Brooks, Felix, Cohen, Kim, & Putnam-Hornstein, 2011).

Parent engagement in early prevention programs is a topic that is often overlooked as being a primary outcome in child maltreatment studies. Too often, prevention programs utilize a generic approach by creating a one-size-fits-all model of change (Daro, McCurdy, Falconnier, & Stojanovic, 2003). Current research highlights parent engagement as one of the cornerstone principles for involving families in decisions about themselves, their children, use of community services, and community involvement (McCurdy & Daro, 2001). Underpinning parental

engagement efforts are the systemic and inherent beliefs that everyone has assets and strengths, and with support, everyone has the opportunity to affect positive change in his/her environment. Previous values and beliefs have held that families who are the poorest, live in low-income areas, and possess low education levels, have the lowest child outcomes. Moreover, intervention efforts have failed to produce the desired results for these children and families (Chaffin, Bonner, & Hill, 2001).

Alternatively, approaching prevention and intervention efforts with a focus on parental strengths and family goals leads service practitioners to engage parents as partners (Krysik, LeCroy & Ashford, 2008; Lee, August, Bloomquist, Mathy, & Realmuto, 2006). In this paradigm, a differential response framework is utilized, where parents are viewed as capable of accomplishing their goals, learning new behaviors, and identifying what their greatest needs are. Similarly, communities with strong group values are viewed as powerful forces capable of changing entire neighborhoods (LeCroy & Whitaker, 2005). The differential response approach is "characterized by voluntary provision, greater respect for families, and increased community involvement" (Friend, Schlonsky, & Lambert, 2008, p. 15). Prevention efforts that are usually aimed at high-risk families would be reframed with a focus on families in crisis and lower-risk families who, under traditional child welfare services, would often receive nothing (Conely, 2007 as cited in Friend, Schlonsky, & Lambert, 2008). More education, health care, social services, early childhood care and education agencies are beginning to embrace the notion of parents as the primary means for improving child outcomes (McCurdy & Daro, 2004). Service providers are also affirming their commitment to parent engagement. Federal, state and local policies call for programs and agencies to provide opportunities for parents to be heard and engaged when discussions and decisions are about them and their families. Perhaps most salient in the discussion of parent engagement is the issue of parental buy-in for service and treatment

plans. If parents become part of the decision making process for service use, their buy-in helps ensure shared goals and outcomes. In addition, community networks of support and services are built by and around engaged parents and other residents (Haskins, Paxson, & Brook-Gunn, 2009; Olds & Kitzman, 1993; Luker & Chalmers, 1990).

Background and Significance

Prevalence. Child maltreatment, which includes both child abuse and neglect, continues to be a growing and a serious problem in the United States. For the Federal Fiscal Year (FFY) 2011, 51 States reported 676,569 unique victims of child abuse and neglect, which translates to a victim rate of 9.1 victims per 1,000 children in the population according to the most recent annual statistical report on child maltreatment from the Administration on Children, Youth and Families (United States Health Services; Child Maltreatment, 2011). Children under the age of 1 are at the highest risk of maltreatment, and neglect is the most common type of maltreatment experienced by children (Children's Bureau, 2011; Dube, Felitti, Dong, Felitti, Edwards, & Croft, 2002; Shaw & Kilburn, 2009; U.S. Health Department, 2002). The U.S. spends millions of dollars, both public and private, each year on prevention and intervention services for child abuse and neglect (U.S. Health Department, 2002). Evaluation of these services and the associated risk factors for abuse and neglect has informed a wide range of practices and programs that aim to prevent child abuse and neglect.

Early prevention programs targeted towards families at-risk for child abuse and neglect are at the cornerstone of the child welfare system's efforts to provide services and resources for these families and prevent future acts of child maltreatment. However, a high number of cases reported in the system are duplicate cases that have been previously reported (Haskins et al., 2009). Analogous to high rates of recidivism among juveniles in correctional facilities, repeat

cases of child maltreatment further perpetuate the cycle of risk, leaving children vulnerable to extended periods of neglect.

Intervening effectively in the lives of these children and their families cannot be the sole responsibility of the child welfare system. On the contrary, the emergent problem requires a shared community concern (Dumas, Nissley-Tsiopinis, & Moreland 2007; Goldman & Salus, 2003). Legislation overseeing child protection services is governed by Federal statutes formed by the Child Abuse Prevention and Treatment Act (CAPTA) in concordance with the Adoption and Safe Families Act (ASFA). However, legislation alone is not enough to eliminate the prevalence of the problem, and researchers in the field are reporting more evidence that illustrate the urgent need to adopt a community model that encompasses a collaborative effort among policy makers, educators, communities, and families (Daro, 2000; Goldman & Salus, 2003; Haskins et al., 2009; McCurdy & Daro, 2004).

The Children's Bureau (Administration on Children, Youth, and Families in the U.S. Department of Health and Human Services) is attempting to address this issue in a variety ways. For example, the Children's Bureau collects data on the children who are served by child protective services (CPS) agencies. Their annual publication, *Child Maltreatment* (Children's Bureau, 2011), presents national data about child abuse and neglect known to child protection agencies in the United States (maintained in the National Child Abuse and Neglect Data System). During FFY 2011, child protection agencies received an estimated 3.4 million referrals involving the alleged maltreatment of approximately 6.2 million. Of these referrals, 60.8% were screened in for a response and more than 2 million reports received a disposition (27.4 per 1,000 children). An analysis of 5 years' worth of data reveals only slight fluctuations in the number and rate of reports that received a response and resulted in a disposition. Victims in the age group of birth to 1 year had the highest rate of victimization, at 20.6 per 1,000 children of the same age

group in the national population. Victimization was split between the sexes with boys accounting for 48.2% and girls accounting for 51.1%. Eighty-seven percent of unique count victims were comprised of three races/ethnicities: African-American (21.5%), Hispanic (22.1%), and White (43.9%). However, victims who reported multiple ethnicities or who identified as bi-racial accounted for the highest rates of victimization respectively, per 1000 children in the population of the same race. As in prior years, the greatest proportion of children suffered from neglect.

These staggering statistics reported above reveal the urgent need for state and local agencies, along with researchers, practitioners, and communities to target prevention efforts on reducing abuse and neglect through a new lens. A review of literature on prevention efforts shows a wide array of services which include, parenting classes, community events, resource awareness, and home visiting programs (Daro et al. 2005; Duggan et al., 2004). One of the overarching goals of these future prevention strategies rests on designing programs aimed at focusing on building upon family strengths as a means of stabilizing the family environment. The research suggests that successful engagement of families at risk may depend on emphasizing parental empowerment and well-being as a key factor in reducing risk for child maltreatment and neglect (Morrisey-Kane & Prinz, 1999).

Definitions of Abuse. The Child Abuse Prevention and Treatment Act (CAPTA) provides minimum standards for defining physical child abuse, child neglect, and sexual abuse that states must incorporate in their statutory definitions to receive Federal funds. Under CAPTA, child abuse and neglect means:

> "Any recent act or failure to act on the part of a parent or caretaker that results in death, serious physical or emotional harm, sexual abuse, or exploitation; an act or failure to act that presents an imminent risk of serious harm" (Children's Bureau, 2011, p. 15).

The definition of child abuse and neglect refers specifically to parents and other caregivers. A child under this definition generally means a person who is under the age of 18 or

who is not an emancipated minor (Children's Bureau, 2010). Neglect is frequently defined as the failure of a parent or other person with responsibility for the child to provide needed food, clothing, shelter, medical care, or supervision such that the child's health, safety, and well-being are threatened with harm (Children's Bureau, 2011). Approximately 24 states, the District of Columbia, American Samoa, Puerto Rico, and the Virgin Islands include failure to educate the child as required by law in their definition of neglect (Barnett & Miller-Perrin, 2005; Kesner, Bingham, & Kwon, 2009). Seven states specifically define medical neglect as failing to provide any special medical treatment or mental health care needed by the child. In addition, four states define as medical neglect the withholding of medical treatment or nutrition from disabled infants with life-threatening conditions (Kaplan, Schene, DePanfilis, & Gilmore, 2009).

Engagement and Retention

Engagement, often defined relative to the specific service context, generally refers to an individual's enrollment and participation in services (Altman, 2008). Engaging clients in services is a requisite step for the implementation of interventions that reduce present and future risk for child maltreatment. Studies indicate that at-risk families report better outcomes, including greater self-efficacy and improved family functioning as a result of engaging in services (MacLeod & Nelson, 2000; Olds et al., 1999; Partnerships for Families Initiative Evaluation Team, 2009). Families that do not engage have a greater likelihood of child maltreatment recidivism (DePanfilis & Zuravin, 2002).

Despite findings demonstrating improvement in family functioning as a result of participating in child maltreatment prevention programs, at-risk families do not always engage in voluntary services (McKay, McCadam, & Gonzales, 1996). Initial engagement in voluntary services is inherently and historically difficult to measure, but rates of enrollment are typically assumed to be 10-25% of recruited participants (Coatsworth, Duncan, Pantin, & Szapocznik,

2006; Gomby, Culross, and Behrman, 1999). Basic intervention efforts, such as a reminder phone call prior to the first appointment, have been shown to increase initial engagement by as much as 32% (Shivack & Sullivan, 1991). Early childhood scholars contend that family intervention programs offer particularly promising opportunities to prevent child maltreatment; yet, the success of these programs is limited by the extent to which families engage in services (Astuto & Allen, 2009). Families who initially participate in services often drop out before completion at rates between 20 and 80% (Gomby et al., 1999; Ingoldsby, 2010). The lack of sustained involvement dilutes the efficacy of services. Initial research shows a positive correlation between length of service and family functioning (Franke et al., 2009; MacLeod & Nelson, 2000).

Defining Parent Engagement. Parents' and families' involvement in planning and decision making are crucial whenever an organization, school, private provider, or public agency representative enters a child's life. There are a number of strategies and methods that aim to involve parents in decisions and actions that affect them, their children, and their community (Dumas et al. 2007; Hutchfield, 1999; McCurdy & Daro, 2001). The following outlines several types of parent engagement and provides examples and reported benefits.

Literature on parental engagement reveals an underlying pattern of values. Old notions that services, in conjunction with community partnerships fix those who need help and support failed to produce the expected results for children and families (National Council for Community and Education Partnerships Resource Center, 2009). Alternatively, valuing families for their unique strengths and respecting their values and beliefs, leads service practitioners to engage parents as partners. Reinforcing community building engagement approaches provides fidelity to the organic and complex processes of change, which continually informs new developments

and understanding (Center for Study of Social Policy, 2003; Ingoldsby, 2010; Yancey, Ortega, & Kumanyika, 2006).

Parent Engagement in Services and Programs. Of all types of parent engagement, the most common form across fields is direct participation in services and supports to improve outcomes for children, specifically, services that support children aged 0-5 years. During children's early development, service providers are most likely to conduct outreach to parents and work to directly involve them in services and programs (Olds, Henderson, Kitzman, & Cole, 1995). Examples of federally sponsored programs that use a parental engagement model include the Even Start family literacy program, Head Start, and Early Head Start. Parent engagement in education includes participation in classroom and community educational activities, in addition to parents' responsibility in their children's learning at home. Research demonstrates that students with involved parents, regardless of background or income, are more likely to succeed in school (Coatsworth et al., 2006; Lee et al., 2006; Krysik et al., 2007).

Many community-based initiatives likewise engage parents to improve outcomes for children. In the family support field, community-based parent and engagement approaches recognize that strong parents and families are critical to child development, safety, and well-being (Barth, 1991; Conely, 2007). Networks of community services and supports help parents strengthen their child development knowledge, hone their parenting skills, and develop family resources for achieving goals for their children (Dumka, Garza, Roosa, & Stoerzinger, 1997). When network building moves beyond linking people with services to promoting broader community relationships and social networks of mutual support for all parents and residents, it has the potential to impact entire communities.

Involving parents in decisions about the services, support, treatment, or response to their children is a best practice and a legal requirement in some fields. This approach presupposes that

parents are the experts regarding their children. They are the best source of information about their children and the strategies that will contribute to child safety, health, and well-being. In the child welfare field, family team decision making that includes parents, youth, and members of the family and employs family team meetings, and family team conferences, are considered best practice models (Hutchfield, 1999).

Research demonstrates that these models for making decisions about family goals and service plans result in more detailed and individualized plans, more informal resources on the family's behalf, and a greater voice in decision making for the families (Steib, 2004). The Anne E. Casey Foundation launched the Family to Family Initiative, a nationwide child welfare and foster care reform initiative that provides strategies and tools to help states and local child welfare agencies achieve better outcomes for children and families. The initiative's four core strategies are: Recruitment, Development and Support of Families (RDS), Building Community Partnerships (BCP), Team Decision Making (TDM) and Self Evaluation (SE). Findings from the Initiative reveal that practitioners report the participatory approach provides an opportunity for family members to add their own cultural identity and strengths to plans for children (DeMuro & Rideout, 2002). In addition to building personal relationships that impact children and families, these and other community activities help bond community networks of mutual support. Strategies range from the informal support of friends and neighbors to more organized self-help groups, support groups, and formal programs operated by public or private agencies. In addition, schools, early childhood programs, child abuse and neglect prevention initiatives, and other social services providers sometimes employ parents as mentors and staff (Munson & Freundlich, 2008).

The Parent Partner program in Contra Costa County is an example of peer support within the child welfare field. The program, which is being replicated in other jurisdictions, enlists

mothers and fathers who have experienced child removal and reunification to serve as program staff. With training and support, these experienced parents help other families navigate the complicated child welfare court and service system, help parents gain awareness of their rights and responsibilities, and participate in training for child welfare workers, foster parents, attorneys, and court staff. Their unique experiences as former clients of the child welfare system position Parent Partners to offer an alternative perspective to that of social workers and allied professionals (Anthony, Berrick, Cohen & Wilder, 2009).

Research also illustrates that community environments have a profound effect on both individual and population-level outcomes for children, including safety, health, and school success. Civic engagement of parents and other residents is one of the essential building blocks for strong communities (Dero et al., 2003). By joining together, parents, residents, and local organizations strengthen the mutual support networks that boost protective factors for children. The result of these collaborations can often be the stepping-stone to change in policy and legislation. For example, community groups could advocate for community economic development, safe playgrounds and recreation, access to nutritious food and health care, and the range of public and private assistance needed to ensure that their children have a positive, nourishing environment.

Increasing numbers of parents are involved in school and community organizations that empower them to demand accountability for their children's schools and to participate in civic decisions that impact education (Epstein, 2001). As parents become informed about quality education and see the influence they can have in school improvement and outcomes for their children, the impact of their advocacy grows. In some communities, these efforts have spread beyond schools to broader, community improvement efforts (Epstein, 2001). Studies show that incorporating parents and families in school and community decision making contributes to

upgraded school facilities, improved school leadership and staffing, higher-quality learning programs for students, new resources and programs to improve teaching and curriculum, and new funding for after-school programs and family supports (Pennell & Anderson, 2005). Examples include parent education and organizing, facilitation of parent dialogue with child welfare policymakers, parent participation in professional education of child welfare workers, production of parent-authored publications and work with the media, ongoing development of a peer-led parent leadership curriculum, and preparation of parents to serve as uniquely qualified policy analysts (Daro, McCurdy, Falconnier, & Stojanovic, 2003).

Challenges to Parental Engagement. Both parents and organizations admit to an array of barriers to parent involvement, participation, and partnership. A literature review of parent engagement in schools concludes that discomfort and mistrust arise from misconceptions that staff and families hold about each other's motivation, practices, culture and beliefs. Across systems, parents report that they often feel unwelcome by service providers and that service worker's attitudes toward them can be patronizing and demeaning. For families who represent ethnic or cultural minorities, barriers range from perceptions of biased communication to overt prejudice and "system-wide, deep-seated institutional racism and an unconscious belief that select groups cannot be successful" (Coatsworth et al., 2006, p. 215). Across programs and initiatives, other factors that contribute to parents feeling unwelcome include language barriers, lack of understanding that supports the family's culture, and difficulty navigating complex service systems (Garvin, DePanfilis, & Daining, 2007).

Across fields, competing demands on parents' time hinder their participation. General findings from federal child and family services reviews revealed that inflexible work schedules and inadequate child care were reported most frequently as a primary barrier to engagement (Administration for Children and Families, 2004). Also noted were challenges surrounding

community engagement. The report revealed residents from low-income households, and who had low rates of education, reported that safety concerns within their neighborhoods were the number one issue that prevented their participation in community activities (Administration for Children and Families, 2004; Crowley, 2005). In addition, residents with limited income cite resource barriers to community engagement, including inadequate transportation and lack of child care (Coulton, Korbin, Su, & Chow, 2009).

Characteristics of Successful Parent Engagement Approaches. Home visiting as an early prevention strategy for at-risk families with children under 5 years old has become an increasingly common approach in the social service industry (Eckenrode et al., 2000; Olds, Henderson, Kitzman, & Cole, 1995). But just how effective these home visit programs are in reducing the risk of child maltreatment and neglect are at the center of debate among researches and practitioners in the field. What factors contribute to a program's success, and where do programs fall short of achieving their desired result of reducing child maltreatment and neglect, are now being critically examined. Formative research is being conducted to explore how the implementation (e.g., policies and procedures), frequency (e.g., number of visits or length of visit), and quality of visits (e.g., worker training, topics of focus, and worker attitude) impact program outcomes and affect family cohesion (Daro, McCurdy, & Nelson, 2005).

While strategies for engaging parents in specific types of activities and roles differ, common principles and characteristics can be identified across fields and purposes. A meta-analysis of successful characteristics and experiences for involving parents in services reveal the following core characteristics of successful approaches to engaging and retaining families at-risk. The Prenatal and Early Childhood Nurse Home Visitation Program, developed by David Olds and his colleagues (Olds, 1988; Olds, Kitzman et al., 1997; Olds and Korfmacher, 1997), was designed to help low-income, first-time parents start their lives with their children on a solid

foundation and prevent the health and parenting problems that can contribute to the early development of antisocial behavior. Successful engagement strategies revealed included using trained, experienced, mature nurses with strong interpersonal skills make home visits; having home visitors focus simultaneously on the mother's personal health and development, environmental health, and quality of caregiving for the infant or toddler; and having home visitors involve family members and friends in the program and help families use other community health and human services when needed (Olds, Hill, & Rumsey, 1998).

A focus on clear, understandable shared goals for their children contribute to motivating many parents to participate in services, community activities, and advocacy. Parents must have a personal stake (i.e., a sense of buy-in) in the outcomes and a sense of ownership in the process for achieving goals. Direct involvement in setting the agenda, assessing challenges, and being involved in possible solutions helps to sustain parental involvement. Respect for individual experiences, views, and culture also can be helpful in creating a sense of trust between parents and their service workers. Value and respect for each parent is a common thread throughout successful parent engagement efforts (Crowley, 2005; Geeraert, Van den Noortgate, Grietens, & Onghena, 2004).

The Child Welfare Organizing Project (CWOP), a parent professional partnership dedicated to public child welfare reform in New York City, takes a more advocacy-focused approach to parent engagement. The staff and Board, which consist largely of parents involved in the child welfare system, contribute to a wide range of evolving, constituent-driven activities and strategies. Examples include,

> parent education and organizing, facilitation of parent dialogue with child welfare policymakers, parent participation in professional education of child welfare workers, production of parent-authored publications and work with the media, ongoing development of a peer-led parent leadership curriculum, and preparation of parents to

> serve as uniquely qualified policy analysts (Child Welfare Organizing Project, 2010, p. 17).

Successful strategies also include intentional efforts made to solicit and listen with respect to parents' views about their children, their communities, and their goals. Training, dialogue, and other learning opportunities help dispel misconceptions about both parents and professionals. A warm environment, which includes positive interaction and relationships, makes parents feel supported, respected, and acknowledged for their time and efforts. Family-friendly supports that facilitate participation in community activities and services include food, child care, transportation, and spaces where families feel safe, comfortable, and valued (Child Welfare Organizing Project, 2010)

One common complaint reported among families is related to strangers coming into the home one-time and disappearing, never to be heard from again (Mendez, Carpenter, LaForett, & Cohen, 2009). Having the same caseworker or home visitor who showed up consistently, was reported repeatedly to be extremely important to families. Effective strategies for engagement tended to focus on consistent, multiple, and clearly communicated expectations as key elements in maintaining and sustaining parent involvement and eliminating sporadic interactions and miscommunication (Conely, 2007). Mutual respect, trust, and reciprocity developed between parents, service workers, and other community leaders are likely to lead to sustained participation in community-building efforts and to strengthen the voices of parents and other residents in their communities. Family engaging services and programs that are responsive to the experiences and feedback of parents, community leaders, educators, and children themselves, lead to sustained participation in programs and services. Longer and sustained periods of time in social service networks organically facilitate motivation to share a common goal of well- being (Conely, 2007).

Problem Statement

Families at risk of child abuse and/or neglect are generally from marginalized populations with little knowledge of available support services and who have various challenges and barriers to receiving and utilizing services (Dore & Alexander, 2006). Hence, engagement in social service programs tends to occur in times of crisis with the focus on an immediate threat or risk. Once the immediate threat is considered under control, efforts at retaining families in service programs often fall by the wayside, which does not allow for long term behavioral changes and ultimately results in the return of the family into the system. Thus begins the repeating cycle of risk in the family and underscores the critical need for successful engagement and retention strategies (Collins, 2000).

Study Purpose. There is a large gap in the research, which requires a rigorous examination to evaluate the process of incorporating strength based approaches (i.e., using the positive family attributes to build upon) in programs that aim to prevent child abuse and neglect. While research focusing on strength based approaches in this area are sparse, one evaluation of client level outcomes across a statewide group of family support programs revealed that among 1,600 clients that were primarily low income and identified as moderate to high risk for child maltreatment, agency collaborative programs had a 65% participant dropout rate, and programs that focused primarily on parenting classes had a 46% participant drop- out rate before the completion of the intended number of home visits (Duggan et al., 2006). These high percentages of drop-out rates support the need to examine the notion of obtaining parental buy-in to ensure that strong strength based relationships between parents and home worker are forged prior to the implementation of the treatment plan or intervention program. This strengths based approach through the use of home visiting prevention programs is the primary model of examination for this paper. Specifically, the focus on the families' perceptions of engagement in the programs

and the focus on the importance of recognizing and stabilizing the more immediate needs of the mother and creating a sense of personal empowerment as it relates to improving outcomes and the relationship with her children (Franke et al., 2009; Olds et al., 2008). An example of a strength-based approach, First 5 LA's Partnership for Families (PFF) Initiative, was used as a preliminary model for strength-based engagement and retention strategies.

The Partnerships For Families Initiative. Partnerships For Families (PFF) is a child abuse prevention program designed to address the needs of pregnant women and families with children age five years or younger who are at risk for child maltreatment in Los Angeles County. In conjunction with the Department of Children and Family Services (DCFS), the joint goal is the prevention of child maltreatment by ensuring that families with children eighteen years and under live in physically and emotionally safe environments. The program's objectives include

- improving the quality of services and supports for at-risk families;
- increasing capacity of community partners to coordinate, collaborate and mobilize, as well as identify, engage, and serve at-risk families; and
- increasing information about prevention of child abuse and neglect.

PFF is a community-based prevention strategy designed to strengthen families and build community capacity through direct service, such as family engagement, community network development, and organizational capacity building. The PFF model for services requires a minimum of two home visits per month, a pre and post assessment of family functioning, and approximately 6 months of services. Although a family may receive services from a number of community-based organizations, each family's services are planned and coordinated by the lead agency as well as any partner agencies in the respective service provision area (SPA). This method brings aspects of home visitation together with ecological and place-based models. The combination is designed to engage families in a reciprocal flow of outreach intended to foster

caregivers' competency to seek help and sustain social connections after PFF service closure. The community and social connections established through this process are thought to be protective against child abuse and neglect (Olds et. al, 1998). The PFF initiative is based on the idea that child safety will be augmented as a result of increased family strength, stability, and well-being. Such family-level changes are evidenced by decreased social isolation; existence of positive, pro-social, and nurturing interfamily relationships; good physical and mental health; and increased functioning levels of family members.

Funded by First 5 LA to prevent abuse and neglect of vulnerable, young children from birth through age 5, PFF incorporates core values and practices supported by national research (American Humane, 2008), which identifies strengthening families' protective factors (i.e., using what already works well in the family) to support families and reduce child abuse risks. Targeted families include high-risk pregnant women and families with a child determined by the Los Angeles County Department of Children and Family Services (DCFS) to be at high or very high risk of child abuse or neglect. Local PFF partners respond immediately with concrete support and a range of home-based and center-based services. In-home counselors respectfully join with parents as partners to help them eliminate safety risks, obtain critical information about child development and parenting, and build on their existing strengths and skills. Local networks of peers and community organizations reduce families' isolation and ensure access to ongoing supports. In the process, these networks help build strong communities where all children and families can thrive. The PFF Initiative sample consisted of established service provision areas (SPAs) as defined by geographic representations across Los Angeles and surrounding counties (see Table 1).

Table 1.

Service Offerings by Service Provision Area (SPA)

SPA	Organization	Service Offerings
1	Children's Bureau of Southern California	Child abuse services, family life education and foster care services for people of all ages
2	The Help Group	mental health and therapy services for children with special needs
3	SPIRITT Family Services	Child abuse services, domestic violence services, family life education, substance abuse services, and youth services
4	Para Los Niños	child care, clothing, counseling services, family life education, and youth services
5	St. John's Child & Family Development Center	Family support services and mental health services to children and families
6	SHIELDS for Families	Family preservation services, mental health services, residential substance abuse treatment, substance abuse services, vocational education services and youth services
7	Bienvenidos Children's Center	Family support services, foster care services, health services, substance abuse services, and welfare-to-work services
8	National Council on Alcohol-Drug Dependence of South Bay /South Bay Center for Counseling (SBCC)	Substance abuse services, domestic violence services, family preservation services, residential treatment for substance abuse for pregnant/parenting women, and welfare-to-work support services

The following is an evaluation of the PFF Initiative to identify the key components in successful engagement and retention of families at-risk using data collected during the initiative's implementation, specifically programs targeted at child maltreatment prevention that emphasize parental collaboration (working as partner with agency worker) and parental empowerment (focusing on parenting strengths). The primary areas of examination include: What are the salient factors that allow for long term engagement and retention of families participating in child maltreatment prevention programs as reported by parents involved in these programs? Are child maltreatment prevention services that emphasize parental collaboration and parent well-being successful in engagement and retention of families at-risk for child maltreatment and neglect? It is proposed that the way families are identified is less important than the way they are treated once enrolled. Whether families are targeted for being at-risk, or universally selected to receive services, the ability to achieve long term engagement and retention may be more related to the way the worker empowers the family to be self- sufficient. The next chapter will provide a detailed review of home visiting programs, methodologies for successful retention of families, and findings resulting from these efforts.

Hypotheses and Research Questions

This research identified the key components in successful engagement and retention of families at-risk. Specifically, programs targeting child maltreatment prevention that emphasize parental collaboration (working as partner with agency worker) and parental empowerment (focusing on parenting strengths) were examined. The primary areas of inquiry included: What are the salient factors that allow for long term engagement and retention of families participating in child maltreatment prevention programs as reported by parents involved in these programs? Are child maltreatment prevention services that emphasize parental collaboration and parent

well-being successful in the engagement and retention with families at-risk for child maltreatment and neglect? The following hypotheses were proposed:

1. Programs that utilize strategies that focus on parent strengths (e.g., acknowledge what parent does well) are successful (met program goals/requirements) in the engagement and retention of families participating in child maltreatment prevention programs.

    1a) Parents who participated in the PFF program will have an increased sense of parental strengths (a sense of what they do well) after participating in the program.
2. Programs that emphasize community engagement as a focal point in service planning and decision making are successful (met program goals/requirements) in the engagement and retention of families participating in child maltreatment and neglect prevention services.

    2a) Parents who participated in the PFF program have a stronger sense of community engagement (a feeling of connectedness to the community) after participating in the program.
3. Programs that emphasize available community resources in service planning and decision making are successful (met program goals/requirements) in the engagement and retention of families participating in child maltreatment and neglect prevention services.

    3a) Parents who participated in the PFF program have a greater sense of available community resources (know where to go for help) after participating in the program

Conceptual and Operational Definitions

The concept of successful engagement and retention was defined as whether the program goals and requirements were met (i.e. bi-monthly home visits for 6 months time). Successful engagement and retention were measured with three questions in the focus group, including: (a) "Once you began getting services, what kept you involved (e.g., classes, family events, relationship with case manager, things they gave you, etc.)?" (b) "To what extent were/are you involved in decisions about your services? Could you please offer an example of how you have

participated in your own service plan?" and (c) "What kinds of things made you feel more comfortable? What kinds of things made you feel less comfortable?"

The concept of parent strengths was defined as what the parent does well. Examples of questions included: "I think I am a person with many strengths", "I have confidence in myself" and "I think my opinion matters". Responses were based on a 5-point Likert scale with 1) Strongly Agree and 5) Strongly Disagree. (Appendix C).

The concept of community engagement was defined as the parents' use of support systems. Community engagement was measured in the focus group and survey. Specifically, focus group participants answered the questions, "Since participating in [program], have you developed any new or stronger support systems for your family? Where do you turn when you need support? Is this different from before you began receiving services through [program]?" and "To what extent do you feel safe in your community? Has this changed since participating in the program? If yes, how so? Additionally, from the quantitative survey questions such as, "I have friends in this community who know they can depend on me", "I feel active and involved in this community", and "I feel useful in my community" Responses were based on a 5-point Likert scale with 1) Strongly Agree and 5) Strongly Disagree. (Appendix C).

The concept of available resources was defined as the knowledge of support resources within the community. Focus group participants answered the questions, "To what extent do you feel you know more about available resources in your community since participating in [program]?" and "How comfortable do you feel about seeking services in the future, should you need them? Is this different from how things were before you began with the program? How so?" Additionally, from the quantitative survey questions such as, "If I need to do an errand, I can easily find someone to watch my child", "If I need a ride to the doctor, friends or family will help me", and "If my child is sick, friends or family will stop by to check how things are going"

Responses were based on a 5-point Likert scale with 1) Strongly Agree and 5) Strongly Disagree. (Appendix C).

CHAPTER 2

CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

Review of Home Visiting Programs

Recent studies in which home visit programs are evaluated have shown that anywhere from 20% to 67% of families drop out of service use before the programs have ended (Tandon, et al., 2007). As a result, more and more social service programs are targeting parental engagement as a primary means for improving child outcomes. Embedded in statewide grants, policies for program development which include a forum for parents to be heard and included in family service planning efforts are becoming the standard for future prevention funding opportunities. The same standards for parental engagement can already be seen in educational and healthcare settings (Kohl, Liliana, Lengua, & McMahon, 2010; U.S. Department of Veteran Affairs, 2003) as prevention programs are increasingly drawing attention to the importance of parental buy-in in achieving successful prevention outcomes. For community-based organizations and community-building efforts, parent and family engagement helps ensure buy-in for shared goals and strategies. In addition, literature reveals that community networks of support are built by and around engaged parents and other community residents (Sheldon, 2002).

Recent studies of home visiting programs suggest that positive outcomes may occur in not only short term, but long term changes for mothers and children receiving home visitation services. There have been a few select home visit-based models that have been put forth and are being established in communities throughout the U.S. Two of the most replicated programs are: Healthy Families (HF), in which the home visitor is a trained paraprofessional supervised by a social worker and health personnel, and the Olds' model, in which the home visitor is a nurse supervised by a social worker. Over 425 HF sites (Prevent Child Abuse America, 2000) and over 140 Olds' sites (Gomby, 2000) have been established.

The Prenatal and Early Childhood Nurse Home Visitation Program, developed by David Olds and his colleagues (Olds, 1988; Olds, Kitzman et al., 1997; Olds and Korfmacher, 1997), was designed to help low-income, first-time parents start their lives with their children on a solid and healthy course and prevent the health and parenting problems that can contribute to early development of maladaptive behaviors. The efficacy of the Olds' model was first evaluated in a randomized clinical trial in Elmira, New York, with a mostly White population. The Nurse Home Visitation Program (NHVP) developed as a university-based demonstration program in Elmira, New York. The model was studied again in Memphis, Tennessee, and Denver, Colorado, and is now being replicated nationally where nurses provided home visitation services to a group of poor, unmarried, teen mothers.

In the Elmira trial, 500 women were invited to participate and 400 enrolled, 85% of whom were either low income, unmarried, or younger than 19 years of age at registration; none had had a previous live birth. Eighty-nine percent of the sample were White. There were no socio-demographic differences between those who enrolled and those who declined, although participation was higher among African Americans. At randomization, the treatment groups in the Elmira trial were essentially equivalent on all background characteristics examined. At the 15-year follow-up, assessments were completed on 324 women. Eighty-one percent of the women were originally randomized and 87% of those cases had no fetal, maternal or child death. The treatment groups remained essentially equivalent on background characteristics for those individuals on whom the 15-year follow-up assessments were completed. Olds and colleagues showed important short-term and long-term (through the child's 15th birthday) effects on reports to protective services, the child's behaviors, parenting behaviors, and the mother's own development (Olds et al., 1997; Olds et al., 1998; Olds, Henderson, Chamberlin, & Tatelbaum, 1986; Olds, Henderson, Kitzman, & Cole, 1995). Only 4% of the nurse-visited families had

verified reports of child abuse and neglect compared to 19% of the families who did not receive home visits by nurses (Eckenrode, 2000). Researchers suggest that the nurse home visits prevented the occurrence of many types and chronic forms of maltreatment and also prevented maltreatment that extended across several important development stages (e.g., maltreatment that occurred both in childhood and early adolescence). The maltreatment that did occur in the treatment group children tended to occur earlier in the children's lives and did not continue over long periods of time. These findings suggest that home visiting by nurses reduces the risk of child maltreatment as well as potential future behavioral problems among children and youth born into at-risk families.

Similar results to the Elmira trial were likewise found in studies in Colorado and Memphis. In each of the three studies, women were randomized to receive either home visitation services during pregnancy and continued for the first two years of their children's lives or comparison services. Although the nature of the home-visitation services was essentially the same in each of the trials as described above, the comparison services were slightly different. The Memphis trial was designed to replicate the Elmira program and to determine if the encouraging results could be replicated when the program was conducted through an existing health department and when it served low-income African American women, children, and their families living in a major urban area (Olds, 2002). The study focused on those groups where Elmira effects had been greatest, that is, low-income, unmarried women (most of whom were teens) and gave greatest attention to those outcomes where the benefits had been greatest (e.g., health risks in pregnancy, childhood injuries and ingestions, rates of subsequent pregnancies).Women with few mental health resources (defined in Memphis as having "high rates of mental-health symptoms, limited intellectual functioning, as well as limited beliefs in

their control over their lives") were hypothesized to benefit the most from the program (Olds, 2002).

In the Memphis study, 1290 women were invited to participate and 1,139 enrolled through the obstetrical clinic at the Regional Medical Center in Memphis. Women were recruited if they were less than 29 weeks of gestation, had no previous live births, had no specific chronic illnesses thought to contribute to fetal growth retardation or preterm delivery, and had at least two of the following risk conditions: unmarried, less than 12 years of education, and unemployed. There were no differences in the socio-demographic characteristics of those who enrolled and those who declined, except that African Americans were more likely to participate than were Whites. As in Elmira, the Memphis sample consisted of a very large portion of the women who had these characteristics, which increases the generalizability of the Memphis findings. Overall, 92% of the 1,139 women registered were African American, 98% were unmarried, 65% were aged 18 or younger, and 85% came from households with incomes at or below the federal poverty guidelines. Those who registered were randomly assigned to one of the nurse-visited or comparison groups. The program was conducted through the Memphis/Shelby County Health Department. The Memphis study comes closer to an effectiveness trial, further increasing the generalizability of its findings. This study may thus provide a good estimate of what the program might be able to achieve if it were replicated on a large scale. Moreover, the beneficial effects of the program during the first 2 years of life on child abuse and neglect and on childhood injuries were greater for mothers with little belief in their control over their life circumstances (Olds, 2002).

The Elmira and Memphis trials demonstrated that the nurse home visitation program achieved two of its most important goals; a reduction in the dysfunctional care of children and an improvement in maternal life course. Consistent program effects from the Elmira, Memphis and

Colorado trials include: improvement in women's prenatal health, fewer childhood injuries, fewer subsequent pregnancies, increased intervals between births, increased employment for mothers, reductions in welfare and food stamps, and improved school readiness for children. Overall, The Elmira, Memphis, and Colorado trials demonstrate that the nurse home visitation program achieved improved prenatal and subsequent care of children and improved effects on women's life course. A follow-up study further supported these positive results: the number of verified reports of child maltreatment for the nurse-visited group of mothers was nearly half that of mothers who did not receive home visitation services during the next 15 years (Eckenrode 2001; Olds, 2002). The programs are grounded in theories of human ecology (Bronfenbrenner, 1979; 1995), self-efficacy (Bandura, 1977), and human attachment (Bowlby, 1969). Human ecology theory emphasizes that children's development is influenced by how their parents care for them, and that, in turn, is influenced by characteristics of their families, social networks, neighborhoods, communities, and the interrelations among them (Bronfenbrenner, 1979; Olds, 2002).

Home Visiting Programs for Reducing the Risk of Child Maltreatment. The Healthy Families Program (HF) has recently been adopted by the National Committee to Prevent Child Abuse, (Prevent Child Abuse America 1992), and was implemented in several states across the country. One trial took place in Arizona, one of the first states to begin implementing the Healthy Families America (later renamed Prevent Child Abuse America) home visitation program. This national model is designed to help expectant and new parents get their children off to a healthy start. Families participate voluntarily in the program and receive home visiting and referrals from trained staff referred to as home visitors. By providing services to overburdened families, Prevent Child Abuse America fits into the continuum of prevention services provided to families in many communities.

The three overarching goals of the Healthy Families America program were: "(a) to promote positive parenting, (b) to enhance child health and development, and (c) to prevent child abuse and neglect" (Krysik et. al, 2007, p. 3). The home visitors were a mix of paraprofessionals and entry-level professionals. Home visiting for new enrollees was usually once a week for 1 hour, but may have been more frequent if determined necessary. A critical aspect of the program is the development of a trusting relationship between the participant and the home visitor. Findings surrounding the relationship between the home visitor and the parent revealed that the nature and quality of relationships is widely recognized as a key factor in providing health and human services (Krysik et al., 2007). A qualitative sub-study was conducted on families participating in the program in Arizona. The purpose of this qualitative study was to better understand the nature and quality of services received from a home visitation program. Another objective of this qualitative study was to provide program planners and policy makers with information about different dimensions of program impact not addressed in traditional outcome evaluations. A stratified sample of 46 randomly chosen, currently enrolled families was administered semi-structured interviews that included open-ended and scaled response items to elicit their opinions of program services and procedure Participants were stratified according to the three sites that were offering home visitation services, a large urban site, a medium-sized urban site, and a rural site. The population sample included 38%, teen mothers; 71% were not married upon entry to the program, and 63% had less than a high school education. The median, gross annual family income was $9,600. The participants were culturally diverse with approximately 54% identifying as Hispanic; 22% White, non-Hispanic, 8% American Indian; 7% African American; 8% reporting a mixed-race identity, and 1% other.

Each participant was asked: "Tell me about your home visitor. Was she like a friend, a teacher, a parent or an authority figure?" The intent of this question was to examine how the

participant viewed their relationship with the home visitor. Twenty-nine of the 46 respondents (63%) characterized their relationship with the home visitor as being more like a friend than a parent or teacher (Krysik et.al, 2007). Some examples of their responses include: "A friend. Someone who never judges you. She understands everything I am going through" (Krysik et al., 2007, p. 4). Many of the participants felt a close emotional bond with their home visitor. The aim of the study was to describe the experiences of 46 women who participated in the home visitation program. The overall focus of the study was to examine, from the participants' point of view, "how they understood the nature and quality of services received from the Healthy Families program" (p.4).

This qualitative account adds a more complete understanding of how this program was implemented, as well as received by families. In particular, the study focused on four aspects of the participants' experience: their experience with the intake process, their understanding of the programs primary purpose, their perceptions of their home visitors, and how their commitment to the program has changed over time. The findings support that the intake process was perceived by most program participants as positive or neutral and as an opportunity to receive help. However, 17% of the participants expressed concerns about being recruited into a voluntary home visitation program (Krysik, 2007; LeCroy & Ashford, 2007). Overall concerns reported were centered around an uncertainty of what the home visitors role in the home would be in addition to a lack of trust of service systems in general. Researchers argue that the screening and eligibility process for assessing families at-risk may create a negative perception of families as being "targeted." This feeling of being singled out for services can impact engagement and retention strategies for the family. If the family feels stigmatized by receipt of services, they may be less likely to remain enrolled for the duration of services or program (Krysik, 2006; LeCroy, 2006).

Another theme noted in these and other responses to this question was the value that the participants placed on being able to talk to their home visitor about any topic. Many participants made reference to the importance of the home visitors' nonjudgmental approach. The participants' answers indicate that they value having informal relationships with their home visitors and that they assign substantial weight to these relationships in their evaluations of the Healthy Families program (Krysik et al., 2007). A trusting relationship with case workers/home visitors was also seen as essential in the delivery of home visitation services among other child maltreatment prevention programs.

This is important to note due to the alarming numbers of families who report negative interactions and perceptions of social service workers (Palmer, 2006). The findings suggest that participants who perceive that they have very close relationships with their home visitors also reported being more open to sharing their needs and utilizing the service model. In character with the personal nature of family problems, there is a need for consistent and reliable contact by the caseworker resulting in a partnership whereby the relationship becomes important to the delivery and acceptance of the program's services. Also, past studies and reviews (Gomby et al., 1999; Guterman, 2001; McCurdy & Daro, 2001; McGuigan, Katzev, & Pratt, 2003) have noted the lack of family retention as a critical issue in the delivery of home visitation services and that a trusting relationship is seen as essential in the delivery of home visitation services (Paris & Dubois, 2005).

There has been some debate among legislators about the nature of home visiting in general, questioning whether programs are too intrusive for families. Paris and Dubois (2005) research suggests that this is not the case for most mothers. The implications of prior research suggest that the intake workers should: (a) provide a clear rationale for why the mother is being contacted, (b) emphasize that the program is for all mothers with newborns and not only for first-

time, single, or low-income mothers, (c) explain the need for the nature of the screening questions, and (d) frame the program's purpose within the broad goal of giving children a healthy start (Krysik et al., 2007).

While many of the programs agreed that creating a trusting relationship between parents and home visitors was an essential step in the program, none of the evaluations described a protocol or examination of how these trusting relationships were formed and maintained over a period of time. In addition, the literature suggests that increasing parental awareness and increasing parental knowledge of child development trajectories are necessary first steps. There is little discussion of strategies and/or techniques for building secure relationships between home visitors and parents. This missing information (i.e., how to create and maintain parental engagement) is generally lacking in the literature, and may be a crucial factor in the long-term engagement and retention of families at-risk.

Many of the programs focus on providing parents with the skills to interact with their children in a more effective manner. Thus, by providing parents with better parenting skills, they predict a greater success in decreasing abuse and neglect in the home. Sweet and Appelbaum (2004) conducted a meta-analysis of evaluations of over 60 home visiting programs. The analysis yielded several key domains for change in home visiting programs. Among the primary domains revealed were parent's attitudes towards child rearing, knowledge and behavior regarding parenting skills, child abuse and neglect behaviors; and children's health and development. The overall implementation and objectives of each program were the same: send workers into the homes of families with young children with the goal of improving children's lives through reducing the risk for child maltreatment and neglect. Most of the programs aimed to create change by giving parents support, assistance, resource awareness, and parenting skills. Programs reviewed differed in the onset, duration, and intensity of services, but the desired program

objectives and outcomes remained consistent: improving the lives of children at-risk for abuse and neglect.

This meta-analysis illustrates the reasons that home visiting programs are becoming more and more popular among social service agencies. It is hypothesized that home visiting programs are useful to help decrease stress in the home by providing parents with new parenting techniques and ways to manage stress. However, numerous studies of home visiting programs reveal that while these parenting skills are an important element in reducing child maltreatment, there is an overwhelming body of evidence that reveals parents typically drop out of the program after a few sessions and frequently discontinue the home visits due to conflict in timing or other life events (Conely, 2007).

Engagement and retention strategies may also be affected by home visitor training or lack thereof; in this review all home visitors were paraprofessionals with a high school diploma or bachelor's degree. All home visitors also went through additional training, which on average was one week in duration. There is some evidence that home visit workers have varying and diverse backgrounds ranging from social service backgrounds to no prior experience at all. Little information is provided about the background and training of the home visit practitioners. Future research should explore the training received by home visit workers. In almost all studies reviewed, providing maternal empathy and proving support resources yielded higher rates of participation and successful outcomes for reduction of child maltreatment. Based on findings from this study, training methods and knowledge of home visitors may be a crucial aspect for the success or lack of success for these program outcomes.

In a review of program goals across all the described studies, promoting positive parenting and enhanced parent-child interactions were consistent findings. None of the programs established the provider/home visitor relationship as key in yielding any long-term change. In

fact, the evaluation goes a step farther and reveals that all programs reviewed struggled with enrolling and retaining families in the programs. In addition, after families were enrolled, they only completed half of their visits on average. For example, in the Hawaii Healthy Start Program (HSP) in which home visits were scheduled weekly, evaluation data reported high rates of attrition and with only 40% of families receiving the intended number of home visits. Families within HSP target communities without prior interaction with CPS and who gave consent were eligible to participate. Most participants were fathers, high school graduates, employed, and reported substance abuse issues. Program attrition rates (defined as fewer than planned or no home visits over time) were particularly high. Fifty-one percent of families were inactive by the time their target child was 12 months old (Duggan et al., 1999).

The literature suggests that low levels of parental involvement may be attributed to families' lack of interest or inability to manage time commitments leading to missed appointments. In light of the overburdened social welfare system, case managers often have extremely high case loads and are unable to follow-up with families who have missed scheduled appointment times until their next scheduled visit. This time lapse weakens the parent-home visitor relationship, leaving the services as a low priority to parents as they lose their connection to their caseworker.

The consistency of attrition across these studies illustrates that program implementation and service delivery may not be the problem. The studies described show that some families benefit more than others, however there is no consistent reason across studies. There is a growing body of literature that suggests the relationship fostered between the home service worker and the parent is crucial in seeing families through to the end of the services and treatment. Establishing parental "buy-in" and trust may in fact be more important than the actual implementation of the program itself. Evaluation efforts may need to create outcomes that can

be assessed in light of the relationships built with caseworkers as well assessments of enrollment and retention strategies (Conely, 2007; Crowley, 2005; Dumas et al., 2007; LeCroy, 2006). Engagement and retention rates among programs of this type are poor and may contribute to lack of long-term results in child maltreatment and neglect. This literature suggests the need for strong evidence based models of parental engagement to ensure quality retention and affect long-term change.

Family Systems Theory. The costs of preventing child maltreatment dwarf in comparison to the costs incurred as a result of child maltreatment, which include foster care, child healthcare, special education services, as well as the expenses associated with the increased likelihood of criminal behavior (Widom, 1989). Despite the cost-benefit ratio of child maltreatment prevention, state and local governments facing budget shortfalls will seek funding cuts to social programs that address maltreatment. Considering the complex reality of prevention, treatment, and intervention service delivery, researchers have designed a variety of models that conceptualize the interactions between emergent factors that predict enrollment and retention. While there are numerous approaches to family engagement, McCurdy and Daro's (2001) Integrated Theory of Parent Involvement (ITPI) posits that the following four factors influence participation: individual characteristics of the parent and family (match between program and personal goals), provider attributes (cultural competence and delivery style), program characteristics (manageable caseload and stable funding), and neighborhood characteristics (degree of social cohesion). ITPI hypothesizes that individual cognitive factors such as motivation and intent as well as perceived necessity of services, readiness to change, and past program experience are the primary influences on enrollment and engagement. Provider, program, and community factors are considered to be less influential. Previous applications of

ITPI have yielded higher levels of engagement in controls than comparisons groups (Budde et al., 2011).

ITPI is an essential part of Family Systems Theory (FST) which emphasizes the relationship between family members and their individual relationships with the service provider in engagement. Focusing on the importance of this bond in encouraging engagement, Dakof and colleagues (2003) use Engagement Specialists (trained case-workers/counselors) to get parents involved. However, once the engagement specialist transitions the family to a primary service provider, rates of involvement drop, underscoring the importance of the bond between caregiver and service provider in keeping families engaged. Similarly, the Social Ecological perspective incorporates family relationship dynamics, but also integrates consideration of goodness of fit with the social environment. The better the fit between the family's expectations and needs, the service provider, services provided, method of service delivery, and environmental conditions, the more likely the family will engage in services (Chaffin et al., 2004; Budde et al., 2011).

Predictors of Enrollment and Engagement. Findings from a handful of studies have shown a number of factors associated with family engagement in terms of both initial enrollment and sustained involvement in services. Generally, these factors relate to (a) individual (i.e., child or caregiver) and family level characteristics, and (b) program and service characteristics (Budde, Sessoms, Brooks, Felix, Cohen, Kim et al., 2011). Individual characteristics discussed in the engagement literature include, but are not limited to: child age and ethnicity; and caregiver characteristics, such as mental health issues, substance abuse, personal history of trauma, perception of stigma around receiving services, perception of service efficacy, and socioeconomic indicators (Damashek, Doughty, Ware, & Silovsky, 2011). Prenatal status is most significant among characteristics as it increases enrollment five-fold (Daro et al., 2007; McCurdy et al., 2006). Likelihood of enrollment has also been found to be higher in mothers experiencing

depression or multiple stressors (Ammerman et al., 2006). However, parental substance abuse and mental health problems have been correlated with lower levels of participation overall (Littell &Tajima, 2000).

At the family level, increased levels of engagement are associated with the following: high prenatal or infant health risk, the presence of another adult relative living in the home, domestic violence, and living in a disorganized or hostile community. Conversely, studies reveal decreased engagement when primary caregivers are isolated from extended family and friends (McGuigan, Katzev, & Pratt, 2003) and if there is a strong likelihood that a family will be moving within six months (McCurdy et al., 2006). While 70% of children in 2009 lived in a two-parent household (Forum on Child and Family Statistics, 2010), fathers are notably absent in child welfare literature (Huebner, 2008), and research has not assessed the impact of paternal effects on engagement.

Regarding race and ethnicity, McCurdy and colleagues (2003) found that White parents enrolled in home visitation services at lower rates than Latino or African American, a finding that contradicts prior center-based studies which found higher levels of initial enrollment among European American families. The same study also showed that European American families had higher program drop-out rates. The authors point to obstacles and stresses unique to racial and ethnic minorities which can motivate greater enrollment and sustained engagement. Research regarding engagement among immigrants is scarce, though being foreign-born has been found to be correlated with an increased chance of supervision neglect (being left home alone) compared with American-born children (Hussey, Chang, & Kotch, 2006; Budde et al, 2011).

Successful Program Characteristics. While many individual, family, and provider characteristics cannot be altered, different program and organizational characteristics can change engagement outcomes. Ammerman et al. (2006) suggests early engagement outcomes can be

enhanced by wider promotion of home visitation services to mothers with greater psychosocial resources. These caretakers may not need the emotional support, but could benefit from services which focus on parenting strategies, home safety, infant nutrition and child development (Ammerman et al., 2006). A strong collaborative relationship between service program worker and parents is often pivotal to successful treatments of childrearing and child behavioral problems and home visitation models offer a unique advantage in developing this bond (de Kemp & Van Acker, 1997). Moreover, home-based maltreatment prevention programs have demonstrated stronger engagement rates than community models (Damashek et al., 2011).

However, empirical research on predictors of service engagement following an unsubstantiated investigation of child maltreatment is lacking. Child welfare agencies are often viewed with distrust by many families (Hill, 2006). Yatchmenoff (2005) notes that parents can also be superficially or passively engaged without being sincerely motivated to positively participate. While the literature on family preservation evaluates services among families with substantiated child maltreatment (Chaffin et al., 2004; O'Reilly, Wilkes, Luck, & Jackson, 2010; Waldfogel, 2009), there is little regarding how to engage moderate to high risk families with unsubstantiated maltreatment in voluntary services.

Challenges to Successful Engagement. As previously mentioned, in light of the overburdened social welfare system, case managers often have extremely high case loads and are unable to follow-up with families who have missed scheduled appointment times, until their next scheduled visit. This time lapse, only serves to weaken the parent-home visitor relationship leaving the services as a low priority to parents as they lose their connection to their case worker. There is some evidence in the evaluation review that families who receive more contacts do indeed benefit more. In addition, it is reported that three to six months of services may be required before change can occur (Garvin, DePanfilis, & Daining, 2007).

In addition, high rates of agency staff turnover have been noted as a barrier in successful service delivery for home intervention programs. Families report that their home visit worker often reschedules appointment times, fails to show up, and then eventually is replaced by a new worker. This scenario presents a significant problem in the success of such programs. Forging a partnership between the home visit worker and the parents is an essential factor in bridging effective relationships with families, and once a new worker is introduced, families often become frustrated or lose interest in participating in service use. Creating a bond with families and fostering a trusting environment has been shown to be crucial in maintaining behavior change, and building trust within the family unit (Krysik, 2006). With such high staff turnover rates at social service agencies, it is often quite difficult to manage consistent relationships among care providers and families. This inconsistency has been shown to have a significant impact on the success or failure of child maltreatment and neglect programs (Duman et al., 2007).

Also critical is cultural sensitivity for the family's practices and customs. It is essential that home visitors are trained to address cultural barriers in a way that that demonstrates a respect for the family's values and beliefs. Many mothers express feelings of social isolation and stress and are unaware of resources within their community. It is important that mother's feel acknowledge in their own struggles and that case workers carefully listen and assist parents in developing strategies and plans for decreasing their own stress so they can focus more on their children's needs (Krysik, 2006).

This research explored the notion that if parents feel supported and empowered to improve the circumstances of their own daily life, they are more apt to have the time, patience, and motivation to devote the time needed to follow service plans and/or prevention efforts. Whether families are targeted for being at-risk or universally selected to receive services, the ability to achieve long term engagement and retention is related to the way the worker empowers

the family to be self- sufficient. The following chapter will provide the methodology used in this research including the sampling frame, research design, and analytic approach.

CHAPTER 3

METHOD

With an increasing number of families whom had exited out and/or graduated from the PFF Initiative, this research examined the impact of the PFF Initiative on family functioning and child maltreatment outcomes. The research focused particularly on parents' experiences with engagement and retention in the PFF program, services received, and parenting and family functioning developments. The current research employed a retrospective examination using a mixed methods approach. The research design was a one group pre and post-test design. Two data sets were utilized that included; qualitative focus groups with families participating in the PFF program and quantitative surveys administered to those families at the conclusion of the focus groups. Given the nature of this research, experimental groups utilizing random assignment were not a feasible option. The primary purpose in this research was to examine engagement and retention of PFF families in PFF services, not to compare engagement of PFF families with engagement of families participating in other child maltreatment prevention initiatives or programs.

Participants

One hundred seventy parents participated in 18 focus groups, of which 128 completed the survey following the focus group session (see Table 3 for sample demographics). Focus group sizes ranged from two to 25 people, averaging nine people per group. The sample was a purposive availability sample selected from service agencies participating in the PFF Initiative. Families were recruited from two populations: general and special. General focus groups were open to any parent enrolled in the PFF Initiative who expressed interest in participating. One general focus group was conducted in each Collaborative, with the exception of the Collaborative in SPA 8. Special population focus groups were specifically requested by funders

of the Initiative. Inclusion criteria for the special populations included (a) pregnant women and teens, (b) African Americans, (c) Undocumented Latinos, (d) Monolingual Spanish speakers, and (e) Fathers. Two special population focus groups were conducted in each Collaborative. The availability of a suitable number of special population families in each SPA dictated the number and types of focus groups that were conducted in each SPA.

The largest racial/ethnic groups represented 77% of the sample which were Hispanic/Latino followed by 13% African American. Eighty-percent of participants reported earning an income of less than $20,000 in the prior year and 36% reported having less than a high school education. Women who were not accompanied by a partner or spouse (N=120) were the largest group in attendance. The average age of the sample were between their 20's and 30's representing 84% of the sample respectively. This group included single women and women with partners who were not present at the focus group interviews. Men, specifically those in fathers-only focus groups (n=19), represented the second largest population of attendees, although they were far less numerous than unaccompanied women. Although the invitation to participate in focus groups was open to all PFF caregivers, couples were least represented in focus groups (n=5). Most notable was that 60% of the participants reported having been in the PFF program for 6 months or more.

Recruitment

Parent recruitment was ongoing throughout the data collection period. A summary of family focus groups, including the recruitment strategy used to coordinate each group, is presented in Table 2. Point persons from each lead agency acted as liaisons between the investigator, Collaborative staff, and program participants. Existing parent group meetings, who met for sessions, events, classes or councils, offered convenient pools of potential participants. Family focus group interviews were held during existing parent group meeting times to attract a

larger number of respondents and minimize participant burden. Facilitators met with ten such groups (in Collaboratives 1, 3, 4, 6, and 8). The point person, group facilitator, or class instructor informed parents of the focus group prior to the scheduled event. Parents were told that during an upcoming meeting time, a focus group would substitute their normally scheduled activity. Pregnant teens, who largely receive services and support through their schools, participated in focus groups during a regularly scheduled class period. Direct recruitment was also used in the absence of existing parent groups, when case manager recruitment yielded low response from parents, or when contacting parents exceeded the agency staff's capacity. Participants were recruited directly for two focus groups.

Table 2.

Summary of Focus Group Recruitment Strategies by SPA

SPA	Focus Group Population	Language	Estimated Attendees	Recruitment Strategy
1	General	English	25	Existing Group (Event)
	Spanish monolingual (incl. undocumented)	Spanish	25	Existing Group (Event)
	African Americans	English	9	Existing Group (Event)
	Fathers	English	7	Existing Group (Event)
2	General	English	8	Case Management
3	General	English	6	Existing Group (Council)
	Undocumented	Spanish	3	Direct
4	General	English	5	Case Management
	Pregnant Teens	English	5	Existing Group (Class)
	Fathers	Spanish	12	Existing Group (Session)
5	General	English	2	Direct
6	General	English	12	Existing Group (Class)
	Undocumented	Spanish	10	Case Management
7	Alumni	English	8	Case Management
	General	English	3	Case Management
	Spanish monolingual (incl. undocumented)	Spanish	6	Case Management
8	Pregnant Teens	English	4	Existing Group (Class)
	Spanish language (incl. undocumented)	Spanish	20	Existing Group (Meeting)

For six of the focus groups that were conducted, PFF case managers recruited parents. PFF case management staff members were the best point of access to parents, because of their good rapport and strong relationships with PFF parents. Case managers were asked to present the focus groups during their conversations with parents and to encourage parents to participate. Case managers collected the names, phone numbers, and number of children who would attend from interested parents.

Participants varied by demographics, referral mechanism (DCFS or pregnant women), duration of PFF service receipt, and program enrollment status (current or alumni). Six out of 18 focus groups were conducted in Spanish (and later translated and transcribed), and the remaining 12 in English. Nearly 45% of focus group participants primarily spoke Spanish, thus these individuals participated in Spanish language groups. Fifty-five percent of participants spoke English or were Spanish-English bilingual, and participated in English language groups. All participants received a free meal and an entry into a raffle for a $20 Target gift card (chances of winning were one in six).

Table 3.

Demographics and Characteristics of Sample Participants

Characteristic	Frequency	Percent
When did you begin coming to this program?		
Less than 6 months ago	49	39.5%
6 or more months ago	75	60.5%
Collaborative/SPA		
Children's Bureau/SPA 1	59	42.8%
The Help Group/SPA 2	2	1.4%
SPIRITT/SPA 3	11	8.0%
Para Los Ninos/SPA 4	18	13.0%
St. Johns/SPA 5	2	1.4%
SHIELDS/SPA 6	23	16.7%
SBCC/NCADD/SPA 8	20	14.5%
Unknown	3	2.2%
Survey language		
English	74	53.6%
Spanish	64	46.4%
Ethnicity		
American Indian/Alaska Native	2	1.6%
Asian	1	0.8%
Black/African-American	16	12.5%
Hispanic/Latino	98	76.6%

Characteristic	Frequency	Percent
Native Hawaiian/Pacific Islander	1	0.8%
White	10	7.8%
Year of birth		
Pre-1960	7	5.6%
1960s	18	15.3%
1970s	43	42.6%
1980s	47	42.0%
1990s	10	14.5%
Language spoken at home		
Chinese	1	0.8%
English	54	45.4%
English; Spanish	4	3.4%
Spanish	55	46.2%
Spanish; English	5	4.2%
Household income last year		
Less than $20,000	98	79.7%
$20,001-$50,000	21	17.1%
More than $50,000	4	3.3%
Referral source		
DCFS	67	49.6%
Another agency	17	12.6%
Self-referred	23	17.0%

Characteristic	Frequency	Percent
Other referral	28	20.7%
Have people in household aged:		
0-2	75	58.1%
3-5	83	64.3%
6-17	71	55.0%
18-60	98	76.0%
More than 60	6	5.0%
Adults other than self in household		
No	34	26.4%
Yes	95	73.6%
Live with a spouse/partner		
No	53	41.1%
Yes	76	58.9%
Live with other adult relatives		
No	91	70.5%
Yes	38	29.5%
Live with adult non-relatives		
No	125	96.9%
Yes	4	3.1%
Highest level of education completed		
Some school, no diploma	43	35.5%
High School Grad/GED	36	29.8%

Characteristic	Frequency	Percent
Some college, no degree	26	21.5%
College degree	5	4.1%
Trade school/Vocational certificate	9	7.4%
Graduate or professional degree	2	1.7%
Number of moves in the past 2 years		
0	61	48.8%
1	26	20.8%
2	22	17.6%
3	7	5.6%
4	5	4.0%
5 or more	4	3.2%

* Multiple responses were allowed

Measures

Focus Group Protocol. Focus group facilitators asked participants three questions with follow-up questions, when needed:

1. We'd like to start by talking about when you first came to [PFF program name]. What made you decide to take part? What has kept you involved?
2. Please tell us about how it's been to use [program's] services. We are interested in knowing if the services you needed were easy to connect to, and how things have worked out.
3. We're interested in hearing whether, and in what ways, your involvement with [program] has changed things for you – in terms of your parenting, family relationships, or other areas.

The questions were focused on engagement and retention, services, and outcomes, yet were broad enough to allow parents to freely share their individual experiences. Wording was specifically selected to encourage substantial and robust responses from parents.

Facilitators followed-up each question with prompts when parents seemed confused about the question, or when facilitators needed information on more precise aspects of the overarching question. For example, subsequent to asking why parents decided to take part and stay in the PFF Initiative (Question 1), facilitators asked parents, "What kinds of things made you feel comfortable or uncomfortable?" and "When someone from the agency first talked to you about [the program], what did they tell you?"

Survey. The survey (Appendix C) was a compilation of measures designed to assess nurturing and attachment in familial relationships, parental self esteem, social connections, and service satisfaction before joining the program and "today". The survey provided the researcher with a retrospective response from parents as to how family functioning was prior to enrolling in

PFF and how family functioning currently was perceived. The questions focused on experiences of parenting and family functioning prior to the PFF and perceptions of those experiences "today". For example, "My child and I are close to each other," "I am able to comfort my child when he/she is upset," "I spend time with my child doing what he/she likes," and "I have confidence in myself." Ratings of agreement ranged from 1 (strongly disagree) to 5 (strongly agree). Other questions address perceptions of the relationship between family and community. For example, "To what extent do you feel strong ties with the other people in your community?" "My family is connected to other families in the community," and "I feel active and involved in my community." Ratings for the amount that the statement was perceived included, (1) not at all, (2) not much, (3) somewhat, and (4) definitely perceived.

A principal components factor analysis with varimax rotation was conducted to explore the factor structure of the survey. The analysis was run separately for the BEFORE and TODAY items. For both analyses, examination of the scree plot, factor loadings, and percentage of variance accounted for yielded three factors, each with eigenvalues less than 1.5 (see Tables 4 and 5 for factor loadings by factor). The factors revealed three distinct concepts: (a) community engagement, (b) personal strengths, and (c) available resources. These factors explained 58% of the variation in BEFORE responses and 65% of the variation in TODAY responses. There was very little crossloading of items across factors. For the BEFORE FA, all items loaded >.55 on one factor and <.40 on the other factors. For the TODAY FA, all but two items loaded >.60 on one factor and <.45 on the other factors.

The sum of responses to the items defining each factor was calculated to obtain subscales scores for community engagement, personal strengths, and available resources, for both BEFORE and TODAY. Internal consistency of the subscales was high, with Cronbach alpha

values of 0.88, 0.91, and 0.92 respectively for BEFORE, and 0.90, 0.88, and 0.83 respectively for TODAY.

Table 4.

Factor Loadings from a Principle Components Analysis with Varimax Rotation of the Family Strengths Scale (BEFORE).

	Community Engagement	Personal Strengths	Resources Available
5d. I feel active and involved in this community	0.82		
4b. When you need a little company...neighbor...	0.74		
5a. I feel useful in this community.	0.72		
5c. I feel ready to change things in my community	0.72		
4c. If you need advice...local neighborhood	0.69		
6b. My family is connected to other families in the comm...	0.66		
6a. My children are involved in the community	0.63		
5b. I have friends...can depend on me	0.63		
6c. My family works and communicates well with each other	0.63		
4a. ...strong sense of ties...local neighborhood	0.58		
3m. I think I am a person with many strengths.		0.84	
3h. I am able to comfort my child...		0.82	
3g. My child and I are very close...		0.81	
3l. I have confidence in myself.		0.79	
3k. I think my opinions matter		0.78	
3n. My actions make a positive difference in my		0.73	

	Community Engagement	Personal Strengths	Resources Available
community.			
3j. I have a good sense of my family values		0.71	
3i. I spend time with my child...		0.67	
3f. I am happy being with my child.		0.58	
3b. If I need a ride to get my child to the doctor...			0.81
3a. If I need to do an errand...			0.76
3c. If my child is sick...			0.76
3d. If my child is having problems at school...			0.74
3e. I have others who will listen...			0.67

Note. Rotation converged in 5 iterations.

Table 5.

Factor Loadings from a Principle Components Analysis with Varimax Rotation of the Family Strengths Scale (TODAY).

	Community Engagement	Personal Strengths	Available Resources
10d. Today, I feel active and involved...community	0.87		
10a. Today, I feel useful in this community	0.87		
11b. Today, my family is connected...community	0.85		
10c. Today, I feel ready to change...my community	0.83		
9c. Today, if you need advice...	0.83		
10b. Today, I have friends...can depend on me	0.72		
11a. Today, my children are involved...community	0.72		
9b. Today, when you need a little company...	0.68		
9a. Today...strong sense of ties...local neighborhood	0.50		
8g. Today, my child and I are very close...		0.82	
8j. Today, I have a good sense of my family values		0.77	
8h. Today, I am able to comfort my child...		0.76	
8f. Today, I am happy being with my child		0.73	
8m. Today, I think I am a person...strengths		0.71	
8i. Today, I spend time with my child...		0.70	
8k. Today, I think my opinions matter		0.70	
8l. Today, I have confidence in myself		0.69	
8e. Today, I have others who will listen...		0.69	

	Community Engagement	Personal Strengths	Available Resources
8g. Today, my child and I are very close...		0.65	
8j. Today, I have a good sense of my family values		0.44	
8b. Today, if I need a ride to get my child...			0.82
8a. Today, if I need to do an errand...			0.81
8c. Today, if my child is sick...			0.65
8d. Today, if my child is having problems at school...			0.65

Note. Rotation converged in 5 iterations.

Procedure

As an incentive for participating in the focus group interviews, food was provided for attending families. Parents and their children dined together before the focus group began. The researcher provided child care for families during select groups where parents might otherwise not be able to participate. All parents who participated in focus group interviews received a participant information sheet. Parents who were younger than 18 years old at the time of focus groups, however, completed an assent form that also served as a participant information sheet, and their legal guardians completed an informed consent form. All parents were encouraged to review the information and ask questions about the focus group at any time prior to, during, or after the discussion.

Each group was led by a focus group facilitator and co-facilitator. In cases where two or three focus groups were scheduled on the same day, frequently only one facilitator conducted each group. Before beginning the group discussion, the focus group facilitator asked the group for permission to audio record the discussion in order to capture all important quotes and to identify response patterns and new topics across all focus groups. No parents declined to be recorded; however, a few parents appeared to carefully word their responses, especially with regard to service provider quality. The focus group facilitator continually reiterated the confidential nature of the discussion and explained that only she and the research team would have access to focus group notes and audio files, that no names would be linked to responses, and that their honest opinions were valued above all else.

Focus groups lasted between 45 and 90 minutes, depending on the number, length, or depth of participants' responses. Following the focus group interviews, parents were asked to complete the survey. Parents generally completed the survey in approximately 10 minutes. All groups were digitally recorded, transferred electronically to the Olympus DSS Player V.6.3

transcription program, password protected, and then deleted from the recorder. Focus groups were transcribed into password protected Microsoft Word 2007 files; once these files were reviewed for accuracy against the digital recording, the texts were transferred to software for initial coding, and recordings were erased from the transcription program. All preliminary coding and text extractions were facilitated by ATLAS.ti 5.2. This software allowed the investigator to mechanically mark portions of text (e.g., words, phrases, sentences, paragraphs) that had been selected by the investigator as emergent code. It also allowed the investigator to create a link between other similarly selected texts with a similar code.

Analytic Approach

Qualitative Content Analysis. Families at-risk for child maltreatment and neglect represent a diverse population with unique experiences and environmental circumstance. Content analysis using a directed approach is guided by a more structured process than in a conventional approach (Hickey & Kipping, 1996). Using existing theory or prior research, researchers begin by identifying key concepts or variables as initial coding categories (Potter & Levine-Donnerstein, 1999). Next, operational definitions for each category were determined using the theory (Appendix B). Therefore, a qualitative approach using in depth interviewing was best suited to meet the objectives of this study.

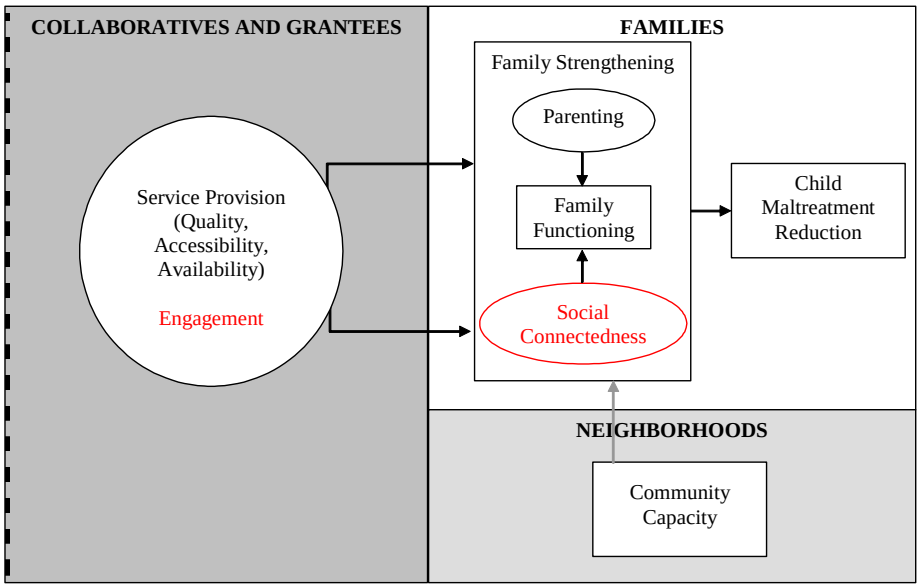
The value of in-depth interviewing is embedded in its subjectivity, perspectivity, and its grounding in time, place, and personal experience. Lincoln and Guba (1985) suggest that the use of the human instrument is the primary method to gather information in qualitative inquiry. During this process of gathering stories, the narrator not only recounts, but also reconstructs the meaning of life events and actions. The investigator as learner gains not only a deeper understanding of each individual identity and his/her systems of meaning, but also of the narrator's cultural self in his/her social world and the cognitive processes used to reconstruct her

experiences, including his/her attributions. The analysis required reviewing all transcripts for 1) the frequency and commonality of response topics across all focus groups; 2) perspectives from parents about their experiences with engagement, retention, and services within Collaboratives; 3) new or previously unheard developments within Collaboratives; and 4) parents' observations about how their parenting skills and households had changed since their participation in the PFF Initiative. The emic perspective led to a better understanding about a still larger collection of cases, and, perhaps, contributed to an alternative theoretical framework for research and practice.

All focus groups were recorded and transcribed. Transcripts were read and inductively coded for emergent major themes guided by the research questions. This involved the investigator reading through text, marking selecting segments of narrative, assigning a code to the text, and then linking the text and code. As previously mentioned, the software program allowed for this mechanical marking and linking, not for actual generating of the code or for analysis Texts were then re-analyzed by the investigator against this emerging framework of themes and codes for further analysis and modification as new themes or negative cases emerged from the re-reading of the texts. Content analysis was conducted directly by analyzing the transcripts to develop a coding guide, which included a list of topics that were common throughout the groups, and concepts outlined in the PFF Initiative Logic Model (see Figure 1) that could be heard in parents' responses. Topics were arranged by major focus group question type (e.g., engagement and retention) then by sub-question (e.g., When you first came to PFF, what made you decide to take part?). The final coding guide (Appendix B) was used to conduct content analysis of all transcriptions of groups. Using the coding guide, data were independently reviewed by two reviewers using the transcripts of the focus groups. The codes produced by the two reviewers were then compared for inter-rater reliability. Inter-rater reliability was defined as response topics identified by both reviewers.

Figure 1.

PFF Logic Model.



Research Notes. In addition to content and pattern analysis, research notes contributed to the trustworthiness of the findings, because they documented the analytic process and revealed implicit assumptions (Lincoln & Guba, 1985; Strauss & Corbin, 1998). Descriptions and observations that could not be captured on audiotape were recorded immediately following the interview. Recorded observations included clarifications or enhancements to the interview guide, emergent themes, and nonverbal responses of participants.

Quantitative Survey Analyses. Matched paired t-tests were used to describe the change reported in participant responses prior to entering the program to the current day. Rather than collecting data from control groups and treatment groups for comparison, this retrospective approach to pre- and posttest analysis has been shown to not only be easier to administer and collect data, but has also been advocated by some evaluators and researchers, when relying on self-reports, as providing a more accurate evaluation of interventions, because they eliminate the possibility of response-shift bias (Taylor, Russ-Eft, &Taylor, 2009). Howard et al. (1979)

suggest that many evaluators and researchers using self-report measures to evaluate outcomes of interventions have failed to find effects, and that such failures could be due to changes in individuals' understanding of items on outcome study rating scales as a result of having undergone the intervention, what they labeled a response-shift bias. There have been many studies published which debate the efficiency of using a retrospective approach (Bray & Howard, 1980; Howard &Dailey, 1979; Howard, Dailey, & Gulanick, 1979; Howard et al., 1979; Birkenbach, 1986; Hoogstraten, 1982; Hoogstraten, 1985;Pohl, 1982; Pratt, Mcguigan, & Katzev, 2000; Rhodes & Jason, 1987; Rice & Contractor,1990; Sibthorp, Paisley, Gookin, & Ward, 2007; Stieglitz, 1990; Terborg & Davis, 1982) and which have been aimed at demonstrating the response-shift bias phenomenon, and the superiority of retrospective pretests over traditional pretests, when measuring outcomes from self-ratings across a wide range of interventions. Additionally, items that assess constructs that were not specifically addressed in the intervention can be embedded in retrospective pretest and posttest measures as control items, providing evaluators with a baseline measure of respondents' tendency to show improvement despite the fact that the training did not address those skills (Cook & Campbell, 1979).

CHAPTER 4

RESULTS

The PFF initiative is based on the idea that child safety will be augmented as a result of increased family strength, stability, and well-being. Such family-level changes are evidenced by decreased social isolation; existence of positive, pro-social, and nurturing interfamily relationships; good physical and mental health; and increased functioning levels of family members. One crucial aspect of evaluating any service-related program is capturing the voices of the families and communities actually being served by the program (Ownsworth, 2008). Focus groups yielded important insights about families' sense of personal well –being, social connectedness, possible barriers posed by some fathers' lack of involvement, and parents' level of resource awareness. Parents felt that they had more self-confidence and better ability to regulate their stress after participating in PFF services. In addition to increased attention to self-care, parents reported improvements in parenting skills and knowledge. Specifically, parents described using new skills with their children and teens, such as fostering open communication and implementing behavior reward systems. Further, they reported having better communication with their spouses/partners. Results from both the focus groups and quantitative surveys are presented below.

Hypothesis 1 and 1a

As stated in Hypothesis 1, programs that utilize strategies that focus on parent strengths (e.g., acknowledge what parent does well) were expected to have successful (met program goals/requirements) rates of engagement and retention for families participating in child maltreatment prevention programs. The focus group findings supported the PFF program as focusing on parent strengths. According to 77% of participant responses, successful engagement into PFF services seemed to be largely influenced by PFF case managers' attributes. Parents in

many of the focus groups (12 of 18) offered that their decision to enroll in the PFF Initiative was driven by the characteristics of their PFF case managers. When asked "When you came to PFF, what made you decide to take part?" parents most often responded with descriptions of and praise for their PFF case managers (including in-home counselors). Parents used such adjectives as "caring," "enthusiastic," "insistent but from the heart," and, most often, "non-judgmental." The latter characteristic was often accompanied by comparisons to parents' experiences with DCFS.

In response to the question, "What efforts were made to involve you in the service plan?" 87 participants in seven groups indicated that they felt fully involved in their service plans. Case managers were reported to have engaged parents with an assessment of families' resources and supports for a stable home, and a service plan strategy that largely required parents' input. Parents' responses indicated services were not prescribed; they confirmed being active in their service plans and being aware of the services in which they would participate. It gave parents the sense that case managers aimed to "support and look for the best way to benefit [families]," as one parent articulated.

The concept that parents should be equal partners with PFF case managers during the PFF enrollment process was conveyed as an important and comforting aspect to continuing in the program. Although parents' reported being involved in developing their service plans in seven focus groups, 12% of parents reported they were unaware of their expected role. Some of the comments from parents indicated that they relied on their case managers to recommend resources and services and were happy to be guided in their selections. More than half of all parents reported feeling that being in the program allowed them to feel more in control of their lives and as a result made them feel better about themselves as parents. As one parent reported:

> …parenting classes helped me realize how to take care of my kids better and how to control your anger, what to do…. I feel like I am becoming a better parent just because I can really talk to my PFF case manager.

Another parent noted:

> Since joining the PFF program, I finally feel like someone is on my side. I always felt like I was doing something "wrong" but now I feel like someone really understands my situation and wants to help. It is a huge relief… I feel more confident now because I know I can call my case manager if I have a problem and [she] is always encouraging.

Parents were directly asked about outcomes that resulted from their participation in the PFF Initiative. The most resounding responses to the question "In what ways has your involvement with PFF changed things for you?" were improved parent self-confidence, new strategies learned, and new strategies used. Over 80% of parents who participated in the family focus groups felt that they had more self-confidence and better ability to regulate their stress after participating in PFF services. In addition to increased attention to self-care, 68 parents reported improvements in parenting skills and knowledge. Specifically, parents described using new skills with their children and teens, such as fostering open communication and implementing behavior reward systems. Further, they reported having better communication with their spouses/partners. A teen mother offered,

> I think my parents feel that I'm responsible now. I came home with insurance packets and they're like, "How did you do that?" They see that I'm trying to take responsible [sic] for my baby even though I'm young and I'm in school, and I'm pretty much under their support. They see me trying to at least take care of my baby and not always depend on them for everything.

Parents' increased self-confidence was a particularly popular response among groups conducted in Spanish (4 of 6 groups). Confidence took many forms across all focus groups. In some groups, it implied becoming more independent; in others, it suggested engaging others socially. The following quotes capture a sample of ways in which parents indicated developing

confidence. Both quotes show parents' personal growth and the ways personal growth impacts parents' environments. One mother of very young children shared,

> The counseling, the parenting, the [domestic violence classes] has helped us a lot… I'm not even stressed. I'm back in school. I'm working. It helped me become stronger. It helped me become an individual again because I had become [my husband]… I forgot about what I wanted and what my goals were and what I felt my future was.

One parent credited their case worker's flexibility as an important factor for staying with the program,

> Flexible. She always looked for a way to support us, right? She had that flexibility so that we would never, like we say, "lose air" but she was always there, we were going along with the program.

Through supports from the PFF Initiative, she was able to reclaim her sense of self. This, in turn, helped to reduce her stress.

Results from the quantitative analysis of the parent surveys were also consistent with findings from the qualitative data. Dependent samples t-tests found a significant increase ($p < .001$) in mean scores for personal strengths BEFORE and TODAY (see Table 6). Personal strengths increased from 38.0 (before) to 42.5 (today).

Table 6.

Personal Strengths Descriptive Statistics and t-test Results

Before: Mean (SD)	Today: Mean (SD)	t	df	p
37.97 (7.71)	42.45 (4.42)	-5.45	104	< .001

Unanticipated Outcomes. In addition to improved self-confidence, parents reported learning useful strategies, not all related to parenting. Parents reported, for example, learning how to communicate with and relate to others, including spouses and children. In fact, "change in communication at home" was a popular response, emerging from parents across 10 focus groups. Parents reported feeling closer to their children. They were more knowledgeable about how to engage children even in stressful situations or how to "talk to them well even if we feel

like exploding." This latter comment suggests that some parents have developed greater ability to cope in stressful situations. Beyond changes of their own, parents offered that the effect of new parenting skills was evident in children's behaviors. To note, changes in children's behaviors was not as common a response across focus groups (emerging in 5 of the 14 groups). However, such changes were spoken of as evidence of effective parenting skills, the popular response.

Parents also reported learning how to become more open with others and build new relationships. More aptly, they learned "how to relate to other people. Sometimes one closes oneself. When one has experience where you feel friendship, one starts to open oneself more to things," according to one parent. New friendships and partnerships were explicit in parents' responses to the question "What kept you involved [in PFF]?", wherein developing community and camaraderie was a common response across general and special population focus groups.

The analysis of the focus group data created a distinction between parenting strategies which respondents felt they learned, and strategies that respondents reported that they actually used. The information gained from focus groups was not robust enough to clearly assess if parents practiced all of the skills learned through the PFF Initiative; however, there is indication that certain skills were practiced more often than others, per parents' responses. Responses suggest that knowledge of new services did not always indicate *use* of services. Similarly, lessons on ways to calmly address children in stressful situations did not negate the use of yelling at children as a strategy to gain their attention, according to parents in one group. Exercising patience with children and striving for open communication were mentioned numerous times as skills learned through the PFF Initiative. Patience not only involved restraint, but the willingness to communicate with children, per one parent's comment: "I can say I now have patience, how to explain things to my child." Instead of immediately reacting to children's misbehaviors, parents described employing strategies that give children opportunities to slowly develop better

behavior. For example, one parent reported using a praise chart that she learned about through her case manager. She explained her use of the chart:

> I used to spank my kids a lot. And I noticed that I stopped the spanking but my hollering got worse. I would yell at them more. I really, really tried that whole praising them and the praising chart. I used to have it on the door. And I showed them... They have a color-coordinating thing at school. If you have an awesome day, you got a purple. If you got sent to the office and you got a detention, and you had to speak to the principal, you got a red. And this week, I had three purples in three days. I was like 'Oh wow, if you get two more purples, you can stay up an extra five minutes before going to bed.' ...I kind of learned that praising not just with candy and going and buying [gifts]. ...I learned to love praise.

Parents also described spending more time talking, and learning valuable lessons about their role in communication at home, particularly how to minimize tension caused by yelling. One parent offered the following experience:

> The best thing my worker helped me with... It was kind of like a slap in the face too when he told me. I was like, 'You've been here 20 minutes and you learned that much?' We were talking and playing with my kids and he was like 'Can I tell you something? ...You know what your problem is? You're a yeller.' I was like, 'Yeah,' 'cause I do yell a lot. I rather yell at them than hit 'em.' He's like, 'You have one tone. So, when they're in trouble you scream. And when they're doing good, you scream. Your kids don't understand when they're doing right... You need to show them the difference. You need to have a different tone when you're mad and you want them to listen and a different one when they're doing something to praise them.' I tried with my daughter and that worked.

Similar responses were reported by two other parents: "The best thing is that is there is no more arguing in the house….hardly ever fight…" Another comment mirrored the previous, "….we, like, argue never", we're so much better", when we do see each other, like, it's cool" Based on responses, it appears that parents were using what they had learned through the PFF Initiative to improve how they interacted with their children. One parent added that she learned how to better communicate and collaborate with her teens through a program affiliated with a PFF Initiative lead agency. Because of this parent's involvement in the auxiliary program, she shared that, "My [teen] daughters now watch my boys. They cook. They clean. Now it's an open communication."

This finding is likely related to earlier findings about parents' new sense of closeness to their children. "I was able to get to know my children better," said one parent of this burgeoning closeness. For some families, attempts to open communication and strengthen family bonds were further bolstered by the addition of productive family time. For example, one teen reported regulating the time her family spent watching television, opting instead to "do a family activity."

Hypothesis 2 and 2a

As stated in Hypothesis 2, programs that emphasize community engagement in service planning and decision-making will have successful rates of family retention and engagement in child maltreatment and neglect prevention services. For purposes of this study, two aspects of engagement were identified: service engagement and community engagement. Service engagement is the rate of participation in services as well as the extent to which PFF families stayed involved in services over time. Community engagement is the extent to which families participated in community building activities, such as attending Collaborative meetings or helping an agency to organize family-related events.

Each focus group began with questions about service engagement, specifically why parents enrolled into the Initiative and why they remained involved with it. When discussing their initial enrollment into PFF, one third of all parents described experiencing anger or fear, resentment, and apprehension during that time period. At least one of these topics was discussed in six unique focus groups. Parents described fears of being separated or kept away from their children. Parents also seemed fearful of PFF Initiative services – of not knowing what the Initiative was about and how enrollment related to DCFS presence in their lives. Parents who reported feeling intimidated by or upset with the DCFS process often stated that PFF case management staff seemed benevolent in comparison. One parent captured a popular sentiment among focus group participants with the following statement, "[DCFS social workers]

dehumanize their position... They don't believe you. Everything you say is potentially a lie. But [PFF case managers], they just want to help you."

According to more than half of all participant responses, successful engagement into PFF services seemed to be largely influenced by PFF case managers' attributes. Parents in many of the focus groups (12 of 14) offered that their decision to enroll in the PFF Initiative was driven by the characteristics of their PFF case managers. When asked "When you came to PFF, what made you decide to take part?" parents most often responded with descriptions of and praise for their PFF case managers (including in-home counselors). Parents used such adjectives as "caring," "enthusiastic," "insistent but from the heart," and, most often, "non-judgmental." The latter characteristic was often accompanied by comparisons to parents' experiences with DCFS. Some parents conveyed that they felt that participation in PFF was mandatory; that is, to avoid future interactions with DCFS, parents felt they had to participate in PFF. This was a sentiment initially heard during the early implementation of the PFF Initiative, but then faded from current PFF Initiative parents' accounts. In conducting the focus groups, however, it was not often clear who was responsible for suggesting to parents that participation in PFF was mandatory, whether it was DCFS staff and/or PFF agency staff, or a misconception solely on the part of the parents. One example of potentially coercive language was shared by a parent, "I was told that it was my decision to come, but that if I didn't they would have to report to the (DCFS) social worker." A different parent recalled, "I never had an open case with DCFS. But, then again they say it's still an open case because you have this program." According to the eligibility criteria for PFF, parents with open DCFS cases are not eligible for enrollment in the PFF program. As such, statements about maintaining open DCFS cases until parents complete PFF services could be construed as a way to compel parents into PFF enrollment.

Across six focus groups, parents also spoke about the communities (or "extended families") they developed while being part of the PFF Initiative. In response to the question, "Since participating in [program], have you developed any new or stronger support systems for your family?" More than half of parents described having bonded with other families in similar situations, and having found support within their PFF Collaboratives. Eighty-eight percent of parents spoke positively about being able to join a community where no parent is marginalized for their involvement in the program. As one parent stated, "When we come here, we're all the same... We share all the same struggles." These similarities fostered bonds between parents, and, according to parents, became reasons to stay enrolled in PFF services.

The common concept of camaraderie appeared to be highly valued and protected among members of the all of the undocumented focus groups. Through their regularly scheduled PFF group sessions, the families had built a small community in which they could disclose their concerns and fears. According to one participant, once in the PFF meeting space, she no longer felt "isolated as a single mom." The respondents largely valued meeting with other mother's in the same situation, with whom they could share concerns, lessons, and developments unique to their situation. Parents from 3 separate groups commented, "I have built up such a support system from being part of PFF, I definitely would know where to call if I needed something." "I would call my PFF case manager, I know she would help me with….." "My case manager gave me a list of places that I could find dental care for my son…that was a big help…"

Parents reported developing invaluable relationships with their case managers and other PFF families. Parents stated that these relationships alleviated their previous social isolation. To a lesser extent, parents noted that they remained with the PFF program to take part in the variety of available services.

In response to the question, "What has kept you involved?" participants' responses overwhelmingly revolved around relationships. Specifically, parents felt that their relationships with their PFF case managers, as well as new ties within their communities, kept them involved in the PFF program. In regards to their relationships with their PFF case managers, parents reported that case managers provided benefits such as respect, concern and "emotional support." Case managers were considered to be more than resources; they were viewed as invaluable, genuinely caring friends who were a consistent presence in families' lives. One parent shared that PFF case managers "make us feel more at home than our own family, without judging." Comments from 3 participants in the fathers groups expressed the following: "[The PFF case managers] are all very approachable and easy to talk to," "I have a new sense of what other parents are going through and this makes me feel better," and "[The PFF caseworker] came to my house and explained the program, and I felt comfortable with the worker. Some of my friends are now in the program too." In describing the perceived benefits of PFF, one father explained,

> [PFF] helps families, preserve the family unity. They truly apply their mission statement. I enjoy going to the parenting classes and interacting with other fathers who show up.

Results from the quantitative analysis of the parent surveys were also consistent with findings from the qualitative data. Dependent samples t-tests found a significant increase ($p < .001$) in mean scores for community engagement BEFORE and TODAY (see Table 7). Community Engagement increased from 24.4 (before) to 29.9 (today).

Table 7.

Community Engagement Descriptive Statistics and t-test Results

Before: Mean (SD)	Today: Mean (SD)	t	df	p
24.42 (7.45)	29.89 (7.69)	-7.02	104	< .001

Hypothesis 3 and 3a

Programs that emphasize available community resources in service planning and decision-making are successful in the engagement and retention of families participating in child maltreatment and neglect prevention services. Parents reported that the most useful services were those that helped bolster control in the home – mainly parenting classes and skill courses (e.g., financial education). Depending on the Collaborative, parenting classes refer to courses designed only for parents as well as opportunities for parents and children to participate in co-learning activities. Parents identified fewer service needs than were identified in previous evaluation reports. Beyond services that were outside of the Collaboratives' control such as housing, parents shared a desire for more widespread opportunities for teen fathers to participate in family strengthening, and financial training to stabilize families' incomes. Responses indicated that, in seven focus groups, many parents felt involved in developing their families' service plans. While this was the case, in all but one of the 16 groups, a small portion of parents seemed unaware that they, along with their case managers, were equal partners in creating the plan. Service provision includes the types of services that families use and parents' perceptions of the quality, availability, accessibility, and appropriateness of PFF services. The process of service provision, particularly the ways in which PFF case managers worked with parents, was also an essential dimension of services. In line with these dimensions, the researcher asked parents about their level of involvement in developing a PFF service plan appropriate to their personal and familial needs, the types of services in which they participated, and which services were the most beneficial to their families.

Parents in more than half of the focus groups (10 of 14) expressed satisfaction with and appreciation for PFF services received. Many parents were impressed with the range of assistance from concrete services (also referred to as basic needs), such as food and furniture, to

more complex needs, such as services for children with special needs. Parents occasionally demonstrated their satisfaction with services by choosing to continue receiving PFF services when given other service options, or referring other parents to the Lead Agencies.

The most useful services provided by the PFF Initiative, per parents' responses, were parenting and skills classes. Parents in more than half (9) of the focus groups reported that parenting classes and skill classes (e.g., financial education) were the most helpful to their families. The researcher has defined parenting classes as those attended by parents alone (as opposed to classes attended by both parents and children together). Less commonly, parents listed parent-child activities as being most helpful. Parent-child activities were defined as activities attended by both parents and children, where co-learning was the primary purpose. Only parents in two focus groups distinctly identified parent-child activities as most helpful.

Beyond parenting classes and skill classes, parents specifically named the following services: (a) Concrete services or basic needs, (b) information via books, handouts, group discussion, (c) therapy or counseling for the parent or child, (d) personal attention and support, (e) transportation, and (f) childcare. Thus, parents recognized concrete services or basic needs (e.g., financial support, supplies for babies, furniture, and transportation assistance), new information, and therapeutic services as highly important to their family, and more urgent during their enrollment in PFF than parent-child activities.

When asked to describe the specific services or resources that were available to them through PFF, respondents stated that many of their needs were met by PFF services. One teen stated that before her involvement with PFF, she did not know so many services were available to her:

> [The PFF case manager] told me it was a program to help me with the baby. And it had included the daycare, the parenting classes, the trips, and help… help for her and for me, like, stuff I needed if I was unable to afford it or my parents.

Another respondent explained,

> [The PFF case manager] helped me out a lot and she gave me a lot of good information that I really liked" [Referring to information about parenting classes, workshops, and for counseling].

An additional prevalent response offered by parents was that their knowledge of available resources increased (7 out of 14 groups). For example, in 7 distinct groups, mothers seemed more confident that they could find services through word of mouth among peers, their doctors' offices, and online in addition to guidance from their PFF case manager/class facilitator. Many parents indicated that they would return to the lead agency for help if they needed to locate resources. A small group of parents (10) reported that in the absence of their PFF case managers or the PFF program, they would not know where to find assistance. This finding can be interpreted in different ways, such as showing high levels of dependency on PFF case managers, or having the need for intermittent support from the case manager to address ongoing needs. Findings suggest inconsistent knowledge across parents about where to find resources, and general uncertainty about how to even begin the search process. While many parents felt confident about finding resources post PFF, a sizeable number were still uncertain.

Results from the quantitative analysis of the parent surveys were also consistent with findings from the qualitative data. Dependent samples t-tests found a significant increase ($p < .001$) in mean scores for resources available BEFORE and TODAY (see Table 8). Resources available increased from 17.41 (before) to 20.98 (today). Additionally, families were generally satisfied with the referral process and its length; however, 25% reported feeling *pressured* or *somewhat pressured* to accept PFF services. Participants imparted that their case managers' ethnicities or languages made it easier to relate to him or her. The most commonly cited problem by participants was financial issues, followed by employment, housing, parenting, and

relationship issues with a partner. Overall, responses were largely positive across all domains. Areas that presented challenges were some reports of perceived coercion in the PFF referral process, and difficulty accessing services due to waitlists (e.g., for childcare services) or transportation problems. However, once service use was initiated, satisfaction levels remained high.

Table 8.

Resources Available Descriptive Statistics and t-test Results

Before: Mean (SD)	Today: Mean (SD)	t	df	p
17.41 (6.00)	20.98 (4.44)	-6.64	116	< .001

It is noteworthy to mention that a number of families indicated they were referred to PFF due to a problem or situation with an older child in the household. While each family did in fact have a child age 0-5 in the house, the primary reason for DCFS referral of these families to PFF was due to a problem with an older sibling. The remaining reasons for referral varied from neglect to domestic violence in the home. The total number of children in the home, ages of children in the home, and parental status (i.e., single, partnered, or married) may warrant further exploration in evaluating services needed and utilized by PFF families.

CHAPTER 5

DISCUSSION

PFF is a community-based prevention strategy designed to strengthen families and build community capacity through direct service, such as family engagement, community network development, and organizational capacity building. This method brings aspects of home visitation together with ecological and place-based models. The combination is designed to engage families in a reciprocal flow of outreach intended to foster caregivers' competency to seek help and sustain social connections after PFF service closure. The community and social connections established through this process are thought to be protective against child abuse and neglect. Findings suggest that parents' participation in services is shaping the ways in which they engage their families and others. Parents seemed to value the relationships they built during their enrollment in PFF, which kept them involved in services. Relationships between families and their PFF case managers were both a core part of the PFF experience as well as an outcome of PFF enrollment, per parents' accounts. Parents reported the most useful services were those that helped increase control in the home such as parenting and life skills courses. Parents reported that certain characteristics of case managers, such as being caring and non-judgmental, were central reasons for their enrollment in PFF.

In describing their relationship with their PFF case manager, it was clear that many families viewed the case manager as a means for readily receiving practical assistance. Several families felt that they could call upon their case manager anytime, including after hours or on weekends, and that their case manager would be available to assist them. The knowledge that there was someone they could "count on for assistance" provided a great sense of relief for many families. Respondents also reported feeling a sense of empowerment and accomplishment when completing tasks assigned to them by their case managers. Several parents gave examples of this,

including creating résumés, finding employment, becoming involved in parent advisory committees, and learning about resources in their community. One parent asserted, "[The PFF case manager] helped me write a résumé and I got the job, and have been there for a whole year." Another respondent stated, "[The PFF case manager] really helps me think things through to make good decisions."

In addition to receiving practical support from the case managers, many of the respondents described ways in which their PFF case managers provided much needed and appreciated emotional support. The following statements exemplify these sentiments: "My case manager is like family to me….just someone to listen to me has been so helpful," "My case manager is the only one who can calm me down when I am freaking out," "[My PFF case manager] was just very, very human and very, you know, on the same level with me. And she wasn't, like, talking to me like I was three," and

> [My PFF case manager] went to court with me, I will tell you… I mean, I will tell you… I do not know, I tell my friends, I told them, [she] was like an older sister to me, she would give me her support. If I felt like crying I would call her, "[PFF case manager's name], this is happening to me.

Many, (64%) of the respondents expressed great relief over having the PFF case manager as someone to lean on. One single mother explained that the emotional support she received from her PFF case worker made a big difference in her life. "I'm very, very happy that I found that flyer and that I was able to call and get connected because I think, most importantly, I had the emotional support from [my case manager]…" Another mother said, "I can be open with her. I can talk to her, and she understands me." And further, "the most important thing my [PFF case manager] has given me "alguien con quien hablar y escucharme [having someone who she can speak to and get some advice from]."

The emotional support given by the PFF case manager was not limited to primary caregivers, but rather extended to the entire family. Thirty-seven respondents attributed the support of the case manager as a reason for stress reduction in the household and improved communication among family members. For example, one respondent stated,

> We like having [the PFF case manager] to come here because this person is very charismatic. She always has a smile for all of us, right, right, ah, you can say, she does not come here in a bad mood or brings problems.

Previous values and beliefs have held that families who are the poorest, live in low-income areas, and possess low education levels, have the lowest child outcomes. Moreover, intervention efforts have failed to produce the desired results for these children and families (Chaffin, Bonner, & Hill, 2001). The current research presents an alternative hypothesis in reaching these families, as 70% of families who participated in the PFF Initiative were from low income, Latino populations suggesting that using a strengths-based approach to engagement retention may allow for a larger percentage of at-risk families from low income families minority populations to have improved child outcomes.

One of the overarching goals of these future prevention strategies rests on designing programs aimed at focusing on building upon family strengths as a means of stabilizing the family environment. This research suggests that successful engagement of families at risk may depend on emphasizing parental empowerment and well-being as a key factor in reducing risk for child maltreatment and neglect.

Regarding community engagement, parents' responses suggest a new understanding of the relationship between Engagement and Family Strengthening shown above. According to parents, new social (non-family) relationships or community ties result from engagement. These ties may keep parents involved in community based services and prevent future social isolation

post-PFF. Having such ties may then facilitate sustained rate of parental/caregiver involvement in family strengthening activities after completion of PFF services.

The concept of social connectedness includes both involvement with other families and linkage to formal resources in the community. In addition to informing revisions of the logic model, findings also hold unanticipated implications. Two such implications emerged regarding involuntary participation and parents' preparation to identify resources once they completed their PFF Initiative services.

Implicit in the idea of engaging the family is that both parents (or caregivers), when available, will participate in PFF as a team. Joint participation of mothers and fathers could, in theory, have considerable benefits. For example, parents who learn and practice new parenting skills collaboratively may be better able to parent effectively and support the healthy social and emotional development of their child (Feinberg & Kan, 2008; McHale, Kuersten-Hogan, & Rao, 2004). Yet PFF, like most other child welfare and child abuse prevention programs have considerable difficulty systematically engaging fathers in services. Fathers' lack of direct involvement in PFF services can stem from many different factors, including the individual problems of many fathers in high risk families, family conflict and dysfunction, and pervasive cultural attitudes about their role within the family and about social services (Mitchell et. al, 2007). In addition, the fact that most PFF case managers were women and the relative paucity of interventions specifically targeted to helping fathers may contribute to low rates of engagement.

When these fathers discussed their concerns, they focused on employment and managing what was happening in their homes. Not surprisingly given their perceived role and concerns, the services fathers identified as most beneficial were concrete in nature, including financial help, shelter, and transportation. As part of ongoing efforts to improve family outcomes, it is suggested that strategies to more effectively engage and involve fathers in services be examined.

Similarly, communities with strong group values are viewed as powerful forces capable of changing entire neighborhoods (LeCroy & Whitaker, 2004). In addition, community networks of support and services are built by and around engaged parents and other residents (Haskins et al., 2009; Olds & Kitzman, 1993; Luker & Chalmers, 1990).

When asked where they would go should they need resources post-PFF, parents in five groups responded that they would return to the lead agency or call their PFF case manager. Some parents said they were unsure of where to find resources other than what the PFF Initiative provides. This finding highlights parents' needs for guidance about how to identify and secure resources following their involvement in the PFF Initiative. Further, parents' lack of knowledge of resources beyond the lead agency suggests the need to revisit how "community engagement" is perceived in the Initiative and its logic model. In addition to building personal relationships that impact children and families, these and other community activities help bond community networks of mutual support. Strategies range from the informal support of friends and neighbors to more organized self-help groups, support groups, and formal programs operated by public or private agencies. In addition, schools, early childhood programs, child abuse and neglect prevention initiatives, and other social services providers sometimes employ parents as mentors and staff (Munson & Freundlich, 2008). For example, community groups could advocate for community economic development, safe playgrounds and recreation, access to nutritious food and health care, and the range of public and private assistance needed to ensure that their children have a positive, nourishing environment. some communities, these efforts have spread beyond schools to broader, community improvement efforts (Epstein, 2001).

Lastly, it was observed that some parents struggled to identify and locate community resources after leaving PFF. Whereas the Initiative was designed to foster information seeking among parents, responses indicated that some parents were not aware of how to locate and

acquire resources once they left the Initiative. In one focus group, parents reported creating a resource book to be shared among the group. In a teen focus group, girls reported using word of mouth, information from doctors' offices, and the internet to find new information. Otherwise, parents were comfortable with using their current resources (the PFF agency and case manager). Some parents responded that they would return to the lead agency or call their PFF case manager if they needed assistance in the future. This common response could be seen as contradicting parents' sentiments that they feel confident they can engage the community when needed. But, in fact, some parents may have seen the PFF agency or the case manager as representing 'the community,' and/or they may continue to feel the need for support that PFF case managers provide. The fact that some parents continued to seek out support from PFF case managers and agencies after terminating PFF services should not be seen as a negative outcome. While the goal of autonomous functioning (e.g., in locating resources) is good in the long term, it is entirely unrealistic for many parents who are in families with chronic problems or who have minimal social support. It is important to recognize that for some parents, continuing to ask for help from PFF was a good thing.

At the same time, PFF agencies endeavored to help parents learn about available services in the community. Future efforts might include formal introductions, in which PFF case managers to representatives from services in the community that may not be related to the Collaborative, but provide local, high quality services.

Limitations

Limitations with this type of research include social desirability or acquiescence bias—parents reporting to home visit workers information they believe the worker wants to hear. If parents do not feel a sense of trust and mutual respect from their home visit workers, it is likely they will report what they believe they should report to satisfy workers and keep CPS out of the

home. This bias can affect the way success rates are reported and/or why inconsistencies can be found between self-report data and actual outcome data. Additional limitations to this research include lack of long term follow-up data on families at-risk for child maltreatment and the use of a purposive sample including families in and around Los Angeles County.

Focus group data collection did not come without its complications. While the researcher is confident of the quality of information yielded from groups, the quantity of information processed was limited by parent attendance, the availability of special populations, and logistics. First, parent attendance was inconsistent across groups. Occasionally, parents experienced challenges that included car malfunction, homelessness, and pregnancy-related health issues that prevented their attendance to focus groups.

Second, the variety of focus group populations was hindered in part due to the limited availability of such groups. The small to nil representation of clients from particular groups such as Asians and Pacific Islanders, for example, constrained recruitment possibilities. Thus, excluding the ability to definitively draw conclusions across special population groups beyond Spanish speakers (including undocumented parents) and pregnant women and teens, who were more prevalent in the PFF Initiative than African Americans.

Conclusion

There is also a need for further examination around the topic of support systems for families following termination from programs such as PFF. As discussed earlier, interviewed parents and caregivers placed a lot of importance on their relationships with their PFF case managers; and for many, the case manager played a central supporting role in their lives. While one of the explicit goals of PFF was to help families attain a level of self-sufficiency, it is important not to undervalue the helping relationship between the case manager and the family. For some parents who have endured trauma and instability in their own lives, consistently

experiencing care and respect from case managers may provide an alternative model of relationships that can have a profound effect on them. These relationships can help some disempowered individuals realize that they deserve to be treated well. Furthermore, optimally, these relationships can be an essential element in helping parents to become more responsive and caring toward their own children.

At the same time, the time limited relationships parents and family members have with case managers are often insufficient in and of themselves. Parents often need other types of support for themselves and their families, especially following termination from services. Their options for ongoing support after termination from services include linkage to longer term specialized social services (e.g., mental health, substance abuse), participation in normative and family support programs available within a lead agency (thus also maintaining an indirect tie with the case manager), and the parents' informal social support network.

Results from a randomized comparison study by Damashek and colleagues (2011) indicate that program characteristics, such as program model and method, are more meaningful than family or individual factors but further evaluation and replication are necessary. Additionally, only preliminary research exists on how to improve a program's perceived benefit, particularly among families who may be skeptical or even distrustful of social service intervention (Damashek et al., 2011). If programs fail to enroll families in services, the risk of maltreatment persists. Without intervention, rates of substantiated maltreatment recurrence have been found to exceed 50% (DePanfilis & Zuravin, 1998). Ultimately, it is incumbent upon social work professionals to engage families in services effectively. There is also a need for further examination around the topic of support systems for families following termination from PFF. As discussed earlier, interviewed parents and caregivers placed a lot of importance on their relationships with their PFF case managers; and for many, the case manager played a central

supporting role in their lives. While one of the explicit goals of PFF is to help families attain a level of self-sufficiency, it is important not to undervalue the helping relationship between the case manager and the family. For some parents who have endured trauma and instability in their own lives, consistently experiencing care and respect from case managers may provide an alternative model of relationships that can have a profound effect on them. These relationships can help some disempowered individuals realize that they deserve to be treated well. Furthermore, optimally, these relationships can be an essential element in helping parents to become more responsive and caring toward their own children.

Many prevention programs, similar to PFF, emphasize increasing informal social support (i.e., from non professionals) and maintaining these supports beyond the time frame of formal interventions. These objectives are appealing because they consistent with widely held practice principles of supporting family strengths and because they can potentially reduce the high costs of long term formal interventions. Informal social support interventions generally aim to enhance informal social support by mobilizing existing family networks or by expanding informal support networks. But programs face considerable challenges in implementing strategies to achieve either of these objectives (Budde, Daro, et al., 2001).

Furthermore, there is still relatively little evidence showing that informal social support can be consistently enhanced in high risk populations, that increased social support can be sustained over a long time period, or that improvements in informal support are predictive of better child safety outcomes (Budde and Schene, 2004). Empirical attempts to understand, quantify, and predict family engagement are sparse. Studies have addressed individual, family, provider, and program factors related to initial engagement. Higher levels of readiness to change, higher perceived benefits of participation, maternal depression, and higher prenatal or infant health risk predict higher rates of enrollment (Daro et al., 2007; Girivin, DePanfilis, & Dainnig,

2007; McCurdy et al., 2006). And most consistently, a positive connection or relationship with the service provider translates to higher levels of both initial and sustained engagement.

While research on family engagement is increasing, this is still a fairly new area of study. McCurdy and Daro (2001) highlight the need to learn much more about the experiences of parents in family support programs from the time of recruitment to termination, and about the differences between parents who become involved and sustain their involvement, and those who do not. Unlike child protection agencies which typically aim to reduce the length of services (e.g., shorter stays in foster care, shorter services for in-tact families), child abuse prevention programs and other types of preventative services often aim to retain families in services as long as necessary so that they can receive the full benefits of the program and potentially improve outcomes. PFF services were intended to last for 6 months but over 40 percent of families reported that they had been involved in the PFF program for upwards of 9-12 months. There is strong evidence that longer involvement in services is predictive of improved outcomes in some child abuse prevention programs. For example, DePanfilis and Dubowitz (2005) found that caregivers in a 9-month intervention showed significantly greater reductions in depression than caregivers in a 3-month program that used the same model. Future research should explore outcomes in child maltreatment programs with a comparative analysis of the length of time parents are involved and engaged in services.

Policymakers and funders can support improved family engagement and better child abuse prevention programs by encouraging systems, programs, and practitioners to develop and implement strengths-based programs. These programs need to have explicit strategies for: addressing the challenges of engaging parents in addressing risk factors, engaging parents who participate in programs because of perceived or real pressures from authority figures, and lastly, developing referral and handoff procedures that promote communication and collaboration.

Since there is considerable room for improvement in the area of family engagement in child abuse prevention and many other fields, policymakers and funders can support thoughtful and innovative approaches and strategies alongside and even within evidence-based practices.

APPENDIX A

FOCUS GROUP PROTOCOL

ENGAGEMENT & RETENTION

*We'd like to start by talking about when you first came to [**PFF program name**]. What made you decide to take part? **[Reinforce confidentiality]** What has kept you involved?*

- Can you give us some examples of how you were approached and told about [**program**]?
- When someone from the agency first talked to you about [**program**], what did they tell you?
- What kinds of things made you feel more comfortable? …less comfortable?
- Once you began getting services, what kept you involved (e.g., classes, family events, relationship with case manager, things they gave you, etc.)?
- If you've ended your regular meetings with your case manager [**i.e., finished the program**], are you still involved with the program, the agency, or other [**program**] families? In what ways?

SERVICES (SERVICE AVAILABILITY/ACCESSIBILITY/QUALITY)

*Please tell us about how it's been to use [**program's**] services. We are interested in knowing if the services you needed were easy to connect to, and how things have worked out.*

- Did the service agency/agencies seem to make an effort to make sure you and your family felt comfortable with the service plan?
- Describe any difficulties you've had with receiving services through [**program**]. What has the agency done, or what could it do, to make it easier for you to receive services?
- Have you experienced any difficulties with waitlists? What are some other barriers you may have experienced?
- To what extent were/are you involved in decisions about your services? Could you please offer an example of how you have participated in your own service plan?
- Overall, how satisfied do you feel with the services you are receiving or have received from [**program**]?
- What service or services do you think have helped your family the most? (specific examples)

OUTCOMES

*We're interested in hearing whether, and in what ways, your involvement with [**program**] has changed things for you – in terms of your parenting, family relationships, or other areas.*

- Since participating in [**program**], have you developed any new or stronger support systems for your family? Where do you turn when you need support? Is this different from before you began receiving services through [**program**]?
- Do you feel that the services you have received have taught you new ways to deal with problems in the household? How so?

- To what extent do you feel safe in your community? Has this changed since participating in the program? If yes, how so?
- To what extent do you feel you know more about available resources in your community since participating in [**program**]?
- How comfortable do you feel about seeking services in the future, should you need them? Is this different from how things were before you began with the program? How so?

APPENDIX B

FAMILY FOCUS GROUP CODE GUIDE

Collaborative Number:
Focus Group Type (General, Undocumented, Latino, African American, API):

ENGAGEMENT AND RETENTION

When you first came to PFF, what made you decide to take part?

Topic	Tally	Notes
Anger or Fear		
Available Services		
Case Manager Characteristics		
Case Manager on Same Level		
Case Manager's PFF Pitch		
Difference from DCFS		
Initial Apprehension		
Reinforced Voluntary Nature		
Transparency from Case Manager		
Other		
Other		
Other		
Other		

What has kept you involved?

Topic	**Tally**	**Notes**
Activities/Events for Families		
Alumni Opportunities		

Available Services		
Case Manager Relationship		
Childcare		
Classes		
Community/ Camaraderie		
Difference from DCFS		
Engagement of Kids		
Genuine Care		
Guidance with Resources		
Initial Apprehension		
Transparency from Case Manager		
Other		
Other		
Other		
Other		

SERVICES (SERVICE AVAILABILITY/ ACCESSIBILITY/ QUALITY)

What efforts were made to involve you in the service plan?

Topic	Tally	Notes
Parents Did Not Feel Fully Involved in Planning		
Parents Felt Fully Involved in Planning		
Parents Identified Strengths and Barriers with Case Manager		
Parents' Schedules Accommodated		
Parents Felt Aware of What		

Was Going on		
Other		
Other		
Other		
Other		

How has it been to use the services? What service(s) do you think have helped your family the most?

Topic	Tally	Notes
Classes Offered Repeatedly		
Classes Not Always Available		
Financial Education Classes		
Grateful for Services		
High Quality of Services		
Incredible Years Class		
Low Quality of Services		
New Information Gained From Services		
No New Information Gained From Services		
No Waitlists Experienced		
Parenting Classes		
PFF Services were Compared to non-PFF Services		

Problem With Services		
Satisfied with Services		
Unsatisfied with Services		
Waitlists Experienced		

How has it been to use the services? What service(s) do you think have helped your family the most?

Topic	Tally	Notes
Other		
Other		
Other		
Other		

OUTCOMES

In what ways has your involvement with PFF changed things for you (parenting, family relationships, etc.)?

Topic	Tally	Notes
Able to Address Children's Issues		
Able to Address Teens' Issues		
Better Parent Disposition		
Family Members Have Clear Roles		
Knowledge of Resources Increased		
Knowledge of Resources Remained the Same		

Less Stress at Home		
More Parenting in the Home		
More Stress at Home		
New Parenting Strategies Learned		
Sense of Extended Family		
Unable to Address Children's Issues		
Unable to Address Teens' Issues		
Other		
Other		
Other		

APPENDIX C

SURVEY

For this survey we are interested in how you were feeling about a number of issues just BEFORE COMING TO THIS PROGRAM and how you are feeling TODAY.

1. When did you begin coming to this program?

- ❒ Less than 3 months ago
- ❒ More than 3 but less than 6 months ago
- ❒ More than 6 but less than 9 months ago
- ❒ More than 9 months but less than 1 year ago
- ❒ More than 1 year ago

2. In a handful of words (adjectives such as *calm* or *tired*), please describe your family life just BEFORE COMING TO THIS PROGRAM in the box below. .

3. For the next set of questions, please tell us how much you agreed or disagreed with these statements just BEFORE COMING TO THIS PROGRAM.

	Before Coming to this Program				
	Strongly Disagree 1	**Somewhat Disagree 2**	**Neutral 3**	**Somewhat Agree 4**	**Strongly Agree 5**
a. If I need to do an errand, I can easily find someone to watch my child	❒	❒	❒	❒	❒
b. If I need a ride to get my child to the doctor, friends or family will help me	❒	❒	❒	❒	❒
c. If my child is sick, friends or family will call or come by to check on how things are going	❒	❒	❒	❒	❒
d. If my child is having problems at school, there is a friend, relative, or neighbor I can talk it over with	❒	❒	❒	❒	❒
e. I have others who will listen when I need to talk about my problems	❒	❒	❒	❒	❒
f. I am happy being with my child	❒	❒	❒	❒	❒

	Before Coming to this Program				
	Strongly Disagree 1	**Somewhat Disagree 2**	**Neutral 3**	**Somewhat Agree 4**	**Strongly Agree 5**
g. My child and I are very close to each other	❒	❒	❒	❒	❒
h. I am able to comfort my child when he/she is upset	❒	❒	❒	❒	❒
i. I spend time with my child doing what he/she likes to do	❒	❒	❒	❒	❒
j. I have a good sense of my family values	❒	❒	❒	❒	❒
k. I think my opinions matter	❒	❒	❒	❒	❒
l. I have confidence in myself	❒	❒	❒	❒	❒
m. I think I am a person with many strengths	❒	❒	❒	❒	❒
n. My actions make a positive difference in the community	❒	❒	❒	❒	❒

4. Please tell us how you felt about the following statements just BEFORE COMING TO THIS PROGRAM.

	Before Coming to this Program			
	Not at All 1	**Not Much 2**	**Somewhat 3**	**Definitely 4**
a. To what extent do you feel a strong sense of ties with the other people who live in your local neighborhood?	❒	❒	❒	❒
b. When you need a little company, to what extent can you contact a neighbor you know?	❒	❒	❒	❒
c. If you need advice about something, to what extent could you ask someone in your local neighborhood?	❒	❒	❒	❒

5. Please tell us how you felt about the following statements just BEFORE COMING TO THIS PROGRAM.

	Before Coming to this Program			
	Not at All 1	**Rarely 2**	**Some 3**	**A Lot 4**
a. I feel useful in this community	❒	❒	❒	❒
b. I have friends in this community who know they can depend on me	❒	❒	❒	❒
c. I feel ready to change things in my community	❒	❒	❒	❒
d. I feel active and involved in this community	❒	❒	❒	❒

6. Please tell us how you felt about the following statements just BEFORE COMING TO THIS PROGRAM.

	Before Coming to this Program			
	Not at All 1	**Rarely 2**	**Some 3**	**A Lot 4**
a. My children are involved in the community	❒	❒	❒	❒
b. My family is connected to other families in the community	❒	❒	❒	❒
c. My family works and communicates well with each other	❒	❒	❒	❒

At this point in the survey would like to know how you feel about these same issues TODAY.

7. In a handful of words (adjectives such as *calm* or *tired*), please describe your family life TODAY in the box below.

8. Please tell us how you feel about the following statements TODAY.

	TODAY				
	Strongly Disagree 1	**Somewhat Disagree 2**	**Neutral 3**	**Somewhat Agree 4**	**Strongly Agree 5**
a. If I need to do an errand, I can easily find someone to watch my child	❒	❒	❒	❒	❒
b. If I need a ride to get my child to the doctor, friends or family will help me	❒	❒	❒	❒	❒
c. If my child is sick, friends or family will call or come by to check on how things are going	❒	❒	❒	❒	❒
d. If my child is having problems at school, there is a friend, relative, or neighbor I can talk it over with	❒	❒	❒	❒	❒
e. I have others who will listen when I need to talk about my problems	❒	❒	❒	❒	❒
f. I am happy being with my child	❒	❒	❒	❒	❒
g. My child and I are very close to each other	❒	❒	❒	❒	❒
h. I am able to comfort my child when he/she is upset	❒	❒	❒	❒	❒
i. I spend time with my child doing what he/she likes to do	❒	❒	❒	❒	❒
j. I have a good sense of my family values	❒	❒	❒	❒	❒
k. I think my opinions matter	❒	❒	❒	❒	❒
l. I have confidence in myself	❒	❒	❒	❒	❒
m. I think I am a person with many strengths	❒	❒	❒	❒	❒
n. My actions make a positive difference in the community	❒	❒	❒	❒	❒

9. Please tell us how you felt about the following statements TODAY.

	TODAY			
	Not at All 1	**Not Much 2**	**Somewhat 3**	**Definitely 4**
a. To what extent do you feel a strong sense of ties with the other people who live in your local neighborhood?	❒	❒	❒	❒
b. When you need a little company, to what extent can you contact a neighbor you know?	❒	❒	❒	❒
c. If you need advice about something, to what extent could you ask someone in your local neighborhood?	❒	❒	❒	❒

10. Please tell us how you felt about the following statements TODAY.

	TODAY			
	Not at All 1	**Rarely 2**	**Some 3**	**A Lot 4**
a. I feel useful in this community	❒	❒	❒	❒
b. I have friends in this community who know they can depend on me	❒	❒	❒	❒
c. I feel ready to change things in my community	❒	❒	❒	❒
d. I feel active and involved in this community	❒	❒	❒	❒

11. Please tell us how you felt about the following statements TODAY.

	Before Coming to this Program			
	Not at All 1	**Rarely 2**	**Some 3**	**A Lot 4**
a. My children are involved in the community	❒	❒	❒	❒
b. My family is connected to other families in the community	❒	❒	❒	❒

	Before Coming to this Program			
	Not at All 1	**Rarely 2**	**Some 3**	**A Lot 4**
c. My family works and communicates well with each other	❒	❒	❒	❒

12. Which best describes you?
Please check ALL that apply.

- ❒ American Indian or Alaska Native
- ❒ Asian
- ❒ Black or African-American
- ❒ Hispanic or Latino
- ❒ Native Hawaiian or other Pacific Islander
- ❒ White
- ❒ Other race *(Please specify):*

14. What language do you speak at home most often?
(Please specify):

15. Please choose the one that best describes your total household income, from all sources, last year:
- ❒ Less than $20,000
- ❒ $20,001 – $50,000
- ❒ More than $50,000

16. How were you referred to this program?
Please check ALL that apply

- ❒ Department of Children and Family Services
- ❒ Another agency
- ❒ Self-referred / Walked in
- ❒ Other

(please specify):

17. Counting yourself, how many of the people living in your household are:

0-2 years old?

3-5 years old?

6-17 years old?

18-60 years old?

Older than 60 years old?

18. Who are the adults (18 years or older) living in your household?
Please check ALL that apply.

- ❒ Self
- ❒ Spouse or partner
- ❒ Adult relatives

(Please specify):

- ❒ Adult non-relatives

19. What is the highest grade or year of school that you completed?
Please check ONE.

- ❒ Some school, no diploma
- ❒ High School Graduate/GED
- ❒ Some college, no degree
- ❒ College Degree
- ❒ Trade School/Vocational Certificate
- ❒ Graduate or Professional Degree

20. How many times have you moved in the past 2 years?

_____

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