Introduction to Family Connections and the National Replication Effort

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The purpose of this special issue of *Protecting Children* is to profile lessons learned and "tell the story" of the national replication of Family Connections (FC), a multi-faceted community-based service program that works with families in their homes, in the context of their neighborhoods, to help them meet the basic needs of their children and prevent child maltreatment. Based on promising results from the initial pilot program, FC was recognized in 2003 by the Office on Child Abuse and Neglect (OCAN), U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau as an effective program for

preventing child maltreatment in the report *Emerging Practices in the Prevention of Child Abuse and Neglect* (Thomas, Leicht, Hughes, Madigan, & Dowell, 2003). In following up on the report, the Children's Bureau awarded eight 5-year cooperative agreements, as well as a national cross-site evaluation to examine whether the grantees could replicate FC with fidelity in other settings with different target populations.

The FC Program was originally developed in 1996 through partial support from OCAN. The study design for the initial demonstration involved randomly assigning families that met risk inclusion criteria, but were not currently involved with child protective services (CPS), to receive FC services for either a 3- or 9-month period. Results of this study indicated changes for both groups, including positive changes over time in protective factors (parenting attitudes, parenting competence, social support); diminished risk factors (parental depressive symptoms, parenting stress, life stress); and improved child safety (physical and psychological care of children) and child behavior. Results further reflected that families served for 9 months reported greater improvements in the behavior of their children than families served for 3 months (DePanfilis & Dubowitz, 2005). These initial results are graphically depicted in Figure 1. Later analysis determined that the 3-month intervention was more cost effective than the 9-month intervention for all outcome domains except child behavior (DePanfilis, Dubowitz, & Kunz, 2008).

This introduction to the special issue briefly describes the history of the development of FC and the national replication effort, provides an overview of the program and fidelity criteria, identifies the replicating sites, and shares information about the national cross-site evaluation. Finally, it introduces the reader to each of the articles in this issue.

Description of FC

The FC Program operates from an ecological developmental framework using Bronfenbrenner's (1979) theory of social ecology as the primary theoretical foundation. Developed primarily to prevent child neglect, the program conceptualizes the problem as evolving when risk factors related to the child, caregivers, family system, and the environment challenge the capacity of caregivers and broader systems to meet the basic needs of children. FC uses a home-based, family-centered model of practice consistent with other home-based, tailored intervention approaches (Dunst, Trivette, & Deal, 1988; Kinney, Strand, Hagerup, & Bruner, 1994). Nine practice principles guide FC interventions: community outreach, individualized family assessment, tailored interventions, helping alliances, empowerment approaches, a strengths-based perspective, cultural competence, developmental appropriateness, and outcome-driven service plans (DePanfilis, Glazer-Semmell, Farr, & Ferretto, 1999). Individualized intervention is designed to increase protective factors (e.g., social support) and decrease risk factors (e.g., parental depressive symptoms) associated with child maltreatment.

FC uses a home-based, family-centered model of practice consistent with other home-based, tailored intervention approaches.

The core components of the FC Demonstration Program included: (1) Emergency assistance; (2) home-visiting family intervention (family assessments, outcome-driven service plans, individual and family counseling); (3) advocacy

and service coordination with referrals targeted toward risk and protective factors; and (4) multi-family supportive and recreational activities. Because the authors were interested in understanding whether shorter- versus longer-term services were more effective in supporting families to achieve positive outcomes, families were assigned to receive the same core services, but for different lengths of time (3 versus 9 months). Clinical self-report and observational measures (DePanfilis et al., 1999) were integrated into each family assessment, and service plans were developed accordingly. Similar to other home-based interventions (Lutzker & Rice, 1987), FC combined the education of graduate students with service to the community. First- and second-year social work interns completed the objectives of field placement courses by providing most of the services delivered for either 3 or 9 months. These services were provided under the close supervision of a faculty member. Interns received weekly individual supervision and clinical seminars, and they followed a detailed intervention manual (DePanfilis et al., 1999). The program was based in the community and most services were provided in participants' homes.

Background

In federal fiscal year 2001, the Children's Bureau initiated the Emerging Practices in the Prevention of Child Abuse and Neglect Project to harvest new information on child maltreatment prevention programs and initiatives operating around the country, and to disseminate that information to the professional community. The project involved scanning the environment for current information on prevention and seeking input directly from child maltreatment prevention programs. Under the guidance of an advisory group of experts in the field of child maltreatment prevention, including both practitioners and researchers, OCAN developed and implemented a program nomination strategy to learn more about current effective and innovative prevention programs. Through this effort, FC was highlighted as an effective program in the *Emerging Practices* report that was released in federal fiscal year 2003 (Thomas et al., 2003).

The Children's Bureau planned to support future work based on the findings of this report that would contribute to advancing theory, policy, and evidence-based practice in child maltreatment prevention. In fiscal year 2003, the organization issued a funding announcement, *Replications of Demonstrated Effective Programs in the Prevention of Child Abuse and Neglect* (*Program Announcement No. CB-2003-01.D1*). The overall purpose was to provide financial support to replicate and evaluate critical components of programs that had demonstrated success in preventing or reducing the risk of child maltreatment by testing their effectiveness in other settings. Applicants could choose to replicate the demonstrated effective program identified in the Emerging Practices report (i.e., FC) or another program of equal merit. The projects funded under this priority area would incorporate features and components that held promise for contributing to the knowledge base about effective strategies in child maltreatment prevention.

The eight highest-scoring applications selected for funding all proposed to replicate the key components of the FC Program. Each of the projects planned to test the effectiveness of the program with a variety of different populations and geographic areas. Grantees were required to conduct rigorous local evaluations that included process, outcome, and cost components. The Children's Bureau also funded a national cross-site evaluation to examine whether the FC Program could be implemented with fidelity in other settings. The national evaluation is examining any adaptations that were made to the original model by the replicating sites and the impact of such changes that were made to meet the needs of each site's target population.

The study is also evaluating the effect of the replication projects on reducing risk factors, increasing protective factors, and preventing child maltreatment for families served. Finally, the national evaluation includes a comprehensive cost analysis that incorporates aggregate and case-level costs that were collected across all the replication sites.

The FC replication sites differed in a variety of ways, including their target populations (e.g., age and race/ethnicity), target community (e.g., large city or rural), program staff background (e.g., intern or clinician with a master's in social work), experience with federal grants, and experience with program evaluation and research (Filene, Kass, Smith, Hafford, & Bell, 2009). The eight replication sites were:

- **Asian Pacific Counseling and Treatment Center (APCTC)**. Located in Los Angeles, California, APCTC was established in 1977 to provide mental health services targeting Asian Pacific groups: Chinese, Filipino, Japanese, Korean, Vietnamese, Cambodian, Lao, and Thai individuals and families. APCTC is one of the oldest and largest mental health centers serving the Asian Pacific community throughout Los Angeles County. The APCTC Project proposed to reach out to Korean and Cambodian immigrant families that were living in Los Angeles County, met risk criteria for neglect, and were not receiving services from the public child welfare agency. These families were encouraged to participate in FC services for 3 or 6 months.

- **Black Family Development, Inc. (BFDI).** BFDI is a private, nonprofit, comprehensive family counseling agency that was created in 1978 by the Detroit Chapter of the National Association of Black Social Workers. Since that time, BFDI has grown to accommodate the increased demand for specialized, family-focused counseling and advocacy services in the community. The BFDI Project proposed to serve families that were living in two high-risk communities in Wayne County (Detroit and Highland Park), met risk criteria for neglect, and were not receiving services from the public child welfare agency. The families could participate in FC services for 3 or 6 months.

- **Child and Family Tennessee (CFT).** Located in Knoxville, Tennessee, CFT is a private not-for-profit corporation that was founded in 1929. Since then, CFT has been a prominent service provider dedicated to helping children and families in East Tennessee by providing prevention, treatment, and advocacy services. The CFT Project proposed to reach out to families that were living in the Knoxville Empowerment Zone (a federally designated neighborhood with high rates of poverty and violence), met risk criteria for child abuse and neglect, and were not receiving services from the public child welfare agency. These families could participate in one of four different versions of the FC intervention: (1) FC for 3 months; (2) FC for 3 months, enhanced with parent education groups; (3) FC for 9 months; or (4) FC for 9 months, enhanced with parent education groups.

- **Children's Institute Inc. (CII).** CII is a private, nonprofit, multi-service agency located in Los Angeles, California, that is active in child welfare policy development, professional practice, and research and evaluation. Founded in 1906, CII has a long history and extensive experience in developing and implementing both child maltreatment prevention programs and home visitation programs. The CII Project proposed to reach out to families with young children (birth to 3 ½) that were living in high-risk neighborhoods in South Central Los Angeles, met risk criteria for neglect, and were not

receiving services from the public child welfare agency. They could participate in one of two different interventions: (1) FC for 9 months; or (2) Project Stable Home (a locally developed family preservation program) for 9 months. However, due to funding changes for Project Stable Home, CII stopped assigning families to Project Stable Home and added an individualized information and referral services group to its design.

- **DePelchin Children's Center (DCC).** DCC is a private, nonsectarian United Way agency that has served the greater Houston area for more than 110 years. The agency runs over 30 programs dedicated to adoption, foster care, counseling services, prevention services, residential services, and other service areas. The DCC Project proposed to reach out to families whose children were attending schools in the high-risk neighborhoods in Dickinson, Texas, that met risk criteria for neglect, and that were not receiving services from the public child welfare agency. These families could participate in one of four different versions of the FC intervention: (1) FC for 3 months; (2) FC for 3 months, enhanced with Just for Me Time (parental self-nurturing activities); (3) FC for 6 months; or (4) FC for 6 months, enhanced with Just for Me Time.

- **Respite Care of San Antonio ("Together in Strength" or TIS).** TIS is a collaborative effort formed by two separate agencies: Respite Care of San Antonio (RCSA) and Any Baby Can San Antonio (ABC). RCSA provides relief services to families struggling with the day-to-day challenges of caring for and raising children with developmental disabilities. ABC serves families with children facing serious health or developmental challenges. The TIS Project proposed to reach out to families with children between the ages of birth and 17 who had developmental disabilities or chronic health conditions, were living in one of two Texas counties (San Antonio or Bexar), met risk criteria for neglect, and were not receiving services from the public child welfare agency. These families could participate in one of three different groups: (1) Services as usual; (2) FC for 6 months; or (3) FC for 12 months. TIS implemented a step-down service model that consisted of a gradual decrease in the intensity of services over a period of time, starting with weekly visits that tapered to monthly contacts and phone calls toward the end of the program.

- **University of Maryland, Baltimore Grandparent Family Connections (UMB-GFC).** UMB-GFC implemented the Grandparent FC Project through the UMB Center for Families (now reconstituted as the Ruth H. Young Center for Families and Children). The mission of the Center for Families was to promote the safety, health, and well-being of children, families, and communities through community and clinical services, research, education, and advocacy. The UMB Project proposed to reach out to grandparent families that were living in high-risk neighborhoods, met risk criteria for neglect, and were not receiving services from the public child welfare agency. These families could participate in one of three different versions of the FC intervention: (1) FC for 3 months; (2) FC for 6 months; or (3) FC for 6 months, enhanced with health and legal services. In addition, a fourth group was randomly assigned to receive no FC services.

- **Youth Health Service, Inc. (YHS).** YHS was created in 1978 to provide health, education, and social benefits to youths and their families residing in Barbour and Randolph counties, a rural, low-income region of north central West Virginia. The agency offers an array of behavioral health services. The YHS Project proposed to

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reach out to families that were living in the aforementioned counties, met risk criteria for neglect, and were not receiving services from the public child welfare agency. They could participate in one of four different versions of the FC intervention: (1) FC for 6 months; (2) FC for 6 months, enhanced with a motivational interviewing intervention; (3) FC for 12 months; or (4) FC for 12 months, enhanced with a motivational interviewing intervention. YHS also implemented a step-down service model. Families assigned to receive 6 months of services received weekly visits during the first 3 months, bimonthly visits for the next 3 months, and then an additional 3 months of monthly visits if they chose to participate in an optional booster period.

'Fidelity Criteria' for Replicating FC

During the first year of replication, the eight sites and the UMB Center for Families agreed on a set of "fidelity criteria," and each program developed an implementation manual that set forth its plans to replicate FC. These fidelity criteria (see Table 1) specified a set of nine philosophical principles, 14 criteria related to program structure, five criteria related to administrative activities, five criteria related to professional development activities, and six criteria related to research activities. The methods used to assess cross-site fidelity to the FC Program rely on an examination of the program staff's verbal and written reports of implementation, including archival data abstraction, semi-structured interviews, case record review, and focus group discussion.

National Cross-Site Outcome Measures

Cross-site outcome measures were chosen based on evidence of acceptable reliability and validity of the measures in previous research. Three measures were selected to assess the following protective factors:

- Parenting attitudes: *Adult-Adolescent Parenting Inventory (AAPI-2)* (Bavolek & Keene, 1999)
- Social support: *Support Functions Scale* (Dunst, Trivette, & Deal, 1988)
- Family functioning: *Family Assessment Form* (Children's Bureau of Southern California, 1997)

Two measures were selected to assess the following risk factors:

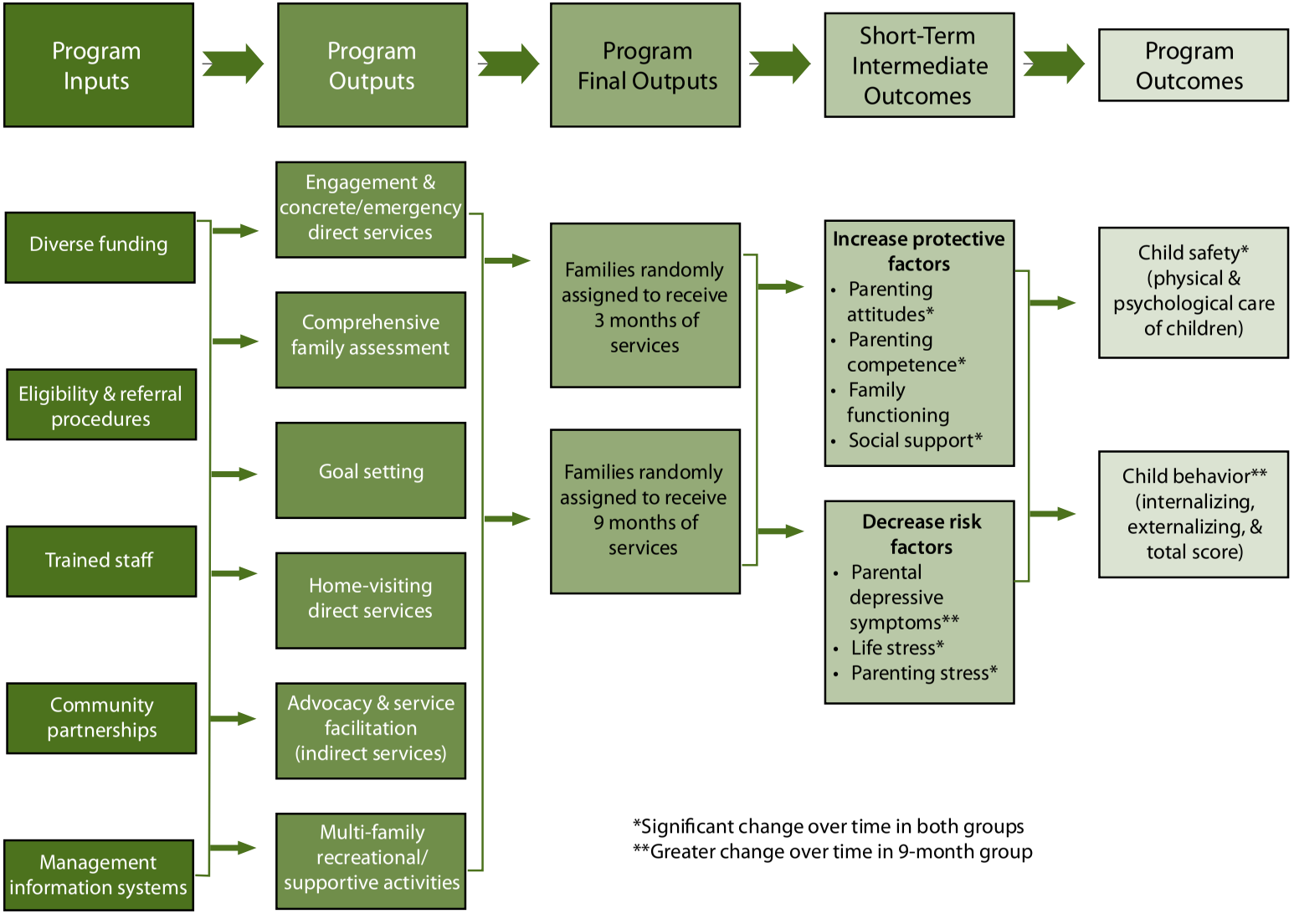
- Parental depressive symptoms: *Center for Epidemiologic Studies, Depressed Mood Scale* (Radloff, 1977)
- Parenting stress: *Parenting Stress Index, Short Form* (Abidin, 1995)

One additional measure was selected to assess child well-being: *Child Behavior Checklist* (Achenbach, 1991). Beyond the cross-site outcome measures, each site administered a variety of site-specific measures.

Articles in This Issue

In the first article, Sheila Tsai Wu, Akiko Mimura-Lazare, Carrie J. Petrucci, Naomi Kageyama, and Chong Suh describe three culturally competent practices that were

Figure 1. FC Logic Model
Assumptions: Home-based services focused on reducing risk factors and strengthening protective factors will result in increased safety and improved child behavior.



implemented in APCTC's replication of FC with Cambodian and Korean families: (1) "Buy-in" from the target population; (2) tailored service delivery protocols; and (3) cultural adaptations to FC for Cambodian refugee and Korean immigrant population groups.

The second article, by Kenyatta Stephens, Crystal Mills, Cynthia Williams, Tana Bridge, and Enos Massie, provides an example of the development of a helping alliance between a consumer and a counselor in BFDI's replication of FC. The article presents a case illustration of the clinical and programmatic processes associated with a helping alliance that were used by BFDI counselors to achieve a high level of engagement and successful outcomes with one high-risk family.

In the third article, Matthew T. Theriot, Kathryn R. O'Day, and Kathy Hatfield investigate client characteristics and service use measures predicting successful completion of CFT's replication of FC. Findings suggest that families served for 3 months were more likely to complete services than families served for 9 months. Further findings indicate that families receiving more comprehensive direct services were more likely to successfully complete the program, whereas families with housing problems, more children living in the home, and that received a greater number of different referral services were more likely to drop out of the program.

The fourth article, by Susan Zaid, Charity Eames, Demori Driver, and Adrienne LeGendre, describes DCC's implementation of Therapeutic Assessment (TA) as a therapeutic technique to help high-risk families and as an avenue to collect data on program performance in a community-based mental health setting. TA was used to enhance the implementation of the core components of FC, with specific emphasis on integrating research and practice.

The fifth article, by Tanya L. Sharpe, Diane DePanfilis, Frederick Strieder, and Gillian K. Gregory, describes modifications made to FC to address the needs of grandparent families. It also describes the perspectives of grandparents after their participation in UMB's Grandparent FC services. Qualitative findings revealed that the impact of the program fell into three domains: (1) Supports and services; (2) skill building; and (3) affect and behavioral changes.

The sixth article, by Melissa Lim Brodowski and Jill H. Filene, discusses the importance of involving and engaging program staff, including direct practice staff, in cost analyses. The article describes how program staff were engaged in the process of conducting an economic evaluation of the replications of FC and the lessons learned in conducting a comprehensive cross-site cost analysis. The paper concludes with key recommendations for practice and offers insight into how the process of conducting an economic evaluation can be used to facilitate ongoing learning and reflection regarding program practice, implementation, and research.

The seventh article, by Phaedra Corso and Jill H. Filene, consists of a description of the methods for conducting rigorous programmatic cost analyses, presenting cross-site cost analysis of the replications of FC as an example. The article includes the average programmatic costs of replicating FC across all eight sites.

Over the 5-year grant period, each of the FC replication projects was able to implement and rigorously evaluate the FC Program with varying levels of success. The articles in this special issue offer a rich opportunity to delve deeper into the unique aspects and lessons learned from five of the eight grantee projects. In addition, the two cost analysis articles provide sorely needed information to the field regarding the importance and relevance of economic evaluation. There are no short cuts to offer when attempting to

implement and rigorously evaluate a program proven to be effective in some instances in other jurisdictions and with entirely different target populations. Nonetheless, everyone involved with the projects is committed to ensuring that research informs future practice. This commitment is infused in all seven articles available in this issue of *Protecting Children*.

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Appendix: FC Fidelity Criteria

Agreed to on January 13, 2004, by all replicating programs

The table presented below specifies the conditions necessary to replicate the FC Program. Each replicating program will develop an implementation plan that verifies how it will assure that the program is implemented with integrity.

FIDELITY CRITERIA
Philosophical Principles
Uses FC philosophical principles in the delivery of services: 1. community outreach 2. family assessment 3. individualized, tailored intervention 4. helping alliance 5. empowerment approaches 6. strengths perspective 7. cultural competence 8. developmental appropriateness 9. outcome-driven service plans
Program Structure
Uses, at a minimum, the original FC screening criteria (with the exception of geographical requirements and age limitations) as clear inclusion criteria for targeting and screening program clients
After clients are assigned to the FC intervention, an FC practitioner assigned to work with the family on an ongoing basis initiates the therapeutic alliance through face-to-face contact with the client within 1 business day of acceptance at intake
Provides at least 1 hour of face-to-face FC services to families at least once per week for at least 3 months
Provides most services in the community, meeting families where they live
Uses clinical assessment instruments to guide the identification of risk and protective factors associated with child neglect (or maltreatment) as part of the comprehensive family assessment
Develops and implements marketing and recruitment procedures targeted toward potential program clients
Establishes and manages referral procedures for actively reaching out to eligible families with offers of service
Forms and utilizes a community advisory panel that incorporates consumer input
Provides emergency services to address initial concrete needs and on an ongoing basis as needed
Conducts comprehensive family assessments to guide the service delivery process
Develops outcome-driven service plans geared to decrease risk and increase protective factors associated with child maltreatment
Delivers tailored, direct therapeutic services to help clients reduce risks, maximize protective factors, and achieve service outcomes and goals
Advocates on behalf of clients in the community and facilitates services provision by other organizations/individuals
Implements process for evaluation of client change over time and at case closing

Administrative Activities
Establishes safety policies for practitioners related to their work in the community
Develops, implements, and manages continuous methods for assessing quality assurance
Develops, implements, and manages risk management procedures (e.g., child abuse and neglect reporting, self-injurious behavior)
Tracks time units of service by type of services delivered
Tracks costs of all service units
Professional Development Activities
Recruits and supports a professional workforce (social work education or equivalent)
Provides initial training and orientation to all staff and provides all staff members with the FC intervention manual as revised by each program
Provides at least weekly clinical supervision to FC service providers
Fosters an organizational culture that reinforces the FC philosophical principles, intervention methods, and procedures via weekly clinical seminars or team meetings, and interpersonal interactions
Provides opportunities for staff to participate in seminars, conferences, and/or other training to support their continuous professional development in FC-related social work practice methods
Research Activities
Uses a logic model to specify the connections between outputs and outcomes
Uses an experimental research design with random assignment to at least two alternate treatment conditions or alternate interventions, or random assignment to treatment and control conditions
Measures change over time in risk factors, protective factors, and child safety and well-being outcomes, including at least a 6-month follow-up (after services end) measurement interval
Implements strategies that document the process of implementation and the service delivery process, and records time units of services
Uses a combination of self-report and observational standardized measures and collects data on official child abuse and neglect reports to assess change over time
Uses specific core measures as agreed on with other FC replication grantees