RESEARCH REPORT

Evaluation of Parent Therapy/Training in a Community-based System of Care

Principal Investigator
Mary Kay Falconer, PhD
Ounce of Prevention Fund of Florida
Research, Evaluation and Systems

Abigail Zohn, MSW, MPA
Ounce of Prevention Fund of Florida
Research, Evaluation and Systems

FLORIDA INSTITUTE for CHILD WELFARE

CONTENTS

Abstract

The priority selected for this project was evidence-based services for children birth to five. The project was designed to evaluate evidence-based interventions (EBIs) currently offered to families receiving case management services within the system of care managed by Big Bend Community-Based Care (BBCBC). The project encompassed two studies. The implementation study evaluated the performance of one EBI, Child Parent Psychotherapy (CPP). Ten parents in nine cases were recruited for this study. Data collection methods included a survey measuring perceptions of parent competence, interviews with parents regarding their views on their therapeutic experiences, and accessing case-related data in the Florida Safe Families Network (FSFN) and case management files. Several Child and Family Services Review (CFSR) measures were calculated. There were no verified or not substantiated maltreatment findings during participation in the EBI and study time period. One family was reunified during participation in the EBI. The key informant study supplemented the implementation study and used qualitative methods to examine views of three stakeholder groups (case management staff, service providers, and Circuit 2 judicial representatives) on EBIs to improve parenting and related outcomes among at-risk families of children between the ages of birth to five. Findings revealed favorable views of EBIs although barriers and challenges were identified that limited their success. Therapies and services that were not EBIs were also valued highly, and collaboration among child welfare partners was considered essential. There appeared to be no use of standard criteria for the selection of EBIs.

Project Description

The project was designed to evaluate parenting programs and therapies currently offered to families receiving case management services within the system of care managed by Big Bend Community-based Care (BBCBC). The parent programs were evidence-based interventions (EBI) and included Circle of Security (COS), Early Childhood Systematic Training for Effective Parenting (STEP), and Child Parent Psychotherapy (CPP). The programs were expected to be offered to parents of children birth to five years of age referred to case management that were assessed as "unsafe" due to impending danger at the close of the child protection investigation. There were 10 parents recruited for the study and each parent signed a project consent form and submitted a completed pre-questionnaire. One provider recruited the participants for the evaluation. This provider offered COS and CPP to parents. The research team maintained contact with the provider in order to monitor the delivery of services and facilitate ongoing parent participation in the study. Data collection methods included a survey of participants using a questionnaire to measure parenting competence, interviews, and documentation using the Florida Safe Family Network (FSFN) and case files. Measurement included Child and Family Services Review (CFSR) outcomes (child safety, child permanency, and child well-being), parent sense of competence, and satisfaction with the program. Quantitative and qualitative analyses were conducted. The Western Institutional Review Board (WIRB) was the institutional review board used for this research. In this report, this research is referred to as the "implementation study".

During the first quarter of the project, two major barriers were encountered that did not allow the implementation study to proceed as originally intended. First, there were not enough providers available to participate in the study. Two of the CPP/COS providers that had expressed interest in participating in the study subsequently retired before the study began. Other CPP providers expressed interest in participation, but later declined to participate because of their lack of experience implementing the therapy model and anticipated uncertainty adding the responsibilities of a study protocol. Referrals to one of the parent training programs (STEP) during the first six months of the project year were too low to ensure the confidentiality of the participants. There were attempts to recruit additional STEP providers by offering training to interested candidates but there were no funds available to conduct this training. During the second quarter of the study period, it was clear that only one CPP/COS provider was available and in agreement to participate in the study. With only one provider participating, an advisory group of multiple providers to review protocols and guide subsequent progress of the study was not feasible.

Second, attempts to form a comparison group were not successful. One group of parents that was under consideration as a comparison group in the implementation study was already being recruited for another study funded by the Florida Institute for Child Welfare. With the low participation on the part of the providers and parent participants, the comparison group design in the implementation study was not achievable.

In acknowledgement of the barriers in the implementation study, the need to identify factors that support and/or hinder the implementation of EBIs in the target community became apparent. It was further determined that this information could be systematically gathered through key informant interviews.

The plan for the key informant study was developed during November and December of 2015 and initiated in January 2016. The purpose of the research was to build on the implementation parent program study by seeking input from service providers and therapists, case management, and judicial representatives with regard to their experiences and perceptions of program implementation processes, service barriers, what works, and outcomes, as well as their views on the use of evidence-based interventions in improving parenting and related outcomes among at-risk families of children between the ages of birth to five. The research was descriptive, qualitative, and exploratory and aimed to answer the following primary question: "What are the experiences and views of service providers and therapists, case management, and judicial representatives regarding the 1) current operations of parenting education services and 2) the use of evidence-based interventions in improving parenting among at-risk families of children, age birth to five?" Questions regarding collaboration with professional partners in the child welfare system were also answered. The Florida State University (FSU) Institutional Review Board approved the human subject protection protocols in the research. Case managers employed with the Children's Home Society (CHS) as a subcontractor with BBCBC were recruited for the case management interviews. Dependency court judges and other judicial officials in Judicial Circuit 2 were identified with the assistance of the Office of the State Courts Administration (OSCA) and were recruited for interviews. Finally, the providers participating in the initial parent program evaluation and others identified by BBCBC were contacted for interviews. Hypotheses were not tested and quantitative outcomes were not measured in the supplemental research. Interviews were conducted in-person or by telephone. The analysis identified and described common themes within and between stakeholder groups. The supplemental research is referred to as the key informant study in this report.

Implementation Study

The evaluation that is referred to as the implementation study initially encompassed COS and STEP in its measurement of performance. CPP was added due to its importance in serving the target families in BBCBC. The evaluation attempted to include process, formative, and summative components. Process and formative components were included in order to carefully document and monitor the implementation of the parent therapy/training programs. Recording of the timeframes for the delivery of the program were planned and compliance with key standards or requirements for achieving fidelity in each model were to be monitored. The formative component would have allowed updates related to the progress of the evaluation in data collection and measurement to be shared with the providers monthly. The formative component also allowed opportunities for providers to share their observations on practice during the project timeframe. The summative component included the calculation of several outcomes within the three CFSR categories. The final evaluation plan was intended to be reviewed and approved by the advisory group formed for this project in the initial phase. However, the advisory group was not formed due to the limited participation among providers.

Initially, the implementation study aimed to:

1. Document the implementation of each parent program (COS and STEP) with process measures and detailed

descriptions of the activities conducted and information shared with the parents in each session, as a baseline to identify needed changes in future interventions.

2. Strengthen the implementation of each parent program (COS and STEP) through a formative approach that would share useful updates on process and performance with the providers and BBCBC.

3. Measure the performance of each parent program, as well as the "other services" intervention, on outcomes.

4. Compare the performance across the parent programs on outcomes.

5. Develop recommendations for future implementation of the parent programs.

Target Population: The target population included families referred to BBCBC case management with "unsafe" children age birth to five during the project time frame. The determination of the "unsafe" status was based on the Impending Danger Assessment conducted by the child protection investigator. Parents with "unsafe" children birth to five in the home or out of the home were included. It was assumed that parents with "unsafe" children birth to five in the home would have a safety plan. All parents participating in the evaluation were also assumed to have a case management plan that specified participation in COS, STEP, or other services. Additional assessments conducted at the end of the investigation were also to be consulted for eligible parents. Based on information available through the BBCBC for the most recent fiscal year, the projected total number of parents participating in the parent programs evaluated in this project was 45.

Evaluation Design: This project initially planned to use a quasi-experimental design to compare parent and children groups in different parenting programs. Due to the participation of only one provider and the challenges associated with forming a comparison group, the design was modified to be a single group design with two time points for measurement (beginning of participation of parenting program and end of parenting program).

Data Collection Methods: Multiple data collection methods were used. These methods relied on primary and secondary data sources. Primary methods included measurement tools administered with the parents prior to and/or at the end of participation in the program and in person interviews with the parents. Secondary methods included accessing data in FSFN and in paper files maintained by case managers and providers for parents participating in the project.

Interviews with the parents were conducted in person after they completed or were very close to completing the parent program. The questions developed for the interviews with the parents attempted to address themes and measurement domains that were represented on the tool selected for administration with these parents. Members of the advisory group would have been asked to recommend questions that would be helpful for them as feedback in the delivery of their services but the advisory group was not formed. The interviews used a semi-structured format that had several closed response categories and several open-ended response questions that allowed for elaboration. The interviews were planned to not exceed 45 minutes. Even though all of the parents interviewed already signed a consent form prior to the interview, informed consent was reviewed with each parent at the beginning of the interview.

A protocol for data collection was planned to be developed and approved by the members of an advisory group. The advisory group was not formed due to the lack of participation among providers. The protocol would have included the administration of any measurement tools completed by parents, interviews with parents (in person or telephone), and any information that must be recorded by providers. Plans regarding observation of the group sessions and accessing participant data from FSFN and/or other electronic files maintained by BBCBC were also to be shared with and approved by the advisory group.

Measurement: The measurement for this evaluation included a wide range of information needs and relied on several data sources. Information needs included measures that could be compared pre/post participation in the parent program as well as information about the parents, family and children. Some of the information was identified to augment explanations of findings at the end of the project time period. The overall measurement goal was to document thoroughly the experience of each parent and child(ren) in the child welfare system participating in this project prior to, during, and up to six months (depending on when they complete the parent program) after their participation in a parent program.

Characteristics of participants (parents and children) included a set of data items recorded for this study. Process measures that captured dates referring to the most recent and previous maltreatment reports and investigations were included. Dates and length of time for each parent training or therapy session as well as brief descriptions of the activities and information content shared with the parents during each session were planned to be recorded by each provider. Outcomes included child safety, permanency, well-being and several family or parent well-being measures.

A secondary data source for the selected process and outcome data was FSFN. Other information was provided by BBCBC or case managers and each provider as specified in the protocols. Child well-being measures that refer to developmental levels, immunizations, and child care were to be obtained in the on-going Family Functioning Assessment (FFA) updated by the BBCBC or case managers. Paper case files maintained by case managers were accessed to record data not available in electronic data files. Assessments completed by the investigators and included in case management electronic or paper files were also accessed.

After reviewing several tools, the parent well-being measure was based on a modified version of the Parenting Sense of Competence (PSOC) Scale. This was a scale that had been used in research conducted with the COS-P program. The modified PSOC is in Appendix A. The Interview Guide for the interviews conducted with the parents is in Appendix B.

An impressive set of data items and other measurement information that was planned to be collected for this project is in the list below:

Characteristics of Participants (Biological Parents and Children)

    Date of birth of child(ren)

    Gender of child(ren)

    Race of child(ren)

Ethnicity of child(ren)

Date of birth of parent(s)

Gender of parent(s) participating in program

Race of parent(s)

Ethnicity of parent(s)

Employment status of parent(s)

Marital status of parent(s)

Family size (number of siblings)

Birth order of the children

Health and Child Care Experience of Children

Developmental level for child(ren)

Immunization records for child(ren)

Childcare experience of child(ren)

Child and Family Assessments

Impending Danger Assessment

Risk Assessment completed at the end of the investigation

Information on the Most Recent Maltreatment Report and Investigation

Date of recent report

Date of closure of recent investigation

Date of referral to most recent case management

Maltreatment findings in recent investigation (V, NS)

Type(s) of maltreatment in recent investigation

Which children were included in the recent investigation

Parent(s) role (perpetrator, adult in home, victim, and other appropriate statuses)

Information on Previous Maltreatment Reports, Investigations and Case Management

Child(ren) victims in previous investigations

Parent(s) in previous investigations

Dates of previous investigation closures

Findings in previous investigations (V, NS)

Roles of parent(s) in Previous Investigations

Previous referral to case management and services received in case management

Information on Placements and Visits

Number of placements for children during training and within six months after training

Number of visits between parent and children if children are removed from the home

V=Verfied; NS=Not Substantiated

For the outcomes child safety, permanency and well-being, the appropriate indicators were identified. Several of the data items included in these indicators are listed above. Family and parent well-being measures were based on a self-report tool completed by the parents on parenting

skills (PSOC), and parental satisfaction in responses to questions during the interviews with parents. The selection of tools and development of questions for the interviews was intended to be based on input provided by the advisory group and national model experts. As indicated earlier, the advisory group was not formed due to the lack of participation among providers.

Data Analysis: With the planned measures calculated, bivariate and multivariate statistical techniques were to be used to compare performance for all indicators pre/post program participation and across the groups in the initial evaluation design (Langbein & Felbinger, 2006; Randolph & Myers, 2013). In the multivariate techniques, models were to be estimated in order to control for characteristics, previous experiences in child protective system, and current experiences with the parenting programs that were identified as theoretically important in affecting subsequent child safety, permanency and well-being. The dependent variable for the safety outcome used in most of the statistical models was identified as maltreatment occurrence (verified or with both verified and not substantiated findings combined) as a dichotomy (did not occur = 0 and occurred = 1). Permanency measures were also to be dependent variables as dichotomies with the occurrence of events being removal of child or reunification of children (did not occur = 0 and occurred = 1). The child well-being outcome measures were also planned as dichotomies. Therefore, binary logistic regression was selected as the primary statistical technique in the analysis to allow the calculation of odds ratios (King, 2008). The equivalency of the members at both pre and posttest across all groups in this design was also intended to be examined as part of the statistical analysis but the modification to a single group design did not require this check for equivalency. The low N (9 cases and 10 parents) did not allow the statistical analysis that was planned originally.

Participant Compensation: Parents participating in and completing the evaluation were compensated with a $20 gift card from Publix.

Human Subject Protection of Participants: Consent for participation in this study occurred when the family was referred to a provider offering the parent program in this project. All procedures for protecting human subjects were consistent with formal protocols and operating procedures adopted by or required of the BBCBC and DCF. For this study, an application for the protection of human subjects was submitted to Western IRB (WIRB) for approval. Participants were assigned IDs that were only known by members of the evaluation team and each participating provider. Communication regarding participants with each provider used participant IDs. No personal identifying information for each participant was included in email communication with a provider or with the BBCBC.

Key Informant Study

This study built on the implementation study's interest in parent training/therapy EBIs for families with children birth to five years of age. The participating agencies included BBCBC, the CHS, dependency court representatives in Judicial Circuit 2, and various community-based public or private service providers and therapists contracted by the BBCBC. In terms of protection of human subjects, the review and approval to conduct the study was granted by the Institutional Review Board at Florida State

University. In order to gain a more comprehensive understanding of program experiences and operations, as well as professional views on the use of EBIs in working with at-risk families, the key informant study gathered information from three groups of stakeholders (i.e., service providers and therapists, case management, and judicial representatives) who are involved with families in the current study and who have important roles in facilitating positive behavior change among these families. It should be noted that case management services are provided by the CHS through a contract with the BBCBC. The overall research question was, "What are the experiences and views of service providers and therapists, case management staff, and judges regarding: 1) the current operation of parenting programs and therapies and 2) the use of evidence-based interventions in improving parenting among at-risk families of children, ages birth to five?"

This key informant study research was descriptive and exploratory. The data were considered pilot data in order to gain an understanding of the current functioning of parenting interventions and views on the use of EBIs. Thus, we did not test hypotheses at this stage of the research.

Evaluation Design: The key informant study had a cross-sectional, descriptive, qualitative research design that involved conducting one set of individual interviews with members of three key stakeholder groups (i.e., service provider and therapists, case management, and judicial representatives) involved in parenting services and therapies for families with children ages birth to five.

Data Collection Methods: We used qualitative methods, which included completing individual interviews with service providers and therapists, case management staff, and judicial representatives that included dependency court judges/magistrates and administrators who are a part of the overall system of care. The majority of interviews were conducted in person. Interviews with several therapists/service providers and one dependency court judge were conducted by telephone. A brief description of each stakeholder group follows:

- Service Providers and Therapists - The BBCBC agency contracts with service providers and therapists in the Big Bend area to provide services and therapies to families with children ages birth to five who have come to the attention of the Florida Department of Children and Families (DCF) due to risk of abuse and/or neglect.

- Case Management Staff - Case management services are provided to these at-risk families by staff employed by the Children's Home Society. The staff are responsible for coordinating services (including therapeutic intervention) for families with children ages birth to five who have come to the attention of the DCF due to risk of abuse and/or neglect.

- Judicial Representatives - Judges and magistrates that hear DCF dependency cases in the BBCBC area (also referred to as Judicial Circuit 2), were included. In addition, court administrators and managers were included in this category.

Measurement: Four categories of questions were developed for measurement in the key informant study. The first set of questions asked about professional responsibilities and interaction with the families. Another set of questions captured experiences with and opinions of EBIs, including criteria for selecting EBIs, strengths and limitations, and their facilitation of family friendly placements, healthy visitation, and reunification. Another set of

questions addressed views on collaboration with partners. A final question category requested recommendations regarding the development of a system of care in the BBCBC that has EBIs to adequately meet the needs of at-risk families with children ages birth to five. The order and specific questions varied across the stakeholder groups. The Interview Guides are in Appendix C. The time required for the interview was planned to require 45 minutes but there were several interviews that extended beyond that time frame.

Data Analysis: Data analysis identified and described themes within and between stakeholder groups. The qualitative software used for the analysis was NVivo Pro (Version 11). The recordings for each interview conducted were transcribed. These transcripts were coded using a list of themes that was developed primarily using a deductive approach that referred to the research categories and actual interview questions. Based on the documents for each theme and each stakeholder group, specific findings were identified. A procedure to determine the reliability of findings across two reviewers was implemented. A final analytical objective was to compare the findings across the stakeholder groups. Specific analytical steps and the list of themes used in the qualitative analysis are listed below.

Step One:
First analyst coded electronic versions of transcripts for each group using the themes below in NVivo Pro. Second analyst coded hard copies of transcripts using the themes below. The coding was compared and differences were resolved when both analysts met to confer and reach consensus.

Step Two:
Content in the transcripts coded for each theme were compiled in separate electronic documents using NVivo Pro. These theme documents had labels for each stakeholder source of the content (Case Manager, Case Manager Supervisor, Judge/Judicial Representative, or Therapist/Service Provider interview).

Step Three:
Key points or findings in each theme document were highlighted by source using a standard format. The points included quotes or paraphrasing of transcript text. After the first analyst completed highlighting the key points in the content for a theme, the second analyst reviewed the highlighting of the first analyst. If there were differences in the key points highlighted, they were resolved when both analysts conferred and reached consensus.

Step Four:
The key point highlights in Step Three were used to answer the study questions for each group and to assess variations across the stakeholder groups. Variation between groups was considered present if a majority of those in each group had key points (highlights) that were different across groups. In other words, the threshold was when a majority of those in one group had key points that were different from a majority of those in another group.

Themes for the Qualitative Analysis: The themes for the qualitative analysis are listed below in the four broad categories: 1) professional position and interaction with families; 2) EBIs (criteria for selection, strengths, and limitations); 3) collaboration with partners; and 4) recommendations for the system of care. These themes varied in their level of relevance and/or

attention across the stakeholder groups. Some comments were appropriate for inclusion in more than one theme and were coded accordingly. The themes with the largest volume of data were coded in strengths of EBI models and services, limitations of EBI models and services, positive collaboration, negative collaboration, and recommendations.

Position and Interaction with Families
Position Responsibilities: Statements that describe position responsibilities

Caseloads: Points that specify caseloads and/or reasons for caseloads

Contact with Family: Statements that describe the frequency of contact with the family

Positive Experiences: Statements that describe positive experiences with at-risk families

Negative Experiences: Statements that describe negative experiences with at-risk families

EBIs
Barriers in Services and Therapies: Statements that identify barriers that affect participation in an EBI

Criteria for Selecting EBI: Statements that address how or why services are selected

Strengths of EBI Models and Services: Statements that express opinions about the strengths of therapy models and services

Limitations of EBI Models and Services: Statements that express opinions about the limitations of therapy models and services

Prevention EBIs: Statements that express opinions about EBIs that prevent the removal of children

EBIs Promoting Family like Setting: Statements that express opinions about EBIs that promote family like settings

EBIs Promoting Healthy Visitation: Statements that express opinions about EBIs that promote healthy visitation

EBIs Facilitating Successful Reunification: Statements that express opinions about EBIs that facilitate successful reunification

Collaboration with Partners
Collaboration Negatives: Statements that express negative opinions about collaboration

Collaboration Partners: Statements that specify a collaborating partner

Collaboration Positives: Points that express positive opinions about collaboration

BBCBC Collaboration: Statements that address collaboration with BBCBC

Children's Legal Services (CLS) Collaboration: Statements addressing collaboration with CLS

DCF Collaboration: Statements that address collaboration with DCF

Judicial Collaboration: Statements that address collaboration with the judiciary

Therapist Collaboration: Statements that address collaboration with therapists and service providers

Recommendation for System of Care
Recommendations: Statements that include recommendations for improving the system of care

Results

This section of the report presents results for the implementation study and the key informant study. The results based on the implementation study are presented first.

Implementation Study Results

This section contains the results based on the quantitative and qualitative analyses conducted in the implementation study. The sample size for this study (*N* = 10 parents in 9 cases) was lower than expected and there was only one therapist that participated in the study. Because of the participation of a single EBI provider, comparison across more than one EBI model was not possible. In addition, it was not possible to form a comparison group that did not participate in any EBIs due to a lower number of at-risk families with children age birth to five served during the study time frame. Despite these limitations, the results provided valuable information on relatively complex cases with parents that did participate in a therapy model that is well-respected in the BBCBC area. Six of the families were participants in the Early Intervention Court and three were in the Early Childhood Court which was launched recently in Judicial Circuit 2.

Case Studies
Information from FSFN and case management files was collected in order to prepare an overview of the 9 cases (10 parents) included in this study. This information contributed to our understanding of the complexity of these cases and their wide variation in previous experience in the child welfare system. The data collection forms that contain the relevant items for each case and family are available in the documentation for this study. Several summary descriptions of the cases are listed below, beginning with maltreatment and then demographics, number and type of placements, child care, reunification status, and assessments and services:

Child Maltreatment
- Seven parents had their current cases opened in 2015. The earliest current case opened was in 7/2014.

- There were seventeen reports with no findings. Three parents had three reports each with no findings and one of those dated back to 2006 when the parent was a child victim.

- Closed reports with findings provide one accurate indication of the parent's prior experience with the child welfare system. Among the 9 cases, there were 38 closed reports with verified and/or not substantiated findings. One parent had eight closed reports with findings, another had seven and a third had five. The types of verified findings in this set of closed reports included abandonment, deadly weapon injury, environmental hazards, family violence threatens child, inadequate supervision, physical injury, substance misuse (alcohol or illicit drugs), and threatened harm. Five parents had verified findings of substance misuse. An additional two

parents had not substantiated findings of substance misuse. All cases had multiple maltreatment types with one having five types of maltreatment represented in the findings.

- Two parents had open reports initiated during the study time period. One report was opened on 03/24/16 and closed on 05/18/16 with "no jurisdiction." The second report was opened on 03/02/16 and closed on 03/16/16 with no findings of maltreatment.

- Only one parent had a family support case. The date that case was initiated was 10/2013.

- Four parents had their parental rights terminated (TPR) for one or more children. There were a total of eight children that had a TPR. Most of these TPRs were in 2016 with none of them earlier than 2012.

Demographic

- The number of cases with Black/African American children birth to age five was 10, white children was 2, multi-racial children was 2.

- Based on the available information, only one case had parents with a "married" status.

- All but one of the parents were between the ages of 23 and 32. One father was 48.

Placements and Child Care

- The number of children birth to five with more than one placement was five and the number of children with relative placements/living arrangement with parent was 6. One case had a child with 4 placements and another child with 3 placements.

- All children were attending childcare at the time of data collection.

Reunification Status

- One case had reunification occur two days after the intake for CPP.

- The parents for one case moved back into the home where the child is currently living.

Assessments and Services

- Assessments that were scheduled for these parents included domestic violence risk assessment, substance abuse assessment, psychological assessment, psychiatric evaluation, and parenting evaluation. No or partial compliance in completing the assessments were the statuses for the cases that had this information available.

- Services that were court ordered or included in case plans were CPP, COS, anger management, vocational training in order to obtain verifiable income, individual counseling, couples counseling, domestic violence counseling, and housing assistance. Urine analyses were also required for the majority of these cases. No compliance or partial compliance were the compliance statuses for most of the services for the cases that had this information available.

- There were substantial delays and substantial variation in the number of days between the opening of a case and the initiation of CPP. The average number of days between the participants' case opening and the date they signed the consent form for this study was 218 days and the range

for the number of days extended from 66 to 464. For the participants that had service dates, the average number of days between the participants' case opening and their CPP intake was 120 days and ranged from 44 to 343 days.

- One parent completed CPP and COS.

- Two parents involved with the same case completed COS.

- The following attendance and completion records for services were available for seven parents:

  » One parent attended 13 CPP sessions and missed/cancelled 12 CPP sessions. The same parent attended 6 COS sessions and missed/cancelled 9 sessions.

  » Another parent attended 9 CPP sessions and missed/cancelled 8 CPP sessions.

  » A couple on the same case attended 7 CPP sessions and missed/cancelled 2 sessions. The same couple attended 5 (father) and 6 (mother) COS sessions and missed/cancelled 1 session. This couple successfully completed COS.

  » A fifth parent attended 13 CPP sessions and missed/cancelled 4 sessions.

  » The sixth parent with service dates attended 10 CPP sessions and missed/cancelled 6 sessions. This parent successfully completed CPP.

  » The final parent with service information attended 9 CPP sessions and missed/cancelled 8 sessions.

Referring to the bulleted list of findings above and additional information, there were several noteworthy challenges in these cases. Inconsistent or intermittent attendance in therapy was common. When asked about how the cancelled sessions or no-shows affect the therapy, the provider indicated that the therapy "picks up" from where it ended in the previous session that was attended. It is unclear how these gaps in therapy impact effectiveness. No stable housing and employment were challenges that confronted at least seven parents. Two parents were homeless. One parent was pregnant in the later stages of her therapy but did not inform the therapist or case manager of this condition. Placing the children with a relative in another state that was agreeable to the father was a complication that was addressed in one case. Incarceration was a challenge confronted by four parents in four separate cases (three mothers and a father). More specifically, one parent was incarcerated three times since her case opened.

CFSR Measures
With the revisions to the implementation study, the CFSR measures were revised to reflect a single group research design with no performance comparisons across therapy groups. They now serve as baselines for this parent program or therapy model that is a combination of CPP and COS for most of the parents in the study. The total number of parents was 10 (9 cases) and the total number of children in the care of their parents at study enrollment was 18 with 14 of these children under the age of five. Several measures could not be calculated due to missing or incomplete information.

Child Safety
Outcome 1: Children are first and foremost protected from abuse and neglect.

- Percent of children birth to five with no verified maltreatment during participation in the parent program:
  - » *100% or 14 of the 14 children had no verified maltreatment during participation in the parent program.*
- Percent of children birth to five with no verified or not substantiated maltreatment during participation in the parent program:
  - » *100% or 14 of the 14 children had no verified or not substantiated maltreatment during participation in the parent program.*
- Percent of children birth to five with no verified maltreatment within three months after the completion of the parent program:
  - » *We were unable to calculate this measure due to continuing participation of parents in the program or missing service end dates.*
- Percent of children birth to five with no verified or not substantiated maltreatment within three months after the completion of the parent program for those families that complete a parent program at three months or more before the end of the evaluation:
  - » *We were unable to calculate this measure due to continuing participation of parents in the program or missing service end dates.*
- Percent of children birth to five with no verified or not substantiated maltreatment within six months after completion of the parent program for those families that complete a parent program at six months or more before the end of the evaluation:
  - » *We were unable to calculate this measure due to continuing participation of parents or missing service end dates.*

Outcome 2: Children are safely maintained in their homes whenever possible and appropriate.

- Percent of children birth to five remaining in-home during the parent program:
  - » *0% or 0 of the 14 children remained in the home at the time of initiating their therapy.*
- Percent of children birth to five remaining in-home within three months after the completion of parent program:
  - » *We were unable to calculate this measure due to continuing participation of parents or missing service end dates.*
- Percent of children birth to five that remain in-home for six months after completion of the parent program for those parents that complete a parent program at six months or more before the end of the evaluation:
  - » *We were unable to calculate this measure due to continuing participation of parents or missing service end dates.*

Child Permanency

Outcome 3: Children have permanency and stability in their living situation.

- Percent of children birth to five with one placement during the parent program:
  - » *57% or 8 of 14 children had only one placement.*
- Percent of children birth to five with one placement during the parent program and within three months after the completion of the parent program:
  - » *We were unable to calculate this measure due to continuing participation of parents or missing service end dates.*
- Percent of children birth to five with one placement during parent program and within six months after completion of the parent program for those parents that complete a parent program at six months or more before the end of the evaluation:
  - » *We were unable to calculate this measure due to continuing participation of parents or missing service end dates.*
- Percent of children birth to five that reunified during the program for those families that had child(ren) removed prior to the parent program:
  - » *7% or 1 of 14 children were reunified during the parent program.*
- Percent of children birth to five that reunified within three months after the completion of the program for those families that had child(ren) removed prior to the parent program:
  - » *We were unable to calculate this measure due to continuing participation of parents or missing service end dates.*
- Percent of children that did not re-enter out-of-home care within three months of the completion of the program for those families that completed a program three months or more before the end of the evaluation and reunified during or after the completion of the program:
  - » *We were unable to calculate this measure due to continuing participation of parents or missing service end dates.*
- Percent of children birth to five that did not re-enter out-of-home care within six months of the completion of the parent program for those families that completed a parent program at six months or more before the end of the evaluation and reunified during or after the completion of the parent program:
  - » *We were unable to calculate this measure due to continuing participation of parents or missing service end dates.*

Outcome 4: The continuity of family relationships and connections is preserved for children.

- If child(ren) are removed from the home, the number of visits between children birth to five and parent during the parent program.

  » *We were unable to collect this information because it is not documented systematically in the case manager files or FSFN.*

Child Well-Being

Outcome 5: Families have enhanced capacity to provide for their children's needs.

- Percent of parents at a high level of parenting skills (Sense of Parenting Competence Scale):

  » *33% or 3 of 10 parents that completed the sense of parenting competence scale before CPP/COS had a high level of parenting skills. (Number of parents that had 5.5-6.0 average on the strongly agree items and 1-1.50 on the strongly disagree items).*

  » *33% or 1 of 3 parents that completed the sense of parenting competence scale after CPP/COS had a higher level of parenting skill after CPP/COS.*

- Percent of parents at a high level of satisfaction:

  » *100% or 3 of the 3 parents that were interviewed had a high level of satisfaction with CPP/COS.*

Outcome 6: Children receive appropriate services to meet their educational needs.

- Percent of children enrolled in child care and early learning programs that are licensed:

  » *100% or 14 of 14 children are enrolled in childcare but it was not documented if they are licensed.*

Outcome 7: Children receive services to meet their physical and mental health needs. For the measures listed below, parent program participants will achieve 100%.

- Percent of children at appropriate developmental level based on age:

  » *7% or 1 of 14 children are at appropriate developmental level. We were only able to collect Ages and Stages Questionnaire (ASQ) information for one child.*

- Percent of children with required immunizations for age.

  » *36% or 5 of 14 children are up to date on immunizations. We were not able to collect the information for the other 9 children.*

Parenting Competence Survey (Quantitative Analysis)

There were 10 parents that completed the pre-questionnaire *Sense of Parenting Competence* and three parents that completed both the pre and the post questionnaire. Most of the responses for the pre-questionnaire administration indicated a relatively high sense of parenting competence. Using a 6-point disagree-agree response scale (1 = strongly disagree and 6 = strongly agree), a numeric response indicating a high sense of parenting competence depended on the wording of the statement on the tool. Some statements affirmed a high sense of parenting competence with a strongly agree response. Other statements affirmed a high sense of parenting competence with a strongly disagree response. The responses indicating the highest levels of parenting competence were in response to the following statements:

#17. Being a good parent is a reward in itself. (mean was 6.0)

#1. The problems of taking care of a child are easy to solve once you know how your actions affect your child. (mean was 5.70)

#15. I honestly believe I have all the skills necessary to be a good parent to my child. (mean was 5.60)

#2. Even though being a parent could be rewarding, I am frustrated now while my child is at his/her present age. (mean was 1.50)

#12. My talents and interests are in other areas, not being a parent. (mean was 1.50)

#14. If being a parent of a child were only more interesting, I would be motivated to do a better job as a parent. (mean was 1.60)

There were only three responses for the administration of the post-questionnaire and this was an inadequate sample size to make a comparison of the pre and post responses meaningful. One of three parents had a higher post average total score compared to the pre average total score (5.0 to 4.5).

Parent Interviews (Qualitative Analysis)

The three parents interviewed had all participated in CPP with techniques in COS were added as needed for each parent. All of the parents interviewed had a favorable opinion of the therapy and the provider. All parents did not think raising a child was easy. The responses to the question about being in control as a parent varied across parents interviewed. One parent indicated that control was not something he/she was trying to accomplish. Another parent indicated he/she was in control "sometimes." The third parent responded more affirmatively on his/her control and the child's acceptance of the mother/father and child roles. Two parents viewed their parents as better parents than they were. Responses to the question on whether the parents knew what was troubling their child, there was admission that they did not always know but they had the desire and the skills to "figure it out." Two of the parents agreed that they had acquired more parenting skills in COS therapy. They learned about patience, making a child more secure, and about a child's feelings. One of the parents mentioned the value of the therapy with the children, particularly helping them express their feelings. Only one specific suggestion for improving the therapy session was offered by a parent. This suggestion referred to allowing an opportunity to observe parent and child interaction in a more open or "free" setting, such as a playground outdoors. Another parent mentioned that there is "always room for improvement." Also noteworthy was admission by one parent that he/she did not understand the "benefits" of the therapy until six months after starting the therapy. One parent mentioned he/she would like to continue seeing the therapist.

The responses of the three parents interviewed to each question are paraphrased below.

1) Is raising a child easy?

Case 1: No. Bringing up another human being is stressful and costly. There is more good experience than bad, especially with the youngest child.

Case 2: No. But it is interesting and humorous. I am forever learning. Children are experiencing emotions from young to adult. I am conscious of my child and myself. When I look at my son, I see myself and did the same things. For example, I use to take things apart and could not put them together like he does. My daughter wants to know everything. I want to get them ready for the next phase. You have to be stern, but I want them to come talk to me when they want to know something.

Case 3: No. It is a lot of work. It calls for attention and knowledge of how I affect them. I need to know child's needs and how to meet their needs.

2) As a parent, are you in control?

Case 1: Sometimes. Can't control but need to choose how to parent. Need to be firm. It is better now and it is important to find a balance.

Case 2: I don't try to control my kids. I want an agreement with them. They need to be good in order to do things that are fun.

Case 3: Yes. My son knows he is the child and I am the mother. When it is time to get serious, it is time to get serious. Talking to him is better than yelling and I know I need to explain.

3) Are you a better parent than your mother or father?

Case 1: No. My mother had more experience and had 3 kids by the time she was 19. My children were very close in age (3 and 4). The influence of electronic communication has been a negative influence for parents now. Also, a rural setting for upbringing children is better than an urban setting.

Case 2: No. My mom did things that made miracles happen. My mom's shoes are very big and mine are very small. My parents weren't married. Both offered advice but for guy problems I talked with my dad. They never lied.

Case 3: Yes, because I know more and have learned more. I know how to handle the child differently and try to talk about feelings. My mother did not know how to talk about feelings.

4) Do you always know what is troubling your child?

Case 1: Yes. I know when they are missing me. I know more about their emotions now and how to handle them. My son is very competitive and is all about winning in a game. My daughter can't get everything she wants.

Case 2: No, not all of the time. But I can tell when something is wrong. Their personalities change. I might not know exactly what the problem is but I know if something is wrong.

Case 3: No, but I try to figure it out. The parenting videos taught me how to express feelings and use different words to bring out the feelings.

5) At this time, do you think you have the skills needed to be a good parent?

Case 1: Yes. How did you acquire those skills? By listening and being patient and open minded. The Circle of Security was used in my therapy. It took about six months for me to realize the benefits.

Case 2: Yes. I learned watching my grandmother, aunts and uncles and how they raised children. I did not learn the skills from the program (therapy) but the program did assist with my kids. They were in a shell and did not react. But over time, they opened up and became more normal.

Case 3: Yes. I have a broader understanding of being a mother and a parent. In Circle of Security, I learned about my son going to my place and how to interact when he comes in to make him more secure. I learned about feelings, like angry, sad, curious, and happy. My son was being silent and the video helped him talk through those feelings. At first, I was questioning the program but that changed. It also helped with my past.

6) Do you think there is anything that will improve the parent program?

Case 1: What she (provider) had was great but there is always room for improvement. I was with the therapist (named actual therapist) for 12 months and liked her. I would still like to see her.

Case 2: The provider (referred to provider by name) has a great program. I think the play time should have more freedom. There should be a playground for watching parent interaction with children and whether parent can watch all of the children.

Case 3: The program was good for me. It was enough, if not more than enough. I was attending since December and scheduled to come every week. Everything was right on point.

Key Informant Study Results

This section presents results of the qualitative analysis in the key informant study. We present findings separately for each stakeholder group (i.e., case management, service providers and therapists, and judicial representatives), and then across the stakeholder groups. The results for each group are presented in three broad categories: 1) Evidence-based Interventions (EBIs); 2) Collaboration with Partners; and 3) System of Care Recommendations.

Case Manager Interviews

Case Manager Sample

The sample of 20 Children's Home Society (CHS) employees interviewed included dependency case managers, adoption case managers and independent living supervisors, dependency case manager supervisors, and a director. Of the case managers interviewed, the longest length of time employed with CHS was 12 years and the shortest was 4 months. The number of case managers and case manager supervisors with two years or less of employment with CHS was 13. Two of the case manager supervisors had eight or more years of employment in the field. Eight of the interviewees had a master's degree with all but one of these being a MSW. Among those with only bachelor's degrees, seven were in the field of social work.

Evidence-based Interventions (EBIs)

Do case managers rely on criteria to select EBIs? If so, what criteria are employed?

Case management responses to questions on EBI criteria indicated very limited knowledge about criteria for selecting EBIs. There were several case managers that recognized the importance of interventions being evidence-based. The interventions and services that were mentioned by the case management when addressing EBIs included Child-Parent Psychotherapy (CPP), Circle of Security (COS-P), Eye Movement Desensitization and Reprocessing (EMDR) Therapy, individual counseling, and parenting classes.

Instead of referring to a standard set of criteria, case management staff based their selection of services and therapies on their own assessment of the family in a case, recommendations from specialists with BBCBC or therapists that had conducted assessments of a family, and therapies and services that were available. Some case managers also mentioned the selection of a therapy or service based on their perception of the provider. Good rapport with families and receiving timely reports about the progress of a family in therapy were considered positive attributes for selecting a provider.

What are the strengths of the EBI models/services?

Due to the lack of familiarity with the evidence-based models available for serving parents in the BBCBC area among the majority of the case managers, the list of specific strengths of these models was not extensive. The overall impression of the available interventions was positive and there were several case managers that noted they were evidence-based. There was recognition among a few case managers that the models they were most familiar with (CPP and COS) were trauma informed and were based on a sound understanding of infant mental health.

Also mentioned as an intervention strength was the combination of more than one EBI or parenting course in a single session or series of sessions with one parent or family. EBIs and other therapies included in these combinations were viewed as more flexible and combining therapies was considered desirable in efforts to "streamline" or reduce the number of sessions a parent would need to attend. An example of a more common combination was CPP and COS which included an evidence-based therapy for parent-child bonding in CPP along with a focus on parenting skills in COS. Several case managers mentioned positive comments regarding individual counseling but there was not a particular therapy model associated with this reference to counseling.

What are the limitations of the EBI models/services?

Specific limitations of each EBI model were not shared by case managers. This was attributed to the lack of training and familiarity with the models available to the families in the BBCBC service area. Instead, limitations shared by the case managers referred primarily to conditions that could reduce the effectiveness of an EBI or other services. These conditions included:

- Parent lack of motivation and interest in participation

- Inadequate skills of a provider (engagement, cultural competency)

- Inappropriate "matching" of a provider with a client

- Inadequate number of visitation sessions each week between parent and child to reinforce the bonding and parenting skills learned in CPP, COS and parenting classes

- Low level of parent literacy

- Lack of transportation for parents to attend sessions

Other observations raised additional questions about the implementation of interventions. One noted the referral of a family to the same intervention after a subsequent finding of maltreatment and removal of a child. If there was a lack of success with one application of an EBI, justification for referral to the same EBI after another maltreatment finding seemed unjustified. One case manager raised a question about the effectiveness of EBIs for Spanish speaking subgroups. Another set of relevant observations referred to the need for a more comprehensive assessment of a parent and child's needs at intake. There was also concern mentioned frequently about the need for more providers. The general consensus among all case managers was that the demand for providers for EBIs and other therapies or services was greater than the supply, particularly in the more rural counties. In addition, there was interest in ensuring "choice" for parents in the selection of a provider for an intervention.

An intervention strength mentioned earlier was the combination of more than one EBI or parenting program in a single session or series of sessions with one parent or family. Examples cited were CPP, COS, and individual counseling for substance abuse or domestic violence. However, there was uncertainty expressed regarding the effectiveness of these interventions when delivered in a combined manner.

Individual counseling, which was not necessarily based on a single therapy model, had positive comments mentioned by case managers but there were also some observations that were negative. A positive comment referred to its flexibility. One negative comment was the lack of interest in counseling among young adults that were raised in foster homes and had extensive exposure to counseling as teens. One case manager mentioned there were bad treatment plans with some counselors that provided individual counseling. Another case manager mentioned that extensions for individual counseling will often be requested but a year of individual counseling is not necessarily successful.

What are the views of EBIs for prevention purposes?

In general, the majority of case managers supported the implementation of EBIs to prevent child maltreatment and the removal of children. This support referred to the importance of parents recognizing that they need "a little help in life" and more education about parenting can be a positive influence. Noting a lack of attention to prevention, one case manager stated, "More money gets spent on fixing the problem after it occurs as opposed to prevention."

While knowledge of the EBI program and service options available for prevention was limited in this set of case managers, there were specific examples of programs, therapies or services for prevention purposes mentioned. These examples included Healthy Families, Healthy Start, a Family Preservation Program, Intervention Crisis Counseling Services (ICCS), services offered at Boys Town, and the GAIN Assessment. It was noted by one case manager that she was not familiar with providers that actually deliver prevention services. The provision of services in-home with the child in-home was highlighted as an appropriate approach for prevention when domestic violence and substance abuse were not a concern. The voluntary nature of prevention services was identified as a challenge. How parents responded to voluntary services was also considered a learned behavior

that was transferred from one generation to the next. One case manager made a distinction between the ability to prevent removals among older children as opposed to the birth to five age category. It was this case manager's opinion that it was easier to prevent removals for the older children.

Are there EBIs that promote placements in least restrictive and most family-like settings?

The question addressing EBIs with least restrictive and most family-like settings created some confusion among case management but there were viewpoints shared. It was unclear to most of the case managers that there could be EBIs that promote least restrictive and family-like settings. The responses to this question focused primarily on the delivery of services in a home setting or in a "natural environment." CPP and parenting classes were two examples mentioned of therapies and services that have been delivered in the home. Promoting the location of therapies, one case manager shared, "other than in the office because people are comfortable in their own home. Going into your office base with the door closed, they tend to not be as engaged. So when they feel like I'm in my own space, they may open up more and participate more." Another comment regarding an office setting for CPP offered the following:

> …I think it is a loss when they're only seeing for CPP in the office. That is a created environment that is very calm, very manufactured, that doesn't allow for the stresses that a parent might incur when they're in the home in the moment.

There were also responses referring to child placements that were with relatives or placements that kept siblings together. One case manager shared references to foster parents that interact in a positive manner with the bio-parents and want the children and bio-parents to be reunited. A therapeutic office setting that looked more family friendly and like a home was also recognized as what is intended with this type of EBI. There was one provider identified as someone who would go to different settings where children in one family were located to provide services. Transporting children to a single location for therapy was not considered a family-like or family friendly approach by one case manager.

Are there EBIs that facilitate healthy family visitation?

Responses were focused on the visitation options for parents and children. The family visitation center was mentioned by several case managers. Two case managers highlighted the option to have a caregiver facilitating visitation between the bio-parent and the child. Relative caregivers were considered more likely to facilitate healthy family visitation. Supervised visitation was also noted as a requirement with most child removals and required supervision can impact where and how the family visitations occur. The family visitation center was identified as the most common location for family visitation.

Several case managers referred to CPP and parenting classes as EBIs that promote parent and child bonding and parenting skills and contribute to healthy family visitation. Parent-child visitations were viewed not only as opportunities for the parents and children to be together, but to practice skills and techniques that were being covered in the EBIs. Related to the opportunities to practice what is being learned in therapy and parenting classes, case managers noted a need for more guidance at the visitation center. Corresponding to the need for direction, another case manager highlighted the need for "therapeutic visitation." This usually involves the participation of a provider, usually a CPP provider.

Observation of the family interaction at the family visitation center was also considered important by several case managers.

Are there EBIs that facilitate successful reunification?

According to the case managers, achieving reunification is difficult, but usually the goal for permanency is set at 12 months. Case managers noted that the dependency court judge in Circuit 2 pushes for permanency within 12 months along with the providers that think parents are capable of reunification. Behavior change among the parents was considered a primary indication that the parents are moving toward reunification. The cooperation and motivation of the parents in completing their therapies and services was also considered key in reunification. Parent consistency in visits with their children was considered part of that motivation by one case manager. Post reunification services in the home for six months were also considered essential.

A few case managers noted the success that EBIs have had reunifying families. Regarding EBIs, one case manager stated the following:

> I think with evidence-based programs, I feel like we have more reunifications than less. I definitely think that using this model promotes safer reunifications and less chance of a child coming back into care. Prior to this, we were just working based off of a parent completing their services or not. And just because you complete a class doesn't necessarily mean you've learned anything from it. So we did have a higher instance of children—parents doing what they had to do getting their child back and then coming right back into care not six months later. So I definitely think looking at behavior changes will prevent that a little bit more.

CPP was mentioned as an EBI that leads to or facilitates successful reunification. As shared by one case manager, "I do see that it identifies attachment and who the child reaches for in a time of need. So, I see that changing. Normally, the child will run to me, but no, now, they're running to their parents. So, I do think child-parent psychotherapy is a good, good, good, good idea." The sequence of supervised to unsupervised visitations between children and their parents along with family counseling was mentioned as a combination that works toward reunification. Missing counseling sessions was also considered a major limitation toward reunification. As explained by one case manager:

> I think if the parent is open to the service and you have a provider that can speak with the parent and kind of show them that they're on your side, that definitely helps in promoting consistent visits, which obviously go towards a successful reunification. But, it's really that relationship. And I know we have limited amount of CPP people and people who can facilitate therapeutic visitation, but I know they work really hard with our families.

> Of course, we need more, but they definitely work hard with our families to facilitate it and to identify what their needs are.

However, multiple case managers emphasized that success in one therapy without success in parenting skills and addressing other needs is not enough for reunification. Among the major challenges facing parents who have had their child removed, substance abuse is considered a major impediment to reunification. Having the right services in place at the right time was also highlighted by one case manager in the following:

> So I think definitely making sure that the right services at

the right time are set into place. And I do think that the evidence-based model supports that a lot. Because to me it gathers information of the parents' readiness and of where they are as well as the children and where they are because the children has to buy into it as much as the parents because they eventually have to go back to living in this home from where they were removed due to whatever neglectful reason. So I think making sure that all of the pieces are a fluid team per se is definitely the key piece.

As a final observation relevant to reunification, twelve months was questioned by a couple of case managers as insufficient time for some parents to reunify. One reason for questioning this time period was incarceration which can delay initiation and progress on therapies and services. Addressing challenges with substance abuse and mental health were also mentioned as needs that take more time.

Collaboration with Partners

Who are the collaborating partners reported by the case managers?

Case management mentioned DCF, BBCBC, Dependency Court Judges, service providers and therapists, and CLS attorneys. BBCBC performed several roles but the primary responsibilities were to share information with the case managers to help with their services and to provide support in working with the families. Parent attorneys were mentioned as having a role with a preference for them to perform more like partners with those trying to work with and serve the families with their case plan.

What is positive about collaboration?

Many positive comments about collaboration with all of the partners were shared by case management. Their ability to work together at staffings, the benefits of several partners being located in the same building, and the responsiveness or "open door policy" of those who provide key information for case managers when working with families were common reasons for these favorable views. Despite challenges also expressed about communication with providers, there were still many positive comments and observations. The judiciary was also described in a favorable light due to working toward permanency, keeping everyone on track, and keeping the system accountable. Regarding collaboration, the following comments were representative of the views:

It's really all a collaborative effort because we have to have feedback from all these providers to assess what they're seeing in addition to what we're seeing to come to a joint decision on what's the best interest of the child or children.

I think those three (DCF, Big Bend, and CLS), I think we worked really well as a team, and I think that's partially because we're all housed in the same building. So, we have parts of Big Bend here, DCF is here, and CLS is also here. So, it makes communication actually easier and it worked great because if we have issues, we can just walk to CLS advice, and the same applies to Big Bend and DCF.

So, I really like the monthly meetings. You learn a lot. Because especially if you're new and you don't know where to find certain people or where to find a CPP provider or how to put in a request for a provider, it's very informative because it gives you the information.

They've (regarding providers) actually been good. They're very on their job. If you don't email them back, they will continue to contact you, but it's a good thing because it's in the best interest of the child. So, like I said, everybody has been good—I haven't had any bad run-ins with the providers. They're actually pretty good.

They're (regarding providers) very positive. I haven't had a bad issue with any service providers. As far as I'm communicating, they're always available for my families. They're always willing to help. Of course, they are, like I said different levels and I do get to know them so I know what's best for my families.

They've (DCF) always been willing to give information that's needed. That one's so positive. I mean we're not all doing it by ourselves. So everyone has a little part. I wouldn't know what to do if I had to do placement, Medicaid and everything.

A lot of our providers are just great. They understand. They've been providers in our network for a long time and so they understand what we're asking of them and why we're asking them what we need from them. And so, once they kind of get in the groove, they are great, they understand it. And so, if they continue to be one of our providers, it's usually because they get it and they can work with us.

I think we have a good community. I really like being in the building with Big Bend and DCF. It allows us to interact and network, and discuss cases accordingly. Like even when a case has been transferred to on-going services, with Children's Home Society after DCF is done with it, you could still go across the pod and talk to the investigator who knows the family well and see what's working and what's not.

Positive, I do think that the judge wholeheartedly gives the parents chances to be unified with their children and successfully be reunified with their children. And I think that she realizes that if the parents cannot be reunified and the department has worked with this family and offered all services and making sure these services are in place. And if the family is not ready, I can honestly say that our judge will support us and not reunify. And I think that that's a huge positive.

What is negative about collaboration?

There is no doubt that collaboration and communication between partners in the child welfare system is of the utmost importance. All case managers shared at least one comment that highlighted reasons for collaborating and at least one challenge confronting collaboration. One of the major challenges stemmed from needing more understanding of each other's roles and how they contribute to the overall goals of the family.

Articulating this point of view, one case manager stated the following:

I don't think that the communication is where it should be as far as everybody is concerned because everybody has their own way of thinking like PIs think one way. Case management thinks one way. And then Big Bend sees those as you all do the work type of thing in my opinion. So I don't think that there is enough communication and understanding of what each other does. I think that there's a lot of misconceptions of the case managers that they don't do this or they do this.

Narrowing the scope of the partner network to just providers, case managers made it clear consistently that communication with providers is often challenging. Examples of these challenges

included therapy reports not being submitted timely and it was often hard to reach providers due to their sessions during the day. Scheduling sessions in order to ensure parents and children could participate was also considered difficult. One case manager offered the following regarding communication with providers:

> I know sometimes providers don't understand our need for documentation. And even when it's something like counseling, parenting, things like that, we need to have progress reports. We need to at least have, when we're in the sessions that, "How many of these did our clients go to and has progress been made?" And sometimes we get a little pushback or we don't get it back and we have to put that in our judicial review documents. We have to update the court to say are we getting closer to our goal.

Whether or not case managers have a voice in decisions affecting families is another issue that several case managers noted. There are times when other professionals (i.e., CLS or a parent attorney) might take on a stronger role and not listen to the views of a case manager. Dependency judges can be demanding as well and require case managers to cover a lot of bases for the judiciary, including transporting children long distances for a court hearing. One case manager supervisor mentioned how case managers sometimes view providers as licensed with higher professional status and defer to their opinions rather than expressing their own.

Case Managers' System of Care Recommendations

Recommendations offered by case management covered both EBIs and collaboration and often as a combined approach. The need for communication between therapists, service providers and case managers was the overall emphasis in many of the recommendations. An excellent example of this overlap was the recommendation to have a periodic meeting or summit of the case managers and providers in order to share therapies and services and discuss ways to collaborate. It was also suggested that parents who were successful with reunification share their views on the services with the group.

In the next two subsections, we highlight the recommendations offered by the case managers that addressed primarily EBIs and providers and then collaboration among child welfare professionals.

Which recommendations referred to EBIs?

There were no specific recommendations to change EBIs and the models they adhere to. Instead, there were recommendations to facilitate the communication with providers and improve the conditions under which services are selected and participation occurs. A major recommendation was to improve communication between the case managers and the providers. There were several approaches suggested. One was to develop a database that allowed case managers to know which providers were available along with their credentials and models or EBI information. This was described by one case manager as very similar to a system that is currently used by BBCBC to remind case managers of tasks that need to be performed with the families they were serving. Information on insurance coverage was mentioned as an important component of this database. More timely approval of services for families was also considered an improvement that should be undertaken. More timely reports from providers about the performance of families in therapy and

while participating in services were also mentioned as essential by case managers. Better access to electronic information using tablets and other devices in home visits and in the courtroom was also thought to be helpful.

Another set of EBI recommendations referred to the need for more providers. There were several categories of families and needs mentioned for these providers. These included special needs children (i.e., children with developmental disabilities), psychiatric and mental health services, prevention services, adoptive family services, and dental services. The majority of case managers agreed with the need for more providers and mentioned several reasons to justify this recommendation. Current providers were described as being overloaded. Not enough therapy options in the rural counties was also shared as a concern that needed attention. One case manager shared that BBCBC should expand the number of providers serving their families and not necessarily rely on the same providers.

The location and timing for services was another set of recommendations. These referred to more in-home services and more guidance offered for the parents at the family visitation center. The location of multiple services in a community hub or service center (i.e., Panama City) was also mentioned as an appropriate way to improve accessibility to services. Turning to the question of time, another case manager expressed the concern that one year was not sufficient for some parents to complete their treatment and services for reunifying with their children. In these situations, the use of permanent guardianship instead of termination of parental rights was offered as an alternative. Two case managers proposed that CPP be offered after a family is reunited.

As a final recommendation related to EBIs, it was noted that parents need to cooperate and complete their services. As acknowledged throughout many of the responses by case managers, success with EBIs was not possible without parental participation and cooperation. Determining ways to address this was mentioned as a need for EBIs and for successful reunification. Conducting bio-psychosocial assessments was another recommendation that was offered during one case manager interview. This was shared as an approach to improve identification of services needed by a parent and other family members.

Which recommendations referred to collaboration?

Collaboration between and among case managers and providers was promoted by the vast majority of case managers generally with some offering specific suggestions. At the forefront, five case managers recommended a periodic meeting or summit with the case managers and providers participating. This was the major option for improving the communication and exchange of information between case managers and providers. It was intended to be an opportunity to learn more about the services available and the providers that deliver them.

Improved communication from providers about the parents and children they serve to the case managers was another recommendation. A database similar to what is currently used by BBCBC to inform case managers of their required tasks was recommended for providers. Better screening of providers for EBIs was also mentioned as a possible step in efforts to improve collaboration but also to improve the EBIs available to families.

Service Provider Sample

A total of seven service providers were interviewed. They included three therapists that provide individual counseling (CPP and/or COS), one counselor that was also a STEP provider, one Common Sense Parenting Provider, one Early Steps provider, and one Early Learning Coalition provider. Five of the seven providers had master's degrees. Four were licensed (3 LCSW and 1 LMHC). Each provider had one or more specialization. The number of years of experience among this group of providers ranged from seven to 26 years. The length of time each provider had been working with BBCBC ranged from just over 1 year to 16 years.

Evidence-based Interventions

What are the strengths of the EBI models/services?

The therapy model that stood out as one of the strongest evidence-based models serving families in the BBCBC was CPP. Therapists expressed their appreciation for this model due to its focus on the attachment between the parent and the child and the importance of treating attachment disorders. One provider mentioned the need to prevent the generational transfer of attachment disorders with CPP. The CPP model is also considered "trauma-informed" and "developmentally-informed." As explained by one therapist, CPP reinforces "how to help the family or the parent to help that child and process through it or how to better understand it so the child feels understood and supported and actually healed from that early childhood trauma." One description of experience with CPP was that "magical things happened." Another observation was that it was the only therapy that parents have been completing. CPP is also a key therapy in the early intervention court and the early childhood court programs in Judicial Circuit 2.

Another description of CPP emphasized the assessment and how it informs the therapy for a particular family. This view also stressed its flexibility. The following statements cover this perspective:

> I think that's one of the things I like about child-parent psychotherapy is it's not a cookie cutter. It's not one size fits all. You don't see exactly the same thing with each family. You really tailor it to the needs of the family. So, there are several points of focus but you really try to determine, when you're doing the assessment piece, which area needs to have more attention than others. So, it's a good guide.

The evidence-based reputation of CPP was also tied to rigorous training that was completed by providers in order to obtain the necessary credential to implement this therapy. Harris Center for Infant Mental Health in New Orleans was mentioned as the institutional location for the training program. A specialty in infant mental health was also thought to be valuable for CPP therapists.

Acknowledging the success of CPP with the families was consistent across the therapists that use CPP. One therapist described her views of CPP success reunifying parents with children as follows:

> I have two families right now that have been reunified with their children because of the child-parent psychotherapy work that we were able to do together and I was able to go and inform the court and their case manager that there are positive behavior changes and that the children—that

> the parents are exhibiting safety and able to read their children's cues and the children are responding to that. That's a yes. I've seen it work amazingly well for these at the prevention and as court reunifying these children with their parents.

Circle of Security (COS) is another evidence-based model that had high regard among therapists that use it. It is considered a parenting intervention. One therapist indicated she uses it with "any child of any age with the parent that is really struggling with how to deal with their children's behavior issues" and elaborated on her thoughts in the following:

> If the parents are struggling with how to deal with children's behavior problems, which a lot of them are, and don't know how to really—time out doesn't work and this doesn't work. And Circle of Security is so good because it comes from that reflective functioning approach and really asks the parents to look at how they were parented and how that informed their parenting.

> And how to use a time in instead of a time out, how to help your child to learn how to regulate their emotions, how to regulate your own emotions, how to do that check-in with yourself, give yourself a timeout when you feel you're getting angry because your child is having behaviors, how to keep that in check with yourself.

What are the limitations of the EBI models/services?

Comparing the amount of attention the therapists and service providers gave to model strengths as opposed to limitations, the strengths were emphasized more than the limitations. The limitations referred primarily to conditions or situations that made the implementation difficult and/or diminished the effectiveness of the therapy or service. Some of the limitations were labelled barriers and there was a separate theme coded for this purpose. For those using CPP, a background in infant mental health was considered essential in order to be effective with CPP. The intellectual capacity of the parent also needed to be sufficient in order to benefit from COS. Forming a COS group was also considered important by a therapist that uses COS. It was difficult to form such a group for COS during the study time period. Referring to another evidence-based model, STEP, the capacity of STEP to address ADHD and other disabilities in children was not clear.

Cooperation and motivation of the parents to engage was considered key by all providers. This was important for participating in the therapies as well as having the desire to help their children. Contributing to the challenges with parent cooperation, securing transportation to the sessions was considered a barrier for some parents. Scheduling at least four recommended visitation sessions each week was also considered a barrier that required more creativity in identifying relatives and members of a support network that could supervise visitations.

Parental co-existing or co-occurring conditions were recognized as a major challenge affecting EBIs. In order to treat all of the conditions, several therapies and services needed to be in place. One provider stressed the inadequacy of relying on one therapy to address all of these conditions, particularly when reunification was the goal. It was also the view of one provider that one year was not long enough to treat these conditions which made it impossible to reunify within the permanency time frame.

Turning to the multiple needs of children, one provider mentioned the importance of quality child care. Not necessarily evidence-based or one of the parent EBIs, licensed child care was considered essential for children in the child welfare system.

What are the views on EBIs for prevention purposes?
The use of therapies and parent training for prevention purposes was supported among the providers. A couple of the providers mentioned conducting COS and CPP for people even before they are parents or during pregnancy. STEP was also mentioned as a good program for learning to parent. The need to educate mothers of first born children in the hospital where they delivered was emphasized by a provider.

Collaboration with Partners

Who are the collaborating partners reported by the therapists and service providers?
The collaborating partners reported by the service providers were BBCBC, other therapists and service providers, dependency court (early intervention court and early childhood court programs), CHS and Guardian ad Litem (GAL). There was also reference to the bio-parent, foster parent, relative or nonrelative caretakers as being key participants in staffings.

What is positive about collaboration?
The benefit of collaborating was recognized by all providers, CPP, Early Learning Coalitions, Early Steps, and individual counselors. As stated concisely by one provider, "collaboration with other professionals is invaluable in informing work with clients."

According to the therapist and service providers, collaboration has emerged in the form of programs and professional groups. Two programs requiring collaboration that were mentioned were the Early Intervention Court and the Early Childhood Court in Dependency Court in Judicial Circuit 2. A professional group collaboration was called an early trauma-informed group. Referring to the trauma group, one provider stated, the "trauma-informed parent group and different community partnerships, organizations, have really been helpful and really helped keep me up to date with just different trainings going on, professional trainings, and then also, just collaborating with all of these different systems." Staffings were also highlighted as a form of collaboration for each professional to bring his or her concern to the table and make sure all needs are being met for a family.

What is negative about collaboration?
Compared to positive views, there were fewer negative views of collaboration. The inadequacies in collaboration referred primarily to not enough communication between professionals serving one family. One service provider shared that she was not updated promptly and might not know the status of a child's placement and/or reunification before meeting with a parent in a staffing. Talking "about" a parent instead of "with" a parent when a parent is present in a meeting of professionals was not considered appropriate collaboration. The parent should be invited to participate in the discussion. In addition, one service provider mentioned the importance of being more inclusive in staffings. As an example, foster parents, relative or non-relative caregiver and bio-parents should be invited to staffings in order to get a comprehensive picture of what is happening with a family. Limited or no communication with substance abuse providers was considered a weakness among the therapists and service providers interviewed. Low numbers of referrals for parenting classes was considered a limitation and not sufficient

collaboration by two service providers. As a final negative observation, it was shared that high turnover among case managers made collaboration more difficult. In addition, it was asserted that there was insufficient education and training of the case managers to allow for the level of collaboration needed.

Therapists and Service Providers' Recommendations for the System of Care
The recommendations offered by these professionals addressed several aspects of EBIs. They addressed ways to remove barriers to participation and introduced approaches to improve their effectiveness. Better collaboration was often an option highlighted in efforts to improve the EBIs and other services for families. Improving EBIs and improving collaboration were often connected. More frequent communication among those in all roles serving a family was a major recommendation. More collaboration and communication with other providers in order to streamline the services and not overwhelm the families was another recommendation.

Which recommendations refer to EBIs?
While the need for multiple EBIs and other services was not questioned, it was recommended that the services not overwhelm families. Case plans that were loaded with services were thought by one provider to be setting parents up to fail. Ways to streamline and combine services while maintaining effectiveness were being attempted. CPP and COS were examples of combining therapies to address attachment disorders and parenting together. However, there were still concerns about whether this combining of therapies was sufficient to meet all of the needs of parents, particularly when there were multiple co-existing conditions that needed treatment. The one-year time frame was also considered problematic for some parents with co-existing conditions needing treatment.

Directing more attention to childcare services was another recommendation. This theme was not included in the initial selection of themes for the qualitative analysis. Specific reference was made to the childcare available for children during the day. Quality childcare in licensed facilities was considered essential. There was also interest in having more therapies available for children, particularly after reunification in the home. Extending therapy sessions with children to 90 minutes was another recommendation offered by one of the therapists. It was also suggested that Guardians ad Litem (GAL) have more contact with the parent in order to have a more comprehensive understanding of the family.

Which recommendations refer to collaboration?
More collaboration and better coordination were mentioned frequently as recommendations. This emphasis was also apparent in several of the recommendations that referred to EBIs. More specific collaboration recommendations are listed below:

- Need to have more contact with substance abuse providers and they should participate in permanency staffings.

- Staff at the family visitation center should attend staffings since they are with the parent and child for substantial periods of time.

- Domestic violence and dependency service systems should work more collaboratively.

- Therapists and parenting educators should get together in order to discuss needs and how to deliver appropriate

services. Identifying which parents can benefit the most from parenting classes and when they should be engaged in these classes should be part of this discussion.

- There should be more training brought to the community for providers and therapists to expand their knowledge and expertise.

- Parents should be given an opportunity to share their needs and suggestions for services.

Judicial Representative Interviews

Judicial Representative Sample

A total of six judicial representatives in the dependency court system were interviewed. The interviewees included judges, magistrates, and court administrators.

Evidence-based Interventions (EBIs)

Do you rely on criteria to select EBIs? If so, what criteria are employed?

Responses to this question highlighted several points that are noteworthy. First, it was clarified by all judicial representatives interviewed that it is not the responsibility of the judges or the judicial staff to select the actual provider for the delivery of a service. The separation in responsibilities between the judiciary and DCF or BBCBC was explained and emphasized by all of the judicial representatives interviewed. Second, the knowledge and experience of most of the judicial representatives with EBIs were evident in their responses and usually indicated a particular preference for EBIs. There were no standard sets of criteria for EBIs in BBCBC shared by the judicial representatives. However, there were preferences for EBIs expressed by a few. CPP, didactic parenting, EMDR, and individual counseling for substance abuse, mental health and domestic violence were all mentioned as important services.

It was also acknowledged by a couple of the judicial representatives that not all therapies and services were officially EBIs. One judicial representative identified the California Evidence-Based Clearinghouse for Child Welfare (CEBC) as one source for identifying EBIs. In addition, two judicial representatives noted that not being classified as an EBI by one of the sources that have assumed the authority to identify EBIs (i.e., CEBC) did not necessarily mean a therapy or service was not beneficial. Some parents want to select their own counselor and this was still considered acceptable by more than one judicial representative. As stated by one judicial representative, "certainly you can have really good therapists out there that are not evidence based. They are small operators. They just don't have the means to be evidence based but you are getting a lot of good feedback."

Another relevant point shared by one of the judicial representatives elevated the need to focus on the actual progress of the parents and not just the program or service they are referred to. The following comments pertain to this line of thinking:

> I'm not trying to evaluate how good the particular program was or is. I'm trying to assess progress by parents. Do they show that they're getting it, whether from that particular test they were working on, or because they got hit on the head, or somebody talked to them and they had an "aha moment"? Because what I'm looking for is a sign where we

can get the child permanency, particularly in the case where the child has been sheltered from the parents and is in out-of-home care.

What are the strengths of the EBI models/services?

There was certainly a keen interest in and support for high quality services. The importance of and desire to provide quality services for parents was expressed in the following comments by one judicial representative:

> If I am ordering people to do it, I want to make sure that it's a worthwhile intervention. I don't like to just order parents to do things that are not going to have a measurable impact on their ability to be better parents. I don't want to just load parents up with busy work. So I do have…I'd say just from a heartfelt concern about re-education if their children were in foster care. I mean I have a heartfelt compassion for parents that they are going to get to services that they need and that they are going to be quality services.

CPP, EMDR, and didactic parenting were examples of interventions that were viewed as successful. CPP received special recognition as an EBI by multiple judicial representatives. It was labelled by one judicial representative as a "crucial tool," and by another as the most promising. One judicial representative mentioned that parents actually thank her for being referred to CPP. References to the presentations on early childhood court and CPP conducted by Dr. Mimi Graham and Judge Cindy Lederman were shared by multiple judicial representatives. Some attended workshops conducted by these two professionals. Referring to a provider of CPP, one judicial representative stated the following:

> I can't remember exactly what she did but my memory was that she was the one that gave me most confidence that she was actually evidence-based and had gone through the evaluations to actually confirm that the service that she was providing was evidence-based service — that we could have a reliable prediction of what the outcomes were likely to be.

Additional observations on the strengths of CPP are in the following:

> And at least with the child-parent psychotherapy it was intensive, it was frequent, it was monitored. There was structure in evaluations so that you can monitor the progress and they had data points that they were specifically looking for. I am not a scientist but it seemed at least like there was an attempt to measure outcomes.

As a final strength relevant to CPP, it was shared that CPP can be offered with more than one service to treat multiple issues. Domestic violence was an example of another need that could be addressed when also using CPP.

Didactic parenting provided in Gadsden and Wakulla also received glowing praise from one representative. There was a general understanding shared that this service was conducted in-home. Despite the positive view of didactic parenting, its status as an EBI was also questioned. It had not been "certified" as an EBI.

What are the limitations of the EBI models/services?

Similar to the views of other stakeholders, the limitations of EBI models and services did not refer to specific components of the models. Instead, they refer to the challenges and limitations

confronting the parents. These are basically the barriers that make it difficult to deliver the therapy or service. No transportation was one of the major barriers mentioned. There was also a concern regarding delays in the initiation of services. Delaying a service can result in a reduction in parent interest and motivation to participate which can limit the success of a therapy or service. The small number of "qualified" therapists was also considered a limitation, particularly in the rural counties.

One judicial representative highlighted limitations by describing parents in three categories. The categories that are not successful with the available therapies and services have either a substance abuse or mental health condition that makes it not feasible to treat them within the required time period for permanency or do not have the intellectual capacity for engaging in and benefiting from the therapy. The parent category that is successful is described in the following:

> About one third of the parents that come into the dependency system are people that have normal IQs, write, function more or less normally, and they have made mistakes. Either they went overboard on corporal punishment with the child, maybe there was a sexual abuse issue with a paramour versus the mother. Maybe they developed a drug habit… that one third, often responds very well to the parenting interventions because they recognize upfront and early in the case they made a mistake. They avail themselves of the courses, and then we have a tremendously good outcome and we're able to close the case.

Another limitation refers to the importance of triaging services. By not triaging services based on needs, the success of a therapy model that is more appropriate at a later stage in a treatment plan is compromised. Making sure the parent is "clean" before initiating CPP or another EBI was considered imperative by multiple judicial representatives. The limitation is due to an inappropriate sequencing of services. The absence of a comprehensive assessment (bio-psychosocial) was also mentioned as contributing to this limitation.

What are the views on EBIs for prevention purposes?
There was recognition among all judicial representatives that EBIs for prevention purposes are key. This view was often aligned with support for prevention overall along with consensus on doing "a better job of prevention upfront." One judicial representative mentioned the importance of getting information to parents as soon as possible, even in the hospital when their first child is born. References to adverse childhood experiences (ACE) were made and added to the support for prevention. Interest in rebranding maltreatment and dependency were also connected to the prevention focus. Healthy Start and the Early Learning Coalition were also mentioned as examples of prevention programs.

Are there EBIs that facilitate healthy family visitation?
There was acknowledgement by multiple judicial representatives that the experience of parents in the EBIs influenced decisions regarding advances to unsupervised visits for the parent and child. Providers that have positive reports of parent progress can be evidence that a parent is ready for healthy visitation and the child will have a higher level of safety.

Are there EBIs that facilitate successful reunification?
Confidence in EBIs to facilitate successful reunification was expressed by several judicial representatives. However, there are conditions that determine the level of success. Parent

engagement and motivation is part of this. The characteristics of the parents are key in success. Only 1 out of 3 parents was identified by one judicial representative as having a higher probability of success.

Collaboration with Partners
What is positive about collaboration?
Collaboration is important but the judicial representatives emphasize their special role in the child welfare system. This role is addressed by one judicial representative in the following:

> Keep in mind that different judges approach things differently. Some have more of a collaborative approach and as a member of or part of the team. But my view as a judge is to make sure the law is being followed. In regards to the social worker or a psychologist, I need to understand from the evidence if they're making progress.

In addition, the judges are not authorized to select an individual provider but a ruling can require a service to be provided. The selection of the provider is the responsibility of DCF or BBCBC. A judge might also set requirements related to education; for example, not allowing a child's education to be disrupted by changing schools. As stated by one judicial representative, "My role is not to pick them, but again to see how the parents and the therapists are interacting and are the parents progressing."

The early childhood court was perceived as a positive form of collaboration. One judicial representative shared their support in stating, "I like the idea of early intervention and an intensive monitoring that's going to happen with the Early Childhood Court." Another example of positive collaboration mentioned was the community alliance which includes the participation of service providers.

What is negative about collaboration?
The negatives highlighted about collaboration refer primarily to failures in or concerns about communication gaps in the child welfare system. One example was the inadequate communication between foster parents and bio-parents when children are going to doctor appointments. Another was delays in services when a Purchase of Services is submitted but it takes too long for providers to respond and to get services approved and in place. The absence of child psychiatrists was also considered a problem by several judicial representatives. As a final point relevant to collaboration, it was clarified that judges are not "specialists" in the dependency court and there can be two year rotations which can limit the expertise and capacity to collaborate more fully.

Judicial Representatives' System of Care Recommendations
The recommendations suggested by the judicial representatives address a wide range of issues. They stem from concerns that focus on timely services, recruiting more providers of EBIs, particularly in the rural counties, triaging services based on needs, and outreach into the community to educate on trauma and the need for trauma-informed services.

Which recommendations refer to EBIs?
Several of the judicial representatives had an impressive level of knowledge regarding EBIs and what therapies or services can be successful with families that have children birth to five years of age. Continued support for the early childhood court was front and center in the thinking of several judicial representatives interviewed. The need for more EBI providers is reflected in the following recommendation:

> If I had to summarize it, my recommendation would be to

> go out into the community and find Medicaid-accepting professionals that are willing to get certified in evidence-based training and make services to the DCF case as part of the regular business model.

In addition to the recruitment of more EBI providers, there was support for certifying more therapeutic approaches as EBIs. Didactic parenting is an example of a therapeutic model that is highly regarded but does not have the evidence base that is considered necessary for a classification as an EBI. Several counselors are considered competent and there was a general sentiment shared that if a parent prefers a particular counselor, there will be acceptance of that provider for that parent. While utilizing an EBI is seen as a gold star and should be encouraged, there is also an understanding that there is a variety of providers and therapeutic models that can be beneficial for parents. The parent's engagement with the approach and the provider is seen as just as important.

Another view shared referred to the resources that are needed to implement EBIs. The following explains what this entails:

> The problem is the resources to attract qualified people or make qualified people. And then the resources to make certain that you are doing the follow up, to make certain that the evidence-based provider is actually providing evidence-based care and treatment so people are maintaining their knowledge of the state of the evidence in the state of the art. I don't think it's commitment. I think it's resources.

The importance of triaging services was a shared view among several judicial representatives interviewed. The need for parents to be treated for substance abuse before initiating CPP or other therapies was clear. Conducting assessments early was connected to the push for triage.

As a final focus, rebranding and developing a community that is better informed about trauma was highlighted. A family law day was one suggestion voiced to begin that process. The following presents this emphasis:

> But also a re-strengthening of what our policy is here in our second circuit which is that we lower conflict, that we have positive parenting for children, that we limit high conflict for children in the litigation process, that we do preventative measures, that we do education at reach so that people can understand zero to three is when your children's brains are growing and that they actually physically change when they are exposed to the conflict.

> This message to be brought out has to be brought out from everywhere so that everyone in the community embraces it in my opinion.

Comparison of Three Stakeholder Groups

A comparison of the three stakeholder groups in the key informant study is valuable. The combination of the results for each stakeholder group provides a more comprehensive understanding of the themes in this qualitative analysis and can help create a foundation for introducing better approaches and practices that will improve services for families. Differences across the groups were expected. One reason for these differences is the professional training that is required for each group. The working environment for each is different and their roles in the child welfare system are unique. The context that each professional

is in can be an important contributing component in the entire system of care. The themes selected for the comparison of the stakeholder groups are:

- Criteria for Selecting EBIs
- Strengths of EBIs
- Limitations of EBIs
- Collaboration Positives
- Collaboration Negatives
- Recommendations for System of Care

Criteria for Selecting EBIs

Responses addressing criteria for selecting EBIs were only asked of and provided by case management and the judicial representatives. Before offering their opinion on criteria, the judicial representatives emphasized that their professional responsibilities did not include the selection or payment of providers. Neither group mentioned a reliance on a standard set of criteria for the selection of EBIs in the BBCBC. Knowledge of the existence of a national standard for rating EBIs was more evident in the judicial representative group. The California Evidence-based Clearinghouse for Child Welfare was one of the national rating sources mentioned by two judicial representatives.

Strengths of EBIs

The case managers and judicial representatives mentioned a very similar list of parent therapies and services. These included CPP, COS, individual counseling, EMDR, didactic parenting, Common Sense Parenting and anger management. All groups had a favorable impression of EBIs and expressed a desire to have EBIs as services for families. The providers of CPP and COS emphasized the extensive training they received and the specializations that were considered helpful in practicing these therapy models. Multiple providers mentioned assessments that were conducted in order to determine needs before the therapies were initiated. Not all service providers interviewed were providing EBIs but all providers thought that their services were valuable and part of a team effort. Early Steps and Early Learning Coalition services were two categories of services that were represented among the providers interviewed but were not mentioned by case managers or judicial representatives. It was also acknowledged by members in each group that not all services available for parents and children were EBIs. Case managers and judicial representatives identified strengths of services and therapies that were not EBIs. Didactic parenting was one example of a therapy that was not classified as an EBI but still considered very successful as a therapy. Individual counseling was also identified as successful by some case managers and judicial representatives. It was also noted by case managers and judicial representatives that some parents selected their own counselor for addressing substance abuse and other challenges. In the case managers and judicial representative groups, some providers were considered more competent and responsive than others and this was considered a very important element in the strength of a therapy or service. Delivering services in-home was considered the best delivery method among several case managers and judicial representatives. Some of the providers (Early Steps and Early Learning Coalition) mentioned that their services were in-home but the CPP providers did not describe their services as being in-home.

In summary, all three stakeholder groups supported the use of EBIs for families in the child welfare system of care. The EBI therapy mentioned most frequently was CPP. However, there was still support for other therapies and services that were not necessarily EBIs. Individual counseling was one of these. Case managers and judicial representatives recognized that some providers are more competent and more responsive to the families in the system of care. While in-home delivery for therapies and services was a preference among multiple case managers and judicial representatives, the EBI providers participating in this study deliver their therapies in an office setting.

Limitations of EBIs

Despite the overall favorable perception of EBIs, there were several limitations relevant to EBIs mentioned in all three stakeholder groups. These limitations were not always directed to the underlying principals and practice techniques in the actual therapeutic model or approach. Instead, they focused on conditions that were barriers and made the therapy less effective or successful. Lack of parent motivation and transportation challenges were two barriers noted across all three stakeholder groups. The limited cognitive capacity of a parent to participate was also mentioned in all three stakeholder groups. CPP/COS providers mentioned the challenge of forming a parent group which is an important component of their therapeutic model. Limited opportunity to practice skills learned in therapies in family visitation sessions during the week was another concern mentioned by all three groups, particularly when parents do not show for their scheduled visitations. Delay in the initiation of therapies and services was emphasized as a limitation across all three groups. As a final limitation, inadequate resources were believed to be the reason for the shortage of providers, particularly in rural areas. It was agreed by all three groups that there needed to be more providers.

Collaboration Positives

Collaboration in the child welfare system of care was viewed as desirable by all three stakeholder groups. However, there were some differences of opinion between the groups that were noteworthy. Judicial representatives set themselves apart from case management and providers in the system of care. One distinction made was that the judiciary's role was to enforce the law. It was also made clear by the judicial representatives that the judiciary does not select the providers. The providers thought collaboration among child welfare partners was helpful, but mentioned their special appreciation of collaboration among those delivering the same model, such as CPP. They also stressed the need to have better communication with case managers and to educate others about their therapies/services. Case management was the most committed in their views supporting collaboration. They mentioned the highest number of collaborating partners and valued the co-location of key child welfare professionals that made it easier to communicate in person about their cases. They also wanted more opportunities to collaborate through representation of key providers at staffings and summits that allow providers to introduce themselves and their therapies or services. Case management viewed the judiciary as demanding but also maintaining accountability while moving each case to permanency.

Collaboration Negatives

Despite the overwhelming support for collaboration in the system of care, there were several negative views of current collaboration mentioned in all three stakeholder groups. Challenges collaborating were the primary focus of the negative views. These views also varied to some extent across the three stakeholder groups.

Both case managers and service providers found it difficult to collaborate with the high level of turnover of staff in DCF. Case managers thought the judicial expectations of case managers were unreasonable sometimes, particularly when children had to be transported long distances for court hearings. The failure of some providers to submit reports timely was considered problematic by case managers. Delay in the approval of services by BBCBC was considered unfortunate by both case manager and judicial representative groups. Service providers thought there was a lack of understanding of their therapies among case managers.

Recommendations for Collaboration and Evidence-based Interventions

There was some overlap between stakeholder groups in recommendations for the system of care. The need to improve collaboration and communication between case managers, providers and other child welfare professionals was recognized across the three groups. Each group shared different reasons and approaches for improving this collaboration. Service providers mentioned substance abuse and domestic violence providers as two professional categories that needed to have more communication with the dependency system. It was also suggested by a service provider that providers of parenting classes meet with parent/child therapists to discuss ways to meet the needs for the families. All of the barriers and challenges mentioned with EBIs across the three stakeholder groups signaled a need for attention in the final set of recommendations. Lack of parental engagement, motivation and transportation were the most common barriers highlighted. The adequacy of one year for treating the challenges in the families was questioned by case management and service providers. Since the law requires permanency within one year, the judiciary had a slightly different perspective but there were examples shared in which the permanency decision was extended beyond one year by the judiciary. Interest in and support for in-home services among case managers and the judiciary highlighted the need for more of these services. Concerns about the achievability of case plans were mentioned by service providers, case management, and judicial representatives. This concern led to suggestions that services be triaged and based on a bio-psychosocial assessment. Case management and the judicial representatives were adamant about the need for more providers. One of the judicial representatives presented a plan for recruiting providers. Community education on trauma was another recommendation that was emphasized by service providers and judicial representatives. Adopting a prevention strategy was supported by all three stakeholder groups. A judicial representative and service provider targeted moms immediately after the birth of their first born for more parenting education.

Table 1: Summary Comparison of Three Stakeholder Groups in Key Informant Study

Theme	Case Managers and Supervisors	Providers	Judicial Representatives
Criteria for Selecting EBIs	No standard set of criteria for selecting EBIs in BBCBC	Did not ask this question of providers	No standard set of criteria for selecting EBIs in BBCBC
Strengths of EBIs	Favorable view of EBIs (trauma informed) EBIs mentioned were CPP, COS, and EMDR Support for non-EBI therapies/services Provider is key (skill, communication with case managers and other partners)	Favorable view of EBIs (trauma informed) EBIs mentioned were CPP, Early Steps, Early Learning, STEP, and Common Sense Parenting Assessments are important part of EBIs Intensive training for EBIs	Favorable view of EBIs (trauma informed) EBIs mentioned were CPP and EMDR Support for non-EBI therapies/services because they are still successful with families
Limitations of EBIs	Some families come back into the system after participating in an EBI Identified barriers that make EBIs and other services less successful (parent motivation, transportation, cognitive capacity) Delay in initiation of services	Need visitation to practice skills learned in therapy Challenge to form a parent group for EBIs (CPP/COS)	Some parents prefer a counselor that is not an EBI provider and want to support that preference Identified barriers that make EBIs and other services less successful (parent motivation, transportation, cognitive capacity) Delay in initiation of services
Collaboration Positives	Collaboration with professional partners is essential Co-location of professional groups working on cases is very helpful Judiciary keeps everyone accountable	Collaboration among all professionals working with families is important, but particularly appreciate collaboration among therapists providing the same therapy	Support collaboration among professionals working with families but judiciary has a separate role from others that does not always allow them to be a member of the team
Collaboration Negatives	Staff turnover makes collaboration more difficult Judicial expectations are unreasonable sometimes	Case manager turnover makes collaboration more difficult Some available services not getting sufficient number of referrals	Delay in initiation of services
Recommendations	Need to improve communication and collaboration between all professionals serving families in the child welfare system Need to address service barriers (parent engagement and transportation) Case plans need to be achievable Need more services that can be delivered in-home Need more providers Need more prevention Need more community education on trauma	Need to improve communication and collaboration between all professionals serving families in the child welfare system Need to address service barriers (parent engagement and transportation) Case plans need to be achievable	Need to improve communication and collaboration between all professionals serving families in the child welfare system Need to address service barriers (parent engagement and transportation) Case plans need to be achievable Need more services that can be delivered in-home Need more providers Need more prevention Need more community education on trauma

Discussion

This section begins with a review of the research literature on essential components and features of parent training in this at-risk population. In the implementation proposal, parent training EBIs were the primary focus. However, there were also references to parent therapies and the implementation of multiple EBIs in the review which ensures its continued relevance in this project. Selected findings are presented from each of the two studies next. Findings in the implementation study were based on therapy delivered by one provider to 10 parents and their children. This provider conducted an assessment of each family and then designed a therapy plan that combined CPP and COS in sessions as needed. Some of the parents were also in the Early Intervention Court or Early Childhood Court programs. The findings from the key informant study are based on interviews with three stakeholder groups: 1) case management, 2) therapists and service providers,

and 3) representatives of the judiciary. Major findings presented for the key informant study draw primarily from answers to a research question that addresses EBIs. This section also includes a discussion of research limitations which refer primarily to the low sample size and methodological challenges in the implementation study. At the end of the discussion, a review of recent literature on evidence-based service planning (EBSP) is included and several practical applications are presented as recommendations for the BBCBC system of care.

Review of the Research Literature on Parent Training

Important Components and Features of Parent Training Programs

Barth et al. (2005) identify four major phases or components in parent training that lead to effective outcomes. These are: a) parenting problems are assessed; b) parents are taught new skills; c) they apply their skills with their children; and d) they receive feedback about that application (p. 354). In addition to phases

or components, Barth (2009) describes the importance of the "potential use in multiple clinical and service applications, including development of benchmarks for assessing quality of care; simplified therapy training efforts focused on key techniques as opposed to individual treatment manuals; and use in developing individualized modular or stepped-care interventions that fit the unique characteristics of the clients rather than the vision of the treatment designed" (p. 106) in parent training. Other important features include: a) early intervention; b) a strong theory with mechanisms of change; c) targeting interventions at those with parenting difficulties; d) ability to recruit, engage and retain parents in the program; e) variety of referral routes for families; and, f) multiple methods for delivering program content (Barth, 2009, p. 106). In addition, group work may be suitable when the parenting challenges are not too severe (Barth, 2009).

In their meta-analysis of parenting programs, Kaminski et al. (2008) found that content on strengthening the parent-child relationship and opportunities for parents to practice with their child during the sessions were "robust predictors" of positive outcomes for parenting behaviors or skills and child externalizing behavior. The quality of the child-parent interaction was enhanced with parent training in which parents learned positive interaction and emotional communication skills. The inclusion of the practice component in training sessions offer opportunities to reinforce appropriate behaviors and provide immediate corrective feedback as needed.

Several successful parent training programs identified in Barth et al. (2005) do not identify one recommended location for parent training. While there is extensive research on home visiting that considers the home a desirable location for engaging a family, sharing parenting information, and referring families to community services, the home is not necessarily a preferred location for parent training. Exceptions to this are based on the extent to which "individual work" requiring "one-to-one tailored support" is needed (Barth et al., 2005, p. 106). When groups are used, the training commonly occurs at a community or clinic setting. Several parent training programs specify multiple locations that are appropriate.

Challenges and Avenues for Future Research

The evidence to date indicates that parent training programs can make a positive difference in the lives of families in child welfare (Barth, 2009), but there are challenges. These challenges not only impact program implementation but also affect efforts to ferret out the specific features of programs that are most responsible for a program's achievements toward promoting positive change. Some parents and children have clinical needs that extend beyond what a single training program can address (Barth et al., 2005). For instance, behavior associated with trauma can be common among children who have experienced maltreatment. In addition, the challenges of parental alcohol and drug abuse, mental illness and domestic violence are often present among families involved in the child welfare system. The extent to which parent training can affect parenting outcomes under these circumstances is not clear. More specifically, it is not clear how parent training can be a benefit in addressing these issues (Barth, 2009). Attempting to tackle too many issues at once can degrade the success of a single program or treatment.

Another challenge is identifying which families are appropriate for each parent training program (Barth et al. 2005). A family with a very high level of maltreatment risk might not be a good candidate for parent training. The types of maltreatment that brought the family into child welfare can affect a family's acceptance of and

performance in a parent training program (Hurlburt, Barth, Leslie, Landsverk, & McCrae, 2007). It has also been suggested that participation in a parent training program can be an opportunity to observe a parent for assessing their needs and planning future referrals after the parent training has ended (Barth, 2009).

While an impressive body of research on parent training performance has been produced, more research is needed (Barth & Haskins, 2009; Barth et al., 2005; Barth, 2009). Not enough is known about the specifics with regard to implementation and delivery of parent training. Future studies need to not only capture their impacts on parent and child behavior as a standalone intervention, but also when the training is part of a more comprehensive intervention or accompanied by a constellation of other interventions that are offered to address families with complex and multiple needs in child welfare. In the current project, a combination of COS and CPP techniques were implemented when mother-child attachment and trauma needed to be addressed. Barth, et al. (2005) suggests that learning from current parent training might help develop a new generation of parent training programs. Better assessments that more accurately identify the risks and needs, as well as the strengths of families can improve our understanding of which families should be targeted. Educating the court system as well as social service professionals on the appropriate evidence-based expectations for parent training is also called for (Barth et al., 2005).

Implementation Study Major Findings

The aim in the implementation study was the evaluation of EBI parent programs. CPP was the primary EBI that served as the focus but techniques in COS were combined with CPP in treating some of the parents in the study. From these findings, recommendations for future implementation of parent programs and services in a system of care are provided. Because only one provider participated in the study, it was not possible to compare multiple parent programs and services across providers. The formative components proposed in the implementation study were also not achievable due to the unavailability of information. Measures that address the CFSR outcomes that could be calculated with the available data are listed below:

Child Safety
Outcome 1: Children are first and foremost protected from abuse and neglect.

- Percent of children birth to five with no verified maltreatment during participation in the parenting program:

  » *100% or 14 of the 14 children had no verified maltreatment during participation in the parent program.*

- Percent of children birth to five with no verified or not substantiated maltreatment during participation in the parenting program:

  » *100% or 14 of the 14 children had no verified or not substantiated maltreatment during participation in the parent program.*

Outcome 2: Children are safely maintained in their homes whenever possible and appropriate. Percent of children birth to five remaining in-home during the parent program:

  » *0% or 0 of the 14 children remained in the home at the time of initiating their therapy.*

Child Permanency

Outcome 3: Children have permanency and stability in their living situation.

- Percent of children birth to five with one placement during the parenting program:

    » *57% or 8 of 14 children had only one placement.*

- For those families that had child(ren) removed prior to the parent program, the percent of children birth to five that reunified during the program:

    » *7% or 1 of 14 children were reunified during the parenting program.*

Child Well-Being

Outcome 5: Families have enhanced capacity to provide for their children's needs.

- Percent of parents at a high level of parenting skills (Sense of Parenting Competence Scale):

    » *33% or 3 of 10 parents that completed the Sense of Parenting Competence Scale before CPP/COS had a high level of parenting skills. (Number of parents that had 5.5-6.0 average on the strongly agree items and 1-1.50 on the strongly disagree items).*

    » *33% or 1 of 3 parents that completed the Sense of Parenting Competence Scale after CPP/COS had a higher level of parenting skill after CPP/COS.*

- Percent of parents at a high level of satisfaction:

    » *100% or 3 of the 3 parents that were interviewed had a high level of satisfaction with CPP/COS.*

Outcome 6: Children receive appropriate services to meet their educational needs.

- Percent of children enrolled in child care and early learning programs that are licensed:

    » *100% or 14 of 14 children were enrolled in childcare but it was not known if each child care was licensed.*

Outcome 7: Children receive services to meet their physical and mental health needs.

- Percent of children at appropriate developmental level based on age:

    » *7% or 1 of 14 children was at an appropriate developmental level. We were only able to collect ASQ information for one child.*

- Percent of children with required immunizations for age:

    » *36% or 5 of 14 children are up to date on immunizations. We were not able to collect the information for the other 9 children.*

Regarding the performance of the COP/COS therapy, the CFSR findings listed above were mixed. It was positive that none of the children had findings of verified or not substantiated maltreatment during the participation of the parents in therapy. The finding that only one child was reunified during participation in the therapy was disappointing, but this does not discount the possibility that reunification occurred later or after the completion of the therapy and the end of the timeframe for this project.

The extent to which the impact of the therapy on CFSR measures could be evaluated was limited. This was due primarily to unavailable or missing information. For instance, the limited access to and/or availability of information regarding ending dates for therapy and measures of child well-being made it difficult to obtain an accurate account of the experience. The results based on the *Sense of Parenting Competence* instrument indicated that 33% of parents had a high set of parenting skills prior to their participation in the therapy. Only one of the three parents who completed the instrument after participation in the therapy reported a higher sense of parenting competence after participating in therapy. However, all three parents were also interviewed and reported benefits from the CPP/COS therapy and that they were satisfied with the therapy.

Key Informant Study Major Findings

The key informant study answered the overall question, "What are the experiences and views of service providers and therapists, case management staff, and judicial representatives regarding the 1) current operation of parenting programs and therapies and 2) the use of evidence-based interventions in improving parenting among at-risk families of children, age birth to five?" The major findings in response to this question are listed below:

1. Criteria for the selection of EBIs and services by case managers were not standard. Instead, selection of EBIs and services relied on a variety of factors that were based on experience working with families and familiarity with individual providers.

2. EBIs and services were viewed as important by all three stakeholder groups. Strengths of EBIs did not always refer to specific items or components in each EBI model. Strengths referred to general expectations for what should be used to serve an at-risk population. Examples were whether they were "trauma-informed," "developmentally-informed," or flexible in that they could be combined with other models in their implementation to meet the needs of a family more efficiently.

3. Case management, service providers, and judicial representatives thought EBIs could and should be used to prevent maltreatment.

4. Case managers and case manager supervisors thought that EBIs and some other therapies contributed to family friendly placements, healthy family visitation, and family reunification. Individual counseling and CPP/COS were the therapies that were mentioned most often in relation to these three outcomes.

5. Limitations of EBIs and other services were based primarily on inappropriate conditions or challenges that made it difficult for them to be successful. Lack of parental engagement and transportation were two major examples. Delays in initiating EBIs and services were also identified as limitations.

6. While the importance of current EBIs was recognized and supported, there were also other therapeutic approaches that were considered beneficial. These approaches were considered worthy of an evidence-based classification or being included in a process to become an evidence-based classification. An example was "didactic parenting" which was mentioned by a judicial presentative and provided by one of the therapists.

Research Limitations and Challenges

The proposed research design for the implementation study was quasi-experimental with a comparison group. This design was proposed in order to compare multiple parent EBIs. Due to a drop in the number of providers serving families through BBCBC and a lack of participation on the part of newer CPP/COS providers, the design became a single group design with one CPP/COS provider and 10 parents from nine families. Only three participating parents completed the required evaluation activities in the implementation study. With the low sample size, we were unable to measure pre/post changes at a level of confidence considered statistically adequate for generalizing to other at-risk families.

Despite the disappointing participation levels, it should be noted that the cooperation and effort of the participating provider to recruit and maintain parents in the study was outstanding. Coordination between the provider and the research team was strong throughout the study time period. However, detailed information on the combined application of CPP and COS in therapy sessions in each case was not available. This information would have contributed to a better understanding of the EBI implementation. The formation of a parent group which is a component in the COS-P model was also not achieved and could not be observed in this evaluation.

In the implementation study, the collection of information on each family from FSFN and other sources was challenging and hampered for several reasons. While the research team was granted access to most of the information in FSFN, particularly that measuring maltreatment, access to useful documents that contained chronological accounts of services and other comprehensive details was not ensured for each case (e.g., judicial reviews, therapy progress reports). One reason was a lack of consistency in the location of some documents in FSFN. In addition, case plans were in FSFN but it was difficult to determine effective dates, approval statuses, and compliance. While concerted effort was made to retrieve additional information from case management hardcopy files with the assistance of CBC staff working with the Early Intervention Court and Early Childhood Court programs, the organization of the information in the hardcopy files was not consistent across cases. Some information was missing (e.g., ASQs, child immunization records, parent employment). Limited access to information affected the capacity to develop case descriptions and calculate outcomes for some of the CFSR measures.

It is important to note that the one-year timeframe of the project did not allow direct comparison with the federally required CFSR measures as well as the indicators listed in the Florida CBC Scorecard. One of these major reasons was the necessary compression of measurement time periods after the completion of services. The shortening of the time periods to correspond with the one-year project timeframe could have also affected achievement of the study participants.

The key informant study included sample sizes for each stakeholder group that were consistent with what was proposed. Recruitment and cooperation scheduling the interviews were excellent with all key stakeholders, including BBCBC, Children's Home Society, the dependency court in Circuit 2, and several providers (i.e., ELC, Early Steps, CPP/COS, counselors). Compared to the implementation study, the key informant study was successful in both recruiting and completing the interviews, with the exception of not being able to recruit and interview a substance abuse provider or a domestic violence provider.

Practical Applications of the Project

Incorporating Evidence-based Service Planning into a Evidence-based Delivery System

As an outgrowth of the use of EBIs in providing services to vulnerable children and their families in the child welfare system (e.g., Landsverk, Garland, Rolls Reutz, & Davis, 2011, as cited in Berliner et al., 2015), the American Professional Society on the Abuse of Children (APSAC) Task Force (Berliner et al., 2015) introduced an approach referred to as evidence-based service planning (EBSP) in case management activities commonly performed by child welfare workers. The EBSP approach involves incorporating "EBI principles" in service planning. The EBSP approach is informed by three EBI principles including: 1) service selection that prioritizes effectiveness and efficiency, 2) a focused and parsimonious set of interventions that target primary problems (rather than the more comprehensive approach of traditional child welfare service planning), and 3) pursuing a triaged and sequenced approach for families presenting with multiple needs, including the use of "stepped care", defined as "offering the least intensive level of care that is appropriate initially and then 'stepping up' to more intensive care if necessary" (p. 9). The Task Force report concludes with a set of seven recommendations for EBSP practice, which are as follows:

1. Explicit adoption of engagement and motivational enhancement principles and approaches as integral to child welfare services (CSW) practice.

2. Systematic assessment of family and child problems and needs as part of the service plan development process, preferably including the use of standardized assessment measures.

3. Service selection prioritizes effectiveness and efficiency. Plans prefer evidence-based approaches.

4. Service selection and planning is guided by focus and parsimony.

5. Triage and sequencing guide service planning to ensure that basic or high priority services come first. A stepped care approach is used.

6. Service plans are goal driven and outcomes focused. Decision making is based on change and progress toward goals.

7. Interventions are designed to lead to case closure and reunification at the earliest time period (p. 20).

Expert reactions and support for these recommendations have generally been positive. For instance, Barth (2015) suggests that, based on the call for a more "precise and science-informed response" (p. 18), this could result in increased system wide ethical practices, increased fairness to families, and improved relations among the key child welfare stakeholder groups (i.e., caseworkers, mental health providers, courts, and parents) (p. 18). Saunders (2015) also expressed his support of the proposed EBSP guidelines and highlighted four strengths: 1) acknowledgement that EBSP is more than including a list of EBIs, 2) safety, permanence, and well-being are intertwined goals that affect one another, 3) triage, parsimony, and efficiency as guiding principles of EBSP must cut across all service components in order to be effective, and 4) the recognized importance of measuring client outcomes rather than client participation goals.

These experts also noted what Barth (2015) refers to as "modest reservations" (p. 18). His comments are informed by what is currently known with regard to the effectiveness for some recommendations. For instance, knowledge about the

"proper sequencing of services" (p. 18) as a part of a stepped care (vs. concurrent) approach is a critical implication of this recommendation. Saunders (2015) observes that the guidelines do not include interagency collaboration and coordination, and recommends the addition of "multidisciplinary collaboration in the service planning process and the implementation of service plans" (p. 21). He also calls attention to the implications of the recommendations, especially regarding the need for communities to have adequate capacity for EBSP and training issues for the child welfare workforce.

Nonetheless, the APSAC Task Force presents a promising set of guidelines to improve evidence-based practice in child welfare. Researchers have begun to study the use of EBSP in CWS. Fitzgerald and others (2015) tested an intervention, Project Focus Colorado (PF-C), designed to "improve access to EBPs for CWS youth". The focus of the intervention was to strengthen child welfare workers' roles as service "brokers of effective mental health treatment for youth" (p. 39). Results showed that caseworkers who received PF-C were more "knowledgeable about EBPs, child mental health problems, EB treatment components targeting mental health problem areas, and mental health screening instruments", relative to cask workers who did not receive the intervention.

Recommendations for Improving the Inclusion of Evidence-based Interventions in the Local Community-based System of Care

With the backdrop of research literature and the findings covered earlier in this discussion, the primary practical applications are specified as recommendations in the BBCBC system of care. These applications refer primarily to what was recommended by each of the three stakeholder groups in the key informant study. Several of the applications also correspond with principles and guidelines for EBSP endorsed by the APSAC Task Force presented above (Berliner, et al., 2015). The review of the APSAC guidelines in Barth (2015) emphasized the importance of multidisciplinary collaboration in the service planning process. Professional collaboration and communication were also reinforced in many of this project's findings. The recommendations offered for consideration in the BBCBC system of care are below:

1. Criteria for the selection of EBIs and other services for families with children birth to age five years of age should be developed for and implemented by case management. Consideration should be given to therapeutic approaches and models that do not have a strong evidence-base for national ratings currently but have had systematic evidence of impressive performance with this at-risk population. The set of criteria should include this category of therapeutic approaches and models.

2. The evidence-based status of therapies under consideration for at-risk families with children birth to five years of age served in the BBCBC area should be updated annually. The evidence-based status of multiple therapies (i.e., CPP, COS) and a parent training program (STEP) were researched prior to and during the initial phases of this project but additional evidence can become available for inclusion in the status determination.

3. The implementation of EBIs should be monitored to determine if there is model fidelity. Deviations from each model in implementation should be identified and examined to ensure continued effectiveness of an EBI.

4. The impact of EBI models and therapeutic approaches that are combined (e.g., COS and CPP) when working with a family should be examined.

5. There should continue to be periodic summits that allow case managers, therapists and service providers, dependency court professionals and other interested child welfare professionals to meet and learn from each other. Better on-going communication and coordination between case managers and providers should be a primary goal of these meetings. These summits should allow the providers to explain in detail what their services entail and what they can achieve. In this regard, it may be useful to plan meetings between stakeholder groups for each circuit.

6. There should be professional training opportunities brought to the BBCBC area to enhance the professional expertise and competence of all professionals in the child welfare system.

7. More providers and therapists using a variety of EBI models should be recruited for serving families in the BBCBC. This is of particular importance in rural areas, including Wakulla, Jefferson, and Gadsden counties. This is also of importance for certain needs, such as children with disabilities.

8. The limited availability of services, such as dental and psychiatric care, should be reviewed with options developed for improving their availability.

9. As the evidence unfolds with regard to the use of services triage or sequencing, assessments should incorporate these strategies in pursuit of maximum benefit and effectiveness.

10. Unnecessary delays in the initiation of therapies and services should be identified in order to avoid these delays.

11. Challenges and barriers affecting the engagement of families in EBIs and other services should be addressed and minimized with available community resources. Examples of these challenges are:
    a. transportation to services
    b. high number of services that must be completed in a case plan
    c. low level of literacy

12. There should be heightened consideration given to implementing EBIs for the following purposes:
    a. EBIs for prevention of maltreatment
    b. EBIs that deliver services in-home
    c. EBIs that provide services for families after reunification

13. On-going evaluation of parent therapies, training and services should be implemented. The evaluation research undertaken should include formative and summative components. When EBI therapies and programs are implemented, the fidelity of the actual practice to those therapy models should be examined. An evaluation plan should be developed with an advisory committee that is represented by all professional roles in the child welfare system, including the dependency court. Methodological approaches and templates adopted in the implementation and key informant studies covered in this report should serve as initial protocols for on-going evaluation. The limitations and challenges of the methodologies in the studies conducted for this project should also be consulted in order to improve future evaluation efforts.

14. Questions that should be answered by community stakeholders interested in incorporating EBIs in their array of services for families in the child welfare system are the following:

   a. Will standard criteria be used to select EBIs for families in the child welfare system? If yes, will that criteria include consideration of the following?

      - Effectiveness of EBIs when:
         - time frames are much shorter than the 12-month requirement for reaching permanency
         - providing services to a single parent, two parents, an entire family, or group of parents
         - delivering services in different settings (i.e., office, home, supervised visitation center, or otther)
         - attendance of parents at sessions is inconsistent
      - EBI Rating Sources (California Evidence-Based Clearinhouse for Child Welfare, National Registry of Evidence-based Programs and Practices, or other national, state, or community EBI rating source)
      - Commitment of an EBI provider to participate in evaluations

   b. If a service or therapy does not meet the standard criteria for EBIs, will it be funded as a service for families in the child welfare system? If no, what if the therapy and provider is requested by the parent?

   c. Will a process be used to monitor the implementation of an EBI in order to determine its fidelity to its practice model? If yes, what will that process entail?

   d. If a provider uses a therapy model that does not meet the standards for an EBI but is requested by a parent, will that provider be permitted and funded to provide services to that parent?

   e. What process will be used to monitor the implementation of an EBI in order to determine its fidelity to the therapy model?

   f. What are the barriers that affect the implementation of an EBI and jeopardize its model fidelity and effectiveness? How can the impact of these barriers be minimized?

   g. What is the extent to which the child welfare system is "evaluation ready", in order to assess the processes by which EBIs are implemented,(e.g., adherence to the model) as well as achieving intended outcomes, such that evidence of the effectiveness of services for families can be determined? If not, what changes are needed and how can these changes be implemented?

References

Barth, R.P. (2015). Commentary on the report of the APSAC task force on evidence-based service planning guidelines for child welfare. *Child Maltreatment, 20(1),* 17-19.

Barth, R. P. (2009). Preventing child abuse and neglect with parent training: Evidence and opportunities. *The Future of Children*, *19 (2),* 95-118.

Barth, R. P., & Haskins, R. (2009). Will parent training reduce abuse, enhance development, and save money? Let's find out. *Future of Children*, *19*(2), 1-7.

Barth, R.P., Landsverk, J., Chamberlain, P., Reid, J.B., Rolls, J.A., Hurlbert, M. et al. (2005). Parent-training programs in child welfare services: Planning for a more evidence-based approach to serving biological parents. *Research on Social Work Practice*, *15*, 353-371.

Berliner, L., Fitzgerald, M.M., Dorsey, S., Chaffin, M., Ondersma, S.J., & Wilson, C. (2015). Report of the APSAC task force on evidence-based service planning guidelines for child welfare. *Child Maltreatment, 20(1),* 6-16.

California Evidence-Based Clearinghouse for Child Welfare. (n.d.) Systematic Training for Effective Parenting. Retrieved on April 9, 2015 from http://www.cebc4cw.org/program/systematic-training-for-effective-parenting/detailed

California Evidenced-Based Clearinghouse for Child Welfare (n.d.). Circle of Security. Retrieved April 9, 2015 from http://www.cebc4cw.org/search/results/?keyword=Circle+of+Security&q_search=Go&realm=simple

Casey Family Programs. (n.d.) Foster Care Redesign in Alachua and Duval Counties. Retrieved April 9, 2015 from http://www.casey.org/foster-care-redesign-duval-alachua-counties

Cassidy, J., Woodhouse, S. S., Sherman, L. J., Stupica, B., & Lejuez, C. W. (2001). Enhancing infant attachment security: An examination of treatment efficacy and differential susceptibility [Special section]. *Development and Psychopathology, 23,* 131-148.

Cassidy, J., Ziv, Y., Stupica, B., Sherman, L. J., Butler, H., Karfgin, A., et al. (2010). Enhancing attachment security in the infants of women in a jail-diversion program. *Attachment and Human Development, 12*(4), 333-353.

Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., et al. (2004). Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology, 72*(3), 500-510.

Circle of Security. (n.d.) Circle of Security Frequently Asked Questions. Retrieved on April 10, 2015 from http://circleofsecurity.net/about-us/faq

Cooper, G., Hoffman, K., Powell, B., & Marvin, R. (2005). The circle of security intervention. In L. J. Berlin, Y. Ziv, L. Amaya-Jackson, & M. T. Greenberg (Eds.), *Enhancing early attachments: Theory, research, intervention, and policy* (pp. 127-151). New York: Guilford Press.

Fitzgerald, M.M., Torres, M.M., Shipman, K., Gorrono, J., Suzanne, K.E.U., & Dorsey, S. (2015). Child welfare caseworkers as brokers of mental health services: A pilot evaluation of project focus in Colorado. *Child Maltreatment, 20*(1)*,* 37-49.

Hoffman, K. T., Marvin, R. S., Cooper, G., & Powell, B. (2006). Changing toddlers' and preschoolers' attachment classifications: The circle of security intervention. *Journal of Consulting and Clinical Psychology, 74*(6), 1017-1026.

Horton, C. (2003). Protective factors literature review: Early care and education programs and the prevention of child abuse and neglect. Washington, DC: Center for the Study of Social Policy.

Hurlburt, M. S., Barth, R. P., Leslie, L. K., Landsverk, J. A., & McCrae, J. S. (2007). Building strengths: Current status and opportunities for improvement of parent training for families in child welfare. In R. Haskins, F. Wulczyn, & M. B. Webb (Eds.), *Child protection: Using research to improve policy and practice* (pp.81-106). Washington, DC: Brookings Institution Press.

Kaminski, J. W., Valle, L. A., Filene, J. H., & Boyle, C. L. (2008). A meta-analytic review of components associated with parent training program effectiveness. *Journal of Abnormal Child Psychology, 36,* 567-589.

Karoly, L. A., Kilburn, M. R., & Cannon, J. S. (2005). *Early childhood interventions: Proven results, future promise.* Santa Monica, CA: RAND Corporation.

Kaufman, J., & Charney, D. (2001). Effects of early stress on brain structure and function: Implications for understanding the relationship between child maltreatment and depression. *Development and Psychopathology, 13*(3), 451-471.

King, J.E. (2008). Binary logistic regression. In J. W. Osborne (Ed.), *Best practices in quantitative methods* (pp. 358-384). Los Angeles, CA: Sage.

Landsverk, J., Garlans, A., Rolls Reutz, J., & Davis, I. (2011). Bridging science and practice in child welfare and children's mental health service systems through a two-decade research center trajectory. *Journal of Social Work*, 11, 80-98.

Langbein, L. & Felbinger, C.L. (2006). *Public program evaluation: A statistical guide*. Armonk, NY: M.E. Sharpe.

Lewandowski, C. A., & Pierce, L. (2002). Assessing the effect of family-centered out-of-home care on reunification outcomes. *Research on Social Work Practice, 12*(2), 205-221.

Mullins, J. L., Cheung, J. R., & Lietz, C. A. (2012). Family preservation services: Incorporating the voice of families into service implementation. *Child and Family Social Work, 17,* 265-274.

McCroskey, J., & Meezan, W. (1998). Family-centered services: Approaches and Effectiveness. *The Future of Children, 8*(1), 54-71.

National Resource Center for Permanency and Family Connections. (n.d). *Evidence-based practices in child welfare.* Retrieved April 9, 2015, from http://www.nrcpfc.org/ebp/index.html

Pine, B. A., Spath, R., Werrbach, G. B., Jenson, C. E., & Kerman, B. (2009). A better path to permanency for children in out-of-home care. *Children and Youth Services Review, 31,* 1135-1143.

Randolph, A. K. & Myers, L.L. (2013). *Basic statistics in multivariate analysis*. New York, NY: Oxford University Press.

Saunders, B.E. (2015). Expanding evidence-based practice to service planning in child welfare. *Child Maltreatment, 20(1)*, 20-22.

Shadish, W.R., Cook, T.D., & Campbell, D.T. (2002). *Experimental and quasi-experimental designs for generalized causal inference*. Boston, MA: Houghton Mifflin Company.

STEP Publishing, Inc. (n.d.). *Early Childhood STEP Kit*. Retrieved April 9, 2015 from http://www.steppublishers.com/products/early-childhood-step-kit

Substance Abuse and Mental Health Services Administration (SAMSHA) National Registry of Evidence-based Programs and Practices. (n.d.). *Systematic Training for Effective Parenting*, Retrieved on April 10, 2015 from http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=132

Thomas, R. & Zimmer-Gembeck, M. J. (2012). Parent-child interaction therapy: an evidence-based treatment for child maltreatment. *Child Maltreatment 17(3), 253-266.*

U.S. Administration for Children and Families Children's Bureau. (n.d.) Family Preservation Services. Retrieved April 9. 2015, from https://www.childwelfare.gov/topics/supporting/preservation

U.S. Administration for Children and Families Children's Bureau. (2007). Assessing Promising Approaches in Child Welfare: Strategies for State Legislators. Retrieved April 9, 2015 from http://www.ncsl.org/documents/cyf/promising_approaches_childwelfare.pdf

U.S. Administration for Children and Families Children's Bureau. (2013). Child Maltreatment 2013. Retrieved April 9, 2015 from http://www.acf.hhs.gov/sites/default/files/cb/cm2013.pdf

Zeanah, C. H. (2009). *Handbook of infant mental health*. New York, NY: Guilford Press.

Acknowledgements

Parenting Questionnaire Before Training or Services

Participant ID:_____Date Completed: _____

Please read each statement below and circle one number that best represents the extent to which you agree or disagree with each statement. The levels of agreement correspond with the numbers on the scale below:

1	2	3	4	5	6
Strongly Disagree	Somewhat Disagree	Disagree	Agree	Somewhat Agree	Strongly Agree

Read each statement below and then circle one number in the right column for each statement	Disagree Agree
	Circle One Number
The problems of taking care of a child are easy to solve once you know how your actions affect your child.	1 2 3 4 5 6
Even though being a parent could be rewarding, I am frustrated now while my child is at his/her present age.	1 2 3 4 5 6
I go to bed the same way I wake up in the morning, feeling I have not accomplished a whole lot.	1 2 3 4 5 6
Sometimes when I'm supposed to be in control, I feel more like the one being manipulated.	1 2 3 4 5 6
My parents were better prepared to be a good parent than I am.	1 2 3 4 5 6
I would make a fine model for a new parent to follow in order to learn what he or she would need to know to be a good parent.	1 2 3 4 5 6
Being a parent is manageable because problems are easily solved.	1 2 3 4 5 6
A difficult problem being a parent is not knowing whether you're doing a good job or a bad one.	1 2 3 4 5 6
Sometimes I feel like I'm not getting anything done.	1 2 3 4 5 6
I meet my own personal expectations when caring for my child.	1 2 3 4 5 6
If anyone can find the answer to what is troubling my child, I am the one.	1 2 3 4 5 6
My talents and interests are in other areas, not being a parent.	1 2 3 4 5 6
Considering how long I've been a parent, I feel thoroughly familiar with this role.	1 2 3 4 5 6
If being a parent of a child were only more interesting, I would be motivated to do a better job as a parent.	1 2 3 4 5 6
I honestly believe I have all the skills necessary to be a good parent to my child.	1 2 3 4 5 6
Being a parent makes me tense and anxious.	1 2 3 4 5 6
Being a good parent is a reward in itself.	1 2 3 4 5 6

Thank you for completing this questionnaire. Please insert the completed questionnaire in the self-addressed and stamped envelope and mail it.

Hello. Am I speaking with _____? My name is _____ and I am a member of the evaluation team at the Ounce of Prevention Fund of Florida in Tallahassee. We are evaluating the parent program that you participated in. Thank you for agreeing to talk with me today. This interview should take less than 30 minutes. It is my understanding that you signed a consent form earlier to participate in this research study. Do you recall signing a consent form?

> Yes—Thank you for sharing that information. We can proceed with the interview (see below).

> No—We have a copy of the signed consent form and can mail you a copy to you if you like.
>> Will that be helpful? Yes or No
>>
>> If yes, can you give me a mailing address? _____ Are you comfortable continuing with the interview? Yes or No
>>
>> If yes, continue with the interview (see below).
>>
>> If no, is there another day and time that will be more convenient for you? Date and Time for interview:_____ Thank you for talking with us and we will contact you on the day and time you suggested. Have a nice day.

Continue with Interview: Your responses will remain private and only available to our evaluation team. If you do not feel comfortable answering a question, you do not need to answer that question. You also have the option to terminate the interview at any time. Before we begin, do you have any questions regarding the interview?

1) First, I would like to know if you think raising a child is easy? Yes or No   Please explain.

2) As a parent, do you think you are in control? Yes or No   Please explain.

3) Are you a better parent than your mother or father? Yes or No   Please explain.

4) Do you always know what is troubling your child? Yes or No   Please explain.

5) At this time, do you think you have the skills needed to be a good parent? Yes or No.

   a. If yes, how did you acquire those skills? Did the parent program help you with your parenting skills? Why or why not?

   b. If no, why do you not have those skills? Do you think the parent program was helpful to you as a parent? Why or why not?

6) Do you think there is anything that will improve the parent program you participated in? Yes/No Please explain.

Thank you for sharing your responses to our questions during this interview. We value your feedback. If you have any questions regarding this evaluation, please feel free to contact our office using the names and telephone numbers on your consent form.

Appendix C

Evaluation of Parent Programs in a System of Care: Supplemental Study

Interview Questions: Case Managers

Questions about CM Job (Tasks, Caseload Information, and Experience)

- What types of responsibilities and tasks do you perform as a case manager for at-risk families with children ages birth to five?

- Average size of total caseload per month over past six months

- Average size caseload of at-risk families with children agest birth to five over the past six months

- What is your average monthly frequency contact with families?

- How would you describe your experiences (both positive and negative) in providing case management to at-risk families with children ages birth to five?

Questions about Collaboration

- How would you describe our experiences (both positive and negative) in working with agency partners (DCF, BBCBC, other) in providing case management to at-risk families with children ages birth to five?

- How would you describe your experiences (both positive and negative) in working with the judicial system in providing case management to at-risk families with children ages birth to five?

- How would you describe your experiences (both positive and negative) in working with provider therapists in providing case management to at-risk families with children ages birth to five?

  » What is your average monthly frequency of contact with therapists?

  » Are there barriers that make coordination and communication with the provider therapists challenging? If yes, what are the barriers?

Questions about EBI

- What criteria do you use to determine and evaluate the efficacy of parenting interventions in providing case management services to at-risk families with children ages birth to five? Do you consider whether or not they are evidence-based? If yes, what is your source for determining that status?

- What are your perceptions of the strengths and limitations of the different models used in treating the at-risk families with children ages birth to five? Do you have 1-2 models that you think are most promising and effective?

- What are your views on the impact of evidence-based parenting interventions in preventing children ages birth to five from entering care?

- For children who are removed from their families, what are your views on:

  » Impact of evidence-based parenting interventions in promoting placement in the least restrictive and most family-like settings in the Big Beng?

  » Impact of evidence-based parenting interventions in facilitating healthy family visitation?

  » Impact of evidence-based parenting interventions in facilitating successful reunification?

EBI Recommendations

- What are your recommendations regarding the development of a system of care in the Big Bend area that has evidence-based therapies and services to adequately meet the needs of at-risk families with children ages birth to five?

Background Information

- Gender

- Race/ethnicity

- Highest educational degree

- Length of time in the field (time since receipt of last degree)

- Length of time as a CHS case manager

Evaluation of Parent Programs in a System of Care: Key informant Study

Interview Questions: Case Management Supervisors

Questions about CM Supervisor Responsibilities

- How would you describe your role and tasks as a supervisor at the CHS as it relates to providing services to at-risk families with children ages birth to five?

  » Total number of case managers that you supervise

  » Total number of case managers that you supervise who work with at-risk families with children ages birth to five

Questions about Collaboration

- How would you describe your experiences [both positive and negative] in your role as CM Supervisor in collaborating with BBCBC to serve at-risk families with children ages birth to five?

- How would you describe your experiences [both positive and negative] in your role as CM Supervisor in collaborating with the judicial system to serve at-risk families with children ages birth to five?

- How would you describe your experiences [both positive and negative] in your role as CM Supervisor in collaborating with therapists to serve at-risk families with children ages birth to five?

Questions about EBI

- What criteria do you use to determine and evaluate parenting interventions in supervising case managers in their work with at-risk families with children ages birth to five? Do you consider whether or not they are evidence-based? If yes, what is your source for determining that status?

- What are your perceptions of the strengths and limitations of the different models used in treating the BBCBC at-risk families with children ages birth to five? Do you have 1-2 models that you think are the most promising and effective?

- What are your views on the impact of evidence-based parenting interventions in **preventing** children ages birth to five from entering care?

- For children who are **removed** from their families, what are your views on:

  » Impact of evidence-based parenting interventions in promoting placement in the least restrictive and most family-like settings in the Big Bend?

  » Impact of evidence-based parenting interventions in facilitating healthy family visitation?

  » Impact of evidence-based parenting interventions in facilitating successful reunification?

EBI Recommendations

- What are your recommendations with regard to developing a system of care in the Big Bend area that has evidence-based therapies and services to adequately meet the needs of at-risk families with children ages birth to five?

Background Information

- Gender

- Race/ethnicity

- Highest educational degree

- Length of time in the field (time since receipt of last degree)

- Length of time as a CHS case management supervisor

Questions about Overall Experiences working with At-Risk Families

- Overall, how would you describe your experiences [both positive and negative] in providing therapy to at-risk families with children ages birth to five? For instance, are there barriers that make it challenging to work with these families? If yes, what are they?

Questions about Particular EBI Model

- What informed your decision to use [ADD MODEL NAME; e.g., Circle of Security] as an approach to treat the BBCBC at-risk families with children ages birth to five? Did you consider whether the model was evidence-based? Why or why not?

- How do you describe your experience/expertise in providing therapy using the [ADD MODEL NAME; e.g., Circle of Security]?

- What are the strengths and limitations of the [ADD MODEL NAME; e.g., Circle of Security] in treating the BBCBC at-risk families with children ages birth to five?

- What are your views on the impact of your therapy or program model on **preventing** children ages birth to five from entering out-of-home care?

- For children who are **removed** from their families, what are your views on:

  » Impact of your therapy or program model in promoting placement in the least restrictive and most family-like settings in the Big Bend?

  » Impact of your therapy or program model in facilitating healthy family visitation?

  » Impact of your therapy or program model in facilitating successful reunification?

Questions about Collaboration

- How would you describe your experiences [both positive and negative] in working with the BBCBC agency, Children's Home Society (CHS), the local judicial system, and other community partners in providing therapy to at-risk families with children ages birth to five?

Questions about Clients/Caseload

- Number of at-risk families with children ages birth to five referred to you by BBCBC or CHS during the past six months.

- Number of at-risk families with children ages birth to five receiving therapy, on average, each month over the past six months.

- Average length of time at-risk families with children ages birth to five participate in therapy/training.

- Number of at-risk families with children ages birth to five referred to you by BBCBC or CHS who have successfully completed treatment during the past six months.

EBI Recommendations

- What are your recommendations with regard to developing a system of care in the Big Bend area that has evidence-based services to adequately meet the needs of at-risk families with children ages birth to five?

Background Information

- Gender

- Race/ethnicity

- Highest educational degree

- Length of time in the field (time since receipt of last degree)

- Length of time as a BBCBC or CHS provider

- Specializations (e.g., method of therapy, population of focus)

Interview Questions: Judges

January 28, 2016

Questions about EBI

- What criteria do you use to determine and evaluate the efficacy of parenting interventions in your work with at-risk families with children ages birth to five? Do you consider whether or not they are evidence based? If yes, what is your source for determining that status?

- What are your perceptions of evidence-based services and programs for at-risk families with children birth to five in the child welfare system being provided within your jurisdiction?

- Have you identified any evidence-based interventions that you think are more likely to be effective with these parents? If so, what informs your thinking about this?

- How would you describe your experiences [both positive and negative] with parents who have been referred to an evidence-based service or program?

- What are your views on the impact of evidence-based parenting interventions in **preventing** children ages birth to five from entering care?

- For children who are **removed** from their families, what are your views on:

   » Impact of evidence-based parenting interventions in promoting placement in the least restrictive and most family-like settings in the Big Bend?

   » Impact of evidence-based parenting interventions in facilitating healthy family visitation?

   » Impact of evidence-based parenting interventions in facilitating successful reunification?

Questions about Community Collaboration

- Who in the child welfare professional community do you work with in facilitating services for at-risk families with children ages birth to five?

- How would you describe your experiences [both positive and negative] in working with these professionals?

- What challenges do you encounter in referring parents to court-ordered evidence-based services?

Recommendations

- What are your recommendations regarding the development of a system of care in the Big Bend area that has evidence-based services to adequately meet the needs of at-risk families with children ages birth to five?