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## RESEARCH REPORT

# A Randomized Evaluation Examining the Effects of an Incentive-Based Child Welfare Intervention on Strengthening Child and Family Engagement in Services

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## CONTENTS

Abstract .....	1
Project Description .....	2
Purpose .....	2
The Importance of Engaging Children and Families in Services .....	2
Effects of Engagement on Child and Family Outcomes .....	2
Incentive-Based Participation Programs .....	2
Incentive-Base Participation Program in Escambia and Santa Rosa County .....	3
Case Examples from the Pilot Incentive Program at the Lakeview Center .....	3
Current Project Description .....	4
The Evaluation Responded to the Following Research Questions .....	4
Description of Primary Service Programs .....	4
Incentive Program .....	4
Evaluation Procedures .....	5
Measures .....	5
Results .....	6
Meridian Sample Demographics and Outcomes .....	6
CHIPS Sample Demographics and Outcomes .....	6
Cabot Heights .....	6
Discussion .....	7
Recommendations for Practice .....	7
References .....	8

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## Abstract

A randomized controlled design was used to evaluate the incentive program across three primary service programs including a statewide inpatient psychiatric program, a group home, and treatment foster care. Outcome measures included the Working Alliance Inventory and the Child Functional Assessment Rating Scale. Based on these preliminary data, the results on the effectiveness of the incentive program are inconclusive largely due to issues with the sample size. Recommendations for future efforts to develop and evaluate strategies aimed at increasing child and family engagement in child welfare services are provided.

## Project Description

### Purpose

The purpose of this study was to: 1) evaluate an incentive program designed to improve clients' engagement in services and service outcomes; 2) work with agency partners to develop a plan to strengthen and sustain effective engagement practices in the Escambia and Santa Rosa County service areas; and 3) develop recommendations to strengthen and support efforts to increase and sustain family engagement in child welfare services throughout the state of Florida.

### The Importance of Engaging Children and Families in Services

Client engagement is the foundation of child welfare practice that effectively promotes safety, well-being, and permanency.<sup>1</sup> Yet, lack of engagement in services is a salient issue in the field of child welfare impeding child and family outcomes. Engagement has been defined as "a family-centered and strength-based approach to partnering with families in making decisions, setting goals and achieving desired outcomes".<sup>2</sup> Research findings consistently demonstrate that greater client involvement in services results in better service outcomes.<sup>3,4,5</sup>

In 2001, the National Institute of Health identified low client engagement and retention in services as a significant barrier to evidence-based practices; a challenge that remains in the field of child welfare over a decade later.<sup>6,7</sup> The difficulty in achieving meaningful client engagement is largely a manifestation of the involuntary nature of child welfare system involvement; characterized by a power differential between clients and service providers who are viewed as monitoring entities and, who are often in the position of upholding the decisions of the court. This framework promotes a compliance-based approach to service provision versus supporting a collaborative process necessary to engaging children and families.<sup>8</sup>

### Effects of Engagement on Child and Family Outcomes

Research findings support that child and family involvement in child welfare and related services significantly improves service outcomes. Findings from the Child and Family Services Reviews (CFSR) show that collaborative case planning helped build rapport and establish effective working relationships between parents and service providers (U.S. Department of Health and Human Services, (HHS), 2009). States that scored higher on indicators of collaborative case planning had higher percentages of children that achieved permanency and demonstrated greater stability in their placements (HHS, 2004). Further, research findings suggest that greater parental involvement may help to expedite the reunification process.<sup>9,10</sup>

The quality of the caseworker's relationship with the child and family is a key factor contributing to increased engagement<sup>11</sup> and has been linked to improved parenting skills,<sup>12</sup> reduced length of stay in child welfare, and increased rates of reunification.<sup>13</sup> When caseworkers work collaboratively with children and families, they are better able to appreciate

their unique circumstances, perspectives, and needs; an understanding that is essential to developing service plans that are perceived as relevant and that service recipients will be more likely to follow through as active participants.<sup>14</sup>

In a review of 17 randomized studies, Ingoldsby (2010) found effective strategies to increase child and family engagement and retention in child mental health services included the use of motivational interviewing, family-centered approaches, providing supports to alleviate stressors, and assisting clients with developing coping skills.<sup>15</sup> Research findings also show that providing access to concrete resources (e.g., child care, transportation, monetary supports;)<sup>16,17</sup> and frequent contact with case workers improves participation in services<sup>18</sup> and increases the likelihood needed services are received.<sup>19</sup>

Yet, there are many challenges to successfully engaging child welfare involved children and families and retaining active involvement throughout the life of the case. Among the frequently identified issues reported by states in the second round of the CFRs were organizational issues (e.g., high caseloads and employee turnover), caseworkers lacking skills needed to engage families, and attitudes and behaviors of both parents and caseworkers.

There is an increased recognition of the need for flexible service approaches in child welfare.<sup>20,21</sup> Continued progress toward effectively engaging children and families in child welfare services is contingent upon child welfare service providers' willingness to explore and invest in developing and testing innovative strategies aimed at supporting caseworkers and motivating service recipients to engage in a process most often entered into unwillingly and under complex pre-existing circumstances. Children's and families' ability to reap the fully intended benefits of child welfare services, both in the short and long-term, rests upon the extent to which they internalize the process and experience perceived gains associated with engaging in services.

### Incentive-Based Participation Programs

Researchers hypothesized that providing incentives (e.g. certificates, money, transportation, food, paying utilities, etc.), particularly if receiving the incentive is contingent upon following through in treatment plans or completing services, may increase client's motivation to participate in services.<sup>22</sup> Findings from research examining the effects of incentive-based participation programs in the fields of education,<sup>23</sup> health,<sup>24</sup> family self-sufficiency,<sup>25</sup> and parenting programs<sup>26</sup> support the use of incentives when appropriately targeted. Existing evaluations of incentive-based participation programs are primarily focused on those that use cash transfers that are contingent upon enrollment, attendance, and/or completion of goals. A multi-year randomized evaluation of a conditional cash transfer program focused on six low-income communities in New York that sought to increase families' economic self-sufficiency found that it helped to reduce housing issues and material hardships and increase families' receipt of dental care and full-time employment.<sup>27</sup> Another study compared rates of enrollment and attendance in a preventative parenting program in which families were randomly assigned to an incentive or non-incentive condition and found that more parents in the incentive condition enrolled and attended the first session.<sup>28</sup>

Some research findings support that offering incentives may be more successful in getting clients who are higher risk or 'harder-to-reach' to enroll in services. Guyll, Spoth, and Redmond found that offering parents \$100 to enroll in an adolescent drug prevention program significantly increased enrollment rates, particularly among parents with less formal education and who previously reported low intent to enroll.<sup>29</sup> Dumas, Moreland Begle, French, and Pearl found that offering a small cash incentive increased enrollment in an eight week parenting program with greater effects among families that were younger and lower-income.<sup>30</sup> Two separate evaluations of parenting programs found that while cash incentives may increase enrollment rates and initial attendance, they were not effective in increasing retention in services.<sup>31,32</sup> However, this could be due to offering incentives that were pre-determined and not adequately targeted to the families in terms of appropriate type and level of incentive. For example, Dumas et al. (2010) offered three dollars to attend the first two sessions, followed by small incremental increases in the dollar amount with a potential of earning up to \$68 dispersed over two months if families participated in subsequent sessions. The lack of retention among families that was observed may be due to an incentive that was not sufficient enough to motivate participants to commit their time to attending the parenting sessions. The authors noted that attendance dropped off after the first session, an issue that may be partially attributed to the program and other factors exerting influence on attendance that the incentives were insufficient to leverage.

The quality of services and clients' experiences in receiving services impacts levels of engagement. Several factors may have strong potential to overcome challenges to engagement in services, such as using a client-centered approach to implement a flexible incentive-based participation program that emphasizes building high-quality relationships with children and families, partnering to develop service goals, identifying individualized incentives that are offered incrementally and contingent upon active participation, and following through on case goals.

### **Incentive-Base Participation Program in Escambia and Santa Rosa County**

The Children's WRAP Team (TCM/HIS) at the Lakeview Center in Pensacola, in an effort to reduce acute admissions and improve treatment compliance with the parent and child, began utilizing incentives to gain more effective engagement with the family. Based on Maslow's hierarchy of needs, the intent is to address needs and stressors with the family/child to reduce barriers to treatment. By reducing these barriers, the family (parent and child) can focus on appropriate treatment and interventions.

Using a family-centered approach, the clinical therapist along with the family identifies areas of need or stress which are presenting barriers to full engagement in treatment. The best approach to address these needs is determined and then an individualized behavior plan is developed by the therapist, child, and parents. The plan clearly defines expectations or necessary skills that are agreeable to each of the participants (Parent, Child, and Therapist). The incentive is attached to compliance with each step of the behavioral plan. A time frame is established to earn the incentive and upon completion of the

behavioral requirements, it is awarded. If the child or parent are out of compliance with any part of the behavior program, the incentive is withheld. The behavioral plan and incentive are time limited.

### **Case Examples from the Pilot Incentive Program at the Lakeview Center**

The incentive program was initially piloted with four different families. The first, and most successful outcome was with a 17-year-old girl with a significant trauma history. She had eight previous acute care admissions in the previous six months. Each admission lasted for three days. She had been non-compliant with outpatient treatment and was considered for residential treatment following her last acute admission. However, the child was adamant she was not going to a residential program. A behavioral program was offered to allow her to demonstrate she could manage without going to residential treatment. She agreed to follow the behavior plan. Her plan included: 1) participate in weekly trauma focused therapy with no missed appointments; 2) take her medications as prescribed; 3) no self-injurious behavior or threats; 4) no aggression; 5) follow house rules established by her parents; and 6) no further acute admissions. The time frame for earning her incentive of \$50 was one month. The parents' goals included: 1) ensuring the child attended weekly therapy; 2) attending family therapy as recommended by the child's therapist; 3) providing the child with a safe place and opportunities to take self-time outs where she could be monitored; and 4) providing the child with options and appropriate redirections and avoiding power struggles. The parents were offered a \$100 gift card if both the parents and child were compliant with the behavioral plan for one month. Upon receiving the first incentive gift card the father contacted the director of the WRAP team in tears. He stated, "For the first time I can remember, my family feels safe and my daughter is finally happy."

The child and family continued to successfully follow the behavior plan. The child displayed no self-injury, no aggression, and no acute admissions. She was attending trauma-focused treatment which included the family. She was reportedly demonstrating coping skills that she had learned in treatment. The father had sought out his own treatment to deal with past personal trauma, which was above and beyond the requirements of the behavior plan. The WRAP team had committed with the family to monitor the behavior plan for a period of six months. The total investment for this family was \$900 for six months. This is significantly less than just one typical three-day acute admission.

A second family was offered a similar incentive program. The client was a 17-year-old male with ten acute admissions from February 7, 2012 to April 3, 2014. The average length of stay for this child for acute admissions was 10.4 days. The same steps were followed but prior to the plan being implemented, the parent-child relationship became so conflicted that the parents opted to have their child placed outside the home. He was admitted to a Statewide Inpatient Psychiatric Program (SIPP) for the third time with a plan to move to the Sheriff's Youth Ranch at discharge. The incentive plan was never fully implemented.

A third family was offered a much less detailed incentive program. The client was a 13-year-old child who presented with defiance toward the mother and house rules, as well as poor parent-child communication skills. She was also demonstrating irrational fears regarding the family running out of food. She identified that she was willing to engage in treatment and comply with house rules if specific snacks were available each afternoon. The mother indicated she could not afford to provide the snacks requested. A behavior plan was implemented and the requested snacks were provided by the program as an incentive. The child immediately demonstrated increased compliance in the home and school per the behavior plan. The plan was monitored for two months and discontinued. The client had no acute admissions. The cost of this incentive program was a total of \$46.

A fourth family was offered a similar program with the incentive for the child being \$5 for each day of compliance with the behavior plan. The amount was larger and provided daily reinforcement due to the child being a very aggressive and developmentally immature 12-year-old with seven acute admissions in the past six months. Her admissions had an average length of stay of 4.4 days. She also had four SIPP admissions in 2013. The plan was established and implemented. Changes were made several times until it was determined that the child needed more frequent reinforcement. The client was maintained in the home and school setting for a period of two months before experiencing another acute admission, a noteworthy period of stability compared to prior behavioral patterns. The total cost of this program for two months was \$295. Further treatment adjustments were made in order to continue the program following her acute admission.

The total cost of the three successfully implemented incentive programs was \$1,241 to date with a further \$1,000 anticipated to finish out the fiscal year. This will be a grand total of \$2,241 for the three children for a period of seven months. Based on the results that have been observed thus far, the pilot appears to be effective with the right combination of family, therapist, behavior plan and incentive. The availability of the plan for additional families/children has been limited due to funding.

## Current Project Description

Following the pilot, the Lakeview Center's Director of Care Coordination, Rodney Moore and Dr. Boel-Studt (Principal Investigator, PI) collaborated to develop the current project that involved expanding the incentive program to four of the Lakeview Center's primary service programs and conducting a randomized evaluation to examine the effectiveness of adding the incentive program as a supplement to usual services. The evaluation included the Children's WRAP team (community case management), Changing Horizons through Innovative Parenting Systems (CHIPS) (treatment foster care), Cabot Heights (group home) and Meridian (statewide inpatient psychiatric program). Due to budgetary constraints and the challenges of implementing a new program, the project team decided to target youth who were enrolled in each of the programs and to evaluate the effects on youth engagement and outcomes. The Children's WRAP team initially participated in the evaluation but following a change in the supervisor, they chose to withdraw from the evaluation.

## The Evaluation Responded to the Following Research Questions

- RQ 1. Do clients participating in the incentive program demonstrate higher levels of engagement in services than clients receiving treatment as usual (TAU)? (CF SR Outcome: Child Well-being)
- RQ 2. Do clients participating in the incentive program experience greater levels of improvement in functioning than clients receiving TAU? (CF SR Outcome: Child Well-being)

## Description of Primary Service Programs

### Meridian Statewide Inpatient Psychiatric Program:

The Meridian provides intensive inpatient treatment for children and adolescents with severe psychiatric, emotional or behavioral disorders. Designated as a Statewide Inpatient Psychiatric Program, Meridian serves girls and boys from 6 to 17 years old. Services are provided by a multi-disciplinary staff including therapists, case managers, nurses, psychiatric technicians, and a school liaison.

### Changing Horizons through Innovative Parenting Systems

**(CHIPS):** CHIPS is a Medicaid-funded program that provides intensive treatment services to children with emotional disturbances. CHIPS is intended as a short-term therapeutic placement giving children six to twelve months of therapeutic services in a foster home setting.

**Cabot Heights:** Cabot Heights provides transitional or long-term foster care for up to 12 boys ages 13 to 17 who are better served in a group setting than in a traditional or therapeutic foster home. If warranted by their assessed needs, individual boys may receive behavioral health services as well. All referrals to Cabot Heights come from the state's child welfare system, and emphasis is placed on helping the boys learn skills that will allow them to move to either a family setting or an independent living environment.

## Incentive Program

The incentive program was utilized as a supplement to usual services in all three programs. All youth assigned to either the experimental or control group received usual services provided by the program. Youth who were assigned to the experimental group also received the supplementary incentive program. The incentive program utilizes a client-centered and strengths-based approach to engage the client in setting service goals and deciding upon incentives (rewards) the client receives for successfully meeting her/his goals. The process begins with the program therapist talking with the child and caregiver to discuss issues the child is struggling with. The team (therapist, child, caregiver) then selects an agreed upon behavior the child will work on (e.g., anger outburst). The team then creates a behavior change plan based on what the child feels they can achieve (e.g., I will have no more than one angry outburst per week for one month). The therapist works with the child to help her/him to identify personal resources, strengths, and strategies that they can draw upon to help achieve their goal. The team also discusses things that motivate the child (e.g., Lego playset, going to movies, earning an allowance).

The team selects an incentive that is then paired with their goal. The incentive must be feasible for the program to provide, within reason for the child, and that is realistic in relation to the behavior change. The child's progress is tracked over a set period of time and incentives are provided once a goal has been achieved. Once a goal has been achieved, another behavior, goal, and incentive are set with the expectations increasing slightly as the child continues to make progress (e.g., I will have no more than three anger outbursts per month). All goals and incentives are individualized to the child.

Initially, all three programs used monetary incentives in the form of an allowance where funds were put on a debit-type card. About eight months into the evaluation, the programs all chose to adapt the incentive program by setting up small 'stores' in the therapist's office with three levels. Each level corresponds with a number of weeks a child achieves her/his goal (Level 1 = 1 week, Level 2 = 2 weeks, Level 3 = 3 weeks). Using the same process to select behavioral change goals and incentives as was previously described, the child then decides how many weeks they would like to go with meeting their goal in order to earn their incentive. The magnitude of the incentive (level) increases with the number of weeks. The child is allowed to see the store and select what they would like to earn (e.g., Lego set; coloring set) ahead of time. Then they select the behavior they will work on, the reward and the number of weeks they must go successfully meeting their goal in order to earn the incentive. Children can partially meet their goals if they were successful for one week or two but didn't make it to three, for instance. They would be allowed to select a reward from level 1 or 2. Examples of incentives range from stickers and small Lego sets to coloring sets and games. Typical behavioral change goals are set around anger management, social skills, compliance with medication usage, following directions and appropriate behavior at school.

## Evaluation Procedures

A randomized controlled design was used to evaluate the incentive program in each program. Randomization occurred at the program level. For each program, the Principal Investigator created a random assignment protocol in which youth were randomly pre-assigned to either the control or experimental group based on the order in which they were admitted. Random assignment was determined using the Select Cases and Random Sample of Cases functions in SPSS version 22. Spreadsheets with the random assignment condition for each admit following the initiation of data collection and up to 100 youth were provided to the programs.

The evaluation was kicked-off with a training that was held at the Lakeview Center in Pensacola. In total, there were 17 program coordinators and therapists in attendance. The training covered the process of implementing the incentive program and the evaluation procedures. Following IRB approval, random assignment was initiated on July 7, 2015. Data collection was scheduled to occur on a quarterly basis. Project monitoring entailed the principal investigator checking in on a bi-weekly basis for the first two months and then on a monthly basis with the Lakeview Center's Director of Care Coordination who served as the project manager. The PI also began having monthly status

update calls with the program director of two programs and conducted a status update email check with another. During the check-ins, the PI would ask how implementation was going with the incentive program and if there were any issues with random assignment and evaluation procedures. The PI also tracked random assignment through periodic reviews of the random assignment spreadsheets. Additionally, an on-site booster training was held on April 27, 2016 at the Lakeview Center.

The observation period for this study was from July 7, 2015 – November 18, 2016. However, due to slow enrollment, the first cases were not enrolled until October 2015. Slow enrollment throughout the project resulted in a lower than anticipated sample size. Additionally, some cases were excluded early on due to slow uptake of the incentive program within each of the service programs.

## Measures

**Demographics:** Data on youth's age at the time of admission, racial/ethnic identify and gender were collected from the client face sheets.

**Engagement:** The therapist's and youth's perception of the working alliance and quality of relationship/interaction was assessed using the Working Alliance Inventory (WAI; Horvath & Greenberg, 1994). The WAI short-form is a 12 item Likert scaled survey (1 = never, 2 = rarely, 3 = occasionally, 4 = sometimes, 5 = often, 6 = very often, 7 = always), that includes questions related to the quality of the relationship between client and worker, as perceived by the client and worker. The WAI includes a therapist and client form. Example items from the child form include "(insert therapist's name) and I agree about the things I will need to do in counseling to help improve my situation." And "(insert therapist's name) and I are working toward mutually agreed upon goals." Example items from the therapist form include "(insert child's name) and I agree about the steps to be taken to improve his/her situation." and "We agree on what is important for (insert child's name) to work on." Scores range from 12-84 with higher score indicating stronger perceived working alliance between the therapist and child.

**Youth Functioning:** Youth functioning was assessed by caseworkers at intake, three months and discharge using the Children's Functional Assessment Rating Scale (CFARS).<sup>33</sup> For this evaluation, the team was provided with the CFARS conducted following admission that were either most recent to the child's discharge date or the end of the evaluation observation period. This allowed for some assessment of program effects on functioning comparing differences between the experimental and control groups. Specifically, the four CFARS indices were used. The Relational index includes the ratings of hyper affective, interpersonal relationships, cognitive perception, behavior in the home and danger to others. The Safety index includes ratings of social-legal issues, substance abuse, security management, and danger to self. The Emotionality index includes ratings of anxiety, trauma, and depression, and the Disability index includes rating of daily function, medical issues, and thought processes. Each item (e.g., anxiety) was rated a Likert-type scale reflecting the extent to which it is a problem for the child (1 = no problem, 2 = less than slight problem, 3 = slight problem, 4 = slight to moderate problem, 5 = moderate problem, 6 = moderate to severe problem,

7 = severe problem, 8 = severe-extreme problem, 9 = extreme problem). Index scores were computed based on the mean rating of the items in the index with a higher score indicating greater severity of problems.

## Results

### Meridian Sample Demographics and Outcomes

A total of 77 youth admitted to the Meridian were enrolled in the evaluation. Thirty-nine (50.6%) cases were excluded due to missing data. Of the remaining 38 cases, 17 (44.7%) were assigned to the experimental group and 21 (55.3%) were assigned to the control group. Sample demographics and evaluation outcomes focusing on the subset of cases with complete data are presented in Table 1 below. Across groups the majority of youth were males in the early adolescent age-range and identified as white. Results of bivariate analyses (independent samples t-test and chi-squares) showed that there were no statistically significant differences in age, race and gender between the experimental and control groups. Results of independent samples t-test also found no difference in level of client engagement as assessed by the Working Alliance Inventory on either the therapist or child forms between groups. There were no statistically significant differences in outcomes between the groups in the four areas of functioning (i.e., relationship, safety, emotionality, disability) assessed using the Child Functional Assessment Ratings Scale (CFARS). For both groups, index scores on the Relationship and Emotionality subscales indicated that, on average, youth were experiencing slight to moderate issues with interpersonal relationships and managing emotions. Scores on the Safety index reflect slight problems for both groups and the Disability index scores reflect physical and cognitive disabilities were in the less than slight range.

**Table 1: Meridian Sample Demographics and Outcomes**

Variable	Experimental (n = 17) n (%) or M (SD)	Control (n = 21) n (%) or M (SD)	Group Differences χ <sup>2</sup> / t	p-value
Age	11.76 (2.51)	12.71 (2.05)	t = -1.28	.208
Gender			χ <sup>2</sup> = .315	.575
Female	5 (29.4%)	8 (38.1%)		
Male	12 (70.6%)	13 (69.1%)		
*Race			χ <sup>2</sup> = .216	.642
Asian	--	1 (4.8%)		
Black	3 (17.6%)	5 (23.8%)		
Multiracial	1 (5.9%)	1 (4.8%)		
White	13 (76.5%)	14 (66.7%)		
WAI (therapist) (range 12-84)	48.0 (5.89)	53.5 (8.85)	t = -1.11	.292
WAI (child) (range 12-84)	51.0 (23.19)	67.63 (11.17)	t = -1.72	.116
<b>CFARS</b>				
Relationship (range 6-54)	28.53 (5.54)	29.14 (7.06)	t = -0.29	.772
Safety (range 4-36)	13.41 (3.77)	15.10 (4.88)	t = -1.17	.251
Emotionality (range 3-27)	12.94 (3.78)	12.86 (3.51)	t = -0.07	.944
Disability (range 3-27)	6.88 (1.73)	6.09 (2.26)	t = 1.18	.244

Note. Due to low counts across racial categories, race was collapsed into 'white' and 'nonwhite' categories for analyses. Statistical significance = \*p < .05, \*\*p < .01, p < .001.

### CHIPS Sample Demographics and Outcomes

A total of 39 youth were admitted to CHIPS and enrolled in the evaluation. Twenty-four (61.5%) cases were excluded due to missing data. Of the remaining 15 cases, 9 (60%) were assigned to the experimental group and 6 (40%) were assigned to the control group. Sample demographics and evaluation outcomes focusing on the subset of cases with complete data are presented in Table 2 below. Due to low counts, the results are limited to descriptive analyses. Across groups the average age was between 9-10 years of age. Data on gender and race were missing. Descriptive analysis of the Working Alliance Inventory shows that for both groups, therapists' ratings reflect a moderate-high level of alliance between the therapist and child. The child ratings on the WAI reflect moderate-low levels of perceived alliance among this small sample of youth. Scores on the Relationship Index indicated that problems in this area were less than slight for both groups. Safety, emotionality and disability problems were not considered issues for this small sample of youth following receiving services in the CHIPS program with and without the incentive.

**Table 2: CHIPS Sample Demographics and Outcomes**

Variable	Experimental (n = 9) M (SD)	Control (n = 6) M (SD)
Age	9.78 (4.29)	10.17 (5.38)
Gender		
Female	--	--
Male	--	--
Race		
Asian	--	--
Black	--	--
Multiracial	--	--
White	--	--
WAI (therapist) (range 12-84)	M = 63.75 (2.75)	M = 61.60 (5.17)
WAI (child) (range 12-84)	M = 24.66 (5.32)	M = 32.90 (5.82)
<b>CFARS</b>		
Relationship (range 6-54)	M = 17.44 (8.50)	M = 13.50 (7.15)
Safety (range 4-36)	M = 5.78 (3.70)	M = 6.33 (4.37)
Emotionality (range 3-27)	M = 8.56 (4.59)	M = 7.50 (4.55)
Disability (range 3-27)	M = 4.77 (3.23)	M = 4.17 (2.64)

Note. Statistical significance = \*p < .05, \*\*p < .01, p < .001.

### Cabot Heights

A total of 24 youths were admitted to Cabot Heights and enrolled in the evaluation. One case was excluded due to missing data. Of the remaining 23 cases, 9 (39.1%) were assigned to the experimental group and 14 (60.9%) were assigned to the control group. Sample demographics and evaluation outcomes focusing

on the subset of cases with complete data are presented in Table 3. Across groups, the average ages were in the mid-adolescent range and the difference in mean ages between groups was not statistically significant. Data on gender, race and the Working Alliance Inventory were missing. Scores on the Relationship, Safety, and Emotionality Indices indicated these were slight problem areas for both groups whereas physical and cognitive disability were considered less than slight problems.

**Table 3: Cabot Heights**

Variable	Experimental (n = 9) M (SD)	Control (n = 14) M (SD)	Group Differences	p-value
Age	15.11 (.94)	16.14 (1.53)	t = 2.00	.059
Gender				
Female	--	--		
Male	--	--		
Race				
Asian	--	--		
Black	--	--		
Multiracial	--	--		
White	--	--		
WAI (therapist)	--	--		
WAI (child)	--	--		
CFARS				
Relationship	M = 18.56 (5.54)	M = 20.93 (3.67)	t = 1.24	.229
Safety	M = 12.11 (2.57)	M = 12.93 (3.99)	t = 0.54	.592
Emotionality	M = 11.89 (2.09)	M = 12.36 (2.02)	t = 0.54	.598
Disability	M = 6.44 (3.77)	M = 5.36 (1.64)	t = -0.82	.351

Note. Statistical significance = \*p < .05, \*\*p < .01, p < .001.

## Discussion

Overall, the results of this evaluation tentatively show that the incentive program did not result in increased engagement or greater improvements in functioning as implemented across all three programs. The results also show that youth appear to be experiencing problems ranging in the ‘no problem’ to ‘slight-to-moderate’ range after receiving services in all three programs. Based on the limited sample, the results regarding the effectiveness of the incentive program are inconclusive. Future evaluations in which a larger sample is obtained could provide sufficient power needed to detect difference in outcomes that may be present but difficult to discern in the present circumstances. There were several limitations to this study. First, issues with low enrollment across the service programs resulted in a lower than anticipated sample size. Despite extending the study period, these issues persisted. Additionally, for several cases in the sample, there was a substantial amount of missing data resulting in further exclusion of cases.

Following initial challenges with uptake, the therapists figured out how to best implement the incentive program in their settings. The feedback received about the program was very positive.

Some therapists expressed that it was a very useful program and felt it was motivating the youth they were working with. Due to low costs associated with implementing the incentive program it will be sustained in Meridian and possibly the other programs depending on continued interest beyond this evaluation. Some initial reluctance to implement the incentive program was observed but at least part of this was due to the evaluation design and therapists feeling that it was not fair to provide some youth with an incentive while others in the same program were not eligible.

## Recommendations for Research

Child and family engagement are essential elements of effective child welfare services. There is a need for continued efforts to identify strategies to bolster engagement; a long-standing issue impacting the effectiveness of child welfare services outcomes. Future evaluation of innovative programs like the incentive program, should focus on ensuring conditions are conducive to conducting a high quality and rigorous evaluation. The use of small test pilots and planning grants could help set up such studies. Additionally, future evaluation of the incentive program should aim to include a focus on the family in addition to the child, as family involvement is key to achieving positive youth outcomes.

## Recommendations for Practice

**Family engagement content should be in Pre/In-service training including but not limited to: 1) benefits of family engagement; 2) barriers to family engagement; and 3) strategies for family engagement.**

Family engagement is an essential element of effective child welfare service delivery. Educating front-line staff and service providers on family engagement principles and strategies as part of pre-service or in-service training is recommended. There is a need for continued efforts to identify strategies to bolster engagement because this is a longstanding issue impacting the effectiveness of child welfare services outcomes.

**Service providers should be prepared to undergo evaluation in an attempt to enhance the evidence-based acumen in child welfare.**

Future evaluation of innovative programs like the incentive program, aimed at enhancing client engagement, should focus on ensuring conditions are conducive to conducting a high quality and rigorous evaluation. Additionally, since there is focus on integrating evidence-based practices into child welfare services service, providers should have a foundational understanding of evidence-based practice and evaluation. These are prerequisites to child welfare service providers' preparedness to partner with researchers in the conduct of evaluation and in the integration of research into practice. Providing introductory training in evidence-based practice and evaluation to service providers may be a necessary step toward widespread uptake of evidence-based child welfare services.

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