REPORT TO THE INTERAGENCY COORDINATING COUNCIL FOR BUILDING HEALTHY FAMILIES AND THE DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

Evaluation Elements 1-6
Final Report

Submitted by
The Office of Community Projects
The Graduate College of Social Work
University of Houston

August, 2009

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Family Service Association
Family Services Center
Family Support Services
Florida Department of Children and Families
FRIENDS National Resource for Community Based Child Abuse Prevention
The Harbor Children's Alliance and Victim Center
Healthy Family Initiatives Houston
Healthy Families San Angelo
Iowa Department of Human Services
Kentucky Cabinet for Health and Family Services
Llano Estacado Alliance for Families (LEAF)
Michigan Children's Trust Fund
Michigan's Zero to Three Initiative
Minnesota Children's Trust Fund
Missouri Children's Trust Fund
Missouri Department of Social Services
Montgomery County Youth Services
Nevada Children's Trust Fund
North Carolina Division of Social Services
Ohio Children's Trust Fund
Oklahoma Children's Trust Fund
Oregon Commission on Children and Families
Parenting Center Fort Worth
Parenting Cottage
Pennsylvania Office of Children, Youth, and Families
Prevent Child Abuse Delaware
Raising Texas
Tennessee Children's Trust Fund
The Texas Department of Aging and Disability Services
Texas Department of Family and Protective Services (DFPS)
Texas Division of Prevention and Early Intervention (PEI)
Texas Integrated Funding Initiative (TIFI)
TRIAD Prevention Program
United Way of San Antonio & Bexar County
Washington Council for Children and Families

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EXECUTIVE SUMMARY

The Interagency Coordinating Council (ICC) and the Department of Family and Protective Services (DFPS) are engaged in the coordination of child abuse and neglect prevention and early intervention services among Texas state agencies. To assist them in these efforts, the Office of Community Projects (OCP) at the University of Houston Graduate College of Social Work, in collaboration with the Center for Public Policy conducted an evaluation related to financial structures, efficiency, outcomes, program development and quality assurance. Within each of these areas there are a number of opportunities for the ICC, with the help of its members, to further the development of child abuse prevention programming and policy within Texas. After extensive interviews, research, and document review the OCP has outlined a number of strategies in this report that are directed at systems change while recognizing the limited resources of all the stakeholders involved.

Evaluation Element 1: Identify and evaluate streamlined funding mechanisms for programs and services for the prevention of and early intervention in child abuse and neglect
  - Although collaborative and coordinated funding remain a challenge on the state, regional, and local levels, there are multiple opportunities available to move closer to these goals.
  - Several challenges to braiding and blending funds were identified, but there are also numerous strategies that will assist the state, and regional and local programs to coordinate funding.

Opportunities for the ICC and DFPS to facilitate collaborative and coordinated funding include:

  - Invite the participation of nationally recognized, experienced, non-profits (i.e. Prevent Child Abuse America Texas, the Children's Defense Fund Texas) to participate on the Interagency Coordinating Council (ICC). This can add to the resources of the group and open up dialogue regarding what state level collaborative opportunities exist for funding as well as service provision.

  - Develop and maintain a database with information on the prevention programs supported by each state level department in Texas. This should be updated as needed and should include locations, services offered, curriculums used, funding sources and levels, and contact information. This would be the first step towards developing a more integrated collaborative effort of child abuse prevention services in the state. It would also help to address the limited resources of most

departments and local organizations by connecting them with a network of providers with whom they can collaborate.

- Host a "funders meeting" at the next Prevention and Early Intervention (PEI) conference to bring together federal, state, and local public and private funders. This would facilitate a structured dialogue regarding: alleviating barriers to restricted funding, easing application processes, creating more collaborative funding opportunities, and establishing an on-going dialogue for future opportunities..

- Connect with existing Community Based Resource Coordination Groups (CRCG), the Texas Integrated Funding Initiative (TIFI) communities and existing regional and county level collaborations (i.e. the Colonias Project, the Children's Partnership in Austin, and TRIAD in Harris County) to sponsor workgroups designed to facilitate coordinated federal, state, and local funding as well as communication about these efforts. These workgroups could serve as the foundation for a more permanent collaborative funding network throughout the state of Texas.

- Based on these workgroups, establish regional task forces across the state using the resources of existing collaborations (i.e. TIFI sites, Children's Partnership, etc.) as partners in the work of the ICC. These groups could be responsible for local planning as well as dissemination of ICC information and activities.

- Increase the language specificity of the ICC's responsibilities and existence as outlined in statute. Create a more detailed committee/work group structure within the ICC to help in this regard. This could be done in accordance with priorities identified within DFPS' strategic plan.

- Conduct a comparative analysis of requests for proposals among ICC member agencies in order to identify compatible grant funded programs. This would enable ICC member agencies and the organizations with whom they contract to pursue funding collaboratively.

- Work with ICC members to collaborate and structure grant programs so that accountability measures are similar or at least compatible in order to ease braiding and blending of funding.

- Offer a seminar at the Annual Partners in Prevention conference specifically designed to educate community based organizations about opportunities for collaborative funding at the federal, state, and local levels. Resources such as the FRIENDS network could assist in this regard.

- Establish a database accessible through each ICC member's web based home page that will provide community based organizations with the information they need regarding public and private funding sources similar to the Texas

Department of State Health Services Funding Alert. Alternatively, the ICC could collaborate with the Funding Alert to include more prevention and family strengthening funding opportunities on that resource.

Evaluation Element 2: Determine how to best evaluate the cost-effectiveness of state-funded programs and services for the prevention of and early intervention in child abuse and neglect

- Synthetic life cycle models can provide a foundation for understanding the long-term indirect costs of child maltreatment
- The Chapin Hall protocol is a model the state can use for future analyses of the long-term indirect costs of child abuse and neglect to Texas
- Cost-effectiveness is a useful tool for examining the efficiency of child abuse prevention programs
- The cost-effectiveness ratios of PEI funded agencies varied, but the results of the analysis indicate that there are several whose programs are cost effective.

Opportunities for the ICC and DFPS to strengthen the cost-effectiveness of state-funded programs and services for the prevention of and early intervention in child abuse and neglect:

- Review and consider adoption of a research program similar to LONGSCAN, but also consider following the children well into adulthood using a panel study

- If funding is not available, then in lieu of a panel survey Adopt the Chapin Hall protocol

- Continue to train agencies on PEI data system entry to improve data quality. Specifically, to ensure that protective factors survey scores and program completion dates are consistently entered into the database

- Use cost-effectiveness analysis rather than average cost per family served to assess efficiency

- Compare the cost-effectiveness of agencies with similar goals, serving similar populations in order to identify the most efficient interventions

- To facilitate the comparison of programs serving similar populations, develop a measure to better assess client's level of risk. For example, if all programs were required to identify risk factors, a summative score of risk factors in the PEI data system could fulfill this purpose

- Provide more opportunities for agencies with similar goals, serving similar populations to dialogue with Texas and out-of-state agencies regarding effective and efficient implementation

Evaluation Element 3: Evaluate the effectiveness of state-funded child maltreatment prevention programs and services in achieving their intended outcomes

- Instruments currently being used by PEI funded agencies are reliable and valid
  - Consistent use by all agencies should be encouraged
  - Increased monitoring is necessary to decrease data entry errors related to demographics and survey results
- Statistically significant increases from pre to post test protective factor surveys were observed
- Respondents appeared very satisfied with child abuse prevention services
- There was a very low rate of substantiated child abuse cases among program participants

Opportunities for the ICC and DFPS to strengthen the effectiveness of state-funded child maltreatment prevention programs and services in achieving their intended outcomes:

- Continue to monitor the number of participants that complete the pre and post-tests in order to identify solutions to the large number of program participants who fail to complete both of the tests while in the program

- Continue to assess the validity and reliability of the survey instruments being implemented by the contractors since the external and internal environments may change and impact the appropriateness and validity of the instruments

- Add demographic data including age, race/ethnicity, and agency to the satisfaction survey. This will preserve respondents' anonymity while allowing in dept analysis of participants' satisfaction

- Consistently review the PEI database in order to quickly identify and address problems with data entry. This will help to avoid critical errors such as variation in the recorded race/ethnicity of the participants

- Encourage agencies to use the PEI outcome report developed by DFPS for continuous program improvement

- Use evaluation results and other reports to demonstrate the effectiveness of child abuse prevention programs at increasing protective factors and decreasing the likelihood of abuse and neglect.

Evaluation Element 4: Identify methods for transitioning state-funded child maltreatment prevention programs and services to an increased reliance on evidence-based practices.

- Despite the challenges surrounding EBP most PEI funded child abuse prevention agencies have correctly implemented and maintained fidelity to these models
- Numerous opportunities exist to strengthen the use and understanding of EBP among various stakeholders

Opportunities to increase the EBP of state-funded child abuse prevention and early intervention programs

- Use experts in EBP (i.e. FRIENDS, SAMHSA's National Registry of Evidence Based Programs and Practice etc) to provide training and educational materials to all essential stakeholders (legislators, administrators, contract staff, program specialists etc). Opportunities include:
  - o Continuing education opportunities and workshops at the Partners in Prevention conference
  - o Webinars and list serves to connect Texas programs to others using similar curriculum around the country

- Consider sponsoring start up training for one or more new EB programs. The training can be open to all child abuse prevention service providers to support an increased use of EBP across the state

- Assist contract and program specialist staff in strengthening their understanding of the curriculum used by grantees. This is essential for programs to receive the necessary support to set realistic outputs and outcomes, evaluate their efforts, and maintain fidelity

- Facilitate interaction between program specialists and contract staff to assure that grantees receive consistent messages about the importance of implementation fidelity and cost-effectiveness

- Encourage program specialists to establish and maintain contact with developers of curricula used by grantees. This would result in stronger contract arrangements and a more stable support network for grantees

- Assist grantees in developing clear logic models for each of the programs they have in place. This will help PEI grantees, DFPS, and ICC members to clearly define desired program outputs and outcomes based on input from agencies and a clear understanding of the resources necessary to effectively implement the specific curriculum each program uses

- Create clear expectations regarding the EBP level required by administrators and legislators.

- Take EBP requirements into consideration when structuring RFPs and contract requirements. This includes setting reasonable expectations regarding the number of unduplicated clients to be served, budgeting resources for hiring skilled workers, providing initial and ongoing training, and technical assistance, and evaluating EBP at the appropriate level

- Include a rating of the agency's logic model in the grant proposal review process to determine if the proposed EB program is congruent with agency goals, resources, and client population. (The system could be composed of three levels: absent, minimal, evident)

- Provide feedback to agencies on the rating results to assist them in strengthening their understanding of the factors affecting the selection of an EB model

- Account for program evaluation in contract budgets. This is necessary to successfully monitor outcomes across programs

- Facilitate interaction between providers implementing the same EBP. Encourage collaboration in purchasing required training and program supplies as well as problem solving

Evaluation Element 5: Evaluate existing methods for the ongoing identification of additional opportunities for comprehensive improvements to the delivery of services for the prevention of and early intervention in child abuse and neglect.

- Well structured continuous program improvement (CPI) and quality assurance (QA) systems in this area require continuous feedback to all stakeholders as well as appropriate funding levels and infrastructure development.

   Opportunities for the ICC and DFPS to strengthen CPI/QA of child abuse prevention and early intervention services and programming include:

- Develop a framework for creating measures

   The particular challenge in implementing this step is encountered by agencies engaged in prevention services. That challenge involves selecting outcomes to measure most appropriately that a given intervention actually resulted in prevention of child abuse and neglect. While, clearly, the ICC has tackled this numerous times and is somewhat confined to those outcomes mandated by regulatory agencies, there is opportunity for the personnel charged with developing QA and CPI programs to creatively design measures that reflect ICC members' activities and measure their impact. It is suggested that a closer partnership with intervention programs could be productive in this context. The

goals of Safety, Permanency and Child/Family Well-being contained in the Child and Family Service Reviews (CFSR) can serve as guidelines for the development of CPI in prevention programs. These goals could prove effective as a framework for a performance improvement measure since it allows for standards, benchmarks and indicators in the three separate but related spheres of agency operations that may best measure the efficacy of the agencies in meeting their missions. Creating metrics by category also allows agencies to separately analyze their competencies and challenges more accurately.

- Conduct a Status Review

The purpose of this step is for agencies to examine what factors within each of the three CFSR goals they might be currently tracking and to assess the type, quality and relevance of these factors to their self-evaluation, client service and planning. This can be accomplished in partnership with colleagues in child protection or consultants who assist in collecting the information through interviews, surveys of agencies' staff, and through secondary information about best practices in other communities. Also of importance is a comparison between data tracked by agencies and data required by regulatory and funding entities. Once the review is completed and the data analyzed and reported, the next step is to ascertain the standards in each of the three content areas (Safety, Permanency and Child/Family Well-being) against which it would be most appropriate for agencies to measure their performance.

- Select standards, indicators and benchmarks

In collaboration with a consultant or the QA lead staff, standards of care need to be agreed upon by the agencies. An example of a standard in the client experience category might be: "clients who arrive on time for appointments will be seen by workers within 15 minutes of appointment time." These standards of care can be created from a combination of those:

- currently being used by agencies
- mandated by regulatory agencies
- other sources as determined by the agencies

Once consensus is reached by the agencies and the state on standards, then specific indicators of those standards can be set. Indicators are observable features that are used to measure the standards. An indicator from the standard listed above might be a daily record of the wait time for patients with appointments. Indicators are constructed in such a manner that assures they are observable and measurable. Finally, once the indicators for each of the standards are established, benchmarks are set. These are the goals—the performance levels that agencies set for each of the indicators. Again using the previous example, agencies might determine that within 6 months of project,

initiation agencies' operations will result in "90% of clients being seen by staff within 15 minutes of scheduled appointment time."

- Create a performance measure instrument and schedule

  Once the factors to be measured have been agreed upon then a measurement tool is developed by the consultants or QA lead staff for review and final approval by the agencies. The instrument(s) should be computer based if possible and, as much as is feasible, not require duplicate entry of information. Performance measure instruments already known to or in use by the agencies can be directly employed or modified by the agencies if they prove to be valid, relevant measures of the established indicators, especially if they demonstrate ease of use.

- Schedule and Implement

  Logistics for conducting the ongoing data collection are constructed for each agency in collaboration with consultants or QA lead staff. This includes staff assignments, data handling, data storage, and analysis and reporting strategies. Once the measurement instruments have been established, the schedule for implementation of reviews should be decided. The schedule can be on-going, intermittent or a combination of these.

- Establish guidelines and methods for analysis and application of measures to performance review and refinement of practice

  Although listed as a final step, this process is in fact conducted throughout the entire project and informs each step. At the conclusion of the development phase of the project, a training seminar is conducted on the use of the instrument(s) with emphasis on their application in informing practice. At intervals throughout the implementation of the performance review process, agencies assemble with the consultants or the lead QA staff to review the logistics and results of the review and revise the instrument(s) or process, as needed.

- Establish a structured mechanism in order to supply providers with feedback regarding overall progress towards their goals and objectives as well as challenges that they face. This would involve moving beyond output reports available through the PEI data system. A first step in this regard could be disseminating the state's yearly report to providers.

- Begin to dialogue with federal, state and local funders regarding the challenges and benefits of implementing and funding CPI/QA/ improvement. This would allow for a focused and comprehensive conversation on the issue while allowing for input from the diverse communities that fund child abuse prevention.

- Conduct a cost analysis of the implementation of an evidence-based continuous program improvement/quality assurance system for child abuse prevention programs and practices in the state of Texas in order to inform adequate funding of these efforts.

- Establish a peer to peer CPI/QA system among programs funded by the Division of Prevention and Early Intervention in order to supplement and support the current efforts of the program specialists who work with these programs.

Evaluation Element 6: Cost Analysis of Child Maltreatment and Analysis of Funding for Child Abuse Prevention

- Increased funding for child abuse prevention and early intervention at the state, regional and local levels requires governmental, departmental, and organizational goals that support coordinated procurement strategies, knowledge of financial policies and procedures, awareness of the goals and activities of other agencies working in this area, and leveraging of multiple sources of revenue.

Opportunities for the ICC & DFPS to increase funding for child abuse prevention include:

- Establish a work group comprised of the fiscal officers from each state agency that provide funding to programs serving children and families in the state of Texas. Establish commonalities among funding sources as well as opportunities for collaboration.

- Use available resources in order to determine if more state funding can be leveraged to draw down a larger amount of federal Community Based Child Abuse Prevention dollars. The FRIENDS network could assist in this effort given that it is established as the National Resource Center for CBCAP by the US Department of Health and Human Services' Children's Bureau.

- Investigate the possibility of partnering to a greater degree with existing collaborations such as Raising Texas or TIFI in order to further collaborative funding opportunities for all groups.

EVALUATION ELEMENT 1

Identify and evaluate streamlined funding mechanisms for programs and services for the prevention of and early intervention in child abuse and neglect

In order to identify and evaluate streamlined funding mechanisms for programs and services for child abuse and neglect prevention and early intervention, four levels of interviews and document reviews were conducted. These four levels are:

- Community based organizations (CBOs) in the state of Texas
- Regional/county based partnerships in the state of Texas
- Texas statewide collaborations including the Texas Integrated Funding Initiative (TIFI)
- Other states' child welfare organizations

The selection of these four levels was intended to provide the ICC and DFPS with a comprehensive picture of efforts to coordinate services and funding as well as a variety of perspectives that they can use to inform child abuse prevention practice in Texas. Two strategies that were specifically addressed include braiding and blending of funds. Braiding involves money from several sources being used for different components or client groups within a complex program. "Clients experience seamless service delivery and the administrative agency carefully tracks and accounts for the use of each of the funding streams back to its source" (Szekely, 2005, p.5). Blending on the other hand consists of integrating funds from different sources into a single pool from which multiple initiatives can be supported (Szekely, 2005).

More detailed reports on the qualitative interviews with the community based organizations, the regional/county based partnerships, and the out of state departments/collaborations are contained in *Appendix A*.

Texas Community Based Organizations

Community based organizations within the state of Texas were identified through contact with United Way organizations, prevention advocates and other experts who were asked to identify child abuse and neglect providers they considered to be effective and efficient service providers. Nineteen agencies were contacted and 12 agreed to participate. Qualitative interviews were conducted with the executive directors of these agencies to understand how organizations are maximizing funding streams to support

prevention services. If the executive director was unavailable then the interview was conducted with their designee.

A diverse set of agencies participated in the interviews; however, there were several common themes related to the difficulties related to braiding funding. These include:

- The administrative burden of obtaining and coordinating the resources required to track services and maintain financial accounts
- The specificity of funders' program requirements creates inflexibility. The more specific the program components, implementation and outcomes the more difficult it is to braid funds from different sources
- Finding a variety of funding sources for child abuse and neglect prevention

In terms of resources that could weaken or alleviate these barriers, the agencies that were interviewed expressed a range of strategies:

- Having an adequate administrative infrastructure including the staff and software for accounting and outcome tracking unique to each funding source
- Training staff to track clients/services to funding sources so they are able to make the most efficient use of braided funds
- Assistance in identifying funding sources that target similar populations and or services
- Dialoging with funding sources regarding opportunities to increase compatibility of funding streams, in terms of reporting requirements, schedules, accounting and outcomes
- Collaborating with other agencies in order to maximize funding

The last of these strategies, collaboration, was engaged in by all of the agencies interviewed and all but one had formalized these agreements in order to solidify the responsibilities of the members of the collaboration. Several factors that facilitated collaboration were identified:

- Agencies perceive a benefit to participation specific to their organization
- Agencies subscribe to the overall goals of the collaboration
- All participating agencies have a clear understanding of the goals, services and responsibilities
- An identified leader coordinates the efforts of the collaboration - sometimes this takes the form of a lead agency
- Building trust among members - this takes time to build and requires regular meetings to track progress and focus on shared outcomes and benefits of collaboration

There were several barriers to collaboration including insufficient funding to contribute to the collaborative effort as well as limitations of restricted funding that did not allow for flexibility in objectives, tasks, and activities. Finally, agencies indicated that the different policies, procedures, structures, cultures and philosophies of individual organizations sometimes stood in the way of getting the collaboration off the ground.

Texas Regional/County Based Partnerships

Even in a state that is as expansive and diverse as Texas there is often the opportunity for collaboration at the county or regional level. Three collaborations of this type were selected by OCP researchers. These include: TRIAD of Harris County, the TIFI community known as LEAF in the panhandle, and the Children's Partnership in Travis County. Directors from each collaboration participated in phone interviews and OCP researchers reviewed documentation associated with each one.

A common theme across all three of the collaborations interviewed was the importance of integrated funding between the members of the collaborations and in each member organization, leadership that supported the collaborative structure. Both promote a culture that brings individual organizations out of their silos and invests them in working together to achieve common goals regarding prevention. Other factors important to the success of these collaborations include:

- A planning structure that is based on collaborative funding
- Bottom-up as well as top-down communication regarding collaborative funding opportunities
- Clear expectations from public and private funders regarding outcomes, available resources, and an understanding of program processes and needs
- Promoting positive outcomes of collaboration such as increased resources, opportunities to expand the reach of particular initiatives etc.
- Educating other potential partners about using resources more efficiently through collaborative efforts as opposed to separate procurement processes

More detailed information regarding the individual interviews is contained in Appendix A.

State Level Collaborations in Texas

Given the intention of the ICC and DFPS to improve their own efforts at efficiently using existing resources by learning from other state level collaborations, the OCP researchers examined four state level collaborations that work to strengthen children and families. These include the Texas Integrated Funding Initiative (TIFI), Raising Texas, the Colonias Initiative, and the Building Strong and Healthy Families in Texas Initiative.

Texas Integrated Funding Initiative (TIFI)

TIFI was established to assist local communities in developing systems of care for children and youth with complex mental health needs. The original four TIFI demonstration community sites were provided state grant funds. This occurred through the pooling of interagency funds at the state level from the participating state child-serving agencies. Currently, the two operating TIFI community expansion sites are funded through a line item in the Texas Health and Human Service Commission's budget as well as through braiding and separated funding at the local level.

The role of TIFI involves information sharing and policy advising, through service delivery and establishing a community collaborative governance infrastructure. Originally, TIFI was established as a collaboration in which each of the principle partners contributed specific amounts of funding proscribed by legislation. It is modeled in many ways after the federal systems of care and wraparound service delivery approach. At the state level, there is a manager in the Health and Human Services Commission with oversight of policy development, and in the Texas Department of State Health Services that has oversight of the contract management function to the TIFI communities. There is a Memorandum of Understanding (MOU) that exists between the two.

At the local level, two TIFI expansion communities were awarded grants to set up systems of care and wrap around services for approximately ten families a year. In the request for proposal (RFP) it specifies that they must apply for Substance Abuse and Mental Health Services Administration (SAMSHA) funding since the TIFI grant they

receive ($40-$75,000) is seed money. It is also expected that they work to develop local funding.

It was expressed that although TIFI has been successful in promoting the philosophy behind the systems of care model and establishing themselves as a line item in the state budget, there are several barriers at the state level in terms of coordination. These include:

- Staff turnover at the state level which necessitates continuous education of new staff regarding the collaborative vision
- Lack of consolidated tracking and reporting of funding and spending
- Building and maintaining support from the legislature for prevention among other competing priorities
- Lack of understanding of the budgets and fiscal procedures of different state departments which inhibits blending and braiding

Two specific strategies that were suggested to alleviate these challenges were:

- Showing the financial benefits of collaborative efforts to new members as well as funders who could support these efforts
- Increasing the understanding between members of the collaboration regarding the budgets and fiscal policies and procedures that differentiate the different departments

Raising Texas

Raising Texas is an initiative of the Office of Early Childhood Coordination, an unfunded mandate established in 2001. Raising Texas was initiated in 2003 and works to align services for families of children birth to six years of age. There is one facilitator and four teams that address four priorities: access to insurance and a medical home; social emotional development and mental health; early care and education; parent education and family support. Raising Texas has been funded through the US Department of Health and Human Services' Maternal and Child Health Bureau and has worked to bring in other grants to support their efforts.

The initiative has a steering committee composed of nine state agencies as well as the chairs of the four teams. There is also community representation from other public and private organizations. Ideas come to the table through team meetings that are usually held every other month. The teams tackle the goals and objectives of the strategic plan and particular activities are brought to the Steering Committee for

approval. Currently they have established four priorities out of their strategic plan. These were identified by the four teams through a consideration of what each one wanted to pursue in the next year. The selection of these four priorities was based on a desire to demonstrate effectiveness and performance.

It was indicated that they have not begun to coordinate funding among the state agencies to support these activities. This is due to several reasons with the first being that they are working to secure an agreed upon idea of what they want to accomplish as a group. Secondly, given that there is only one dedicated staff member, there has not been time to pursue the foundational work to make coordinated funding a reality. Given the time and resource intensive nature of this activity, Raising Texas instead created a data committee that will initiate a survey of all the Texas Health and Human Services Commission agencies regarding what they spend, the source of these funds, and the number of people they serve.

To sustain this and other initiatives, it was indicated that it will be necessary to obtain legislative support which would mean the legislature seeing this as a priority and dedicating funds to it. This will only be possible if Raising Texas is able to demonstrate an impact on the population they serve. It will also be necessary for the members of the initiative to see results because there will not be buy-in if there is no steady progress towards their goals.

It was reported that although they have made progress over the last few years, collaboration at the state level is difficult because everyone must also focus on meeting the individual objectives of their organizations. In addition, organizations often find it challenging to find the time and appropriate venues to communicate with one another about possible shared opportunities. More money might help alleviate some of these barriers. However, given the limited resources at the federal and state levels, Raising Texas has focused on pursuing private funding sources.

The Colonias Initiative

This effort was established approximately nine years ago in order to improve Colonias residents' access to public services. It consists of a work group at the state level that represents agencies of the Health and Human Services Commission, the

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Texas Education Agency, the Texas Workforce Commission, and Texas A&M University. They act as a strategic planning and problem solving group; however, there is no coordination of funding. However, each agency provides in-kind or in-house resources as a part of the strategic plan.

There are four planning groups that assist the 5 regions of El Paso, Del Rio, Eagle Pass, Laredo, and The Rio Grand Valley (Del Rio and Eagle Pass are considered one region). These groups are facilitated by a regional Border Affairs staff member. One of the major challenges the collaboration has faced includes maintaining the collaboration over time due to staff turnover at the state level that requires retraining and reeducation regarding the initiative's purpose and the distance between services areas and the leadership group.

Despite these difficulties, the Colonias Initiative has worked to create a one stop shop for clients and to assist agencies in their outreach to clients. Resources that have made this possible so far include:

- Leadership that has supported collaborative efforts from the start
- People invested in improving the work that they do
- Paid staff in each region which enhances accountability

Building Strong & Healthy Families in Texas

This initiative is based in the Texas Attorney General's Office and grew out of the Child Support Division's early work with young, unmarried fathers. It currently operates as a federal demonstration project that targets young, unmarried couples and provides wrap-around services beginning at the child's birth. It is a collaborative funding effort with TANF money through the Health and Human Services Commission, private grants, and federal child support funding secured through a Title IV-D waiver. Two sites (Health Families San Angelo and Health Family Initiatives Houston) are the local service providers. Funding is blended; however, several challenges to this type of coordinated funding were reported. These include:

- Restrictions on expenditures
- Multiple reporting requirements
- Expectations regarding institutional roles (i.e. child support working in child abuse prevention)

Overcoming these barriers to success as well as making the collaboration possible requires:
- Trust between agencies
- Creation of a logic model connecting collaborative efforts to goals/outcomes
- Shared interest
- Identified resources that each agency can contribute to and will receive from the collaboration
- Executive leadership support that communicates the priority of collaboration throughout the department

It is also essential for the collaboration to not only plan, but to produce a tangible product in order to create a vested interest among the partners.

Collaborations in Other States

The purpose of this part of the evaluation is to inform the Texas Interagency Coordinating Council (ICC) and the Department of Family and Protective Services (DFPS) of coordinated child abuse and neglect prevention efforts in other states. Primary areas of interest include the structure, policies and practices, and efforts that are employed especially in the area of the coordination (braiding and blending) of funding.

States were identified through four different strategies. The first was a review of state child maltreatment department web pages. This proved minimally successful in identifying contacts. Therefore the lead agency contact list from the FRIENDS National Resource Center for Community Based Child Abuse Prevention as well as the Title IV-E list serve were utilized to arrange interviews with other appropriate individuals. Every state was contacted resulting in qualitative interviews with 17 states from diverse regions of the United States (see *Appendix A* for listing and detailed interview reports). The collaborations in these states were primarily focused on child abuse prevention although in the cases of Colorado and Oregon, the collaborations housed all prevention efforts in the state.

Collaborative structures of the 17 states interviewed included:
- Children's trust funds
- Location within the state child welfare or human services department
- Part of the governor's office
- Umbrella organization for all types of prevention efforts in the state

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- Relationships with private organizations to which prevention services are outsourced

There were common themes that developed through the extensive interviews with the representatives from the state level collaborations. Among larger states this included the need for regional and local level networks through which information could be communicated and assistance provided to all service providers. In terms of membership, there was frequently legislatively mandated participation from a variety of state agencies. All of the collaborations that were interviewed had representation from parents or other members of the public including professionals well versed in the field of prevention. Although few states had membership from their state legislature, those that did indicated it promoted legislative buy-in for their efforts.

There were several responsibilities that were common among the collaborations in other states. These include:

- Funding of prevention initiatives at the county and local level
- Planning and/or development of statewide prevention initiatives
- Provision of technical assistance and support to grantees as well as other state agencies

Collaborative funding was mentioned by only a handful of states interviewed although all were actively working on making this strategy a reality. Several common challenges to these efforts include:

- Restricted funding
- Reporting requirements
- Turf issues
- Lack of top-down support/leadership

Buy-in from collaborative partners as well as the legislature was indicated as an essential factor to overcoming these barriers. More specifically, several states mentioned that high level officials must make the decision to value and fund prevention efforts, especially in the area of universal prevention. Those states that appeared most advanced in terms of collaborative funding stressed the importance of understanding the fiscal rules and procedures of the members of the collaborative.

Opportunities for the ICC & DFPS to facilitate streamlined funding at the community level include:

1) Conduct a comparative analysis of requests for proposals among ICC member agencies in order to identify compatible grant funded programs. This would enable ICC member agencies and the organization with whom they contract to pursue funding collaboratively.

2) Work with ICC members to collaborate and structure grant programs so that accountability measures are similar or at least compatible in order to ease braiding and blending of funding.

3) Connect with existing Community Based Resource Coordination Groups (CRCG), Texas Integrated Funding Initiative (TIFI) communities and existing regional and county level collaborations (i.e. the Colonias Project, the Children's Partnership in Austin, and TRIAD in Harris County) to sponsor workgroups designed to facilitate coordinated federal, state, and local funding as well as communication about these efforts. These workgroups could serve as the foundation for a more permanent collaborative funding network throughout the state of Texas.

4) Offer a seminar at the Annual Partners in Prevention conference specifically designed to educate community based organizations about opportunities for collaborative funding at the federal, state, and local levels. Resources such as the FRIENDS network could assist in this regard.

5) Establish a database accessible through each ICC member's web based home page that will provide community based organizations with the information they need regarding public and private funding sources similar to the Texas Department of State Health Services Funding Alert. Alternatively, the ICC could collaborate with the Funding Alert to include more prevention and family strengthening funding opportunities.

Opportunities for the ICC & DFPS to facilitate coordinated funding & other cooperative efforts at the state level include:

1) Invite the participation of nationally recognized, experienced, non-profits (i.e. Prevent Child Abuse America Texas, Children's Defense Fund Texas) to participate on the Interagency Coordinating Council (ICC). This serves to add to the resources of the group and open up dialogue regarding what collaborative opportunities exist for funding as well as service provision.

2) Develop and maintain a database with information on the prevention programs supported by each state level department in Texas. This should be updated as needed and should include locations, services offered, curricula used, funding

sources and levels, and contact information. This would be the first step towards developing a more integrated collaborative effort of child abuse prevention services in the state. It would also help to address the limited resources of most departments and local organizations by connecting them with a network of providers with whom they can collaborate.

3) Host a "funders meeting" at the next PEI conference in order to bring together federal, state, and local public and private funders. This would facilitate a structured dialogue regarding: alleviating barriers to restricted funding, easing application processes, creating more collaborative funding opportunities and establishing an on-going dialogue for future opportunities.

4) Based on the regional/county workgroups, establish regional task forces across the state using the resources of existing collaborations (i.e. TIFI sites, Austin Children's Partnership etc.) as partners in the work of the ICC. These groups could be responsible for local planning as well as dissemination of ICC information and activities.

5) Increase the language specificity of the ICC's responsibilities and existence as outlined in statute. Create a more detailed committee/work group structure within the ICC to help in this regard. This could be done in accordance with priorities identified within DFPS' strategic plan.

EVALUATION ELEMENT 2

Determine how to best evaluate the cost-effectiveness of state-funded programs and services for the prevention of and early intervention in child abuse and neglect

Four questions guided the evaluation team in assisting the ICC and the Department of Family and Protective Services in determining the cost-effectiveness of child abuse prevention and early intervention programs in Texas. These included:

1) What are the long-term indirect costs of child abuse/neglect to Texas state government?

2) What are the best practices in measuring cost-effectiveness of child abuse/neglect prevention programs that could be implemented on an ongoing basis?

3) How are state-funded child abuse/neglect prevention programs cost-efficient?

4) How can state agencies improve the cost-effectiveness of their child abuse/neglect prevention spending?

In order to answer these questions, the evaluation team undertook three tasks. The first task was the development of a synthetic life cycle model in order to illustrate the long-term indirect costs of child abuse/neglect as they pertain to individuals versus aggregate costs that were addressed in an earlier report to the ICC.[1] The second task was a comprehensive literature review that identified the essential components of cost-effectiveness analysis and the challenges of conducting it within the context of child abuse prevention[2]. The third and final task was two-fold. It included assessment and analysis of the specific cost and outcome data available from the Texas Division of Prevention and Early Intervention in addition to the development of a cost-effectiveness

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[1] "Synthetic" estimates of work-life earnings are created by using the working population's 1-year annual earnings and summing their age-specific average earnings for people ages 25 to 64 years. The resulting totals represent what individuals with the same education level could expect to earn, on average, in today's dollars, during a hypothetical 40-year working life. A typical work-life is defined as the period from age 25 though age 64. While many people stop working at an age other than 65, or start before age 25, this range of 40 years provides a practical benchmark for many people (Day & Newburger, 2002, p. 1).

[2] A comprehensive literature review was submitted to the ICC at an earlier date. A copy is contained in Appendix B of this report.

strategy that ICC members and other stakeholders such as members of the Texas legislature can use in the future.

Life Cycle Models

Cost-benefit analysis is a standard efficiency assessment tool that weighs indirect and direct costs and benefits to determine the most appropriate allocation of resources. There are several challenges related to conducting cost-benefit analysis in the field of child abuse prevention. These include (Daro, 1988):

- The intangible nature of a number of the goals involved in this work
- The use of discounting that does not take into account the prolonged nature of the efforts involved in child abuse prevention
- The lack of consensus regarding what benefits and costs to include
- Difficulty in the availability and quantification of indirect benefits

Although an estimation of cost is supported by research that has identified outcomes for children with a history of child abuse and neglect (Wang & Holton, 2007), building on these studies to isolate specific costs would require the use of panel studies.[3] A prime example of the power of panel surveys is the Panel Study on Income Dynamics (PSID), a federally funded study that dates back to 1968. Although ideal, this research is also expensive, exhaustive, and time-consuming thereby necessitating another avenue for programs and state agencies that must provide concrete evidence that scarce resources are being put to the best use.

Another available technique is the synthetic Life-Cycle model. This tool is used at places such as the Census Bureau and has the advantage of using actual data to formulate experiments of conditions individuals face over the course of their lifetime (Day & Newburger, 2002). A life-cycle model assumes that individuals maximize their

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[3] Panel studies use surveys or other data collection methods to follow a particular group over time. In general the cohort of interest can be composed of individuals or geographic areas as well as subsets of these groups. At the least, two points in time are established at which to obtain information. Panels can be used to isolate either a discrete event, which occurs between the survey waves, or how changes in some variables effect other variables between waves as well as over time. Panel analysis assists in explaining dynamic processes (Johnson, 1988), by controlling for heterogeneity in the sample and targeting variations in response due to alternations in variables that predict change in the population under consideration. It also provides researchers with the ability to take a particular time period and measure the length, occurrence, and rate of recurrence of events (Duncan & Kalton, 1987). This can be especially intriguing when examining rare populations whose specifications can get lost in aggregate samples. An example of this technique is the PSID (http://psidonline.isr.umich.edu/)

expected discounted utility considering uncertain and uninsured labor income and rate of return risk (Ball, 2008). In other words, individuals' decisions or behaviors vary

Traditional life-cycle models use both endogenous factors (household income or demographic profiles) and exogenous factors (government policy or stock market downturn) and forecast the effect of these factors on an individual's economic condition. For our purposes, a life-cycle model can be employed to evaluate the long-term indirect costs of child maltreatment in terms of predicting and comparing future life circumstances. This presents a general picture of the costs of not preventing or lessening the severity of the associated risk factors of child abuse and neglect.

Life-Cycle Models: Assumptions, Methodology and Parameters to Be Considered

In this section we demonstrate the procedures involved in generating the synthetic life cycle model. The parameters involved closely track those employed by the Census Bureau and the Federal Reserve. This provides a link to forecast validity since the simulations are tied to population proportions and results.

There are many possible variables related to the indirect costs of child maltreatment that can be used to conduct these simulations. However, we chose the link between education and income because both variables provide clear links to the overall indirect cost of child maltreatment to the state. A history of child abuse has consistently been associated with lower educational attainment (English et al., 2005; Kilborn & Karoly, 2008; National Working Group on Foster Care and Education, 2008; Stipanicic, et al., 2008; Zolotor, et al. 1999). We trace these consequences in educational attainment to lifetime earnings and tax payments. The implications of these simulations are related to the differential effects of a child receiving services from the state which would ultimately enable a child to achieve his/her economic potential.

The working hypothesis of the life-cycle simulations is that, in the future, the child who is never abused or neglected is likely to have more income than the abused child. And the child who receives early intervention is likely to have more income than the non-treated child (thereby contributing more to society).

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The model components are as follows:

- The Utility Function of Consumption
- The Life-Time Budget Constraint
- The Optimal Level of Consumption

The Utility Function of Consumption

The life-time consumption utility function is:

$$V = \sum_{t=1}^{T} \frac{1}{(1 + \rho)^t} u(C_t),$$

$$(1)$$

where ρ is the discount rate of the utility of consumption at time t. Assuming that the utility function of consumption takes the constant-relative-risk-aversion (CRRA) form:

$$u(C_t) = \frac{1}{1 - \theta} C_t^{1-\theta},$$

$$(2)$$

where $\frac{1}{\theta}$ represents the intertemporal elasticity of substitution between current and future consumption. θ is also called the coefficient of risk aversion.[4] If θ is small (that is, $\frac{1}{\theta}$ is large), the household is less risk-averse and would be more willing to substitute consumption over time, and vice versa. Ball (2008) uses the baseline value of $\theta = 2$. Attanasio and Weber (1995) estimate the risk-aversion coefficient using the consumer expenditure survey data. They find that θ is around 1.5. Gourinchas and Parker (2002) and Alan and Browning (2003) also estimate the coefficient of risk aversion ranging from 0.28 to 2.29 and from 1.2 to 1.95, respectively.

The Life-Time Budget Constraint

We assume that households are not credit-constrained. They are able to choose the level of consumption (C_t) at time t optimally given the level of their life-time income.

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[4] θ is also called the Arrow-Pratt measure of relative risk-aversion which can be defined as:
$$\theta = - \frac{C_t u''(C_t)}{u'(C_t)}.$$

However, the present value of the life-time consumption level for households cannot exceed the present value of their life-time income:

$$\sum_{t=1}^{T} \frac{1}{(1+r)^t} C_t \leq \sum_{t=1}^{T} \frac{1}{(1+r)^t} Y_t,$$

(3)

where r is a constant interest rate, $Y_t - (1 + g_t)Y_{t-1}$ represents the level of income at time t which is growing at rate of g_t, and T is the total of the life-time periods.

The Optimal Level of Consumption

To maximize the life-time utility function in equation (1), we insert the instantaneous consumption utility function (2) into (1) and maximize (1) subject to the life-time budget constraint (3). We have the following Keynes-Ramsey Rule:

$$\frac{1}{(1+\rho)^t} C_t^{-\theta} = (1+r)\frac{1}{(1+\rho)^{t+1}} C_{t+1}^{-\theta}$$

(4)

We now derive the dynamics of optimal consumption level:

$$C_{t+1} = a C_t,$$

(5)

where: $a = \left(\frac{1+r}{1+\rho}\right)^{\frac{1}{\theta}}$. Equation (5) is also called the first-order difference equation. Using equation (5), one can solve the level of consumption at time for $t \leq T$:

$$C_t^* = a^t A_0,$$

(6)

where: $A_0 = \frac{\sum_{t=1}^{T} \frac{Y_t}{(1+r)^t}}{\sum_{t=1}^{T} \frac{a}{(1+r)^t}}$

The Life-cycle Income-Consumption Simulations

Initial Values

Here we assume there are 5 representative individuals (or groups).[5] Group 1 represents the abused group that does not receive intervention. Groups 2 and 3 are the groups who received some type of intervention. Groups 4 and 5 are assumed to be the control groups. For our purposes in this example, these latter two groups could be classified as never experiencing abuse or being at risk but never victimized. Determination of proper control groups would need further refinement in the course of creating the actual design.

To study the differences of the life-time incomes, consumption levels and tax payments among different groups, we also assume that all groups have the same initial income at the age of 17. However, we assume that their income earning characteristics/abilities (e.g., growth rate of income, retirement age and life expectancy) and saving-consumption preferences (e.g., interest rate, risk aversion and discount rate) vary.

Income-Earning Characteristics/Abilities

Recall that based on the literature, we assume that abuse and neglect may have a negative effect on children's education attainment (English et al., 2005; Kilborn & Karoly, 2008; National Working Group on Foster Care and Education, 2008; Stipanicic, et al., 2008; Zolotor, et al. 1999), and this affects lifetime earning abilities (Day & Newburger, 2002;). By assuming that the abused group has the lowest level of educational attainment, we calculate the average income growth rates for different age categories by different levels of education attainment: Note that the categories overlap. This allows us is to compare each group and to determine the changes that can be ascribed to the additional educational level.

- **Group 1:** The average income growth rates of: (1) not a high school graduate; (2) high school graduate; and (3) some college.

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[5] If panel surveys are to be conducted in the future, then determination of various categories would be of critical importance.

- **Group 2:** The average income growth rates of: (1) high school graduate; (2) some college; and (3) associate's degree.

- **Group 3:** The average income growth rates of: (1) some college; (2) associate's degree; and (3) bachelor's degree.

- **Group 4:** The average income growth rates of: (1) associate's degree; (2) bachelor's degree; (3) master's degree.

- **Group 5:** The average income growth rates of: (1) bachelor's degree; (2) master's degree; (3) professional/Ph.D. degree.

To simulate lifetime earnings for different groups, we also assume that they may have different ages of retirement given the nature of their careers. The groups with less education attainments are assumed to retire earlier.[6]

Saving-Consumption Preferences

Based on the life-cycle consumption model described above, we assign the values of the parameters for each group's utility function and budget constraint. We assume that the interest rate (r) and the degree of risk aversion (θ) are consistent for all groups. However, because we assume that persons with less education (Group 1) are more likely to retire early and less likely to save, the discount rate (ρ) for Group 1 is larger than the other groups. Table 1 describes the initial values of the simulations.

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[6] Research suggests a negative relationship between education level and "white" collar occupations and willingness to retire. The intuition behind this relation is that the greater physical demands in "blue" collar occupations make the probability of delaying retirement less likely (see Hardy, 1984 and Hayward et al., 1989).

Table 1: Parameters and Initial Values for the Simulation

Group	Initial Income When age is 17	Annual Real Interest Rate (r)	Discount Rate (ρ)	Risk Aversion (θ)	Retirement Age	Life Expectancy	Tax Rate
Group 1	30000	0.03	0.03	2	60	97	0.15
Group 2	30000	0.03	0.025	2	65	97	0.20
Group 3	30000	0.03	0.02	2	70	97	0.20
Group 4	30000	0.03	0.015	2	75	97	0.20
Group 5	30000	0.03	0.01	2	80	97	0.25

The Growth Rate of Income by Age

Group	18-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	Life-Time
Group 1	0.0151	0.0135	0.0314	0.0135	0.0151	0.0015	0.0117	-0.0017	-0.0185	-0.0185	0.0063
Group 2	0.0186	0.0153	0.0339	0.0153	0.0186	0.0015	0.0077	-0.0021	-0.0273	-0.0273	0.0054
Group 3	0.0179	0.0194	0.0392	0.0194	0.0179	0.0017	0.0129	-0.0057	-0.0359	-0.0359	0.0051
Group 4	0.0088	0.0277	0.0411	0.0277	0.0088	0.0045	0.0081	-0.0041	-0.0368	-0.0368	0.0049
Group 5	0.0000	0.0626	0.0610	0.0626	-0.0014	0.0123	-0.0063	0.0180	-0.0022	-0.0022	0.0204

Figure 1: Lifetime Annual Growth Rate of Income and Gross Income
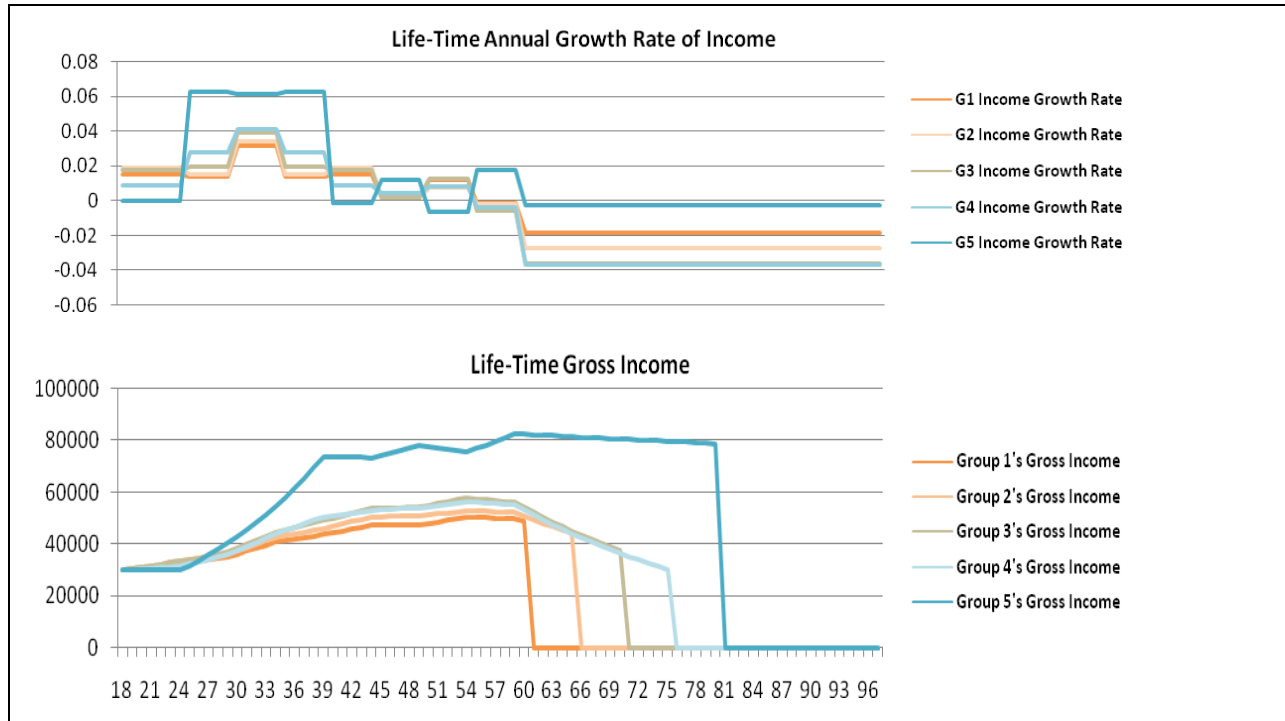
Simulated Lifetime Incomes

Using the model parameters and the initial values, Figure 1 summarizes and reports the lifetime annual growth rates of income for different groups and their simulated lifetime gross income, respectively. A break down of each group's lifetime income by age is contained in Table 2. Table 2 shows that the lifetime income of an individual in Group 1 is about $1,500,000 (within the age of 25 and 64) which is only about 60% of the individual's lifetime income in Group 5. In assessing the benefits of intervention, magnitudes this size have important public policy ramifications and underscore the importance of prevention.

Table2: Gross Income by Age and by Group

Age	Group 1	Group 2	Group 3	Group 4	Group 5
25-29	$34,183.09	$35,075.07	$35,358.34	$34,339.52	$36,123.43
30-34	$38,552.36	$39,996.72	$41,290.80	$40,956.53	$48,708.78
35-39	$42,659.11	$44,707.47	$47,194.26	$48,137.82	$65,796.96
40-44	$45,840.22	$48,709.04	$51,718.87	$52,155.77	$73,706.99
45-49	$47,434.57	$50,742.86	$53,837.58	$53,798.26	$76,252.19
50-54	$49,275.32	$52,077.60	$56,144.88	$55,620.67	$76,665.44
55-59	$50,172.58	$52,550.79	$56,614.35	$55,825.20	$79,882.61
60-64	$9,815.24	$48,192.77	$50,216.41	$49,547.82	$82,208.09
Lifetime Estimate (25-64)	**$1,589,662**	**$1,860,261**	**$1,961,877**	**$1,951,907**	**$2,696,722**

Simulated Lifetime Tax Payments

We also simulate the individual's lifetime tax payments for different groups. Given the tax rates for different groups in Table 1, we simulate the lifetime tax payments for each individual in between the ages of 25 and 64 in Table 3. Each individual in Group 1 pays about $240,000, whereas each one in Group 5 pays $670,000 as the lifetime tax payment. Hence, we see that each individual in Group 1 will pay $430,000 less than an individual in Group 5 --- nearly 66 percent less.

Table 3: Tax Revenues by Age and by Group

Age	Group 1	Group 2	Group 3	Group 4	Group 5
25-29	$5,127.46	$7,015.01	$7,071.67	$6,867.90	$9,030.86
30-34	$5,782.85	$7,999.34	$8,258.16	$8,191.31	$12,177.19
35-39	$6,398.87	$8,941.49	$9,438.85	$9,627.56	$16,449.24
40-44	$6,876.03	$9,741.81	$10,343.77	$10,431.15	$18,426.75
45-49	$7,115.19	$10,148.57	$10,767.52	$10,759.65	$19,063.05
50-54	$7,391.30	$10,415.52	$11,228.98	$11,124.13	$19,166.36
55-59	$7,525.89	$10,510.16	$11,322.87	$11,165.04	$19,970.65
60-64	$1,472.29	$9,638.55	$10,043.28	$9,909.56	$20,552.02
Lifetime Estimate (25-64)	**$238,449**	**$372,052**	**$392,375**	**$390,381**	**$674,180**

Since we also assume that individuals in Group 5 have a longer working life than other groups, we demonstrate in Figure 2 that each individual in Group 5 may pay as much as one million dollars in total tax payments given their lifetime earnings.

Figure 2: Total Collection of Lifetime Tax Payments
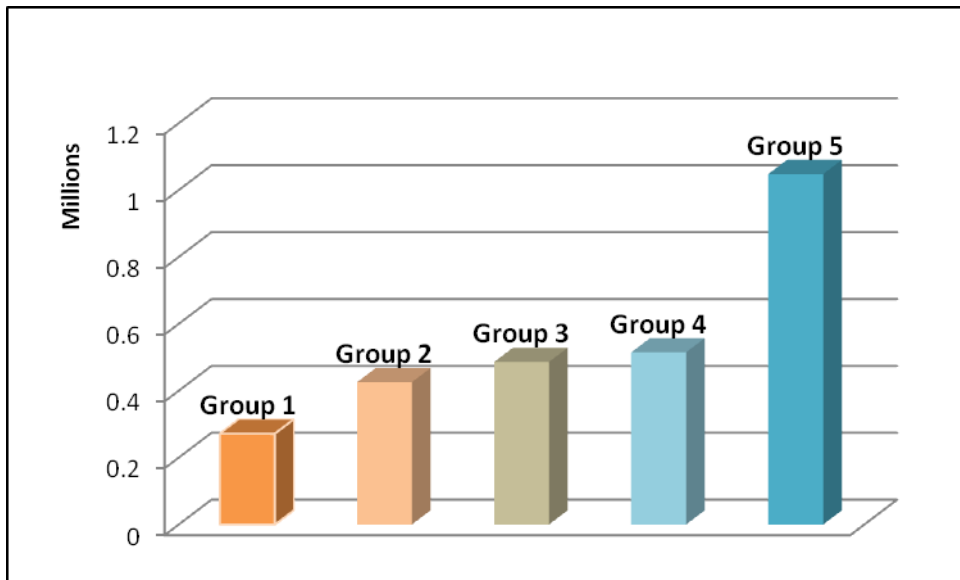
As shown in Figure 2, it is almost 4 times larger than the lifetime tax payments paid by an individual in Group 1.

Summary

In this section of the analysis a Life-Cycle model was used in order to provide a model for examining the indirect costs of child maltreatment to the state of Texas. A Life-Cycle model uses actual data to formulate experiments of conditions individuals face over the course of their lifetime.

Summary of Assumptions

The Life-Cycle model assumes that over time a person makes different decisions due to changes in variables such as household income and that these decisions have consequences for human capital development and can be impacted by government intervention. Linking these assumptions to the Life-Cycle modeling tool provides an analytical device for assessing the costs and ultimate benefits of not preventing or lessening the severity of the associated risk factors of child abuse and neglect. Our specific example focuses on educational attainment as a symbol of human capital development.

Summary of Findings

We examine both lifetime income and lifetime tax payments. Among other things we find the lifetime income of a group with the lowest educational attainment (Group 1) is about $1,500,000 (within the age of 25 and 64). This is approximately 60% of the individual lifetime income of the group with the highest educational attainment (Group 5). As one might expect, the findings for income attainment are highly correlated with lifetime tax payments. We find that individuals in Group 1 pay about $240,000, but individuals in Group 5 pay $670,000 --- or more than 2.5 times the payments of Group 1.

Discussion

The life cycle model is an apporpriate tool for cost analysis in child abuse prevention because of the ease with which factors can be adjusted to simulate various characteristics/abilities and outcomes. It is also beneficial because it provides a general model that could be enhanced with information from a panel study. The results of this life-cycle simulation demonstrate significant monetary benefits are possible. These benefits could ultimately be juxtaposed directly to program costs on a per-capita basis

for aggregate analysis, or for individual analysis to determine the effectiveness of various interventions by case severity.

However, as previously noted, the panel surveys that elicit this information are expensive to create and sustain. Despite their cost, panel surveys do exist for this program and policy area. For example, the University of North Carolina's **Longitudinal Studies of Child Abuse and Neglect** (LONGSCAN) has been in existence since 1990 with grants from the National Center on Child Abuse and Neglect (see http://www.iprc.unc.edu/longscan/). LONGSCAN tracks the same children and their families until the children themselves become young adults. Interviews and assessments are made at various ages, ending at age 18. Data are made available on a restricted basis.

Opportunities for future analysis of long-term indirect costs of child abuse/neglect to Texas:

1) Review and consider adoption of a research program similar to LONGSCAN, but also consider following the children well into adulthood through a panel study.

2) Adopt the Chapin Hall protocol in lieu of a panel survey.

    A less expensive alternative to a panel survey is an approach pioneered by the University of Chicago's Chapin Hall Policy Research Center (see http://chapinhall.org/). Chapin Hall blends administrative databases to provide useful information that can also be augmented with intermittent surveys of the subjects. For child abuse and neglect prevention programs the activities could include:

    • Reorganizing administrative databases with the child as the unit (rather than transactions)

    • Linking this new database (when feasible) with other public and private databases

    • Conduct periodic follow up surveys of children (and their parents)

    As an example, Chapin Hall's research on Foster Care and Adoption has developed partnerships with the relevant state agencies in Alaska, Arizona,

Connecticut, Florida, Georgia, Illinois, Indiana, Maryland, Missouri, New Hampshire, New Jersey, New York, Pennsylvania, Tennessee, and Washington. Among other things, this active partnership involves:

• Agencies providing their foster care and adoption administrative records to Chapin Hall for inclusion in a multistate data repository

• Organization and placement of data into a longitudinal database by Chapin Hall

• Development of a web tool by Chapin Hall to give all relevant administrators data access to create individual or aggregated reports

Measuring Efficiency

Cost-effectiveness analysis was selected to measure the efficiency of state funded child abuse and neglect programs. While there are other approaches to measuring efficiency e.g. cost benefit analysis, the cost-effectiveness methodology is particularly well suited for ongoing assessments because it requires relatively little expertise and uses data readily available in the PEI and TDFPS data management systems. The only limitation of cost-effectiveness analysis is that programs cannot be evaluated independently, but rather in comparison to each other.

Cost-effectiveness draws links between financial inputs and outcomes associated with different courses of action. This technique recognizes that not all results can be quantified as is necessary in cost-benefit analysis. Cost-effectiveness is also useful in comparing across different strategies and is especially beneficial in the field of child abuse prevention given the recognized difficulties associated with monetizing and evaluating impacts in this field (Daro, 1988; De Panfilis et al., 2008; Gift, Haddix & Corso, 2003; Issel, 2004). In addition, where few programs have been shown to be universally effective, cost-effectiveness analysis can be used to compare different implementations of the same evidence based program.

Despite the somewhat flexible nature of this tool, there are several elements essential to its use for accurate assessment and decision making. The first element is appropriate classification of the issue or problem under consideration (Gift, Haddix & Corso, 2003). At the most basic level, programs to be evaluated must be grouped based on common goals or outcomes. Comparing programs with multiple goals or the

inclusion of goals that are amorphous and/or complex makes it difficult to draw conclusions regarding the cost-effectiveness of a particular activity (Levin & McEwan, 2001). In addition to outcomes, determining appropriate groupings should be based on similarity in client populations (Gift, Haddix & Corso, 2003). This is important because costs will vary with the population served and the type and intensity of the units of service that are provided (Barnett, 1993). Thus programs serving high risk participants should not be compared to those serving participants who are at little or no risk of abusing their children and those with rural programs would not be compared to urban programs.

The second element includes selecting the outcome measures that will assist in determining efficiency (Gift, Haddix & Corso, 2003). The selection of outcomes can be challenging due to a scarcity of reliable and valid instruments across programs and inconsistent short and long-term data collection. Typically positive changes in risk and protective factors as well as increases in child and family functioning are used as consistent indicators (DePanfilis et al., 2008). The absence of child maltreatment is also used although this presents several issues.

The first challenge when using absence of maltreatment pertains to population size (De Panfilis et al., 2008). The sample of child maltreatment prevention participants is typically too small to allow for observation of a discernable decrease in abuse rates. In addition, the ability to identify clients who come into the child welfare system as those who had previously received prevention services is problematic if there is not a consistent identifier available for tracking such as a social security number. Finally, there is the issue of creating an accurate cost structure. Cost calculations in the child welfare system use the child as a unit of analysis whereas with prevention services the focus is the entire family. This presents challenges to measuring costs in the same metric.

Identifying relevant costs is the last main element in cost-effectiveness. Attempting to include a comprehensive accounting of indirect and direct cost as well as tangible and intangible factors can result in a complex and incomprehensible model (Gift, Haddix & Corso, 2003). Therefore, it is important to determine the accounting

perspective or whose costs will be considered, the government's, the provider's, society's, or the client's (Kaplan & Groessl, 2002).

Cost-Effectiveness Analysis of Texas Child Abuse Prevention Programs

- Step One: Identifying issue/problem under consideration

The analysis aims to identify prevention services that have the greatest impact for the least amount of money. Although all of the direct impacts of a particular program are important to measure, the diverse goals of both the program types (Community Based Child Abuse Prevention [CBCAP], Texas Families Together and Safe [TFTS], and Family Strengthening [FS]) and the individual agencies made it necessary to narrow the focus to a goal common to all agencies funded by PEI, to prevent child maltreatment.

- Step Two: Selection of outcome measures

One outcome that supports the goal of child abuse prevention and is measured by the majority of agencies contained in the Prevention and Early Intervention System (PEIS) database is an increase in protective factors. Therefore, the average change in protective factors as measured by the Protective Factors Survey (PFS) and recorded by funded programs in the PEIS database was selected as an appropriate outcome measure for the cost-effectiveness analysis. The PFS measures protective factors in five areas: family functioning/resiliency, social support, concrete support, nurturing and attachment, and knowledge of parenting/child development (FRIENDS, 2008).[7]

It should be noted that the PFS has been in development for the past several years with several revisions and only recently (August 2008) was the final validated version incorporated into PEIS. Further, the PEIS system is relatively new and providers are only now beginning to consistently enter information into the database. Only 28.7% of individuals served under CBCAP completed the pre and post tests, 32.7% in Family Strengthening and 46.1% with Texas Families Together and Safe. Overall, less than half (40.01%) completed both the pre and post protective factors

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[7] The last construct is used only when a program addresses parenting/child development through the services they provide.

instrument allowing for it to be used as an outcome measure. This contributed to the reliability and validity issues which will be discussed in full in Element 3 of this report.

Despite these challenges, the positive results discussed in Element 3 and the ability to use the instrument as an outcome measure in this Element provide evidence that DFPS' investment is beginning to pay off. It is anticipated that the data will become increasingly reliable as providers become familiar with the PEIS and the final PFS. However, because of the previously mentioned challenges, agency names were not connected to cost-effectiveness data and the results in this section should be interpreted with caution.

- Step Three: Identification of costs

Costs for this analysis were identified from the perspective of the state. Contract amounts for fiscal years 2006 to 2008 were obtained from the Department of Family and Protective Services. In order to consistently match the time frame of the contract amounts (FY 2006-FY 2008) to data available on the number of families served and services provided (April 2006-July 2008); the contract amounts for 2006 and 2008 were prorated. Agencies that were not listed consistently in all three contract years were excluded from the analysis. All information necessary for the cost-effectiveness formulas was then averaged over this time period.

Analysis and Results

An incremental cost-effectiveness approach (Issel, 2004; Sevick et al., 2000), which measures the cost of each unit of improvement, was used to analyze cost and the average change in the PFS. The following formula was used:

$$\text{Incremental improvement in cost-effectiveness} = \frac{\text{Program cost per family}}{\text{Amount of change in a specific impact indicator}}$$

Only programs with complete data and a statistically significant change in the PFS from pre-test post-test were included in the analysis (N=9).

The incremental improvement in cost-effectiveness for the nine funded programs is presented in Table 4. The high dollar amount associated with a unit of change is a

function of the constricted metric of the PFS measurement scale and should not be viewed in isolation. What is clear from the analysis is that the cost-effectiveness ratio of funded agencies varies dramatically from 1:6,084 to 1:41,070. Comparing program A to program I there is a $22,729 savings per unit of services provided [(1,886 – 5,750)/(.31-.14)].

Table 4: Cos- Effectiveness Ratios

AGENCY	PROGRAM TYPE	Total Families served	Average Cost Per Family Served	Protective Factors Score Change	CE Ratio Cost per Unit of Change
A	TFTS	345	1,886	**0.31**	6,084
B	CBCAP	174	2,873	**0.32**	8,978
C	FS	273	1,179	**0.13**	9,069
D	TFTS	364	3,058	**0.27**	11,326
E	FS	228	2,680	**0.2**	13,398
F	FS	239	1,977	**0.14**	14,121
G	TFTS	400	2,698	**0.15**	17,988
H	TFTS	1093	1,183	**0.05**	23,662
I	TFTS	451	5,750	**0.14**	41,070

The efficiency of agencies of the same program type, programs serving similar populations and those implementing the same evidence based program were compared using the following formula:

$$\frac{\text{(Cost per Family Agency 1 – Cost per Family Agency 2)}}{\text{(Amount of Change in Indicator Agency 1 – Amount of Change in Indicator Agency 2)}}$$

For example two funded programs implementing a home based parent education curricula were compared (See programs B and E in Table 4). Using the formula above,

program B produces a $1,608 savings per unit of change compared to program E [(2,873 – 2,680)/(.32-.20)].

Similarly two programs serving similar populations, one center based program (program H) and one providing predominately home based services (program B), were compared. In this situation, program B, the program with the higher cost per family served represents a savings of $6,258.74 per unit of change [(1,183-2,873)/(.05-.32)].

The average cost per family served (cost per output) is also listed in Table 4. While cost per family served and cost per unit of change are related (r=.73, p=.05) the relationship is still imperfect. For example, program H has the lowest cost per families served ($1,183) but is eighth highest when the cost per unit of change is considered (1:$23,662).

Summary and Discussion of Cos-
Effectiveness Findings

The analysis suggests that cost-effectiveness analysis can be a useful tool in selecting, monitoring and improving child abuse and neglect prevention programs. However, cost-effectiveness analysis is most useful when it is used in conjunction with other data including results from program specific outcome valuations and knowledge of the program context including populations served and the environment in which the program is implemented.

The results of this analysis indicate that PEI funded programs' cost-effectiveness ratios varied dramatically suggesting that some programs may benefit from further examination of their costs, selected interventions, and implementation. Further, the analysis revealed that programs that appear to be efficient using the average cost of service calculation can be the most expensive when outcomes are included in the analysis. This emphasizes the fact that relying on average cost as an accountability measure can lead to false economies and less effective services (Farnham & Haddix, 2003).

Ultimately, the analysis presented above is intended to provide a model that can be used now in addition to forming the foundation for the future calculation of more detailed cost-effectiveness ratios. Future models would be strengthened by the

inclusion of additional outcomes such as improvements in child and/or parent outcomes. This would require the consistent use of common instruments among different programs in order to measure these changes.

Opportunities for the ICC & DFPS to strengthen the cost-effectiveness of state-funded programs and services for the prevention of and early intervention in child abuse and neglect include:

1) Continue to train agencies on PEIS data entry to improve data quality. Specifically, ensure that protective factors survey scores are consistently entered into the database at baseline and program completion

2) Use cost-effectiveness analysis rather than average cost per family served to assess efficiency

3) Compare the cost-effectiveness of agencies with similar goals, serving similar populations in order to identify the most efficient interventions

4) To facilitate the comparison of programs serving similar populations, develop a measure to better assess client's level of risk. For example, if all programs were required to identify risk factors, a summative score of risk factors in the PEI data system could fulfill this purpose

5) Provide more opportunities for agencies with similar goals, serving similar populations to dialogue with other Texas and out-of-state agencies regarding effective and efficient implementation

EVALUATION ELEMENT 3
Evaluate the effectiveness of state-funded child maltreatment prevention programs and services in achieving their intended outcomes

Three tasks were completed in order to assist The Interagency Coordinating Council for Building Healthy Families (ICC) and the Department of Family and Protective Services (DFPS) in evaluating the effectiveness of state-funded child maltreatment prevention programs and services in achieving their intended outcomes. First, the evaluators reviewed the instruments PEI funded agencies use to measure the effectiveness of their work. These tools include the *Prevention and Early Intervention Protective Factors Survey for Caregivers,* the *Protective Factors Survey*, and the *Adult-Adolescent Parenting Inventory* (AAPI-2). The psychometric properties of the instruments were identified using the Statistical Package for Social Science (SPSS) software. After evaluating these tools, a process evaluation was conducted to measure the outputs of the agencies in terms of the number of unduplicated families served, the completion of the *Protective Factors Survey* at both pre-service and post-service intervals, and familial satisfaction with agency participation. The output measures were examined at both the aggregate level and by program type [Community Based Child Abuse Prevention (CBCAP), Texas Families: Together and Safe (TFTS), and Family Strengthening (FS)]. Finally, an outcome evaluation was conducted to assess whether the goals and objectives of the agencies that contract with PEI were achieved. The data were evaluated based on the reported increase of protective factors and the validated incidents of child abuse and/or neglect.

Factor Analysis

Factor Analysis[8] was the first step in identifying the construct validity of *The Protective Factors Survey* scales. "The goal is to reduce a large number of variables to a small number of factors, to concisely describe (and perhaps to understand) the relationship of observed variables, and to test theory about underlying processes"

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[8] We were not able to conduct a factor analysis on the Adult-Adolescent Parenting Inventory (AAPI-2) because the data base only contains five aggregate factor scores. Individual item scores were not provided.

(Tabachnick & Fidell, 2007, p. 610). The method used here is principal component analysis (pca) with varimax rotation. PCA transforms several possibly correlated variables into a smaller number of components while retaining most of the variance in the first factor. Varimax rotation helps to make the output more understandable by decreasing the number of large loadings on each factor according to the largest variance (Pett, Lackey, & Sullivan, 2003)

Protective Factors Survey (Pre-Test)

Only twenty-nine of the items contained in the *Protective Factors Survey* were factor analyzed given that the number of responses on items 30 to 44 was low. A seven-factor solution, accounting for 60.63% of the variance was obtained (Table 5). Only variables with factor loadings of .35 or greater were retained. In the following paragraphs, variance refers to the contributions of the variables in explaining the factor.

The first factor included 12 variables:

- I feel proud of my children71
- I try to comfort my child/ren when something is bothering them
- I can usually tell when my child/ren are upset
- Setting limits (ex. rules, guidelines, structure) keeps kids safe
- I praise my children when they behave well
- My family shows each other love and affection
- In my family, we support one another when something goes wrong
- In my family, we take time to listen to each other
- My family is able to solve our problems
- My family members discuss problems with each other
- I make rules and stick to them
- I look for information to make sure what I expect from child is fair (i.e. internet, hotlines, TV, talking to others)

In general, the items were related to the family's ability to share experiences and mobilize when met with challenges. The factor was given the title, *Family Functioning*, and it accounted for 25.64% of the variance.

The second factor included five variables:

- Boys who cry are weak
- My child/ren misbehave just to upset me
- More bad things happen to my family than to other families

- My family members feel closer to people outside the family than to our own family members
- I don't think my family can survive if another problem hits us

The variables represent the family's unique ability to persevere through challenges through the utilization of adaptive skills and strategies. The variables represent the factor, *Resiliency*, which accounted for 7.69% of the variance.

The third factor included three variables:

- I know where to go in my community to get help with family needs
- When I am worried about my child/ren, I have someone to talk to
- I have neighbors, friends, or relatives that help me when I need it

The variables are representative of the family's perceived access to assistance in times of need. Thus, it received the title, *Concrete Support*, and it controlled 6.18% of the variance.

The four variables that loaded on the fourth factor include:

- I use timeout
- I take away privileges
- I ground
- I try to take a break when I am frustrated by my child/ren's behavior

All of these variables are representative of *Knowledge of Parenting*, as seen through the utilization of effective child management techniques. The fourth factor accounted for 6.06% of the variance.

The fifth factor contained the following three variables:

- Some members of my family lose their temper
- I feel like I am struggling to be a good parent
- When I discipline my child/ren, I have a hard time keeping my feelings under control

These items refer to the support that a caregiver perceives as providing for their emotional needs. The fifth factor was labeled as *Social Emotional Support* and controlled 5.46% of the variance.

The two items of the sixth factor include: "I hit" and "I spank". Both of these items are associated with the incidence of child maltreatment. The factor for these variables, *Abusive Behaviors*, accounted for 5.45% of the variance.

Finally, two items were included in the seventh factor:

- Children learn more from watching what you do than from hearing what you say
- When we have disagreements, family members listen to both sides of the story.

Because of the items' associations with the management of potential conflicts, the factor was labeled as *Coping Behaviors*. It accounted for 4.16% of the variance.

Table 5: Protective Factor Survey: Pre-Test Principal Components Factor Analysis

No.	Variable	Factor						
		I	II	III	IV	V	VI	VII
1.	Setting Limits (ex. Rules, guidelines, structure) keeps kids safe.	.841	.078	.161	.023	-.075	.016	-.101
2.	I have neighbors, friends or relatives that help me when I need it.	.420	-.077	.572	-.018	.020	.058	-.120
3.	My family members feel closer to people outside the family than to our own family members.	.062	.516	-.202	.008	.200	-.004	.043
4.	I know where to go in my community to get help with family needs.	.265	.017	.733	.015	-.016	-.026	.042
5.	My child/ren misbehave just to upset me.	-.007	.764	.102	.021	.048	.093	.086
6.	More bad things happen to my family than to other families.	.059	.730	-.028	.000	.073	-.061	-.106
7.	My family enjoys spending time together.	No Data						
8.	When I am worried about my child/ren, I have someone to talk to.	.465	-.084	.611	.079	.029	.032	.045
9.	I don't think my family can survive if another problem hits us.	-.468	.481	-.057	.031	.147	-.202	.043
10.	Children learn more from watching what you do than from hearing what you say.	.017	.013	.355	.224	.074	-.121	-.572

Table 5: Protective Factor Survey: Pre-Test Principal Components Factor Analysis (continued)

No.	Variable	Factor						
		I	II	III	IV	V	VI	*VII*
11.	I can usually tell when my child/ren are upset.	.842	.050	.133	-.001	.001	.017	*-.135*
12.	Boys who cry are weak.	-.015	.775	-.007	-.060	-.137	.075	*.074*
13.	I praise my child/ren when they behave well.	.835	.048	.069	.060	.010	-.071	*-.060*
14.	My family shows each other love and affection.	.818	-.005	.109	.095	-.042	-.041	*.158*
15.	My family is able to solve our problems.	.710	-.112	.273	.108	.022	.079	*.295*
16.	When we have disagreements, family members listen to "both sides of the story."	.484	-.146	.283	.066	.003	-.074	*.530*
17.	When I discipline my child/ren, I have a hard time keeping my feelings under control.	-.229	.193	.133	.081	.615	.103	*.167*
18.	I try to comfort my child/ren when something is bothering them.	.867	.058	.054	.033	-.035	-.530	*-.015*
19.	My family members discuss problems with each other.	.577	-.001	.253	.147	.142	-.097	*.376*
20.	Some members of my family lose their temper.	-.023	.075	.086	-.043	.752	.158	*-.067*
21.	I make rules and stick to them.	.572	-.052	.095	.321	-.095	.045	*.024*
22.	I feel proud of my child/ren.	.908	.047	.076	-.029	-.033	-.001	*-.054*
23.	In my family, we take time to listen to each other.	.717	-.099	.156	.090	.028	-.124	*.300*
24.	I feel like I am struggling to be a good parent.	.097	-.046	-.146	-.036	.724	.024	*-.046*
25.	*I try to take a break when I am frustrated by my*	*.236*	*.133*	*.184*	*.348*	*.188*	*-.150*	*.270*

	child/ren's behavior.						

Table 5: The Protective Factor Survey: Pre-Test Principal Components Factor Analysis (continued)

No.	Variable	Factor						
		I	**II**	**III**	**IV**	**V**	**VI**	**VII**
26.	In my family, we support one another when something goes wrong.	.756	-.068	.181	.133	.044	-.151	.232
27.	I look for information to make sure what I expect from child is fair (i.e. internet, hotlines, TV specials on parenting, talking to others).	.446	-.030	.202	.326	.098	-.201	.210
28A.	I use timeout.	.020	.009	-.055	.748	-.024	.160	-.088
28B.	I spank.	-.043	.121	-.003	-.079	.096	.847	-.022
28C.	I hit.	-.086	-.081	.014	.096	.180	.829	.042
28D.	I ground.	-.016	-.067	.112	.615	-.012	-.096	-.048
29.	My child comes to me when he/she is feeling upset.	.296	.038	-.068	.665	-.022	.008	.054
	Proportion of total variance	25.64	7.69	6.18	6.06	5.46	5.45	4.16

Protective Factor Survey (Post-Test)

After analyzing items from the pre-test surveys, similar analyses were conducted on the post-test surveys. Items 30 to 44 were excluded due to a low response rate on these items. Accounting for 62.26% of the variance, a seven-factor solution was obtained with the results outlined in Table 6. Only variables with factor loadings of .39 or greater were included in a factor.

The first factor included seventeen variables:

- I feel proud of my children; setting limits (ex. rules, guidelines, structure) keeps kids safe

- In my family, we support one another when something goes wrong
- My family shows each other love and affection
- I try to comfort my child/ren when something is bothering them
- I can usually tell when my child/ren are upset
- I praise my children when they behave well
- My family is able to solve our problems
- In my family, we take time to listen to each other; when I am worried about my child/ren, I have someone to talk to
- I make rules and stick to them
- I know where to go in my community to get help with family needs
- I look for information to make sure what I expect from my child is fair (i.e. internet, hotlines, TV, talking to others)
- My family members discuss problems with each other
- I have neighbors, friends, or relatives that help me when I need it
- When we have disagreements, family members listen to both sides of the story
- I try to take a break when I am frustrated by my child/ren's behavior

The variables are associated with the family's ability to engage in open communication and manage problems, which lend themselves to the title, *Family Functioning*. This factor accounted for 28.2% of the variance.

The next five variables of the second factor are as follows:

- More bad things happen to my family than to other families
- I don't think my family can survive if another problem hits us
- Boys who cry are weak
- My child/ren misbehave just to upset me
- My family members feel closer to people outside the family than to our own family members

The factor was labeled, *Resiliency*, because of its connection to the family's possession of adaptive skills that are useful in overcoming crises. This factor accounted for 9.09% of the variance.

The third factor contained only one variable: "I ground". *Discipline Method* was the title given to the factor, and it controlled 5.71% of the variance.

Two variables were found in the fourth factor: "I hit" and "I spank". Both of these variables are linked with the incidence of child maltreatment. The factor for these variables, *Abusive Behaviors*, accounted for 5.39% of the variance.

The fifth factor included three variables:

- I feel like I am struggling to be a good parent

- When I discipline my child/ren, I have a hard time keeping my feelings under control
- Some members of my family lose their temper.

The variables contained in this factor represent the perceived support that caregivers rely on to meet the emotional demands of parenting. The factor, titled *Social Emotional Support*, accounted for 5.38% of the variance.

The two variables of the sixth factor include: "I use timeout" and "I take away privileges". Both of these variables are descriptive of the effectiveness of child management techniques and their utilization, which can be labeled, *Knowledge of Parenting*. The sixth factor controlled 4.62% of the variance.

The final factor included the following variable: "Children learn more from watching what you do than from hearing what you say". The factor, *Coping Behaviors*, accounted for 3.87% of the variance.

Table 6: The Protective Factors Survey: Post-Test Principal Components Factor Analysis

No.	Variable	Factor						
		I	II	III	IV	V	VI	VII
1.	Setting Limits (ex. Rules, guidelines, structure) keeps kids safe.	.817	.000	-.276	-.017	.082	.062	-.049
2.	I have neighbors, friends or relatives that help me when I need it.	.505	-.089	.260	.118	.181	.101	-.274
3.	My family members feel closer to people outside the family than to our own family members.	-.030	.492	.071	.047	.150	.115	-.408
4.	I know where to go in my community to get help with family needs.	.673	-.080	.167	-.011	-.019	.139	.105
5.	My child/ren misbehave(s) just to upset me.	-.069	.700	.004	-.077	.294	-.040	-.003
6.	More bad things happen to my family than to other families.	-.008	.799	-.201	.127	.028	.051	0.28

7.	My family enjoys spending time together.	No Data						

Table 6: Protective Factors Survey: Post-Test Principal Components Factor Analysis (continued)

No.	Variable	Factor						
		I	II	III	IV	V	VI	VII
8.	When I am worried about my child/ren, I have someone to talk to.	.733	-.130	.261	.018	.030	.118	.045
9.	I don't think my family can survive if another problem hits us.	-.288	.774	.098	-.060	-.019	-.077	.072
10.	Children learn more from watching what you do than from hearing what you say.	-.031	.067	.115	.083	.129	.013	.841
11.	I can usually tell when my child/ren are upset.	.754	-.114	-.218	-.040	-.015	.093	.014
12.	Boys who cry are weak.	.021	.773	-.150	-.013	.191	.020	.031
13.	I praise my child/ren when they behave well.	.752	-.055	-.052	-.081	.026	.136	-.005
14.	My family shows each other love and affection.	.806	.049	.030	-.007	-.030	-.056	.053
15.	My family is able to solve our problems.	.740	-.064	.249	.086	-.059	-.071	.007
16.	When we have disagreements, family members listen to "both sides of the story."	.496	.001	.456	-.066	-.207	-.164	.183
17.	When I discipline my child/ren, I have a hard time keeping my feelings under control.	.025	.209	-.115	.071	.687	.022	.150
18.	I try to comfort my child/ren when something is bothering them.	.791	-.094	-.188	-.071	.068	.007	-.072
19.	My family members discuss problems with each other.	.604	-.016	.446	-.075	-.091	-.039	.044

No.	Variable							
20.	Some members of my family lose their temper.	.006	.189	.068	-.003	.565	-.151	-.258

Table 6: *Protective Factors Survey: Post-Test Principal Components Factor Analysis (continued)*

No.	Variable	Factor						
		I	II	III	IV	V	VI	VII
21.	I make rules and stick to them.	.690	.024	.181	.062	.039	.217	.011
22.	I feel proud of my child/ren.	.876	-.032	-.210	.003	.031	.030	-.067
23.	In my family, we take time to listen to each other.	.736	.046	.237	-.104	-.199	-.096	-.120
24.	I feel like I am struggling to be a good parent.	-.023	.085	-.008	.036	.687	-.012	.087
25.	I try to take a break when I am frustrated by my child/ren's behavior.	.392	.065	.264	.065	.270	.178	-.091
26.	In my family, we support one another when something goes wrong.	.814	-.030	.274	.054	-.029	-.023	-.086
27.	I look for information to make sure what I expect from child is fair	.644	-.144	.222	.051	.043	.065	.007
28A.	I use timeout.	-.014	.061	.117	.050	-.077	.812	.107
28B.	I spank.	.068	.117	-.057	.892	-.015	.033	.051
28C.	I hit.	-.092	-.109	-.024	.868	.128	-.012	.009
28D.	I ground.	.092	-.188	.723	-.070	.006	.163	.043
29.	My child comes to me when he/she is feeling upset.	.363	-.049	-.011	-.046	-.023	.702	-.190
	Proportion of total variance	28.2	9.09	5.71	5.39	5.38	4.62	3.87

In examining the factors generated from the pre- and post-test factor analyses, the data support that the factors are consistent with the subscale constructs from The Prevention and Early Intervention Protective Factor Survey for Caregivers as validated by the FRIENDS National Resource Center (2008). This implies that The Protective Factor Survey has established a convergent validity - the degree to which different measures of a construct yield similar results (Grinnell, 2001). Therefore, all the survey findings discussed in association with The Protective Factor Survey are valid.

Prevention and Early Intervention Protective Factors Survey for Caregivers (Pre-Test)

The *Prevention and Early Intervention Protective Factors Survey for Caregivers* (FRIENDS National Resource Center, 2008) is an updated version of the *Protective Factors Survey*. Because the *Prevention and Early Intervention Protective Factors Survey for Caregivers* only includes the first 20 items of the 29 items in the data base, we conducted a factor analysis of the 20 items using the principal components method with varimax rotation to simplify structure based on responses collected prior to participation in the child abuse prevention programs. A five-factor solution, accounting for 46.29% of the variance, was obtained, and the results are presented in Table 7. Only variables with factor loadings of .39 or greater were included in a factor.

The first factor included four variables:

- In my family, we talk about problems
- When we argue, my family listens to "both sides of the story"
- In my family, we take time to listen to each other
- I have others who will listen when I need to talk about my problems

The variables revolved around the cohesiveness of the family, its adaptability, and its levels of support. The factor was categorized as *Family Functioning/Resiliency*, and it controlled 10.52% of the variance.

The second factor included three variables: my child and I are very close to each other; I am able to soothe my child when he/she is upset; and I am happy being with my child. The factor is representative of familial interaction that develops emotional patterns and/or ties within the family over time. Thus, the factor was labeled, *Nurturing and Attachment*, and it accounted for 10.27% of the variance.

The four variables of the third factor include:

- There are many times when I don't know what to do as a parent
- I would have no idea where to turn if my family needed food or housing
- If I needed help finding a job, I wouldn't know where to go for help
- I wouldn't know where to go for help if I had trouble making ends meet

The variables are indicative of the family's knowledge of community resources that are available to meet familial needs. The factor, *Concrete Support*, accounted for 9.68% of the variance.

The five variables of the fourth factor include:

- If there is a crisis, I have others I can talk to
- When I am lonely, there are several people I can talk to
- I know how to help my child learn
- My family is able to solve our problems
- My family pulls together when things are stressful

The factor, *Social Support*, can be seen through the perception of support indicated by these particular variables. The factor controlled 9.35% of the variance.

The fifth factor included four variables:

- I praise my child when he/she behaves well
- When I discipline my child, I lose control
- My child misbehaves just to upset me
- I spend time with my child doing what he/she likes to do

The variables indicate an understanding of age-appropriate child management techniques and their utilization. The factor was given the title, *Child Development/Knowledge of Parenting*, and accounted for 6.46% of the variance.

Table 7: Prevention and Early Intervention Protective Factors Survey for Caregivers: Pre-Test Principal Components Factor Analysis

No.	Variable	Factor				
		I	II	III	IV	V
1.	In my family, we talk about problems.	.779	.059	-.094	-.024	-.108
2.	When we argue, my family listens to "both sides of the story."	.596	.067	.091	.225	.214

3.	In my family, we take time to listen to each other.	.757	.113	.066	.077	.048
4.	My family pulls together when things are stressful.	.329	-.209	.018	.459	-.021
5.	My family is able to solve our problems.	.229	-.006	.242	.504	.120

Table 7: The Prevention and Early Intervention Protective Factors Survey for Caregivers: Pre-Test Principal Components Factor Analysis (continued)

No.	Variable	Factor				
		I	II	III	IV	V
6.	I have others who will listen when I need to talk about my problems.	.530	-.106	-.034	.265	-.263
7.	When I am lonely, there are several people I can talk to.	.051	.165	-.072	.630	-.093
8.	I would have no idea where to turn if my family needed food or housing.	-.089	-.022	.624	.034	.119
9.	I wouldn't know where to go for help if I had trouble making ends meet.	.136	-.067	.528	-.101	.124
10.	If there is a crisis, I have others I can talk to.	.045	-.0000484	-.029	.669	-.117
11.	If I needed help finding a job, I wouldn't know where to go for help.	.033	.086	.611	.106	-.134
12.	There are many times when I don't know what to do as a parent.	-.036	.044	.665	-.083	.085
13.	I know how to help my child learn.	.034	.151	-.099	.514	.025
14.	My child misbehaves just to upset me.	-.213	-.170	.299	-.019	.462
15.	I praise my child when he/she behaves well.	.095	.264	-.330	.202	.619
16.	When I discipline my child, I lose control.	.124	-.096	.358	-.233	.536
17.	I am happy being with my child.	-.048	.612	.053	.030	-.170
18.	My child and I are very close to each other.	.061	.826	-.004	.085	.058
19.	I am able to soothe my child when he/she is upset.	.098	.804	.001	.054	.039

20.	I spend time with my child doing what he/she likes to do.	.085	.322	-.163	.183	-.392
	Proportion of total variance	10.52	10.27	9.68	9.35	6.46

Prevention and Early Intervention Protective Factors Survey for Caregivers (Post-Test)

Twenty out of the 29 items contained in The *Protective Factor Survey* were factor analyzed using the principal components method with varimax rotation to simplify structure. A five-factor solution, accounting for 65.08% of the variance, was obtained, and the results are presented in Table 8. Only variables with factor loadings of .44 or greater were included in a factor.

The first factor includes three variables:

- In my family, we talk about problems; when we argue
- My family listens to "both sides of the story"
- In my family, we take time to listen to each other.

The factor is representative of familial perseverance, adaptability, shared experience, and mobilization that can be labeled as *Family Functioning/Resiliency*, which accounted for 15.21% of the variance.

Three variables were included in the second factor:

- I praise my child when he/she behaves well
- I know how to help my child learn
- My child misbehaves just to upset me.

The second factor, *Child Development/Knowledge of Parenting*, relates to the utilization of effective child management techniques, and it controlled for 13.55% of the variance.

The third factor included five variables:

- I wouldn't know where to go for help if I had trouble making ends meet
- If I needed help finding a job, I wouldn't know where to go for help
- I am happy being with my child; there are many times when I don't know what to do as a parent
- I would have no idea where to turn if my family needed food or housing

These specific variables relate to the access of goods and services perceived by the family. The factor was titled, *Concrete Support*, and it accounted for 13.26% of the variance.

Five variables were included in the fourth factor:

- I have others who will listen when I need to talk about my problems
- When I am lonely, there are several people I can talk to
- My family is able to solve our problems

- My child and I are very close to each other
- My family pulls together when things are stressful

The fourth factor, *Social Support*, controlled for 12.9% of the variance.

The final factor contained three variables:

- If there is a crisis, I have others I can talk to
- I spend time with my child doing what he/she likes to do
- I am able to soothe my child when he/she is upset.

The intra-familial emotional connections that have developed over time are indicated by the factor, *Nurturing and Attachment*, which accounted for 10.17% of the variance.

Table 8: Prevention and Early Intervention Protective Factors Survey for Caregivers: Post-Test Principal Components Factor Analysis

No.	Variable	Factor				
		I	II	III	IV	V
1.	In my family, we talk about problems.	.825	.228	-.110	.115	-.120
2.	When we argue, my family listens to "both sides of the story."	.807	.115	-.004	.062	-.091
3.	In my family, we take time to listen to each other.	.797	.002	.025	.243	.317
4.	My family pulls together when things are stressful.	.328	.122	-.245	.436	.266
5.	My family is able to solve our problems.	.410	.278	-.186	-.543	-.059
6.	I have others who will listen when I need to talk about my problems.	.416	.131	-.068	.752	-.049
7.	When I am lonely, there are several people I can talk to.	.345	.014	-.061	.698	-.020
8.	I would have no idea where to turn if my family needed food or housing.	-.192	.209	.478	-.453	.357
9.	I wouldn't know where to go for help if I had trouble making ends meet.	-.031	.040	.867	-.134	.058

*Table 8: Prevention and Early Intervention Protective Factors Survey for Caregivers:
Post-Test Principal Components Factor Analysis (continued)*

No.	Variable	Factor				
		I	II	III	IV	V
10.	If there is a crisis, I have others I can talk to.	.234	.251	.213	.086	-.759
11.	If I needed help finding a job, I wouldn't know where to go for help.	-.360	.015	.734	.024	.067
12.	There are many times when I don't know what to do as a parent.	.061	-.356	.565	.035	.051
13.	I know how to help my child learn.	.173	.875	-.163	.059	-.046
14.	My child misbehaves just to upset me.	-.034	-.661	.318	-.116	.437
15.	I praise my child when he/she behaves well.	.223	.883	.160	-.011	.159
16.	When I discipline my child, I lose control.	.049	-.212	.249	.221	-.071
17.	I am happy being with my child.	-.322	.057	-.594	.500	.149
18.	My child and I are very close to each other.	-.194	.270	-.102	.516	.310
19.	I am able to soothe my child when he/she is upset.	.174	.433	.137	.360	.456
20.	I spend time with my child doing what he/she likes to do.	.167	.097	.239	.146	.755
	Proportion of total variance	15.21	13.55	13.26	12.9	10.17

Although not all the items in the *Prevention and Early Intervention Protective Factors Survey for Caregivers* loaded according to the description in the FRIENDS National Resource Center (2008) manual, the data from the factor analysis still suggests that the same constructs were measured. The variation of the loaded items might be due to the characteristics of different geographical areas and/or the backgrounds of the targeted populations.

Reliability

    Protective Factors Survey

When looking at data gathered from all agencies, the pre-test Cronbach's Alpha was 0.84 (N=599), and the Cronbach's Alpha for the post-test was 0.825 (N=217). Although 6,011 participants completed portions of the *Protective Factors Survey*, the data from many participants were excluded from this particular dataset because of differing program requirements concerning the completion of surveys (i.e. one program completing numbers 1-29 and another completing 1-44). Only individuals who completed all items were included in the analysis. Individual agency reliability data were also collected based upon the number of items completed by each program. The reliability of the *Protective Factor Survey* was in a good range (.788 to .622).

Table 9: Protective Factors Survey Reliability Data

PEI Agencies	Cronbach's Alpha			
	Pre-Test	**N**	**Post-Test**	**N**
AVANCE (RGV-McAllister)	0.719	225	0.739	77
AVANCE (RGV-Cameron)*	0.654	215	0.589	76
AVANCE (RGV-Hidalgo)	0.636	147	0.783	33
AVANCE (Dallas)	0.895	123	0.903	48
Big Brothers Big Sisters of South Texas	0.463	40	0.563	24
DePelchin Children's Center: Family Connections*	0.674	32	0.541	22
Family Care Connections*	0.823	74	0.720	39
New Horizon Ranch*	0.558	195	0.584	128
The Children Shelter**	0.696	169	0.395	74
The Parenting Center**	0.555	63	0.659	42
YWCA of Metro Dallas*	0.441	18	0.880	14
Family Service Assoc of SA*	0.611	189	0.566	45
Family Outreach of America (10062)*	0.460	143	0.520	87
Catholic Charities FW*	0.628	379	0.730	226
DePelchin Children's Center: Families Count*	0.409	312	0.557	14
Family Service Center, Inc.*	0,603	510	0.625	325
Healthy Families San Angelo*	0.464	255	0.518	126
The Parenting Cottage, Inc.*	0.370	286	0.383	44
United Way of SA/Bexar Co.*	0.630	489	0.614	184

Table 9: Protective Factors Survey Reliability Data (continued)

PEI Agencies	Cronbach's Alpha			
	Pre-Test	N	Post-Test	N
Family Outreach of America (10081)*	0.359	58	0.384	24
Unity Partners dba Project Unity*	0.585	452	0.513	206
Children's Advocacy Center of Tom Green Co.	0.836	64	0.797	35
All Programs	0.841	599	0.825	217

Note: Pre-Test and Post-Test data were not available for item 29. This item was excluded from the analyses.

Prevention and Early Intervention Protective Factors Survey for Caregivers

Data for the *Prevention and Early Intervention Protective Factors Survey for Caregivers* were analyzed by reversing items to maintain consistency in the higher scores reflecting higher levels of protective factors. Reversal transforms a score of 7 to a score of 1, a score of 2 to a score of 6, etc. Then, subscales can be calculated on the basis of the corresponding items. Items that were reversed are as follows:

- I would have no idea where to turn if my family needed for or housing
- I wouldn't know where to go for help if I had trouble making ends meet
- If I needed help finding a job, I wouldn't know where to go for help
- There are many times when I don't know what to do as a parent
- My child misbehaves just to upset me
- When I discipline my child, I lose control

Initially, five subscales were created. *Family Functioning/Resiliency* contained the first five items of the survey:

- In my family, we talk about problems
- When we argue, my family listens to "both sides of the story"
- In my family, we take time to listen to each other
- My family pulls together when things are stressful
- My family is able to solve our problems.

The second subscale, *Social Support*, contained the following three items:

- I have others who will listen when I need to talk about my problems
- When I am lonely, there are several people I can talk to
- If there is a crisis, I have others I can talk to.

Subscale number three, *Concrete Support*, also contained three items:

- I would have no idea where to turn if my family needed food or housing

- I wouldn't know where to go for help if I had trouble making ends meet
- If I needed help finding a job, I wouldn't know where to go for help.

Nurturing and Attachment, the fourth subscale, contained the following items:

- I am happy being with my child
- My child and I are very close to each other
- I am able to soothe my child when he/she is upset
- I spend time with my child doing what he/she likes to do.

The final subscale, *Child Development/Knowledge of Parenting*, was composed of five unique items:

- There are many times when I don't know what to do as a parent
- I know how to help my child learn
- My child misbehaves just to upset me
- I praise my child when he/she behaves well
- When I discipline my child, I lose control.

The creators of the survey do not recommend calculating a subscale score in this case because of the unique nature of the five items. Instead, they suggest using percentages, means, and standard deviations to asses the progress of a program in this area.

All of the remaining four subscales were estimated using an internal-consistency measure of reliability, Cronbach's coefficient alpha that was calculated for the following four subscales: Family Functioning/Resiliency (α = 0.89), Social Support (α = 0.89), Concrete Support (α = 0.76), and Nurturing and Attachment (α = 0.81) (FRIENDS National Resource Center, 2008). Of the twenty-four participating programs, twenty collected data based on client completion of *The Protective Factor Survey,* two programs used *The Prevention and Early Intervention Protective Factors Survey for Caregivers*, and two programs reported survey data gathered from both surveys. From these various programs, completed surveys were gathered at two different intervals, generating reliability data from surveys completed both prior to and following child abuse prevention services (Table 9).

Because the sample size for each of the four programs was small and some participants did not complete all the items, we assigned a zero to those missing values so that reliability tests could be conducted. Of the four programs who gathered data

from the *Prevention and Early Intervention Protective Factors Survey for Caregivers*, the pre-test Cronbach's Alpha was 0.838 (N=237), and the Cronbach's Alpha for the post-test was 0.863 (N=237). Despite the combined participation of 373 clients, data were excluded because of incomplete surveys or because of differing program completion requirements. Individual program reliability data were also collected based upon the number of items completed by each program.

Table 10: Prevention and Early Intervention Protective Factors Survey for Caregivers Reliability Data

PEI Agencies	Cronbach's Alpha			
	Pre-Test	N	Post-Test	N
Family Service Association of SA	0.629	85	0.992	85
Greater Port Arthur Chamber of Commerce	0.540	24	0.994	24
Family Connections Austin	0.848	213	0.800	213
Children's Advocacy Center of Tom Green Co.	0.886	51	0.973	51
All Programs	0.832	373	0.930	373

The reliability of *The Prevention and Early Intervention Protective Factors Survey for Caregivers* (FRIENDS, 2008) was in a good range (.791 to .994).

Process Evaluation

Process evaluation examines program outputs including the number of targeted clients served as well as the level of client satisfaction. The output measures are specified in the Request for Proposals developed by the Texas Department of Family and Protective Services (2007). According to DFPS, "output measures demonstrate performance in terms of the quantity or volume of services provided (i.e., the number of participants served, number and types of services, etc.)" (Texas Department of Family and Protective Services, 2007). All data were retrieved from the PEIS database.

The output measures contain two levels of data. The first level focuses on individual program types that were funded by DFPS. The second level focuses on the aggregate of all programs funded by DFPS. The results from the output measures will identify whether the programs have been implemented according to the proposed plans

including both the number of targeted participants being served and their levels of satisfaction.

Output #1 addresses the number and type of families served by PEI funded child abuse prevention agencies. The purpose of this output measure is to evaluate agency success in reaching targeted families. The evaluator summed all unique family registration ID numbers within the PEIS database.

Output #2 addresses the services participating families received. The purpose is to evaluate the ICC members' success in program implementation. The evaluator summed all unique family registration ID numbers within the PEIS database where at least one individual within the family received a minimum of one service within the fiscal year.

Output #3 addresses *The Prevention and Early Intervention Protective Factor Survey for Caregivers* and *The Protective Factors Survey*. To complete the pre-service survey, the participant must meet the criteria for eligibility and acceptance into the program. Eligibility for completion of the post-service survey is based on receipt of program services for the length of time required to achieve the benefit(s) as approved by DFPS. The evaluator examined the percent of eligible primary caregivers who completed the pre and post-surveys by dividing the number of eligible program participants that completed both surveys by the total number of eligible program participants entered into the PEIS database for the output performance period.

Output #4 examined the DFPS Satisfaction Questionnaire by calculating the percentage of eligible program participants who completed it. The satisfaction survey, which contains a total of five items, was analyzed to measure client satisfaction with program services. . An average score of the five items was computed for each participant. A score of 5 or higher indicates that the participant was satisfied with the program.

Output #1: Participants in Prevention Programs

Demographics of All Participants

Fiscal years 2007 (September 2006 through August 2007) and 2008 (September 2007 through August 2008) were used because they provided the most

complete data. The data from 2007 consisted of 11 FS programs, 7 TFTS programs and 4 CBCAP providers. In 2008, 10 FS, 8 TFTS, and 5 CBCAP programs were represented. In 2007, there were 4,156 families registered in the PEI database for child abuse and neglect prevention services and in 2008, there were 3,941 families. As can be seen in Figure 3, in 2007 and 2008, TFTS registered the greatest portion of new families followed by FS and CBCAP.

Figure 3 Participating Families

2007 and 2008 Registered Families and Program Type

	FS	CBCAP	TFTS	Total
2007	1,185	378	2,584	4,156
2008	1,127	656	2,158	3,941
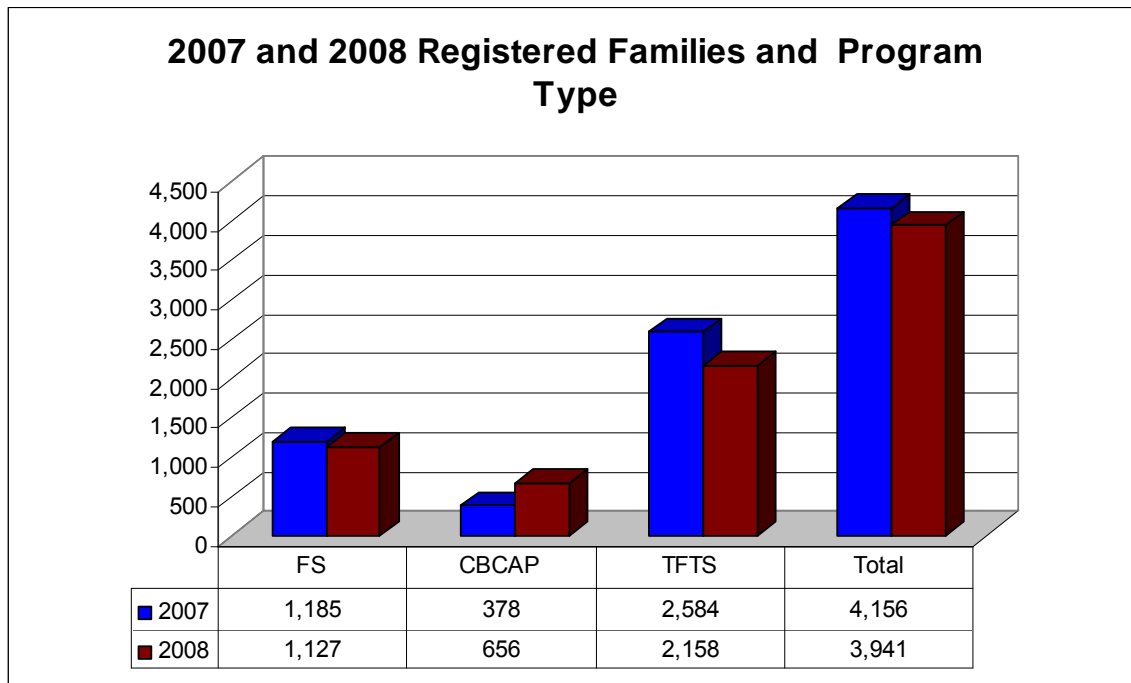
Many of the families served had contact with the child welfare system. In 2007, CPS referred 14% of registered families and in 2008, 11.7% were referred. For many families, 34% in 2007 and 31% in 2008, English was not their primary language. The overwhelming majority of clients were poor. In 2007, 42% had incomes of $10,000 or less and in 2008, 44% of clients had incomes below this level. Finally, a small percentage of families served in 2007 (9%) and 2008 (8%) faced the stress of having a disabled child in the home. Tables 11 through 13 show this pattern of vulnerability across program types particularly FS and TFTS.

Table 11: Family Characteristics of Families Registered in 2007 & 2008

Family Characteristics	2007		2008	
	Number	%	Number	%
Referred by CPS	578	13.9	460	11.7
Primary Language Other Than English	956	34	1,225	31.2
Unknown	155	3.7	413	10.5
Income				
$0 - $10,000	1,747	42.0	1,723	43.7
$10,001 -$20,00	796	19.2	875	22.2
$20,001 - $30,00	332	8.010.5	383	9.7
$30,001+	272	6.58.6	372	9.4
Unknown	1009	24.3	588	14.9
Disabled Child in the Home	367	8.8	319	8.1

Table 12: Family Characteristics of Families Registered in 2007 by Program Type

	2007		
Family Characteristics	FS Percent (n)	TFTS Percent (n)	CBCAP Percent (n)
Referred by CPS	24.3 (288)	10.8 (279)	2.9 (11)
Primary Language Other Than English	38.3 (454)	13.2 (342)	41.3 (160)
Unknown	4.4 (52)	3.3 (85)	4.7 (18)
Income			
$0 - $10,000	45.5 (538)	42.3 (1093)	30.0 (116)
$10,001 -$20,00	11.6 (138)	21.7 (472)	25.1 (97)
$20,001 - $30,00	3.4 (40)	9.5 (245)	12.1 (47)
$30,001+	1.0 (12)	4.4 (213)	12.1 (47)
Unknown	38.6 (457)	18.3 (472)	20.7 (80)
Disabled Child in the Home	4.5 (53)	10.8 (279)	9.0 (35)

Table 13: Family Characteristics of Families Registered in 2008 by Program Type

Family Characteristics	FS Percent (n)	TFTS Percent (n)	CBCAP Percent (n)
	2008		
Referred by CPS	16.0 (76)	13.0 (280)	0.0
Primary Language Other Than English	51.2 (577)	13.9 (300)	53.1 (348)
Unknown	1.4 (16)	15.6 (337)	9.1 (60)
Income			
$0 - $10,000	45.9 (517)	48.2 (1040)	25.3 (166)
$10,001 -$20,00	22.1 (102)	19.3 (417)	31.9 (209)
$20,001 - $30,00	9.14.3 (102)	8.8 (189)	14.0% (92)
$30,001+	8.5 (96)	9.3 (201)	11.4 (75)
Unknown	14.5 (163)	14.4 (311)	17.4 (114)
Disabled Child in the Home	6.7 (76)	9.8 (211)	4.9 (32)

Target Child

Table 14: Target Child, Demographic Characteristics 2007 & 2008

	2007 (N=4,074)	**2008 (N=3,762)**
Gender % (n)		
Male	51.5 (2,098)	50.9 (1,916)
Female	46.7 (1976)	46.0 (1,729)
Unknown	1.8 (72)	3.1 (117)
Average Age (Standard Deviation)	5.6 (4.80)	4.6 (4.8)
Ethnicity % (n)		
Hispanic	62.9 (2,563)	64.6 (2,431)
Non-Hispanic	35.0 (1,426)	33.2 (1,248)
Unable to Determine	2.1 (85)	2.2 (83)
Race % (n)		
White	72.7 (2,962)	78.5 (2,953)
Black	16.9 (688)	14.9 (559)
Other	1.4 (55)	1.0 (38)
Unable to Determine	9.1 (369)	5.6 (212)

For each family registered in the PEIS database, staff is required to identify a target child, whether or not that child will receive services. In 2007, 4,074 children were identified and in 2008, 3,762. In both years the majority of target children were male,

Hispanic, and white (Table 14). The age of the child ranged from prenatal (0 years of age) to teenagers. However the average age was 5.6 years in 2007 and 4.6 in 2008.

Family Members

In addition to the target child, registration data in the PEIS database must include the primary caretaker who is receiving services. Other family members who receive services are also included. In 2007, 10,386 family members were registered in the PEIS database and in 2008, 9,242. As can be seen in Table 15, mothers made up the largest proportion of registered family members (36% in 2007 and 37% in 2008) followed by brothers (18% 2007 and 2008), sisters (18%, 17%) and fathers (16%, 18%). On average 2.5 family members were registered per family in 2007 and 2.4 in 2008. TFTS programs provided services to a greater number of family members compared to CBCAP and FS. In 2007, TFTS registered on average 2.7 family members per family while CBCAP programs registered 2.5 and FS programs 2.1. In 2008, TFTS programs registered 2.5 family members followed by FS programs (2.3), and CBCAP (1.8).

Table 15: Relationship to Target Child of Family Members Registered in 2007 & 2008

Relationship to Target Child	2007 Percent (N)	2008 Percent (N)
Mother	35.8 (3,713)	37.2 (3,438)
Brother	17.9 (1,861)	17.7 (1,640)
Sister	17.9 (1,856)	17.0 (1,569)
Father	15.6 (1,620)	17.7 (1,640)
Grandmother	3.9 (410)	3.4 (313)
Other, Non-Related	1.1 (113)	1.9 (171)
Grandfather	1.2 (121)	.9 (82)
Aunt	1.6 (171)	1.1 (98)
Other, Related	1.1 (118)	.9 (87)
Step Father	1.0 (100)	.8 (73)
Uncle	1.2 (124)	.6 (59)
Cousin	.7 (80)	.8 (73)
Foster Parent	.0 (7)	.6 (56)
Step Mother	.3 (33)	.3 (24)
Unknown	.6 (59)	.7 (65)

Parents

Mothers were more likely to be involved in prevention services and they tended to be younger than participating fathers. In 2007, the average age of mothers was 29.1 and in 2008, 28.4 while fathers' average age was 31.6 and 32.2 respectively. Further, mothers were more likely to be single compared to fathers. Among 2007 registered fathers 52% were married while only 33% of mothers were married. These percentages did not vary much in 2008. Fathers and mothers were similar in terms of education. The majority of fathers in 2007 (51%) and 2008 (53%) had not completed high school. Similarly, at least half of the mothers in 2007 (50%) and those in 2008 (54%) had not completed high school or a GED.

Table 16: Parent Demographic Characteristics

Characteristics	2007		2008	
	Fathers % (n)	Mothers % (n)	Fathers % (n)	Mothers % (n)
Marital Status				
Single	31.4 (508)	44.6 (1,657)	27.6 (413)	43.0 (1,480)
Married	52.0 (842)	31.9 (1,185)	50.9 (761)	32.7 (1,125)
Divorced	6.0 (97)	7.7 (285)	6.6 (98)	8.2 (283)
Separated	5.7 (3)	9.7 (359)	7.3 (109)	9.9 (339)
Widowed	0.4 (7)	0.9 (35)	0.3 (5)	1.0 (36)
Unknown	4.5 (73)	5.2 (192)	7.2 (108)	5.1 (175)
Education Level				
>High School	50.9 (825)	50.3 (1,869)	52.9 (790	53.9 (1'852)
High School Graduate/GED	24.1 (390)	22.2 (826)	26.0 (389	21.2 (730)
Some College	13.5 (218)	15.1 (550)	14.3 (213)	18.4 (632)
College Graduate	4.1 (67)	4.2 (155)	.2 (3)	.4 (15)
Post Graduate	1.0 (17)	.5 (20)	1.1 (17)	.9 (31)
Unknown	6.4 (103)		5.5 (82)	5.2 (178)
Average Age (Standard Deviation)	31.6 (9.22)	29.1 (8.7)	32.2 (9.4)	28.4 (8.9)

Risk of Child Abuse and Neglect

At intake a minimum of 2 risk factors were identified for all FS participants. Staff had the option of recording risk factors for TFTS and CBCAP participants. In 2007, risk factors were assessed for 2,996 families and in 2008, 2,844 families were assessed.

As can be seen in Table 17, clients registered in 2007 and 2008 were relatively similar in terms of the risk factors that were identified. The majority of participants in 2007 (67%) and 2008 (56%) were identified as having stressful lives. Other risk factors experienced by a substantial portion of the client population in 2007 and 2008 were non-traditional family structure (37%, 40%), lack of knowledge about child development (30%, 34%), parental conflict (28%, 26%) and being a teen parent (22%, 21% respectively).

Table 17: Percent of Families with Identified Risk Factors

Risk Factors	2007 (N=2,996)		2008 (N=2,844)	
	Number	Percent	Number	Percent
High general stress level	2,001	66.7%	1,593	56.0%
Non-traditional family structure	1,114	37.2%	1,131	39.8%
Parent/guardian has inaccurate knowledge and expectations about child development	898	30.0%	969	34.1%
High parental conflict/separation/divorce	845	28.2%	741	26.1%
Teen Parent	648	21.6%	594	20.9%
Poor Parent/Child Interaction	441	14.7%	433	15.2%
Social isolation of family/parent/guardian – lack of support	488	16.3%	372	13.1%
Parent/guardian has negative attitudes/attributions about the child's behavior	393	13.1%	373	13.1%
Homelessness	117	3.9%	107	3.8%

Output #2: Services Received

Service delivery was examined for clients registered in 2008. In 2008, 23 grant funded programs, 10 FS, 8 TFTS, and 5 CBCAP provided 72,269 units of service. The definition of a unit of service can vary from one service to the next with one unit being equivalent to one home visit or one parenting class.

Both FS and TFTS provided relatively equal units of service, 36,735 and 32,457 respectively, but FS delivered on average more than twice as many services per family (Table 18). In 2008, CBCAP programs provided fewer services on average per family compared to FS and TFTS programs. The lower number appears to be consistent with CBCAP's dual mission of direct service and community development to prevent child abuse.

Table 18: Units of Services by Program Type Provided to Families Registered in 2008

Program	2008	
	Number of Units	**Average Units per Families Served**
FS	36,735	32.6
CBCAP	3,077	4.7
TFTS	32,457	15.0
Total	72,269	18.3

The most frequently provided services across the three program types were home visitation and parent education and training (Table 19). The least provided services included booster sessions, fatherhood programs, and emergency services. Several services, including parent advocacy, family focused services, home visitation mentoring, life skills, and parent leadership were provided only by CBCAP agencies.

Table 19: Services by Percent of Units of Services Provided Families Registered in 2008 by Program Type

Services	2008		
	FS **N=36,735**	**TFTS** **N=32,457**	**CBCAP** **N=3,077**
Ancillary Service-Basic needs support	1%	5%	1%
Ancillary Service-Child care	5%	2%	9%
Ancillary Service-Parent advocacy	0%	0%	1%
Ancillary Service-Transportation	3%	1%	0%
Booster session	0%	2%	0%
Child school readiness training	7%	7%	0%
Emergency care	0%	0%	0%
Family counseling	2%	3%	0%
Family focused services	0%	0%	3%
Fatherhood program	>1%	0%	0%
Group counseling	0%	2%	0%
Home visitation	23%	29%	18%
Home visitation mentor	0%	0%	2%
Individual counseling	1%	10%	1%
Life skills	0%	0%	3%
Mentoring	16%	>1%	0%
Parent education & training	21%	20%	34%
Parent leadership	0%	0%	3%
Resource & referrals	21%	13%	1%
Support Group	1%	5%	17%

Output #3: Protective Factors Survey Completion Rate

From April 2006 through August 2008, 8,524 families were registered in the PEI data system. Of these 6,153 families completed one or more pre-tests for a 72.2% completion rate. Further as can be seen in Table 20, 3,411 families completed one or more post-tests. Thus, among registered families there was a 40.0% post-test completion rate. TFTS programs had the highest rate of pre-test (77.1%) and post-test (46.1%) completion.

Table 20: Completion Rate for Pre-test and Post-Test April 2006 to August 2008

Program	Pre-Test				
	1	**2**	**3**	**Unduplicated**	**%**
ALL (N=8,524)	5,839	82	373	6,153	72.18
TFTS (N=4,769)	3,676	--	--	3,676	77.08
FS (N=2,649)	1,961	82	85	2,032	76.71
CBCAP (N=1,075)	202	--	288	440	40.89
	Post-Test				
ALL (N=8,524)	3,154	9	257	3,411	40.02
TFTS (N=4,769)	2,200	--	--	2,200	46.13
FS (N=2,649)	870	9	9	871	32.88
CBCAP (N=1,075)	84	--	248	309	28.72

1 – *The Protective Factor Survey*
2 – *AAPI-2*
3 – *The Prevention and Early Intervention Protective Factors Survey for Caregivers*

Table 21: Paired Completion Rate for Pre-Test and Post-Test April 2006 to August 2008

Program	Paired Pre- Post Test				
	1	**2**	**3**	**Unduplicated**	**%**
ALL (N=8.524)	3,150	9	257	3,407	39.97
TFTS (N=4,769)	2,200	--	--	2,200	46.13
FS (N=2,649)	867	9	9	868	32.77
CBCAP (N=1,076)	83	--	248	309	28.72

1 – *The Protective Factor Survey*
2 – *AAPI-2*
3 – *The Prevention and Early Intervention Protective Factors Survey for Caregivers*

The relatively low rate of post-test completion and families who completed both pre-post tests could be the result of several factors. First, it could indicate failure to administer because clients dropped out and were not available to complete the post-test. Alternatively, the rate could reflect low compliance because of inexperience or other staffing issue. Finally, the low rate could be due to the length of service. In programs where clients are expected to receive services for several years such as Nurse Family Partnership, the post-test would not have due during the study period. However, given the variables available in the data base it was not possible to determine the degree to which these factors affected completion rates.

Output #4: Client Satisfaction

The *Prevention and Early Intervention Family Satisfaction Survey* is completed by caretakers following the conclusion of participation in child abuse prevention and/or intervention services and is used to measure client satisfaction. Participants are asked to rate five items on a Likert scale that ranges from one to seven. A score of seven indicates a high level of satisfaction with the program and one indicates that a participant is unsatisfied. The five statements measure participants' perception of the program in the following areas: parenting skill improvement, stress reduction, participant idea/opinion inclusion, staff's respect of participants, and familial goal attainment resulting from program participation.

Satisfaction Survey Completion

Three thousand two hundred and seventy-six caretakers completed the survey from September 2007 through December 2008. Of those 3,276 participants, 2,329 had completed a prevention program and the remainder was in the process of receiving services. A survey completion rate was computed by dividing the number of respondents who had completed a survey by the number of families who became "inactive" (N=2,368) during the data collection period. The inactive classification was used because it is the closest approximation to a discharge date. Thus, it was found that PEI grant funded programs had a 98.35% satisfaction survey completion rate.

Program Satisfaction

As can be seen in Table 22, the majority of respondents rated all items 5 or higher on a 7 point scale suggesting they felt slight to strong agreement with the statements. For example 98.4% felt that the program was helping them reach their goal and 98.0% felt that the staff respected them. While still high (86.9%), the lowest rated item was the ability of the programs to help participants reduce the stress in their lives. Considering the multiple sources of stress that many participants face, the relative lower satisfaction rating is realistic.

Table 22: Rating of 5 or Higher

Survey Item	Percent Rating
This program is helping me reach my goals for my family and me	98.4
I feel that the program staff respects me	98.0
My ideas and opinions are welcomed and included in the program	94.6
This program has helped me improve my parenting skills	92.3
This program has helped me reduce stress in my life	86.9

A total score was calculated by summing the items and dividing by the number of survey items. The average total score was 6.4 (*SD*=.850) on the 7 point scale, again suggesting participants felt positively about their experience in prevention programs.

Of those who completed the survey, 95.4% (N=3,125) had an average survey score of 5 or higher, which denotes that the majority of individuals who completed the *Prevention and Early Intervention Family Satisfaction Survey* felt satisfied with their participation in the prevention program. Overall, respondents reported feeling satisfied with child abuse prevention and intervention programs

A one-way analysis of variance (ANOVA) was conducted to evaluate participant satisfaction scores as they related to the different program types: CBCAP, FS, and TFTS. The ANOVA was significant, $F_{(2, 3273)}=20.26$, p=.000. Follow-up tests were conducted to evaluate pairwise differences among the means. Because of the range of variances among the groups, the assumption that the variances were homogeneous was not made, and post hoc comparisons were conducted using Dunnett's C test, a test that does not assume equal variances among the groups. There was a statistically significant difference in the means of all groups. Thus, while all program types had high average satisfaction ratings, CBCAP programs had highest scores followed by FS and TFTS. The means and standard deviations for the three groups are presented in Table 23.

Table 23: One-way ANOVA on Satisfaction Score by Program Type

	N	Mean	SD
CBCAP	263	6.66	.54
FS	891	6.47	.79
TFTS	2122	6.34	.90

F(2,3273)=20.26, p=.000

In summary, the results of the satisfaction survey suggest that the majority of participants in PEI funded child abuse and neglect services who completed a satisfaction survey find the individual programs useful, inclusive and respectful. This high level of satisfaction is also evident in all three program types (CBCAP, FS and TFTS).

Process Evaluation Summary

Over a two year period, child abuse and neglect prevention programs served over 8,000 families. The demographic data indicates that most of the families served were at risk. Families had few resources with which to cope with stress and seek out assistance with over 50% living on less than $20,000. In addition, half of the parents served did not have the educational attainment necessary to improve their situation and approximately a third had limited English skills. All three program types appear to reach out to include the caretaker and their familial support systems. On average, between 1.8 and 2.7 family members in addition to the target child received services over the two years reviewed.

The most frequently delivered services were home visitation and parent education. However, programs also provided a range of ancillary and clinical services often needed by vulnerable families. Further, services provided by the different programs types, particularly CBCAP appeared to be congruent with the program mission.

Despite the volume of information contained in the database, data collection and data entry could be improved. For example, two risk factors were not documented for every family. Although this is not required of CBCAP and TFTS agencies, it would enhance evaluation of the client population and the impact of the services they receive.

Further, missing data as well as many inconsistencies were noted in the families' records.

Outcome Evaluation

Outcome evaluation assesses whether the goals and objectives of the programs are achieved. Data from two outcome measures were analyzed. Outcome #1 addresses protective factors. The aggregate increase in targeted protective factors, as determined by comparison of the pre-service Protective Factor Survey Questionnaire to the post-service Protective Factor Survey Questionnaire, was calculated. All pre- and post-service data were transformed into an SPSS (Statistical Package for Social Sciences) file. A paired-sample t-test was used to analyze the differences between the pre- and post-service protective factors both at the individual program level and at the aggregate level (all programs combined). Determination of program success is based on the statistically significant value from the paired-sample t-test ($p<.05$). The value of $p<.05$ refers to less than 5% of error in the results.

Outcome #2 addresses the percentage of families in which there is no validated incident of child abuse or neglect at discharge (covering the period during which they received services from the program), and six months and twelve months after program completion. A validated incident of child abuse or neglect refers to an investigated incident of abuse/neglect which results in a finding of "reason to believe (RTB)" as defined at 40 TAC (Texas Administrative Code) Section 700.511(a)(1), whether or not the finding is the subject of an appeal. This term shall not include any incident in which the finding has been overturned on appeal. The numerator is the total number of program participants in the PEIS database that is matched to a client in a validated incident of child abuse or neglect, as indicated in IMPACT, if the validated incident occurred during the outcome performance period. The denominator is the total number of unduplicated program families served by a contractor for the outcome performance period.

Sample Demographics

Analyses of the sample demographic data included participants who responded to either the pre or the post-protective factors surveys. Therefore, this analysis may only reflect the characteristics of this particular population. Overall, 6,321 people who participated in state-funded child abuse prevention and intervention programs were included in the analysis. The great majority were female (85%), unmarried (60.3%) and Hispanic (63.2%). In terms of education almost half (49.4%) of the participants reported having less than a high school diploma and less than 15% denoted that they finished some college. Those who participated in the program mostly classified themselves as immediate family members (87.1%) of the target children while extended family members accounted for only 6.3% of respondents. The entire breakdown of the population can be found in Table 24.

Table 24: Demographic Characteristics of All Participants

Variable	N	%
Gender		
Female	5,373	85.0
Male	881	13.9
Missing	67	1.1
Marital Status		
Married	2,123	33.6
Not Married	3811	60.3
Missing	387	6.1
Race		
Black	967	15.3
White	1,222	19.3
Hispanic	3,994	63.2
Other	33	0.5
Missing	105	1.7
Ethnicity		
Hispanic	3,994	63.2
Non-Hispanic	2,189	34.6
Unable to Determine	33	0.5
Missing	105	1.7
Education Level		
Less than HS	3,120	49.4
Graduated HS/GED	1,424	22.5
Some College	935	14.8

Table 24: Demographic Characteristics of All Participants (continued)

Variable	N	%
College	263	4.2
Post Graduate	38	0.6
Missing	541	8.5
Relationship to Target Child		
Extended Family Member	398	6.3
Immediate Family Member	5,506	87.1
Missing	417	6.6

The participant sample available for this analysis indicates that the majority (3,676) of individuals were participants in the Texas Families: Together and Safe program with the smallest number (440) participating in CBCAP. At survey completion, CBCAP participants were slightly older (32.95); however there was not a wide average age range between the three groups. There was a pattern of high female and low male participation in all program types as well as the majority of participants being of Hispanic origin. The largest percentage of Black participants (18.5%) could be found in the TFTS program group. In terms of marital status, single/never married was the largest group in TFTS (38.3%) and FS (43.8%) whereas in CBCAP this was only 19.5% of the population with married individuals (47.0%) being the largest percentage of respondents.

Education levels did not vary dramatically across program types. TFTS has the largest percentage of respondents who indicate they had graduated from HS/GED (25.8%) while those reporting some college were fairly low across TFTS (15.7%), FS (13.3%), and CBCAP (12.0%).

A similar breakdown was visible across the three groups in terms of the relationship of the participant to the target child. The largest percentage of respondents were mothers followed by a small percentage of respondents in TFTS (12.4%), FS (12.7%), and CBCAP (9.3%) indicating they were fathers. Grandmothers were an even smaller minority with no program type having even 5% of respondents claiming this relationship.

Table 25: Demographics of Participants by Program Type

Variable	TFTS		FS		CBCAP	
	%	N	%	N	%	N
Age (Years)						
0-9	0.1	6	0.2	4	0.7	3
10-19	5.4	200	16.1	327	2.7	12
20-29	40.2	1,476	39.7	809	36.6	161
30-39	34.9	1,283	28.4	578	37.5	165
40-49	13.7	505	11.1	226	13.2	58
50-59	3.8	138	2.7	55	3.2	14
60-69	0.7	25	0.6	13	1.4	6
70-79	0.3	10	0.2	5	0.6	3
80-89	0.1	3	-	-	0.2	1
Missing	0.8	30	1.0	20	3.9	17
Mean (SD)		31.72 (9.62)		29.38 (1.14)		32.95 (10.35)
Gender						
Female	85.4	3,141	85.2	1735	84.8	373
Male	13.7	505	13.8	282	11.4	50
Missing	0.8	30	1.0	20	3.9	17
Marital Status						
Child, N/A	0.7	25	0.7	15	-	-
Divorced	8.8	325	8.7	177	11.8	52
Married	33.2	1,221	31.6	643	47.0	207
Separated	11.3	416	10.9	223	5.2	23
Single, never married	38.3	1,409	43.8	892	19.5	86
Unknown	1.4	52	0.6	13	2.7	12
Widowed	1.6	57	1.4	29	1.8	8
Missing	4.7	171	2.2	45	11.8	52
Disabled						
No	94.3	3,466	96.2	1,959	95.5	420
Yes	4.9	180	2.8	58	0.7	3
Missing	0.8	30	1.0	20	3.9	17
Race						
American Indian/Alaskan Native	0.3	10	0.3	6	-	-
Asian	0.2	6	0.1	3	0.2	1
Black	18.5	681	10.4	212	6.6	29
Native Hawaiian/Pacific Islander	0.1	4	-	-	-	-

Table 25: Demographics of Participants by Program Type (continued)

Variable	TFTS		FS		CBCAP	
	%	N	%	N	%	N
White	22.9	840	11.5	234	17.3	76
Unable to Determine	0.7	25	0.5	10	0.5	2
Missing	0.8	30	1.0	20	3.9	17
Ethnicity						
Hispanic	56.6	2,080	76.2	1,552	71.6	315
Non-Hispanic	41.6	1531	22.2	452	23.4	103
Unable to Determine	1	35	0.6	13	1.1	5
Missing	0.8	30	1.0	20	3.9	17
Education Level						
Pre-K/Kindergarten	0.1	4	0.1	2	-	-
1st-5th Grade	2.6	95	3.8	77	1.8	8
6th-8th Grade	9.7	355	11.9	243	9.5	42
9th Grade	8.8	323	10.4	212	10.2	45
10th Grade	6.9	255	9.9	201	3.9	17
11th Grade	8.2	303	10.3	210	5.0	22
12th Grade	10	369	8.7	177	11.8	52
Did not Graduate	0.9	34	2.3	46	0.2	1
Graduated HS/GED	25.8	949	18.7	381	11.4	50
Some College	15.7	577	13.3	270	12.0	53
College	4.1	151	3.7	75	6.4	28
Post Graduate	0.8	30	0.2	5	0.5	2
Unknown	6.3	231	6.7	138	27.3	120
Relationship to Target Child						
Father	12.4	456	12.7	259	9.3	41
Mother	80.3	2,950	79.6	1,622	79.5	350
Sister	0.1	4	0.0	1	-	-
Grandfather	0.3	10	0.2	5	0.5	2
Grandmother	3.4	126	4.5	91	3.3	14

Table 25: Demographics of Participants by Program Type (continued)

Variable	TFTS		FS		CBCAP	
	%	N	%	N	%	N
Uncle	0.1	4	0.0	1	0.2	1
Aunt	0.9	33	0.3	7	0.9	4
Step Father	0.7	24	0.7	15	1.1	5
Step Mother	0.3	12	0.2	5	0.9	4
Female Cousin	0.0	1	0.0	1	0.2	1
Other, Related	0.2	6	0.1	3	-	-
Other, Non-Related	0.4	13	0.2	4	0.2	1
Missing	1	36	1.1	23	3.9	17

Outcome #1: Paired Sample t-test Result

Protective Factor Survey by Agency

Paired-sample *t* tests were performed for individual agency to evaluate the scores obtained from the *Protective Factor Survey* (Appendix C). The tests were conducted to evaluate whether there was a statistically significant increase in protective factors from prior to service initiation to program completion. The data from the survey, consisting of 44 items, were collected from 6,011 participants in 22 programs and evaluated to determine program effectiveness based on data collection at two different intervals (pre and post-services). Of the 44 items, 14 items were reversed in order to maintain consistency with higher scores indicating a higher level of protective factors (Appendix C). The results indicate that the mean prior to receiving prevention services (M=4.58) was lower than the mean following program participation (M=4.74), $p<0.001$ (higher scores indicate high protective factors). Thus, on average subjects who participated in the child abuse prevention programs had higher protective factors after program completion, which is an indicator of program effectiveness. Tables 26-27 provide a breakdown of those agencies with a statistically significant change from pre to post test.

Table 26: Individual Programs with p<0.001

Agency	N	Pre-Test	Post-Test
AVANCE, Inc. (McAllen)	671	4.59	4.85
New Horizon Ranch & Center, Inc.	242	4.52	4.72
Catholic Charities Diocese of Fort Worth, Inc.	422	4.59	4.74
DePelchin Children's Center: Families Count	410	4.61	4.88
The Parenting Cottage, Inc.	360	4.61	4.92
Unity Partners dba Project Unity	459	4.64	4.78
Children's Advocacy Center of Tom Green County	203	4.91	5.23

Table 27: Individual programs with p<0.01

Agency	N	Pre-Test	Post-Test
AVANCE, Inc. (Cameron County)	301	4.59	4.72
Family Service Center, Inc.	528	4.62	4.67

Table 28: Individual programs with p<0.05

Agency	N	Pre-Test	Post-Test
The Children's Shelter of San Antonio	180	4.36	4.50
Family Outreach of America (10062)	168	4.68	4.76

Further data review was completed on the basis of individual survey items. The impact of prevention services can be viewed in terms of statistically significant positive score gains on items associated with the development of protective factors, with a score of seven indicating the highest degree of a protective factor, and with a score of zero indicating the absence of a particular protective factor associated with child abuse. Scores for each agency on the individual survey items as well as the items for which there was a statistically significant change can be found in Appendix C.

In looking at the individual survey items across agencies, all five protective factors as outlined by FRIENDS (2008) were present. The largest number of survey items where there was a statistically significant change fell in the Child Development/Knowledge of Parenting Subscale. This is not surprising given that the main objective of many child abuse prevention programs is to increase parenting knowledge regarding positive discipline techniques and child development.

There were also a large number of items from the Family Functioning/Resiliency Subscale that had a statistically significant change. The change from pre to post for some items such as "listening to both sides," "taking the time to listen," and "discussing problems" were most frequently observed across agencies. These items relate to the family having the skills to adapt to challenges by sharing and problem solving together.

There was also a significant change in items related to the Social Support and Concrete Support subscales across agencies but this was less frequent. Having someone else to talk to outside the family about problems or child rearing was an item that had a statistically significant change across a number of different agencies. This sign of social support is an important resource for emotional stability. Items that cover the protective factor of Concrete Support did not achieve statistical significance as frequently as the other four subscales. However, there was a statistically significant change in caregiver awareness of where to go in the community to have needs met.

Protective Factors Survey by Program Type

Prior to participation in child abuse prevention programs, participants from CBCAP reported the highest average protective factors pre-test scores (M=4.91), and following prevention services, the mean survey score increased to M=5.23, which is representative of the highest post-test score. Statistically significant score increases were also evidenced in participants from both the FS and TFTS programs (Table 29).

Table 29: *Pre and Post-Test Results by Program Type*

Program Type	Protective Factor Survey	
	Avg.-Pre	**Avg.-Post**
CBCAP	4.91*	5.23*
FS	4.47*	4.60*
TFTS	4.61*	4.78*

*p<0.001

A two-way within-subjects analysis of variance was conducted to evaluate the effect of program type (CBCAP, TFTS and FS) and protective factor pre- and post-test scores. The program type main effect and protective factor pre- and post-test scores interaction effect were tested using the multivariate criterion of Wilks's lambda. The protective factor pre- and post-test scores main effect was significant with,

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$F(6,311645.3)=57.44$, p=.000. The interaction effect of program type and protective factor pre- and post-test scores was significant with $F(1)=61.26$, p=.00. The univariate test associated with the program type main effect was also significant, $F(1,2)=65.49$, p=.000.

Three paired-samples t tests were conducted to follow up the significant interaction. Differences in protective factor pre- and post- test scores were statistically significant between CBCAP and TFTS [$t(6010)=43.34$, p=.000], TFTS and FS [$t(6010)=23.85$, p=.000] and CBCAP and FS [$t(6010)=80.26$, p=.000].

Table 30 Within-Subject Effect of Pre and Post-Tests by Program Type

Source	Type III Sum of Squares	df	Mean Square	F	Sig	Partial Eta Squared
Score	14.03	1	14.03	61.26	.00	.019
Score * Program Type	1.42	2	.71	3.10	.045	.002
Error (Score)	721.61	3151	.23			

Table 31: Between-Subject Effect of Pre and Post-Tests by Program Type

Source	Type III Sum of Squares	df	Mean Square	F	Sig	Partial Eta Squared
Intercept	30284.14	1	30284.14	65547.52	.00	.95
Program Type	60.51	2	30.26	65.49	.00	.04
Error	1455.82	3151	.46			

Table 32: Program Type

Program Type	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
CBCAP	5.069	.052	4.966	5.172
FS	4.537	.016	4.505	4.569
TFTS	4.697	.010	4.677	4.717

Table 33: Score

Score	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	**Upper Bound**
Pre	4.665	.021	4.623	4.707
Post	4.870	.024	4.823	4.917

*Table 34: Program Type * Score*

Program Type	Score	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	**Upper Bound**
CBCAP	Pre	4.91	.060	4.79	5.03
	Post	5.23	.068	5.09	5.36
FS	Pre	4.47	.019	4.43	4.51
	Post	4.60	.021	4.56	4.64
TFTS	Pre	4.61	.012	4.59	4.64
	Post	4.78	.013	4.76	4.81

Prevention and Early Intervention Protective Factors Survey for Caregivers by Agency

A paired sample *t* test was performed to evaluate the scores obtained from the four programs that had used the *Prevention and Early Intervention Protective Factors Survey for Caregivers.* Six of the 29 survey items, were reversed. Overall, the results indicate that the mean scores prior to prevention services (M=5.00) were lower than those obtained after program completion (M=5.20), p<0.001.

The results can also be viewed in light of the individual mean calculated through the *t* test results for each individual program. These results are listed in Tables 35-37 and overall suggest that PEI funded child abuse prevention programs are effective in increasing protective factors that mediate the occurrence of child abuse.

Table 35: Individual Programs with p<.001

Agency	N	Pre-Test	Post-Test
Family Connections	206	5.20	4.99

Table 36: Individual Programs with p<.01

Agency	N	Pre-Test	Post-Test
Greater Port Arthur Chamber of Commerce	13	5.22	5.61

Table 37: Individual Programs with p<.05

Agency	N	Pre-Test	Post-Test
Family Service Association	9	4.78	4.92
Children's Advocacy Center	51	5.01	5.09

Significant changes from pre to post for individual survey items were also examined. Scores for each agency on the individual survey items can be found in Appendix C. Out of the four agencies that had fairly complete data for this update version of the survey, the results indicate that only three had significant changes on individual survey items from pre to post. The majority of items were related to Family Functioning/Resiliency in terms of open communication and having support within the family to make it through challenging times.

Prevention and Early Intervention Protective Factors Survey for Caregivers by Program Type

Data from CBCAP[9] agencies indicates that protective factors increased from the period prior to services (M=5.01) to after program completion (M=5.21). Additionally, those who participated in FS programs evidenced an increase in *Protective Factor Survey* scores after receiving services (M=4.78 to M=4.92).

Table 38: Pre and Post-Service Results by Program Type

	Prevention and Early Intervention Protective Factors Survey for Caregivers	
Program Type	**Avg-Pre**	**Avg-Post**
CBCAP	5.01*	5.21*
FS	4.78	4.92

*p<0.001

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[9] Data were not available for TFTS agencies.

A two-way within-subjects analysis of variance was conducted to evaluate the effect of program type (CBCAP, TFTS and FS) and protective factor pre- and post-test scores. The program type main effect and protective factor pre- and post-test scores interaction effect were tested using the multivariate criterion of Wilks's lambda. Neither the protective factor pre- and post-test scores main effect or the interaction effect between program type and protective factor pre- and post-test scores interaction effect were significant. The univariate test associated with the program type main effect was also not significant.

Table 39: Within-Subject Effect of the Pre and Post-Tests by Program Type

Source	Type III Sum of Squares	df	Mean Square	F	Sig	Partial Eta Squared
Score	.51	1	.51	1.37	.24	.005
Score * Program Type	.02	1	.02	.07	.80	.000
Error (Score)	93.92	255	.37			

Table 40: Between-Subject Effect of the Pre and Post-Tests by Program Type

Source	Type III Sum of Squares	df	Mean Square	F	Sig	Partial Eta Squared
Intercept	1723.00	1	1723.00	3048.10	.000	.92
Program Type	1.17	1	1.17	2.07	.151	.01
Error	144.14	255	.57			

Table 41: Program Type

Program Type	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
CBCAP	5.11	.034	5.04	5.18
FS	4.85	.177	4.50	5.19

Table 42: Score

Score	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
Pre	4.895	.105	4.687	5.102
Post	5.065	.126	4.817	5.313

Table 43: Program Type * Score

Program Type	Score	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
CBCAP	Pre	5.01	.039	4.93	5.08
	Post	5.21	.047	5.12	5.31
FS	Pre	4.78	.207	4.38	5.19
	Post	4.92	.247	4.43	5.40

Adult-Adolescent Parenting Inventory (AAPI-2)

Family Service Association is the only agency that reported the AAPI-2 in the PEIS. A paired sample *t* test was performed to evaluate the scores obtained from the *Adult-Adolescent Parenting Inventory* (Table 44). Low scores indicate lower risks of child abuse based on the known behaviors of abusive caregivers that contribute to the abuse and/or neglect of children. One hundred thirty-eight individual surveys, each consisting of five aggregate scale scores, were collected from one program at two different intervals. The results indicate that the mean of risk factors related to child abuse prior to prevention services (M=6.24) was significantly greater than the mean of child abuse risk factors following prevention services (M=1.05), p<0.05. Prior to receiving prevention services, mean scores on individual items fell between 4.60 and 5.48; upon completion of the program, all of the mean scores on individual items were reduced to M<0.73. The scores corresponding to each of the individual survey items decreased significantly following prevention services. Thus, after completing child abuse prevention services, participants from this particular agency had a significantly lower risk of abuse according to the results of the survey.

Table 44: Paired sample t-test of AAPI Results.

Construct	Period	Mean
1. Inappropriate Expectations of Children*	Pre	5.29
	Post	0.64
2. Parental Lack of Empathy*	Pre	4.60
	Post	0.64
3. Strong Belief in the Use of Corporal Punishment*	Pre	5.48
	Post	0.59
4. Reversing Parent-Child Roles*	Pre	4.76
	Post	0.72
5. Oppressing Children's Power and Independence*	Pre	4.74
	Post	0.45
Total Score*	Pre	6.24
	Post	1.05

N=138 *$p<0.001$

Logistic Regression of Child Abuse Data

The logistic regression is used to identify a set of predictive variables that might have an impact on a categorical (or binary) variable. "The goal of analysis is to correctly predict the category of the outcome for individual cases. The first step is to establish that there is a relationship between the outcome and the set of predictors. If a relationship is found, one usually tries to simplify the model by eliminating some predictors while still maintaining strong prediction. Once a reduced set of predictors is found, the equation can be used to predict outcomes for new cases on a probabilistic basis" (Tabachnick & Fidell, 2007, p. 439). Table 45 provides the Beta coefficient as well as the z-value that indicates statistical significance. The third column for each time period (Exp(B)) is the odds ratio. This provides a more intuitive interpretation of the logit model. In the following analyses the dependent variable is equal to one when a family had a substantiated case of child abuse at discharge, six months, and twelve months after program participation and zero if they did not. The independent variables of interest included martial status, education level, race, relationship to participant child, average pre-test score, and average post-test score.

Child Abuse Cases at Discharge, 6 Months, and 12 Months

    Discharge

        The Chi-square statistic for this model was not statistically significant indicating that the model as whole does not improve prediction beyond random chance. Future models should seek to increase the demographic and other data available in order to enrich the analysis.   The results indicate that being married had a statistically significant affect on reducing the likelihood of a family having a substantiated case of child abuse by 54.9%. Additionally, the data indicate that each additional unit increase in the average post-test protective factor score decreases the likelihood of a confirmed case of maltreatment by 62.1%.

    Six Months

        The overall equation was statistically significant (X^2=37.27, df=10, *p*=.000, Nagelkerke R^2=.072) indicating the model was a good fit. It was found that being married reduces the likelihood of a family having a substantiated case of child abuse within six months of program completion by 57.1%. No other variables produced a statistically significant effect.

    *12 Month*s

        The Chi-Square statistic was not statistically significant at 12 months post program completion and none of the individual variables appeared to have an impact for this time period.

Table 45: Logistic Regression Analysis of Child Abuse Cases at Discharge, 6 Months, and 12 Months (all cases combined)

Variables	Discharge			6 Months			12 Months		
	B	Sig.	Exp(B)	B	Sig.	Exp(B)	B	Sig.	Exp(B)
Age	-.014	.320	.986	.004	.813	1.004	.011	.486	1.011
Gender (0=M, 1=F)	-.016	.967	.985	.191	.647	1.211	.111	.805	1.117
Marital Status (0=Non-Married, 1=Married)	-.796	.013	.451	-.847	.024	.429	-.095	.775	.909
Education (0=<HS, 1=HS or>)	-.266	.316	.767	-.391	.165	.676	-.331	.288	.718
RaceW (0=NW, 1=W)	-.419	.693	.657	17.913	.998	60180740.177	17.453	.998	37986454.491
RaceB (0=NB, 1=B)	-1.095	.311	.335	17.347	.998	34191619.852	17.397	.998	35926537.054
RaceH (0=NH, 1=H)	-1.056	.319	.348	16.220	.999	11069846.574	16.655	.999	17099076.288
Relation to child (0=Extended family, 1=Immediate family)	.260	.360	1.296	-.151	.596	.860	-.204	.492	.815
Avg-Pre	-.155	.487	.856	.051	.839	1.052	-.079	.756	.924
Avg-Post	-.969	.035	.379	.592	.442	1.807	.117	.860	1.124
Constant	*-1.667*	*.373*	*.189*	*-20.993*	*.998*	*.000*	*-20.212*	*.998*	*.000*

At Discharge: X^2=16.96, df=10, p=.075, Nagelkerke R^2=.03
At 6 months: X^2=37.27, df=10, p=.000, Nagelkerke R^2=.072
At 12 months: X^2=8.58, df=10, p=.572, Nagelkerke R^2=.019

Logistic Regression Analysis of Child Abuse Cases at Discharge, 6 Months, and 12 Months by Fiscal Year 2007[10]

Discharge

The overall equation was significant and the results indicate that being married reduces the likelihood of having a substantiated case of child abuse by 81.7%. Also, the data indicates that each unit increase in the average post-test protective factor score reduces the likelihood of a confirmed case of abuse by 76.4%.

Six Months

The overall equation was statistically significant. Being married had a statistically significant negative effect on the likelihood of having a substantiated child abuse case by 68.3%. However, no other individual variables were found to be statistically significant.

Twelve Months

The overall equation for this model was not statistically significant and none of the variables had an impact on a family having a confirmed child abuse case.

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[10] Logistic regression was completed for FY 2007 and for FY 2008 given that these are the two years for which the evaluators had the most complete data.

Table 46: Logistic Regression Analysis of Child Abuse Cases at Discharge, 6 Months, and 12 Months for the Fiscal Year 2007

Variables	Discharge			6 months			12 months		
	B	**Sig.**	**Exp(B)**	**B**	**Sig.**	**Exp(B)**	**B**	**Sig.**	**Exp(B)**
Age	.003	.875	1.003	-.002	.942	.998	-.004	.865	.996
Gender (0=M, 1=F)	.349	.583	1.417	-.319	.530	.727	-.248	.637	.780
Marital (0=Non-married, 1=Married)	-1.701	.008	.183	-1.150	.072	.317	-.276	.553	.759
Education (0=<HS, 1=HS or>)	-.334	.440	.716	-.670	.132	.512	-.098	.822	.907
RaceW (0=NW, 1=W)	17.613	.999	44597107.416	18.143	.999	75740320.279	17.845	.999	56211239.660
RaceB (0=NB, 1=B)	16.914	.999	22168154.313	16.841	.999	20606862.884	16.865	.999	21097802.135
RaceH (0=NH, 1=H)	17.611	.999	44508537.287	16.264	.999	11567224.836	17.386	.999	35528908.651
Relation to child (0= Extended family, 1= Immediate family)	.344	.524	1.411	-.526	.323	.591	-.431	.415	.650
Avg-Pre	-.723	.121	.485	.133	.812	1.143	-.100	.843	.905
Avg-Post	-1.446	.027	.236	-.653	.436	.520	-.473	.560	.623
Constant	-17.95	.999	.000	-17.715	.999	.000	-17.837	.999	.000

At Discharge: X^2=16.86, df=10, p=.07, Nagelkerke R^2=.075
At 6 months: X^2=22.64, df=10, p=.012, Nagelkerke R^2=.109
At 12 months: X^2=4.92, df=10, p=.896, Nagelkerke R^2=.023

Logistic Regression Analysis of Child Abuse Cases at Discharge, 6 Months, and 12 Months by Fiscal Year 2008

Discharge

The Chi-square statistic for this logistic regression was not statistically significant (X^2=11.72, df=10, *p*=.304, Nagelkerke R^2=.043), indicating poor model fit. Caution should be made when interpreting the data.

Six months

The Chi-square statistic for this logistic regression was statistically significant (X^2=29.81, df=10, p=.001, Nagelkerke R^2=.136). However, there were no individual variables that were statistically significant in this model.

Twelve months

The Chi-square statistic for this logistic regression was not statistically significant (X^2=15.75, df=10, p=.107, Nagelkerke R^2=.10). There were no individual variables that were statistically significant in this model.

Table 47: Logistic Regression Analysis of Child Abuse Cases at Discharge, 6 and 12 Months for Fiscal Year 2008

Variables	Discharge			6 months			12 months		
	B	**Sig.**	**Exp(B)**	**B**	**Sig.**	**Exp(B)**	**B**	**Sig.**	**Exp(B)**
Age	-.026	.236	.974	.012	.615	1.012	.028	.322	1.029
Gender (0=M, 1=F)	.178	.777	1.194	17.093	.995	26512480.101	.539	.611	1.715
Marital (0=Non-married, 1=Married)	-.510	.256	.600	-.746	.192	.474	.175	.770	1.191
Education (0=<HS, 1=HS or>)	-.295	.462	.745	-.706	.123	.494	-.853	.134	.426
RaceW (0=NW, 1=W)	-2.567	.039	.077	18.164	.999	77369584.236	17.254	.999	31142336.614
RaceB (0=NB, 1=B)	-3.262	.012	.038	17.418	.999	36685540.278	17.628	.999	45267132.333
RaceH (0=NH, 1=H)	-3.492	.006	.030	15.899	.999	8029528.050	15.603	.999	5976166.483
Relation to child (0=Extended family, 1=Immediate family)	.135	.735	1.145	-.308	.518	.735	-.283	.597	.754
Avg-Pre	.285	.447	1.330	.129	.775	1.138	-.347	.396	.707
Avg-Post	-.610	.454	.543	17.449	.997	37837578.580	17.535	.997	41248708.091
Constant	-1.122	.669	.326	-54.584	.998	.000	-36.833	.999	.000

At Discharge: X^2=11.72, df=10, p=.304, Nagelkerke R^2=.043
At 6 months: X^2=29.81, df=10, p=.001, Nagelkerke R^2=.136
At 12 months: X^2=15.75, df=10, p=.107, Nagelkerke R^2=.10

Logistic Regression by Program Type

Logistic regression analysis by program type was conducted for FS and TFTS. There were insufficient cases to conduct the analysis for CBCAP programs.

Family Strengthening (FS)

A logistic regression analysis was conducted on the Family Strengthening program type to examine the impact of demographic and protective factor variables on the likelihood of a substantiated case of child maltreatment. Looking at cases at discharge, 6 months and 12 months, there were no statistically significant variables.

Texas Families: Together and Safe (TFTS)

Discharge

The results indicate that being married reduces the likelihood of having a substantiated case of abuse by 71%. However, the Chi-square statistic for the model was not significant (X^2=16.30, df=10, p=.09, Nagelkerke R^2=.040), which should lead to cautious interpretation of this result. No other variables were found to be statistically significant.

Six months

The Chi-square statistic for this model was significant (X^2=32.11, df=10, p=.00, Nagelkerke R^2=.085) and it was found that being married reduces the likelihood of a substantiated case of abuse by 52.5%. In addition, having a high school education or above also reduces the likelihood of having a confirmed case of maltreatment by 46.1%.

Twelve months

The overall Chi-square statistic was not statistically significant (X^2=6.69, df=10, *p*=.75, Nagelkerke R^2=.022), and none of the individual variables were statistically significant.

Table 48: Logistic Regression for Family Strengthening Program

Variables	Discharge			6 months			12 months		
	B	**Sig.**	**Exp(B)**	**B**	**Sig.**	**Exp(B)**	**B**	**Sig.**	**Exp(B)**
Age	-.032	.299	.969	-.010	.786	.990	.005	.887	1.005
Gender (0=M, 1=F)	-.471	.553	.624	16.524	.997	15010746.285	.262	.808	1.300
Marital (0=Non-married, 1=Married)	-.130	.815	.878	-.758	.335	.468	.518	.382	1.678
Education (0=<HS, 1=HS or>)	-.006	.991	.994	.418	.539	1.518	-.171	.773	.843
RaceW (0=NW, 1=W)	18.200	.999	80181648.298	17.782	.999	52816512.335	17.779	.999	52645289.611
RaceB (0=NB, 1=B)	17.035	.999	25025667.279	-.342	1.000	.710	18.070	.999	70455496.323
RaceH (0=NH, 1=H)	17.027	.999	24810809.263	16.419	.999	13514483.159	16.410	.999	13392015.666
Relationship to child (0=Extended family, 1=Immediate family)	.804	.103	2.234	.547	.391	1.729	.291	.598	1.338
Avg-Pre	-.558	.133	.572	.057	.928	1.058	-.245	.566	.783
Avg-Post	-1.455	.112	.233	16.793	.998	19643878.728	17.460	.998	38279762.511
Constant	-19.46	.999	.000	-56.61	.998	.000	-39.18	.998	.000

Table 49: Logistic Regression: Texas Families: Together and Safe (TFTS)

Variables	Discharge			6 months			12 months		
	B	**Sig.**	**Exp(B)**	**B**	**Sig.**	**Exp(B)**	**B**	**Sig**	**Exp(B)**
Age	-.008	.607	.992	.01	.785	1.01	.02	.345	1.018
Gender (0=M, 1=F)	-.049	.909	.952	.09	.850	1.09	.25	.645	1.289
Marital (0=Non-married, 1=Married)	-1.237	.004	.290	-.75	.085	.48	-.37	.374	.694
Education (0=<HS, 1=HS or>)	-.343	.267	.709	-.62	.056	.54	-.29	.447	.752
RaceW (0=NW, 1=W)	-1.199	.279	.301	17.88	.999	58006399.34	17.42	.999	36666253.999
RaceB (0=NB, 1=B)	-1.727	.126	.178	17.52	.999	40619557.57	17.08	.999	26177735.864
RaceH (0=NH, 1=H)	-1.600	.147	.202	15.98	.999	8693914.08	16.81	.999	19978533.757
Relationship to child (0=Extended family, 1=Immediate family)	-.019	.957	.981	-.425	.256	.654	-.515	.173	.598
Avg-Pre	-.020	.937	.980	-.002	.993	.998	-.009	.976	.991
Avg-Post	-.879	.106	.415	.429	.588	1.536	-.210	.765	.810
Constant	-.438	.843	.645	-19.09	.999	.000	-19.09	.999	.000

In summary, we found that being married is a significant variable that consistently had an impact on the occurrence of a substantiated case of child abuse throughout the three time periods under examination. The data also indicated that the average post-test protective factor score has an impact on a family having a confirmed maltreatment case at discharge in Fiscal Year 2007 as well as in the overall years combined. This suggests that the child abuse prevention programs that increase the protective factors of the family, as a result, may reduce the number of substantiated cases of child abuse.

Outcome #2: Repeated Measure Analysis of Variance

Child Abuse Cases at Discharge, 6 Months, and 12 Months (Overall)

The evaluator received data from DFPS on confirmed child abuse cases in the IMPACT system and compared them to individuals who had participated in PEI funded child abuse prevention programs. These data were used to conduct a repeated measure ANOVA to assess whether there were significant differences among the three time periods: up to discharge, six months, and twelve months in terms of the proportion of child abuse cases.

Of the data received the total number of child abuse cases up to discharge was 113, at six months 107, and at 12 months 76. Using these numbers, the proportion of child abuse cases was computed at discharge (113/6,321=.018), six months (107/6321=.017) and at twelve months (76/6321=.012). The results are contained in Table 50.

The results of a follow-up paired sample t-test (Table 51 and Table 52) indicate there was a significant difference among these time periods [$F_{(2,12,640)}=4.417$; $p=.012$]. More specifically, there was a significant difference between 6 (M=.0169) and 12 months (M=.0120; p=2.491; df=6320, p=.013); however, not between the proportion of abuse cases at discharge and six months. Furthermore, the follow up t-tests indicate that there was a significant reduction of the proportion of child abuse cases from up to discharge to 12 months.

Table 50: Proportion of Child Abuse Based on IMPACT Data

Variable	N	%
Confirmed Abuse Case At Discharge		
No Abuse	6,208	98.2
Abuse	113	1.8
Total	6,321	100
Confirmed Abuse Case 0-6 Months After Discharge		
No Abuse	6,214	98.3
Abuse	107	1.7
Total	6,321	100
Confirmed Abuse Case 6-12 Months After Discharge		
No Abuse	6,245	98.8
Abuse	76	1.2
Total	6,321	100

Table 51: Repeated Measure ANOVA of the Proportion of Child Abuse Cases

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Abuse	.125	2	.062	4.417	.012	.001
Error(Abuse)	178.542	12640	.014			

Table 52: Comparison of Mean Differences: Discharge, 6 Months, and 12 Months

Variable	Mean	SD	t	df	Sig.
At Discharge	.0179	.13	.420	6320	.674
Six Months	.0169	.13	2.491	6320	.013
Twelve Months	.0120	.11	2.783	6320	.005

Child Abuse Cases at Discharge, 6 Months, and 12 Months by Program Type (CBCAP, TFTS and FS)

A two-way within-subjects analysis of variance was conducted to evaluate the effect of program type (CBCAP, TFTS and FS) on the number of validated incidences of child abuse or neglect cases at discharge, 6 month, and 12 months. The effect and program type interaction effect were tested using the multivariate criterion of Wilks's lambda. Neither the child abuse time main effect nor the interaction effect between program type and time period were significant. However, the univariate test associated with the program type main effect was significant, $F(1,2)=9.83$, $p=.000$.

Three paired samples t tests were conducted to follow up the significant main effect. Similar to the previous analyses, differences in number of child abuse cases

between discharge and six months were not statistically significant. Differences between discharge and the twelve month period were statistically significant [t(6320)=2.783, p=.005] as well as between six month and twelve month [t(6320)=2.491, p=.013].

Discussion

The effectiveness of PEI funded child abuse prevention programs can be positively viewed in light of the average scores reported on protective factor survey items and in terms of participant satisfaction with child abuse prevention programs. The results of the Protective Factors Survey indicate that upon completion of PEI funded prevention programs, participants' average scores were higher than the scores obtained prior to services. The individual items where there was an increase are related to protective factor subscales such as Family Functioning/Resiliency, Social Support, Concrete Support, Child Development/Knowledge of Parenting, and Nurturing and Attachment.

As aggregated by program type, the post scores from *The Prevention and Early Intervention Protective Factor Survey for Caregivers* were reported as higher in all three program types with CBCAP exhibiting the highest average score at both the pre- and post-service intervals.

These results also held true for those agencies that have used the current survey version. There was a statistically significant increase on the average scores reported for specific protective factor items on the *Prevention and Early Intervention Protective Factor Survey for Caregivers* following child abuse prevention services. Similarly, data aggregated by program type for responses to this survey suggests that PEI funded child abuse prevention programs strengthen familial protective factors with CBCAP reporting the highest mean score values.

The success of the programs can also be conceptualized in terms of participant satisfaction with program involvement. As noted, 98.35% of eligible participants completed the *Prevention and Early Intervention Family Satisfaction Survey* with a mean score of 6.40 on a 7 point scale, which indicates, overall, that respondents were satisfied with their participation in child abuse prevention programs. The majority,

(95.71%) recorded average scores of 5 or higher, signifying that the majority of participants felt satisfied with their participation in child abuse prevention and intervention programs.

The logistic regression results reveal the impact of marital status and increased protective factors on reducing the likelihood that a family will have a substantiated case of child maltreatment. At discharge for the overall time period as well as in 2007 these two variables were found to have a statistically significant impact on the dependent variable. At 6 months (overall) after program completion, at 6 months in 2007 and at discharge and 6 months for the TFTS program type, being married significantly reduced the odds of having a confirmed child abuse case. Education also came into play for TFTS participants at 6 months after program completion. The results indicate that the likelihood of a substantiated case of child abuse is reduced by having a high school education or above. Finally, the results of a repeated measure ANOVA indicate that the number of validated incidences of child abuse or neglect cases among the families in fiscal years 2007 and 2008 was significantly reduced from the period up to discharge to twelve months and from six months to twelve months.

The results of a repeated measure ANOVA indicate that the number of validated incidences of child abuse or neglect cases among the families was significantly reduced from discharge to twelve months and from six months to twelve months. Nonetheless, there was not a statistically significant relationship between program type and the three time periods (at discharge, six months and twelve months) in terms of the number of validated incidences of child maltreatment.

Conclusion

The connection between PEI funded child abuse prevention programs and protective factors, becomes quite clear in this analysis. A statistically significant increase in protective factor survey scores was observed from the pre-test period, to the post-test period. In addition, the logistic regression results indicate the importance of protective factors in reducing risk and impacting child abuse. However, the results did not indicate that an increase in the post-protective factors score was a significant variable at six or twelve months after program completion. Although these results

should be interpreted with caution due to data limitations, they should also be analyzed in more detail. It is possible that PEI funded prevention services influence familial interaction and reduce risk over the time period in which the family is involved with the service agency leading to a reduced likelihood of having a validated case of maltreatment during program participation through discharge.

It is also important to bring attention to the pre-test scores for the agencies that were part of this evaluation. Although there was evidence of low protective factors scores on individual surveys, the majority of average pre-test scores hovered at the intermediate level of risk. This may indicate there was no room for improvement of protective factors in the families served calling in to question the selection process. Alternatively, the high pre-test scores may be the result of social desirability bias in which respondents try to provide the socially acceptable answer.

Two other variables of interest that were found to have a statistically significant relationship with the incidence of a substantiated child abuse case are marital status and education. Being married was found to reduce the likelihood of having a confirmed case at 6 months overall and in 2007, and up to discharge and at 6 months for TFTS program participants. The emotional and financial support that is possible with marriage can serve to reduce risk factors related to child abuse. Protective factors such as open communication, positive interaction, and the use of other particular skills and strategies can help couples to make it through challenging times. This emphasizes the need to strengthen and develop supportive relationships and networks for parents to reduce the likelihood of abuse.

Future models should involve the collection of more and varied demographic and outcome data for PEI child abuse prevention program participants. These models can provide greater insight into the specific factors and interactions between variables that lead to a reduction in substantiated case of child abuse.

Limitations

1. Data obtained from DFPS

One of the challenges faced in the evaluation process was the exclusion of program data from the PEIS database. One CD obtained from DFPS covered data from April

2006 to August 2008 and the second covered data from April 2007 to December 2008. The decision was made not to use the second CD because many of the clients were still current in the system and did not complete the post-test. As a result, only the first CD was used for this analysis. In this CD, only 24 funded programs could be identified even though the state funded more than 24. Therefore, the results cannot be generalized to all of the state-funded programs.

2. Change of Race/Ethnicity of the Clients

   In the database that was received from DFPS, the race/ethnicity of a number of clients changed from one line to another making it difficult to judge their actual race/ethnicity. To resolve this issue in these cases we randomly selected the case data to represent the race/ethnicity of the client.

3. Duplication of Client ID

   We found that the Client ID repeated in several occasions in the database. The Client ID is supposed to be a unique identifier so that the same client is not counted twice in the system. To address this issue, we used the computer to randomly select the Client ID to represent the case data.

4. Pre and Post-Test Analysis

   There were a large number of clients who did not fill out the pre or post-test. When a paired-sample t-test was conducted, these clients were excluded from the outcome analysis due to lack of data. Subsequently, the sample size of this particular analysis was significantly reduced.

5. Satisfaction Survey

   The Satisfaction Survey response is not associated with the Client ID in the database provided by DFPS. Therefore, we could not analyze the data in association with client demographics and incidence of child abuse.

6. Completion of the Pre and Post *Protective Factors Survey*

   A significant number of the program participants only filled out part of the pre and/or post surveys. It is difficult to conclude whether they left the item unanswered

intentionally or did not complete the survey due to other reasons. As a result, we computed the total pre and post-test scores based on the number of items completed by the participants. Therefore, the total score may not truly represent the protective factors as identified in this instrument.

7. Instruments

The *Protective Factors Survey* used by most of the programs (N=22) was not completely validated. Despite established convergent validity, results from the older protective factors survey which included more items could not be merged with those of the final version or the *Prevention and Early Intervention Protective Factor Survey for Caregivers* (FRIENDS National Resource Center, 2008). In addition, since only four programs used the *Prevention and Early Intervention Protective Factor Survey for Caregivers* reliability and validity of this survey needs to be analyzed further in the future.

8. Interpretation of the *Protective Factor Survey*

The evaluators could not identify any document to describe the validity and reliability of the older version of the survey. Some of the items on the *Protective Factor Survey* appeared to be reversed items. The evaluators had to make a professional judgment to reverse the score of these items. For example, "I spank" and "I hit" should be reversed items, but documentation to guide the revision of the items could not be located.

9. Process of Trimming Down the Dataset

The original dataset contained 2,037,978 lines. The evaluators had to restructure the variables, eliminate 14,815 empty lines, and consolidate the duplication of the Client ID. Our final unduplicated Client IDs were reduced to 6,011.

10. Target Population

We found that many of the clients served had a higher pre protective factors survey score, suggesting that they were not at risk. As a result, significant improvement from pre to post-test scores was not found. It would be more effective for PEI to

develop criteria for agencies to recruit the targeted population who are at risk of abuse.

11. *Adult-Adolescent Parenting Inventory (AAPI-2)*

Only one agency used the *Adult-Adolescent Parenting Inventory* (AAPI-2) which limits the generalizability of the survey results.

12. Post-test Data

Some programs surveyed participants multiple times. However, only data from the first post-test were analyzed due to the small sample size of respondents with additional post-tests.

13. Incomplete Data

The data provided for the *Protective Factor Survey* was incomplete with no data recorded for item number 7 ("my family enjoys spending time together"). Additionally, the order of items 28A, 28B, 28C and 28D varies from program to program. For example, item 28A (I use time out) appeared to be the first item on the list for one program but was changed to item 28B for another. This made the analyses very complex.

Opportunities for the ICC and DFPS to strengthen the effectiveness of state-funded child maltreatment prevention programs and services in achieving their intended outcomes include:

1) Continue to monitor the number of participants that complete the pre- and post-tests in order to identify solutions to the large number of program participants who fail to complete both of the tests while in the program

2) Continue to assess the validity and reliability of the survey instruments being implemented by the contractors since the external and internal environments may change and affect the appropriateness and validity of the instruments

3) Add demographic data including age, race/ethnicity, and agency to the satisfaction survey. This will preserve respondents' anonymity while allowing in dept analysis of participants' satisfaction

4) Consistently review the PEI database in order to quickly identify and address problems with data entry. This will help to avoid critical errors such as variation in the recorded race/ethnicity of the participants

5) Encourage agencies to use the PEI outcome report developed by DFPS for continuous program improvement

6) Use evaluation results and other reports to demonstrate the effectiveness of child abuse prevention programs at increasing protective factors and decreasing the likelihood of abuse and neglect

Evaluation Element 4

Identify methods for transitioning state-funded child maltreatment prevention programs and services to an increased reliance on evidence-based practices.

In order to assist the ICC and DFPS in evaluating and strengthening Evidence Based Practice (EBP) among Texas state agencies, the Office of Community Projects at the University of Houston Graduate College of Social Work sought to answer several questions: (1) What is the state of the literature on evidence-based child abuse prevention programs; (2) What and how rigorous is the research on the specific curricula used by child abuse prevention grantees of the Department of Family and Protective Services (DFPS); (3) What methods and processes do grantees use to implement evidence-based programs in the field; (4) How can the ICC and DFPS move child maltreatment prevention programs into stronger EBP models. Our approach involved a step-by-step process involving (1) a review of the existing literature, (2) key informant interviews with experts in the field, (3) ranking proposals submitted by agencies, (4) interviews with program directors and staff, and (5) content analysis of case records.

Review of the Literature

It was critical for this analysis to first define evidence based practice and understand what barriers impede effective implementation as well as what strategies reduce these challenges. The full literature review can be found in Appendix C.

Evidence Based Practice can generally be defined as the use of the best empirically derived information in making practice decisions (Chaffin & Friedrich, 2004; Dawes et al., 1999; Sackett et al., 2000; Webb, 2001). The level of research evidence that is required to meet the EBP standard varies, but is derived from traditional research methodologies including random control trials, case experimentation, and double-blind studies (Chaffin & Friedrich, 2004; Webb, 2001). Other evidential criteria include publication of the research in peer-reviewed journals and consistent reliability testing (Rosenthal, 2004). Less rigorous methods such as case studies can also be used, but do not hold the same weight (Witkin & Harrison, 2001) as evidence garnered from the previously mentioned research methods.

Despite the importance of research design and outcomes to the classification systems mentioned above, there is a general consensus in the literature that EBP is not based on rigorous testing alone, but on an appropriate understanding of the problem to be addressed (Wulczyn et al., 2005), a distinct connection between the evidence surrounding the proposed intervention and the target client or family, and consideration of the client's understanding of the evidence based treatment with which they will be involved (Gambrill, 1999; Kessler et al., 2005; Sackett et al., 2000; Steinberg & Luce, 2005). This characterization of EBP illustrates the fact that it does not represent a discrete change, but rather a process connecting research that demonstrates effectiveness with context and appropriate implementation. Unfortunately, there is a division that often exists between these two worlds (Webb, 2001; Witkin & Harrison, 2001; Gambrill, 1999) with research seen as out of touch with the practical day-to-day realities of direct service. Even those practitioners that see the value of EBP would be challenged to find time to collect information on the best available interventions in their field. In addition some research findings do not always result in effective practice outcomes (Walshe and Rundall, 2001) or are relatively scarce for a particular intervention (Wulczyn et al., 2005). This can lead practitioners to conclude that their experience is a better determinate of what interventions work with their client population.

Due to the divergence between practice and research as well as the other arguments against EBP, it has been suggested that effective use of EBP requires a complete paradigm shift (Walshe & Rundall, 2001). Instead of seeing research and practice as mutually exclusive, it is important to understand that effective EBP involves an integration of the two. This transition involves a transformation in research strategies, methods, outputs, and the dissemination and understanding of research to direct service providers.

This paradigm shift is not the only challenge involved in selecting and implementing evidence based alternatives. In the field of child welfare, systemic barriers include:

- Lack of marketing or support for EBP above more traditional practices
- Lack of funding from public and/or private sources for training and infrastructure development that is essential to adding and expanding EBP

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- Connection of funding to outputs (i.e. number of families seen) versus client outcome

Several other more general difficulties include:

- Sorting through and selecting from the various EBP rating systems (i.e. California Evidence Based Clearinghouse for Child Welfare, FRIENDS National Resource Center for Community Based Child Abuse Prevention, SAMHSA National Registry of Evidence Based Programs and Practice)
- Scarcity of resources for implementation including the purchase of curriculum, staff training, maintaining fidelity, and evaluating outcomes (Barth, 2007; Gibbs & Gambrill, 2002; Whiting-Blome & Steib, 2004).
- Lack of clarity regarding purpose of EBP for long-term goals
- Disagreement on desired outcomes
- Political mandates or competing priorities (Chaffin and Friedrich, 2004)
- Maintaining fidelity

Maintaining fidelity is particularly problematic for program effectiveness. Fidelity is adherence to the principles of process and change associated with a specific program model or practice (Harding et al., 2007; Sweet & Appelbaum, 2004). It is highly dependent on the theory of change behind the program as well as the resources available in a particular organization. There are generally two positions in regards to fidelity. The first supports modifications that do not damage the critical elements of the original model (Kessler et al., 2008). This approach recognizes the specific context in which the program is being implemented and the targeted populations it is intended to serve, while ensuring that the factors that led to particular outcomes in the research are not jeopardized. The second position is strict adherence (Blakely et al., 1987), which leaves no room for contextual adaptation to the original model. Making a determination regarding the level of fidelity necessary for appropriate implementation is an important consideration in choosing a curriculum or model because it can interact with any of the challenges listed above and negatively impact desired outcomes.

There are a number of suggested solutions to overcoming fidelity and other challenges; all of which can be applied to the implementation of child abuse prevention programs and practices (Kauffman Best Practices Project, 2004). These include:

- Having a clear conception of the change that needs to take place

- Connecting the process and outcomes of the EBP to the needs of the client population and organization
- Delineating what specific resources will be needed to maintain fidelity in terms of implementation and sustainability. This includes funding, staff, training etc.
- Structuring a clear dissemination plan that begins with the program's logic model
- Acquiring broad based and updated knowledge of what EBP exists in the field

The last of these strategies is made somewhat more manageable by the existence of several national resources that have developed and compiled information on EBP rating systems. The five systems that were identified from the literature and the web include: 1) California Evidence-Based Clearinghouse for Child Welfare (CEBC), 2) FRIENDS National Resource Center for Community Based Child Abuse Prevention, 3) Substance Abuse and Mental Health Services Administration's National Registry of Evidence Based Programs and Practice (SAMHSA NREPP), 4) Office of Juvenile Justice and Delinquency Prevention's Model Programs Guide, and (5) Promising Practices Network. Tables 54 and 55 in Appendix C list the rating of evidence based practices used by agencies that contract with PEI. These resources provided the basis for the key informant interviews and the ranking of agency proposals. The interviews in particular provided a more personal and broader perspective about the nature and challenges of EBP.

Key Informant Interviews

Based on a review of the literature as well as web based resources, three experts in the field of Evidence Based Practice were selected for interviews. This process was intended to provide greater insight into the practical challenges of EBP and strategies that were introduced in the literature. The individuals who were interviewed include Cassandra Firman, Training and Technical Assistance Coordinator for FRIENDS; Kevin Hennessy, SAMHSA Science to Service Coordinator; and Laine Alexandra, Project Manager for California Evidence-Based Clearinghouse for Child Welfare. The complete interviews can be found in Appendix C.

Three themes evolved from the interviews with these experts. The most predominant theme was the need for shared information and dialogue about EBP

among researchers and practitioners. For evidence based practice to be used more effectively, stakeholders at all levels of decision-making, need to come together to discuss the realities of integrating it into the service delivery systems. Secondly, all interviewees noted that clear expectations with regard to the desired level of EBP are essential for success. The third theme was the importance of proper implementation. Often policymakers are focused on outcomes as opposed to the process of EBP including, but not limited to the existence of a continuum including "evidence informed." Success in this area is hindered by lack of fiscal resources, the absence of a theory of change, and poorly trained staff. It is therefore necessary to begin by drawing a clear connection between the needs of the target population, the evidence based program that is selected to address the problem, and the resources of the organization that intends to implement it.

Ranking Agency Proposals

A first step in analyzing the implementation of EBP in the organizations of DFPS grantees was to understand the level of EBP that existed among those agencies funded through PEI. A list of these agencies, contact information, and program proposals for the most recent request for proposals (2008) was provided by DFPS.

The first step in this process was to adopt a system for rating grant proposals submitted to PEI. For consistency with the state classification and the FRIENDS National Resource Center for Community Based Child Abuse Prevention, we adopted the classification of evidence based practice that utilizes four levels: (1) emerging; (2) promising; (3) supported; and (4) well-supported (Table 56, Appendix C).

This classification rating contains nine criteria:

- Theory of change
- Program manual
- Accepted clinical practice
- No evidence of harm
- Research conducted
- Longitudinal research
- Reliable and valid outcome measures
- Program evaluation and quality assurance
- Model fidelity

According to the classification system these characteristics should be rated on a yes/no response. However, the OCP evaluation team believed this was insufficient to capture the complexity of child maltreatment prevention research and programs. Consequently, a more flexible rating system, which ranged from 0 (not included) to 4 (strongly apparent), was developed for each of the criteria specified by the classification system.

Each agency proposal was thoroughly reviewed for the nine criteria listed above. In addition, research on each of the curriculum/programs as listed in the proposals was examined. These curricula included:

- AVANCE
- Big Brothers/Big Sisters
- Homebuilders
- Love and Logic
- 1-2-3 Magic
- Effective Black Parenting
- Family Connections
- Parent's Anonymous
- Healthy Families
- Nurturing Parenting
- Parents as Teachers
- Responsible Fatherhood
- Healthy Start-Grow Smart
- Practical Parent Education
- Child Communication Classes
- STEP
- CALMS
- Parenting Counts
- Brief Strategic Family Therapy
- Nurse Family Partnership
- Dare to be You
- 24/7 Dad
- Enhancing Nurturing Parenting Skills in African American Families
- Children in the Middle
- Parenting Wisely
- Dads Make a Difference
- Middle Way
- African American Nurturing Parenting

Each curriculum was then assigned a score based upon the rating system so that a program proposal containing all EB criteria could receive a total of 36 points. Programs ranged from a low of 9 points to a high of 33 points. The average EBP rating of all 53 programs administered by PEI grantees was 23.2 (Table 56). Several curricula were repeated across programs.

Table 53: Final EBP Rating of Agency Proposals

Mean	Range	Number of programs
23.2	9-33	53

The overwhelming majority of agencies proposed programs that were evidence-based and supported by the scientific literature at varying points on the continuum. However, it is widely understood that the most well planned programs often encounter difficulty in implementation. As a result, we also sought to determine whether agencies were implementing evidence-based curricula the way they were intended, and if not to explore reasons impeding fidelity to the model.

Agency Interviews and Case Review

A total of twelve PEI grantees were chosen for this stage of the evaluation. Agencies were selected from low, medium and high proposal ratings in order to fully explore the range of EBP implementation challenges and strategies for success. Eight grantees, consisting of nine organizations, agreed to participate. Letters were sent to agencies in November 2008 requesting voluntary interviews with a program director and a staff member. In-person one-on-one interviews were conducted in January and February 2009 using interview guides based on key concepts contained in the literature review (Appendix C). Interviews were conducted by members of the evaluation team and lasted approximately an hour. A total of 19 interviews were conducted at nine sites throughout the state. Interview notes were transcribed and a content analysis was performed.

In addition to interviews, case files were obtained from each program that was interviewed in order to determine whether case notes reflected model fidelity. Including

case files in the analysis addressed the validity of the findings. Given that the criteria for each organization would vary based on the model used, separate rating forms were developed for each program.

A score was then created that consisted of the number of EBP criteria that were observed in the case notes divided by the number of criteria that should have been observed in the case notes. This resulted in a percentage of consistency the case file had with the specific fidelity criteria in the curriculum. Given time and personnel limitations, five case files were reviewed for each grantee except in the case of one grantee. In this instance the grantee subcontracted to two different agencies therefore a total of six cases were reviewed. One program did not keep case notes and therefore was not included in this portion of the evaluation. The following is a list of curricula included in the case analysis:

- Nurturing Parenting
- Parents as Teachers
- Healthy Families
- Homebuilders
- Family Connections

Interview Results

  Benefits of EBP

A constant theme in interviews with program directors and staff was the legitimacy an EB curriculum lends to practice and the structure it provides. In terms of legitimacy, staff articulated that using an EBP curriculum encouraged family buy-in because there was proof that the activities in which they were asked to engage in led to positive outcomes. One example provided by staff was sharing information with parents about the positive impact of play and communication on a child's brain development. Program staff also reported that they felt more confident when using a curriculum that was supported by research and provided information and activities already prepared for use with families.

In terms of structure it was indicated that clearly defined lessons, documentation requirements, and evaluation tools eased the use of the curriculum for administration,

staff, and families. However, flexibility was a key benefit. Too many requirements related to paperwork were reported to detract from time with families or to tax the resources available to implement the program. A number of the curricula used by the agencies interviewed did provide alternative fidelity models or flexibility outside core requirements so that programs could match curricula to their resources and the needs of the client population they served. An example of this is the Homebuilders model that has a less intensive Parents and Children Together (PACT) model. Another is the Parents as Teachers curriculum that has versions for low and high functioning parents and is translated into both English and Spanish.

The ability to obtain technical assistance from the curriculum developers was essential to ensuring fidelity when these changes were made. Having resources to seek technical assistance for how to address issues is necessary to maintain model fidelity so that modifications do not damage the critical elements of the original model (Kessler et al, 2008). Many questions arise in the implementation of EBP programs that are not clearly outlined in manuals and/or training. These questions often concerned client issues and demographics of the target population. For the most part, those programs who had made adaptations reported that they consulted with the developer before making the change. Ensuring fidelity throughout the implementation process however was affected by the ease with which this contact took place. A handful of program directors reported that developers were not easily accessible. In addition they mentioned that the problem of inadequate information was exacerbated by the absence of a more formal network among agencies using the same curriculum and a lack of understanding at the state level regarding curriculum components.

Challenges of EBP

While mentioned as a benefit, EBP curricula did vary in regards to the ease with which individual curriculum could be communicated to clients. In some cases it was difficult to translate the evidence to families that were at a lower functioning level. Other families wanted more in-depth information than was available to staff. This led many staff who were interviewed to independently seek out more information or to obtain it from trainings provided by the agency for which they worked. The structure of EB

curricula was also consistently mentioned as a challenge by the program directors and staff who were interviewed. The number of clients to be seen and the duration of necessary contact required by some curricula were sometimes greater than the resources (i.e. number of worker, finances, etc.) available to do so. Several other concerns related to curriculum requirements include:

- Need for masters level workers
- Extensive start up and continuous training/education requirements
- Population needs outweighing length and intensity of service
- Instability of client lifestyle not conducive to nature of service provision (i.e. group meetings or regularly scheduled individual home visits)
- Implementation costs greater than grant provisions
- Cost of evaluation to show evidence of EB effectiveness

Although a number of curricula provided basic tools to evaluate the effectiveness of the work, most program directors indicated they did not have the resources necessary to conduct thorough and ongoing outcome evaluations. A number of agencies conducted informal evaluations through client satisfaction surveys, case reviews, and supervisor consultations; however, for the most part little money was allocated for evaluation.

What also impeded fidelity is the complexity of the problems experienced by clients involved in child abuse prevention programs. The number of diverse issues clients faced sometimes necessitated greater intensity and duration of services than available resources would permit. Program directors reported that EBP requirements often made it challenging to meet and maintain the required number of unduplicated clients served as defined by the contracting office. It was indicated that although *outputs* provided essential information they were not always set with a clear understanding of the nature of the services necessary to affect positive *outcomes*.

Provision of EB services also requires a skilled workforce trained to use the clinical tools that are required by some curricula. The expense associated with this resource is sometimes prohibitive. Some agencies were not able to hire Master's level workers, as some EB curricula mandated, because of the associated cost. In addition, Bachelor's level workers did not always have the clinical skills needed to assess and intervene with these families. In one case, the program director indicated that the agency took the initiative to set up a training program to ensure that workers had the

necessary skills. In other cases however, programs did not use the clinical instruments mandated by the EB curricula because the instruments required a higher educational level to administer than the workers possessed.

Another expense associated with the workforce is related to training. Analysis revealed that both workers and supervisors recognized the need for and challenges of training. Many EBP programs require at least 3-5 days of training in addition to continuing education. Some follow-up is on-line, but others are face-to-face leading to travel costs. Staff turnover exacerbates the cost of training for EB curricula. Despite these expenses, training is necessary in order for a workforce to deliver the EB curricula.

Although many workers tended to feel they were adequately trained by the curriculum developers, others felt more was needed to truly deliver the program the way it was intended (information to share with families regarding family planning, discipline, etc.); and others felt they got no 'real' or 'specific' training on delivery of the program. Although some agencies were able to pay for the initial and additional training through their own budgets, some did not have the resources to do so.

Case Analysis Results

Because programs varied, the evaluation team used criteria that were specific to the curriculum that should/could be clearly found in the client record for each case file to conduct the review. All eight organizations whose case files were reviewed scored fidelity ratings above 50% and half scored above 80% indicating that overall the critical ingredients of the curricula in use are being implemented appropriately as evidenced by case documentation. This is a positive result given the small sample that was possible during the course of this evaluation. The results also revealed an association between case files in which key curriculum concepts were addressed and curriculum models that had a structured reporting system. A primary example of this is the Parents as Teachers curriculum that contains specific indicators to assess fidelity related to home visits, supervision, and other key components. It was also found, for curricula that had well prescribed inputs and outputs attached to a logic model, that case documentation

was clearer and provided a well defined line between the presenting problem of the family, services provided, and results achieved.

Despite these positive results, there were instances where case notes did not illustrate model fidelity. Staff interviews in these cases often indicated that the curriculum was one of a number of choices and was employed because of factors (i.e. low cost, worker familiarity, etc.) other than its direct benefit to the population in question.

However, overall, the majority of case files revealed good fidelity to the models with flexibility employed when allowed. There was very little evidence that workers were making changes based on whims or personal preferences. This supports results from the interviews in which a number of staff members indicated that when they or their clients felt an aspect of the curriculum wasn't working they were able to dialogue with their supervisors about it and make changes in line with model fidelity after consulting the developer.

Discussion

The evaluation of PEI child abuse prevention grantees' contract proposals and a select number of grantees' case files suggest that those programs using evidence based models are for the most part appropriately implementing the models. Over the course of this analysis, evaluators found that programs are striving to use curricula grounded in theory and research for the good of their clients. For the most part, this was observed in the program proposals and in the case reviews and interviews. Although a number of programs had made changes in the implementation stage, the majority were able to maintain fidelity to the original model. In those cases where there was not complete fidelity, there were several suggested strategies that programs can employ to improve in this area:

- Creation of well structured reporting systems based on curriculum core components and logic model
- Staff training in case documentation
- Regular case review by supervisors
- Restructuring of paperwork requirements in line with case work realities and core curriculum components

The last of these strategies was employed by one particular grantee who reported that by reducing duplicate forms and ordering the case file with input from staff they were able to ensure fidelity to the model by making the core components and their implementation clearer.

Opportunities to increase the EBP of state-funded child abuse prevention and early intervention programs

1. Use experts in EBP (i.e. FRIENDS, SAMHSA's National Registry of Evidence Based Programs and Practice etc) to provide training and educational materials to all essential stakeholders (legislators, administrators, contract staff, program specialists etc). This education should move beyond the basics of EBP into a more complete understanding of the resources necessary to appropriately implement different EBP curriculum. Opportunities include:
   - Continuing education opportunities and workshops at the Partners in Prevention conference
   - Webinars and list serves to connect Texas programs to others using similar curriculum around the country

2. Consider sponsoring start up training for one or more new EB programs. The training can be open to all child abuse prevention service providers to support an increased use of EBP across the state

3. Assist contract and program specialist staff in strengthening their understanding of the curriculum used by grantees. This is essential for programs to receive the necessary support to set realistic outputs and outcomes, evaluate their efforts, and maintain fidelity

4. Facilitate interaction between program specialists and contract staff to assure that grantees receive consistent messages about the importance of implementation fidelity and cost-effectiveness

5. Encourage program specialists to establish and maintain contact with developers of curricula used by grantees. This would result in stronger contract arrangements and a more stable support network for grantees

6. Assist grantees in developing clear logic models for each of the programs they have in place. This will assist PEI grantees, DFPS, and ICC members to clearly define desired program outputs and outcomes based on input from agencies and a clear understanding of the resources necessary to effectively implement the specific curriculum each program uses

7. Create clear expectations regarding the EBP level required by administrators and legislators.

8. Take EBP requirements into consideration when structuring RFPs and contract requirements. This includes setting reasonable expectations regarding the number of unduplicated clients to be served, budgeting in resources for hiring skilled workers, providing initial and ongoing training, and technical assistance, and evaluating EBP at the appropriate level

9. Include a rating of the agency's logic model in the grant proposal review process to determine if the proposed EB program is congruent with agency goals, resources, and client population. (The system could be composed of three levels: absent, minimal, evident)

10. Provide feedback to agencies on the rating results to assist them in strengthening their understanding of the factors affecting the selection of an EB model

11. Account for program evaluation in contract budgets. This is necessary to successfully monitor outcomes across programs

12. Facilitate interaction between providers implementing the same EBP. Encourage collaboration in purchasing required training and program supplies as well as problem solving

EVALUATION ELEMENT 5
Evaluate existing methods for the ongoing identification of additional opportunities for comprehensive improvements to the delivery of services for the prevention of and early intervention in child abuse and neglect

The purpose of this element was to inform the Texas Interagency Coordinating Council and the Department of Family and Protective Services of continuous program improvement/quality assurance efforts that were taking place in states around the country in order to determine:

- The extent of on going continuous program improvement efforts
- The components of successful programs, including process monitoring, implementation steps, and maintenance systems
- The results of continuous program improvement systems
- Barriers to developing CPI/QA systems and strategies to overcome them

States were identified using the same methods detailed under Element 1 and were questioned regarding the most appropriate person to interview regarding the CPI/QA system or activities in place. Every state was contacted resulting in qualitative interviews with 17 states from diverse regions of the United States (see *Appendix E* for listing and detailed interview summaries).

Background

For many years regulatory agencies have insisted that the incorporation of business practices into the operations of state, local and community-based social service organizations would improve efficiency, accountability and sustainability. Ostensibly, this mandate is realized with staff training, technological upgrades and the utilization of consultants who may or may not have direct experience in the operation of social service agencies.

Reports from all areas of social services consistently illustrate, however, that the merger of business best practices with the requirements of social service delivery has been fraught with difficulty and, in many cases, has so compromised service delivery that the business practices have been abandoned well before implementation. Many reasons can be cited for this situation. Child welfare agencies, for example, may find that the additional time required for training increases the work load of already overburdened staff; capital outlay for computer upgrades is rarely reimbursed by

funders, and the business practices themselves are often perceived by staff as fiscal measures counter to the mission of the agency. Despite these challenges, studies demonstrate that numerous benefits accrue to agencies that participate in two of these business practices: continuous performance improvement (CPI) and quality assurance (QA).

Quality assurance in social services is the commitment of an organization to enact policies that require ongoing monitoring - thereby ensuring that their operations are consistent with their mission and related standards of care. Performance improvement is the set of strategies in place in an organization that enable staff to revise operations to meet their mission and standards. In other words, quality assurance is the context; performance improvement is the implementation.

Implementation of these practices requires agencies to confront the challenges mentioned above. However, successful models have been developed in child welfare agencies throughout the country. The following discussion addresses the questions posed by the Interagency Coordinating Council for Building Healthy Families (ICC) and explores what quality and performance models are being implemented, to what effect and how and why these models might be replicated in Texas.

Essential Elements

Based on the comprehensive literature review conducted in advance of these interviews, several common elements were identified for a successful model of continuous program improvement and quality assurance (Center for the Study of Social Policy, 2003; College of Lake County, 2004; Florida Department of Education, 2006; Gabor, 1990; Hoffman et al., 2003; Kerk, 1998; National Child Welfare Resource Center for Organizational Improvement, 2004 & 2005). These elements include:

- Cooperation, participation and active engagement of all stakeholders (staff, community partners, clients)
- Extensive training for agency leadership and staff
- Strategy for communication between the CPI/QA office and the agency
- Continuous updates on progress towards goals and objectives
- Legislative commitment

Ensuring Success

One of the factors states mentioned most often about the success of these efforts involved communication with all of the stakeholders. Most states provided feedback to ensure that stakeholders, specifically grantees, were aware of what the performance monitoring process entailed as well as what the outcomes were and how they could improve challenge areas. States delivered feedback at regular meetings, CPI trainings, informal phone conversations, corrective action plans and in one case, a web-based form that provided the opportunity for grantees to give input. A number of states met regularly with their providers through local or regional workgroups. Some conducted one-on-one sessions with individual providers. Michigan in particular expressed a desire to initiate peer-to-peer mentoring. Most states at a minimum posted information about CPI/QA on their web sites. All of the states interviewed had a line of communication set up between themselves and the agencies they funded. The most common communication lines included annual meetings, conferences or trainings where program staff from various agencies could meet each other. States like Florida and Michigan, however, had weekly contact with their providers. Both Nevada and Oklahoma had structured mechanisms in place for communicating about the CPI/QA process. Nevada programs were able to refute results in writing while Oklahoma provided web-based feedback on the CPI/QA design and implementation.

In addition to frequent communication between the state and providers, most states also indicated that success necessitated top-down support. Both factors were critical in larger states such as California and Florida. To ensure consistent and clear communication across the region, California and Florida created either planning teams or local and regional child abuse prevention councils to disseminate information and conduct CPI/QA activities. Communication can be a challenge when child abuse prevention service providers are involved in CPI/QA activities across multiple departments. This issue was mentioned as a problem in Colorado where they are attempting to streamline state-wide prevention efforts.

Barriers

Several states reported a lack of resources for the time-intensive effort involved in a formal CPI/QA process. Another common obstacle was obtaining buy-in from legislatures that would rather fund direct services. The state of Washington, for example, stressed the difficulty of finding funding for CPI/QA activities. Many states did report reluctance from state and local governments to fund CPI/QA activities either because of a desire to see funds entirely allocated to direct services or a misunderstanding about the importance of obtaining CPI/QA outcomes. Colorado specifically described efforts to change its legislature's focus from outputs to outcomes. Rather than concentrate on individual programs, Colorado is moving towards evaluating results for an entire continuum of prevention services.

Another notable barrier was measuring prevention, especially primary or universal prevention, and relating prevention outputs to outcomes. Michigan described an inability to measure outcomes as a primary reason direct service (a secondary effort of their 0-3 initiative) received higher funding. Three states (Florida, Michigan and Oklahoma) struggled with providing conclusive evidence that families who received primary or secondary prevention services would not have abused their children or entered into the child welfare system.

Several states identified agency culture as a barrier to implementing CPI/QA results. None of the states interviewed indicated high levels of opposition from program level stakeholders when first implementing a CPI/QA system. Although occasional resistance to change occurred, consistent and open communication between the state and the provider resolved most issues. Some conducted one-on-one sessions with individual providers. Michigan expressed a desire to initiate peer-to-peer mentoring, and most states posted information about CPI/QA practices on their website.

States found different solutions to address these various barriers. Many thought that prevention services should become a higher priority. A number of states suggested setting clearer expectations for evidence-based practices and CPI/QA efforts. Larger states such as California have worked to disseminate information about best practices through "train the trainer" initiatives so that their state is not solely responsible for

contacting and working with each grantee. Most states indicated some effort to increase and expand technical assistance for providers.

Based on these results from the qualitative interviews as well as the extensive literature review, the ICC consulting team sought to develop a set of specific activities that the ICC could undertake to implement a performance improvement program.

Opportunities for the ICC & DFPS to strengthen CPI/QA of child abuse prevention and early intervention services and programming include:

1) *Develop a framework for creating measures:* The particular challenge in implementing this step is encountered by agencies engaged in prevention services. That challenge involves selecting outcomes to measure most appropriately that a given intervention actually resulted in prevention of child abuse and neglect. While, clearly, the ICC has tackled this numerous times and is somewhat confined to those outcomes mandated by regulatory agencies, there is opportunity for the personnel charged with developing QA and CPI programs to creatively design measures that reflect their activities and measure their impact. It is suggested that a closer partnership with intervention programs could be productive in this context. The goals of Safety, Permanency and Child/Family Well-being contained in the Child and Family Service Reviews can serve as guidelines in prevention CPI programs.

   These three content areas could prove effective as a framework for a performance improvement measure since it allows for standards, benchmarks and indicators in the three separate but related spheres of agency operations that may best measure the efficacy of the agencies in meeting their missions. Creating metrics by category also allows agencies to separately analyze their competencies and challenges more accurately.

2) *Conduct a Status Review*: The purpose of this step is for agencies to examine what factors within each of the three CFSR goals they are currently tracking and to assess the type, quality and relevance of these factors to their self-evaluation, client service and planning. This can be accomplished in partnership with colleagues in child protection or consultants who assist in collecting the

information through interviews and surveys of agencies' staff and through secondary information about best practices in other communities. Also of importance is a comparison between data tracked by agencies and data required by regulatory and funding entities. Once the review is completed and the data analyzed and reported, the next step is to ascertain the standards in each of the three content areas (Safety, Permanency and Child/Family Well-being) against which the agencies prefer that their performance be measured.

3)   *Select standards, indicators and benchmarks*: In collaboration with a consultant or the QA lead staff, standards of care are agreed upon by the agencies. An example of a standard in the client experience category might be: "clients who arrive on time for appointments will be seen by workers within 15 minutes of appointment time." These standards of care can be created from a combination of those:

- currently being used by agencies
- mandated by regulatory agencies
- other sources as determined by the agencies

Once consensus is reached by the agencies on standards, then specific indicators of those standards can be set. Indicators are observable features that are used to measure the standards. An indicator from the standard listed above might be a daily record of the wait time for patients with appointments. Indicators are constructed in such a manner that assures they are observable and measurable.

Finally, once the indicators for each of the standards are established, benchmarks are set. These are the goals—the performance levels that agencies set for each of the indicators. Again using the previous example, agencies might determine that within 6 months of initiation of the project, agencies operations will results in "90% of clients being seen by staff within 15 minutes of scheduled appointment time."

4) *Create a performance measure instrument and schedule*: Once the factors to be measured have been agreed upon then a measurement tool is developed by the consultants or QA lead staff for review and final approval by the agencies. The instrument(s) should be computer based if possible and, as much as is feasible, not require duplicate entry of information. Performance measure instruments already known to or in use by the agencies can be directly employed or modified by the agencies if they prove to be valid, relevant measures of the established indicators, especially if they demonstrate ease of use.

5) *Schedule and Implement*: Logistics for conducting the ongoing data collection are constructed for each agency in collaboration with consultants or QA lead staff. This includes staff assignments, data handling, data storage, analysis and reporting strategies. Once the measurement instruments have been established, the schedule for implementation of reviews should be decided. The schedule can be on-going, intermittent or a combination of these.

6) *Establish guidelines and methods for analysis and application of measures to performance review and refinement of practice*: Although listed as a final step, this process is in fact conducted throughout the entire project and informs each step. At the conclusion of the development phase of the project, a training seminar is conducted on the use of the instrument(s) with emphasis on their application in informing practice. At intervals throughout the implementation of the performance review process, agencies assemble with the consultants or the lead QA staff to review the logistics and results of the review and revise the instrument(s) or process, as needed.

7) *Establish a structured mechanism in order to supply providers with feedback regarding overall progress towards their goals and objectives as well as challenges that they face*. This would involve moving beyond output reports available through the PEI data system. A first step in this regard could be disseminating the state's yearly report to providers.

8) *Begin to dialogue with federal, state and local funders regarding the challenges and benefits of implementing and funding quality assurance/continuous program improvement.* This would allow for a focused and comprehensive conversation on the issue while providing the opportunity for input from the diverse communities that fund child abuse prevention.

9) Conduct a cost analysis of the implementation of an evidence-based quality assurance/continuous program improvement system for child abuse prevention programs and practices in the state of Texas in order to inform adequate funding of these efforts.

10) Establish a peer to peer CPI/QA system throughout Texas in order to supplement and support the current efforts of the program specialists.

EVALUATION ELEMENT 6
Cost analysis of child maltreatment and analysis of funding for child abuse prevention

Total Annual Cost of Child Abuse and Neglect in Texas

Cost analysis can provide the state and others with a detailed picture regarding the cost savings of investing in prevention programs and services. It involves a detailed calculation of both the direct and indirect costs associated with child abuse and neglect. An extensive literature review was conducted in order to determine the direct and indirect costs associated with child maltreatment.

The direct costs are those associated with the actual maltreatment case and include the costs of child welfare services, medical care, mental health services, law enforcement and legal proceedings (see Table 57). However, a growing body of research (e.g., CDC Averse Childhood Experience Study, 2008; Widom & Maxfield, 2001; Walker et al., 1999; Springer et al., 2007) has documented that the cost of child abuse and neglect for the victim and society extends far beyond the incident and into adulthood. For example:

- Childhood abuse and neglect have been linked to an increased likelihood of juvenile and adult criminality. Twenty-seven percent of maltreated youth become delinquent compared to 17% of youth in the general population (Widom & Maxfield, 2001). Forty-two percent of children who are abused or neglected will be arrested as adults compared to 33% of the general population (Widom & Maxfield, 2001).

- Children who are maltreated are more likely than other children to experience psychiatric problems in adulthood (Ravendal et al., 2001; Gutierres & Todd, 1997; Min et al., 2007; Springer et al., 2007).

- Abuse and neglect in childhood has consistently been linked to increased substance abuse (Rohsenow, Colbett & Devine, 1988; Browne & Finkelhor, 1986, Gutierres & Todd, 1997; Brems et al., 2004; Min et al., 2007; Moran, Vuchinich & Hall, 2004). Gutierres & Todd (1997) found that 79% of the women and 41% of the men receiving residential substance abuse treatment reported experiencing emotional, physical and/or sexual abuse in childhood. Brems and colleagues (2004) explored only physical and sexual abuse and found that 20% of men and 50% of the women receiving detoxification services had experienced childhood maltreatment.

- Childhood maltreatment negatively effects brain development (De Bellis & Thomas, 2003) and the ability to learn and adaptive functioning in school (Zolotor

et al., 1999, Stipanicic et al., 2008; Kaplow et al., 2008; English et al., 2005). Poor academic performance and social skills inhibit success in adulthood (Min et al., 2007).

- Poor physical health and increased health care costs in adulthood are associated with child abuse and neglect (Springer et al., 2007; Walker et al., 1999; Shaw & Krause, 2002). Springer and colleagues (2007) found that adults with a history of maltreatment had a higher incidence of allergies, arthritis, asthma, bronchitis/emphysema, hypertension, and ulcer.

Therefore, an accurate cost analysis of child abuse and neglect must include not only direct costs of maltreatment but also the long term effects as well. Adapting the work of previous researchers (Wang and Holton, 2007; Plotnick & Deppman, 1999; Conrad, 2006; Watters et al., 2007), the following indirect costs are included in the cost of child abuse and neglect in Texas: juvenile delinquency, adult crime, special education, mental health and physical health care, substance abuse and dependency, and lost productivity to society (see Table 58).

Estimates of indirect and direct costs were calculated using a combination of methods. An extensive review of the literature was conducted to identify the probability that a victim of child abuse and neglect would incur a specific cost. The actual cost was determined based on past research or from cost supplied by the provider. All dollar amounts were calculated based on the number of confirmed victims of child abuse in 2007 in Texas (71,344) (DFPS, 2007) and were converted to 2007 dollars. The rationale and the assumptions for each specific calculation are in Tables 54 and 55.

Based on the analysis, the direct cost of child abuse and neglect in Texas was $1,022,170,335 and the indirect cost was $5,257,034,038 for a total of $6,279,204,373. The services, programs and activities listed in the tables below are based on previous research (Sedlak & Broadhurst, 1996; Goldman et al., 2003; Kelley et al, 1997) in this area as well as on information received from the Department of Family and Protective Services and therefore represents fairly comprehensive coverage. However, this cost is in all likelihood an underestimation of the cost of child maltreatment in Texas. This is due to two factors. The first is the complex and dynamic nature of the problem that necessitates the involvement and tracking of a number of different interventions. The second factor that leads to the underestimation of the cost of abuse, particularly the

indirect costs, is the high number of unreported child abuse cases. Studies suggest that only a third of the incidence of child neglect and abuse come to the attention of child welfare systems (Sedlak & Broadhurst, 1996).

Table 54: Direct Costs in 2007 Dollars

Texas Child Welfare Services System Rationale: CPS Direct Delivery Staff, CPS Program Support, Statewide Intake Services, TWC Foster Day Care, TWC Protective Day Care, Adoption Purchased Services, Post-Adoption Purchased Services, PAL Purchased Services, Substance Abuse Purchased Services, Other CPS Purchased Services, Foster Care and Adoption Subsidy Payments.	**$993,964,077**[11]
Hospitalization Rationale: There were 878 hospital discharges with child maltreatment diagnosis in 2007. The mean charge for services performed was $30,990.[2] Calculation: 878 x $30,990= $27,209,220	**$27,209,220**
Mental Health Care System Rationale: Cost for average length of stay of children receiving DSHS funded community health treatment was 4.3 months at an average cost of $422 a month in 2007. $422 x 4.3=$1,814.60 average cost per child.[3] 25% -50% of children who are abused will require mental health treatment.[4] The more conservative estimate of 25% is used. There were 71,344 confirmed victims of child abuse and neglect in Texas in fiscal year 2007.[5] Calculation: 71,344 x .25 x $1,814.60 = $32,365,206	**$32,365,206**
Judicial Costs Rationale: 16% of child abuse victims have court action on their behalf at an average cost of $2,404.19.[6] Calculation: 71,344 x .16 x $2,404.19 = $27,443,925	**$27,443,925**

Table 54: Direct Costs in 2007 Dollars (continued)

Law Enforcement Rationale: The cost of police services in child abuse cases varies by the type of abuse: physical abuse $28.69, sexual abuse $78.90, emotional abuse $28.69, neglect $2.87.[4] The calculation of cost is based on the number of duplicated substantiated incidents and assumes that cases involving multiple types of abuse increases law enforcement costs. [3] Calculation: Physical abuse- $28.69 x 15,150 = $434,653.50; Sexual abuse-7,050 x $78.90 = $556,245; Emotional abuse - $28.69 x 839 = $24,070.90; Neglect= $2.87 x 60,257 = $172,937.60 Total $1,187,907	**$1,187,907**
Total Direct Costs	**$1,022,170,335**

[1] Texas Department of Family and Protective Services. Operating Budget. Fiscal Year 2008. Summary of Budget by Strategy

[2] Texas Department of State Health Services. 2006. Hospitalization Discharges and Mean Charges for Children 0-17.

[3] Texas Department of State Health Services. Personal Communication. Received 7/17/08

[4] Miller, T., Cohen, M. Wiersema, B. (1996). Victim costs and consequences: A new look. The National Institute of Justice. Retrieved 7/10/08.

[5] Texas Department of Family and Protective Services (2007). 2007 Data Book (September 1, 2006 through August 31, 2007). Retrieved from DFPS website 6/1/2008, http://www.dfps.state.tx.us/About/Data_Books_and_Annual_Reports/2007/databook/default.asp

[6] Dallas Commission on Children and Youth (1988). A step towards a business plan for children in Dallas County.

Table 55: Indirect Costs in 2007 Dollars

Juvenile Delinquency	
Rationale: There were 71,344 confirmed victims of child abuse and neglect in Texas in fiscal year 2007.[7] 27% of children who are abused or neglected become delinquents, compared to 17% of children in the general population, for a difference of 10%.[8, 9]	
Texas Youth Commission. 3% of offenders are served by Texas Youth Commission.[10] The annual cost for a year in a facility was $61,131.91 in 2007.[11]	
Calculation: 71,344 x .10 x .03 x $61,131.91 = $13,084,184.96	**$13,084,185**
Juvenile Probation. 97% of offenders are served by Juvenile Probation.[10] Funding is10% Federal, 30% state and 60% county.[10] 2005 State and Federal = $141,373,018.93 [4] Total Funding =$332,973,355 serving 102,373 referrals.[4] Cost per referral= $3,252.55	
Calculation= 71,344 x .10 x .97 x $3,252.55= $22,508,843	**$22,508,843**
Adult Criminal Justice System	
Rationale: There were 71,344 confirmed victims of child abuse and neglect in Texas in fiscal year 2007.[7] Total state and local direct expenditures for Texas' criminal justice system (including police protection, judicial and legal services, and corrections) in 2007 was $11,328,883,436.25.[12] 13% of violent crime is associated with a history of child maltreatment.[4]	
Calculation= $11,328,883,436.25 x .13= $1,472,275,484.60	**$1,472,275,485**

Table 55: Indirect Costs in 2007 Dollars (continued)

Mental Health & Physical Health Care Rationale: There were 71,344 confirmed victims of child abuse and neglect in Texas in fiscal year 2007.[7] It was estimated $10,615,987.20 or $148.80 a year increase in medical and mental health care cost for women with a history of child abuse and neglect compared to women with no history of maltreatment in a sample of 163,844 in which 42.8% reported child maltreatment histories. [16, 9] Studies suggest men & women have similar health seeking behavior when condition is taken into consideration[17] and that both men and women who were abused as children experience a high probability of physical and mental health conditions in adulthood.[18] It is assumed that the additional health care costs associated with childhood abuse are similar for males and female victims. Calculation: 71,344 x $148.80 = $10,615,987.20	**$10,615,987**
Substance Abuse/Dependence Rationale: In 2007, 88,452 adults were admitted to Texas State funded substance abuse treatment facilites[19] at an average cost of $2,121.[20] Substance abuse in adulthood has consistently been linked to child maltreatment as a predictor and a consequence.[13] In the adult treatment population, the prevalence of persons with a history of maltreatment, range from 25% (high trauma)[21] to 79% (women).[22] The more conservative rate of 25% is used. Calculation: .25 x 88,452 x $2,121 = $46,901673	**$46,901,673**
Lost Productivity to Society Rationale: The median annual earning for a full-time worker in 2007 was $29,921.74.[23] The average work life is 39.1 years for males and 29.3 years females for an average work life of 34.2.[24] Assuming that on average victims of confirmed child abuse (71,344) will loose on average 5%[25] of their potential earnings. Calculation: $29,921.74 x 71,344 x .05 x 34.2 = $3,650,399,618	**$3,650,399,618**
Total Indirect Cost	**$5,257,034,038**
Total Direct and Indirect Cost	**$6,279,204,373**

[7] Texas Department of Family and Protective Services (2007). 2007 Data Book (September 1, 2006 through August 31, 2007). Retrieved from DFPS website 6/1/2008, http://www.dfps.state.tx.us/About/Data_Books_and_Annual_Reports/2007/databook/default.asp

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[11] Texas Juvenile Probation Commission Statistical Report Calendar Year 2005 TYC. Retrieved 7/10/08 from http://www.tyc.state.tx.us/research/cost_per_day.html

[12] Department of Justice (2007), Justice Expenditures and Employment Extracts, Table #4. Justice system expenditure, by character, State, and type of government, fiscal year 2005. Retrieved 7/10/08 http://www.ojp.usdoj.gov/bjs/eande.htm#selected

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Funding for Child Abuse Prevention

Given the incredibly high and diverse costs associated with child maltreatment it is important to examine the main sources of funding available for child abuse prevention. The Child Abuse Prevention and Treatment Act (CAPTA) Title 1, CAPTA Title 2 (CBCAP), and Title IV-B, Part 2 Promoting Safe and Stable Families (PSSF) were selected given that they represent the three federal funding streams primarily available for child abuse prevention activities (Administration on Children and Families, 2007; Pew Charitable Trust, 2007; Szekely, 2005). It is true that states use varying percentages of CAPTA Title 1 and PSSF for prevention; however, these funding sources were selected in line with their statutory language allowing for their use with child abuse prevention activities as well as the accuracy and availability of the numbers. These criteria provided an appropriate indicator of what federal funding is available for child abuse prevention programming and services and what states are actually using.

- *Child Abuse Prevention and Treatment Act Title I (CAPTA):*

  o CAPTA Title I money is dedicated for the purpose of improving child welfare services including, but not limited to child abuse prevention activities. Funding is based on the state population under the age of 18.

- *Child Abuse Prevention and Treatment Act Title II (CBCAP):*

  o Seventy percent of CBCAP is allocated based on the state's child population and 30% is based on leveraged funds. The latter represents a strategic area for states in that they have a large degree of control over what they choose to bring to the table. The allocation formula is based on total dollars leveraged divided by the total amount leveraged by all state, which is then multiplied by 30% of the total funding set aside for CBCAP leveraged funding. States are allowed to utilize any non-federal funding source to leverage funds; however, it cannot be in-kind, nor can it be funding that is being leverage for another federal grant. In addition, it must be money that comes through the designated lead state agency's budget and is spent or designated within the previous fiscal year. Several sources can be used for leveraged funds including tobacco settlements, statutory dedications, individual donations, and contractual services (FRIENDS, 2007).

- *Title IV-B, Part II Promoting Safe and Stable Families (PSSF):*

  o Promoting Safe and Stable Families is directed at secondary prevention services to families that have been identified as struggling with risk factors known to increase the probability of child maltreatment. It is also used to fund services to families currently involved with children's protective services. This funding source is a capped entitlement whose formula is based on food stamp usage among a state's population.

  Illustrated in Figure 4 is the mid-range placement of Texas when examining total federal funding sources for child abuse prevention per capita according to the child population. While Louisiana spent $11 per child, Texas spent a little over $6 per child in its population. This 2006 data reveals that Texas is 21st in total funding for child abuse prevention. Over a five year period, Texas has moved from 19th to consistently hover in the 20s among the fifty states.

Figure 4: States with Higher Total Funding Than Texas, 2006
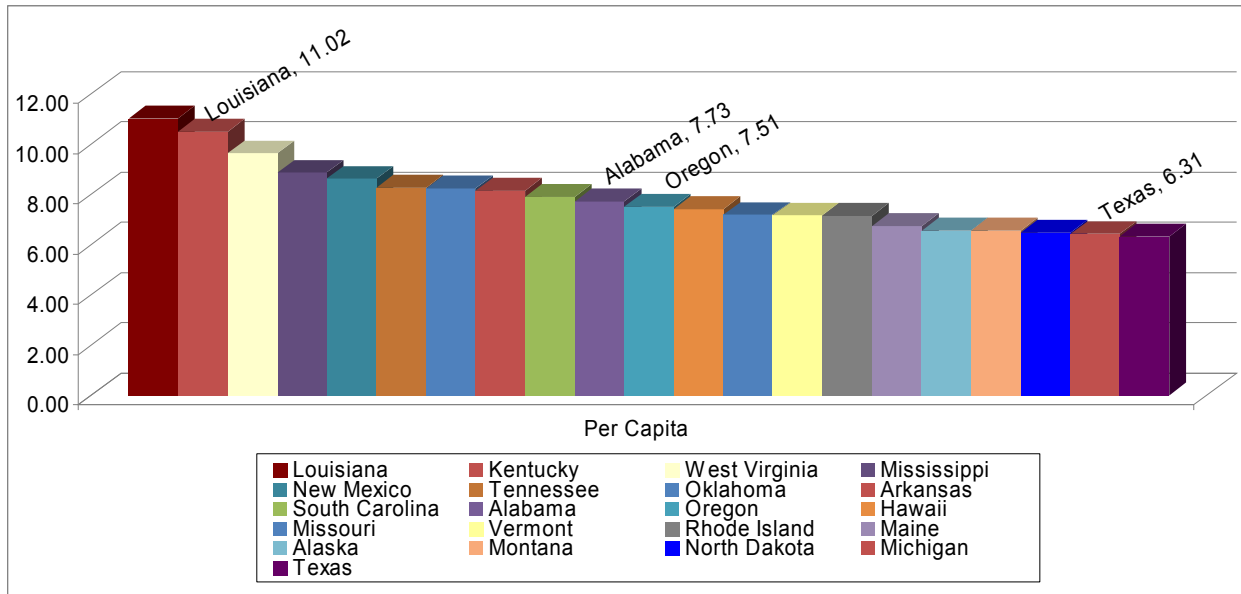
Data source: Administration for Children and Families, Program Instructions, 2006

Texas did not leverage as much funding as a number of other states, placing 43rd in 2006 and ranging from between 43rd to 48th among the fifty states from 2002-2005. Figure 5 draws closer attention to CBCAP leveraging because CBCAP is the only federal funding that is completely dedicated to child abuse prevention. In addition, as opposed to other funding sources that depend solely on the size of a state's population under the age of 18 (CAPTA) or on food stamp usage (Title IV-B, Part 2);

30% of the CBCAP allocation is based on non-federal funds that a state is able to leverage. However, states often do not claim what they can as evidenced by Figure 5 and commentary from some of the states and national experts who were interviewed for the purposes of this evaluation. Here we see that although Kentucky leveraged the most money, this was only $2.28 per child with Texas leveraging only one cent per child. Although the formula that leads to the final allocation amount is not simple nor do states have an overabundance of non-federal funds to leverage, this particular funding source is an area in which states can strengthen their strategy of funding child abuse prevention and early intervention efforts.

Figure 5: States with Higher CBCAP Leveraging Than Texas, 2006
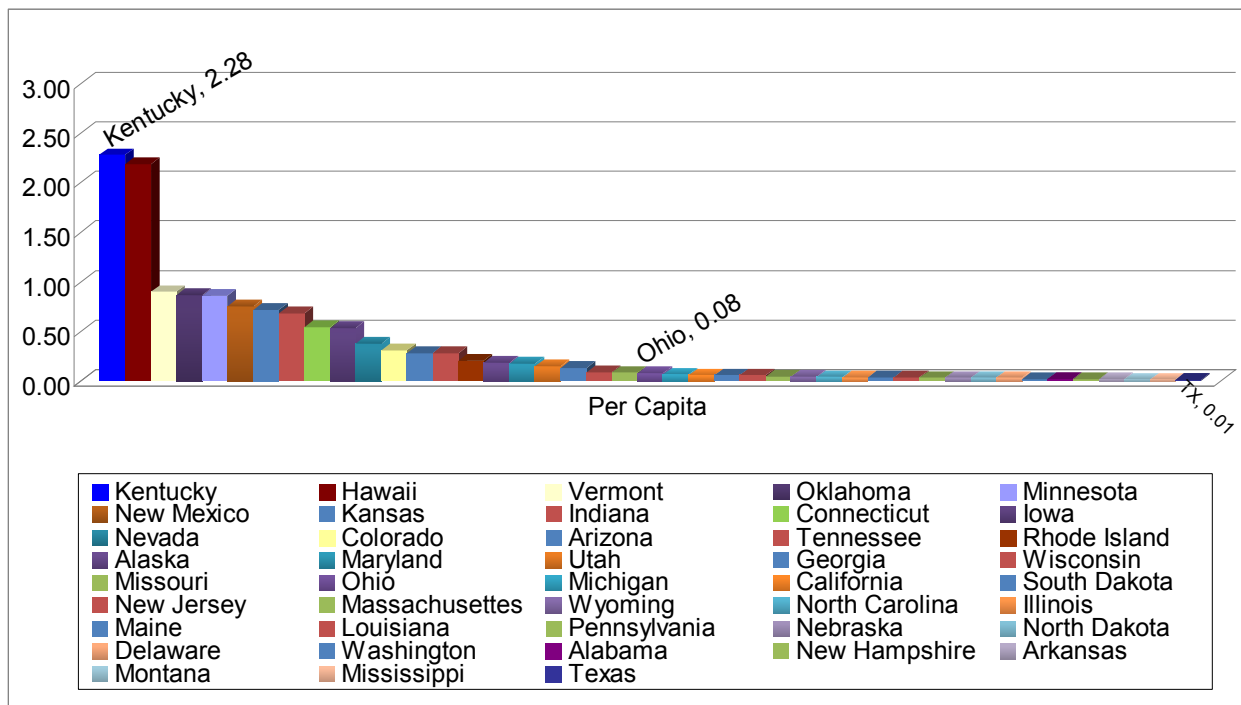
Data source: Administration for Children and Families, Program Instructions, 2006

Funding and Outcomes

Information about funding is most important in light of the ultimate connection to child maltreatment outcomes; however, there are several important points to remember. First, there was not one state interviewed for the purposes of this research that housed all child abuse prevention activities in one state department. In addition, these activities were rarely located in one area of the state's budget. Finally, there was not agreement

regarding the definition of prevention. Therefore, it was not possible to ascertain all of the resources being allocated towards child abuse prevention efforts. Ultimately, the state departments and/or collaborations that were interviewed represented the major child abuse prevention (universal and selected) efforts in that state and contacts were specifically questioned about the public (state and federal) and private funding they received.

In addition, although child abuse rates have often been used to gauge the extent of child maltreatment and therefore, the resources necessary to address it, this alone is not an adequate outcome measure. Although general federal guidelines exist, states vary on definitions of child abuse (Woodruff, 2006; World Health Organization, 2002; Child Welfare Information Gateway, 2007) and policies and procedures that guide the processes by which cases are substantiated and adjudicated. Therefore, comparing states primarily based on child abuse rates is precarious. It is therefore advisable that both national and state level institutional, political and socioeconomic differences be taken into account when attempting to compare funding and expenditures across states (Scarcella et al., 2006). For this analysis, we examined funding for all states that were interviewed and expand the analysis to risk factors as well as the structure of child abuse prevention efforts among those states that are funded at higher levels than Texas.

Funding for prevention efforts between the states that were interviewed varied. The funding source shared by all of those interviewed is the Community Based Child Abuse Prevention (CBCAP) grants that are based on state population (70%) and non-federal leveraged funds (30%). This was followed by the use of state general revenue, which was the largest source of leveraged money for the CBCAP grants. There were also several states that used Title IV-B, Part 2 money (Promoting Safe and Stable Families) for child abuse prevention as well as a portion of funding from birth certificates, license plates, and tax donations. Only the state of Florida indicated the current use of a statewide Title IV-E waiver for these purposes and only two of the states that were interviewed reported the use of Medicaid funds. Three states actually reported the continuing use of TANF funds for child abuse prevention. The largest amount was Florida followed by Michigan whose TANF funds came through a

collaborative relationship with their Department of Health. Texas currently uses TANF funds for child abuse prevention, but will be discontinuing the use of these funds for the Services to At-Risk Youth program (STAR). Although a very small percentage of the total amount of funding, several states supported their prevention efforts with local matches, donations, and fundraising.

Despite these funding sources, it is clear from Figure 6 that out of the total amount of funding reported across these states in particular, state general revenue was the largest source of prevention funding, followed by IV-B, Part 2.

Figure 6: Funding Sources for Fiscal Year 2007
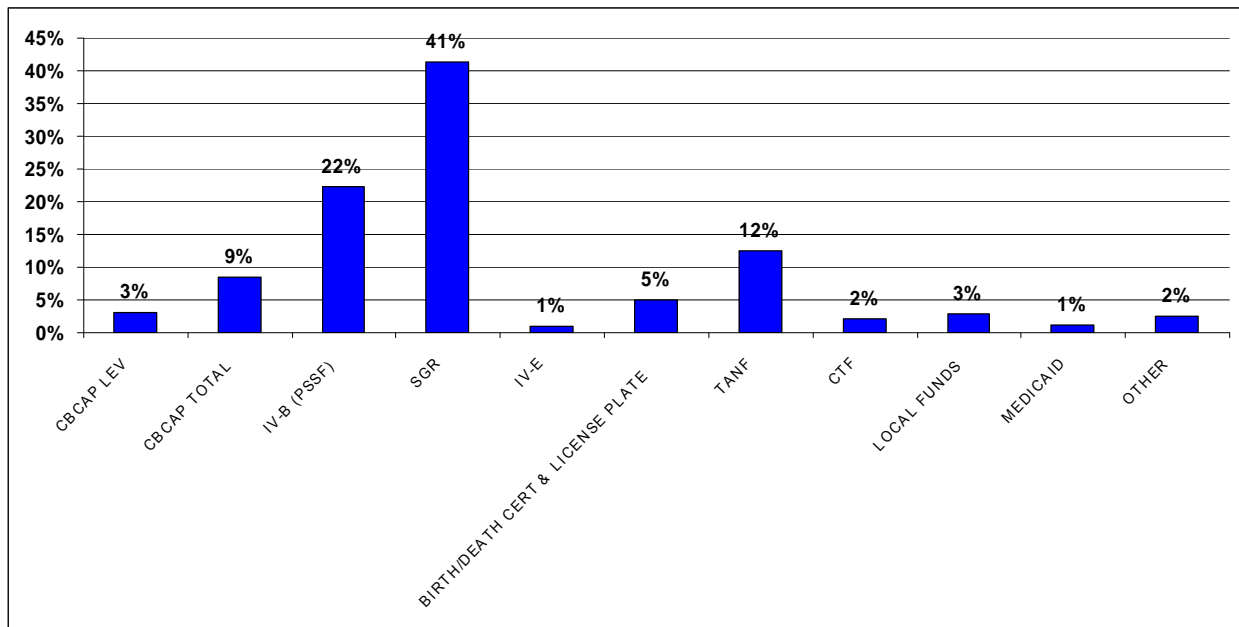
Data source: State interviews

Figure 7 highlights only those states that are comparable in population to Texas. For ease of analysis, the four states closest in population to Texas were selected. CBCAP leveraging per capita is quite small both across time and across these different states. Florida and New York remained below Texas in CBCAP leveraging per capita for 2004-2006; however, in 2003 there were no comparable population states below Texas and in 2002 only Florida remained. Total Funding per capita is quite large in comparison; however, it must be reiterated that CAPTA Title 1 and Title IV-B are not completely dedicated funding sources for prevention although they are available for that use.

Figure 7: Total Funding and CBCAP Leverage for Comparable State Populations, 2002-2006
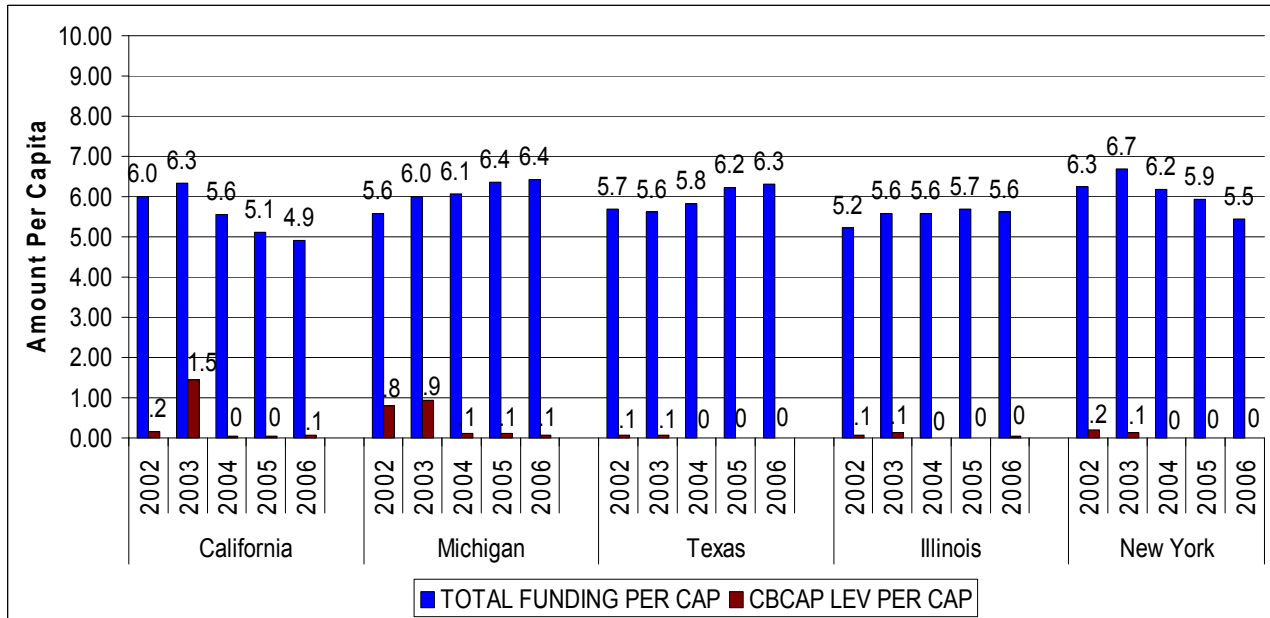
Data source: Administration for Children and Families, Program Instructions, 2002-2006

Figure 8 provides a clearer look at the small amount Texas and states that are comparable in population have been leveraging. Again we see that the dollar amount leveraged per child in the population of all states is fairly low averaging to zero for some states.

Figure 8: CBCAP Leveraged: States with Comparable Populations to Texas, 2002-2006
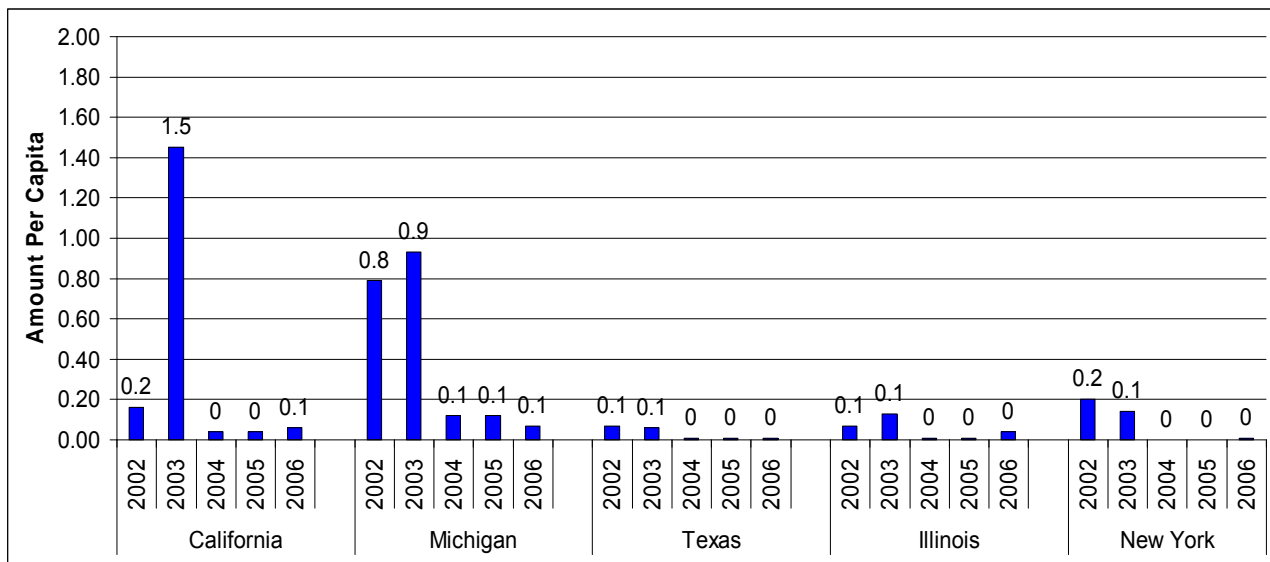
Data source: Administration for Children and Families, Program Instructions, 2002-2006

Funding in relation to child abuse rates is illustrated over a five year period in Figure 9 with CBCAP leveraging per capita and total funding per capita. Leveraging and total funding per capita amounts were included in earlier tables and are used here for comparison. What is clear is that most of these states have been struggling to substantively reduce their child maltreatment rates. New York has seen rates as high as 17.7 victims per 1000 children with Texas rising to 10.6 in 2006. In contrast, total funding available for child abuse prevention as well as CBCAP leveraged per capita has remained fairly static.

Figure 9: Funding and Child Abuse Rates: States with Comparable Populations, 2002-2006
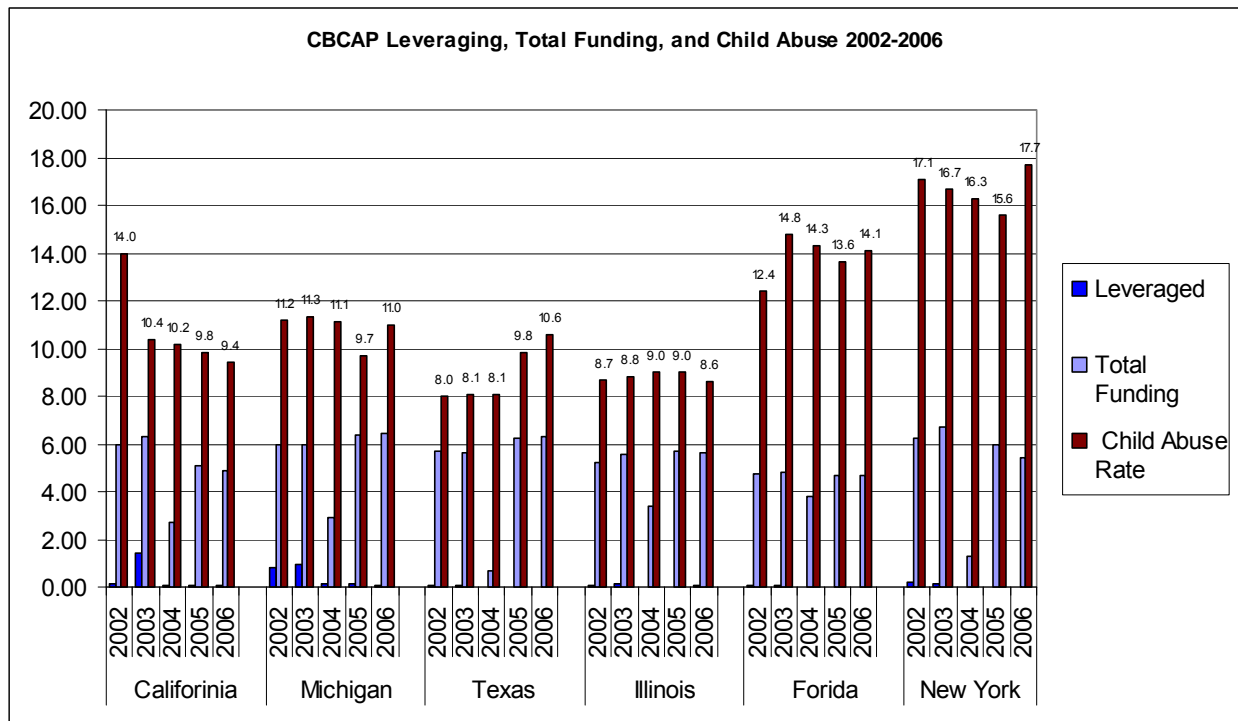
Data sources: (Funding) Administration for Children and Families, Program Instructions 2002-2006; (Child Abuse Rates) Administration for Children and Families, Program Instructions 2002-2006.

In addition to examining funding rates, we also performed correlation analysis to determine the strength and relationship among CBCAP leveraging per capita and child maltreatment rates. Correlation analysis revealed a moderate positive relationship between CBCAP leveraging per capita and child maltreatment (p<.05) rates. This suggests that states are attempting to put more money into prevention to stem the flow of children and families into the life long consequences of abuse and neglect. In order

to understand how this may affect child maltreatment rates, it is important to more closely examine states comparable in population to Texas who are funded at higher levels. It is also appropriate to return to the structures that were mentioned in the beginning of this summary report and that are detailed in *Appendix F*. Two of the states that were interviewed and fit these criteria include Michigan and California. The specific funding amounts and sources as well as the structures of California, Michigan, and Texas are detailed in Tables 56 and 57 below. Specific amounts that are not listed were not available at the time of the interview.

Table 56: Funding Sources for California, Michigan, and Texas, 2007

	CBCAP Population	CBCAP Leverage	IV-B, Part 2	State General Revenue	IV-E	Portion of Birth/ Death/ Marriage Certificates & License Plates	Tax Donation	TANF	CTF	Local Match	Other
California	*3.5 million*	*571,922*	*34 million*	*12 million*		*4 million Birth certificates*	*Part of 4 million*		*Interest*	*Local fundraising*	*Mental health dept.* *Tobacco money*
Michigan	*902,622 CTF*	*165,105 CTF*		*2.6 million 0-3 Dept of Health, Dept of Community Health, and Dept of Education*		*210,000 CTF (license plates)*	*380,000 CTF*	*4 million 0-3 Through Dept. of Health*	*794,000 Interest*	*589,722 CTF (In-kind match)* *2.1 million CTF (Cash match)*	*150,000 CTF (Donations)* *100,000 CTF (Fundraising)*
Texas	2.1 million	91,259	16.7 million	4.1 million				14.3 million	2.6 million	1.4 million	29,183 Conference revenue

Data source: State interviews

Table 57: Collaborations in California, Michigan, and Texas, 2007

State	Estab.	Structure	Members	Duties
California	1983	Department of Social Services	Dept. of Health Services Dept. of Mental Health Dept. of Alcohol and Drug Programs Dept. of Developmental Services Dept. of Education Employment Development Department First 5 Commission Workforce Investment Board Dept. of Justice Judicial Council/Admin Office of the Courts Foundation Consortium	Fund child abuse prevention initiatives Educate community Provide technical assistance & support
Michigan (CTF)	1982	Department of Human Services	State Police Dept. of Human Services Dept. of Education Parent Representation	Fund child abuse prevention initiatives Educate community & promote awareness of prevention Provide technical assistance & support
Michigan (0-3)	1997	Department of Human Services	Dept. of Human Services Dept. of Education Dept. of Community Health	
Texas	2005		Dept. of Family and Protective Services Health and Human Services Commission Dept. of State Health Services Dept. of Aging and Disability Services Texas Youth Commission Texas Workforce Commission Office of the Attorney General Texas Juvenile Probation Commission Texas Dept of Housing & Community Affairs Dept. of Assistive and Rehabilitative Services	Facilitate communication & collaboration among state agencies Provide recommendations to government regarding improvement of prevention & early intervention programs and services

Figures 10 and 11 show that Michigan and California have been able to consistently leverage more CBCAP funding than Texas. In terms of total funding, Michigan has consistently had higher total funding per capita (child population) except for 2002 when it fell slightly below Texas ($5.60 and $5.70, respectively, per child in the population). This was also the case with California although total funding per capita in California fell below Texas in 2005 and 2006.

Figure 10: CBCAP Leveraged: California, Michigan, and Texas, 2002-2006
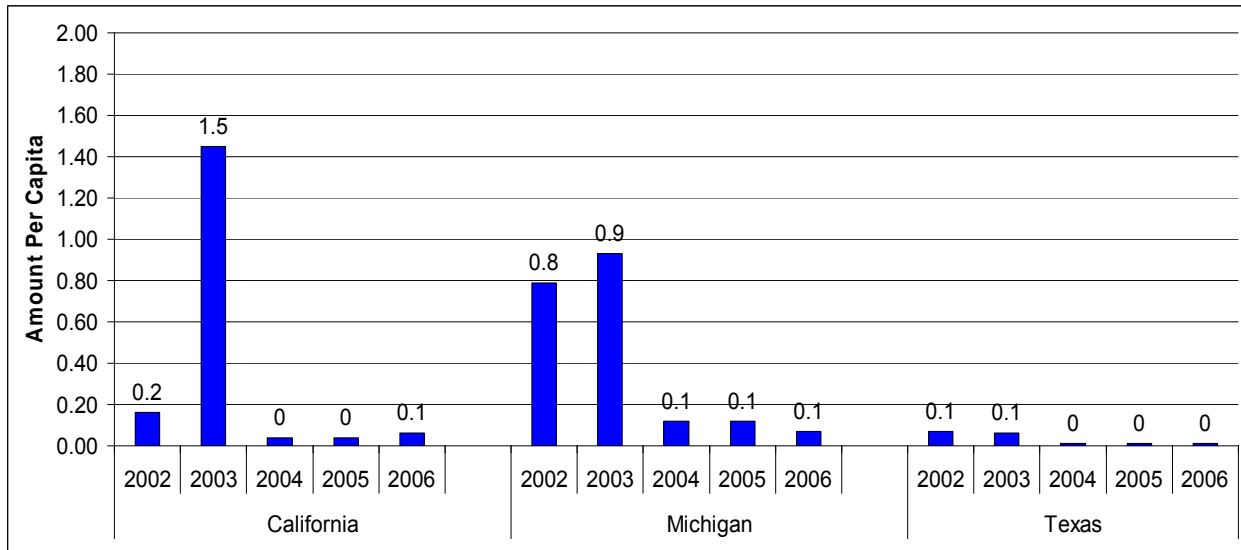
Data source: Administration for Children and Families, Program Instructions, 2002-2006

Figure 11: Total Funding: California, Michigan, and Texas, 2002-2006
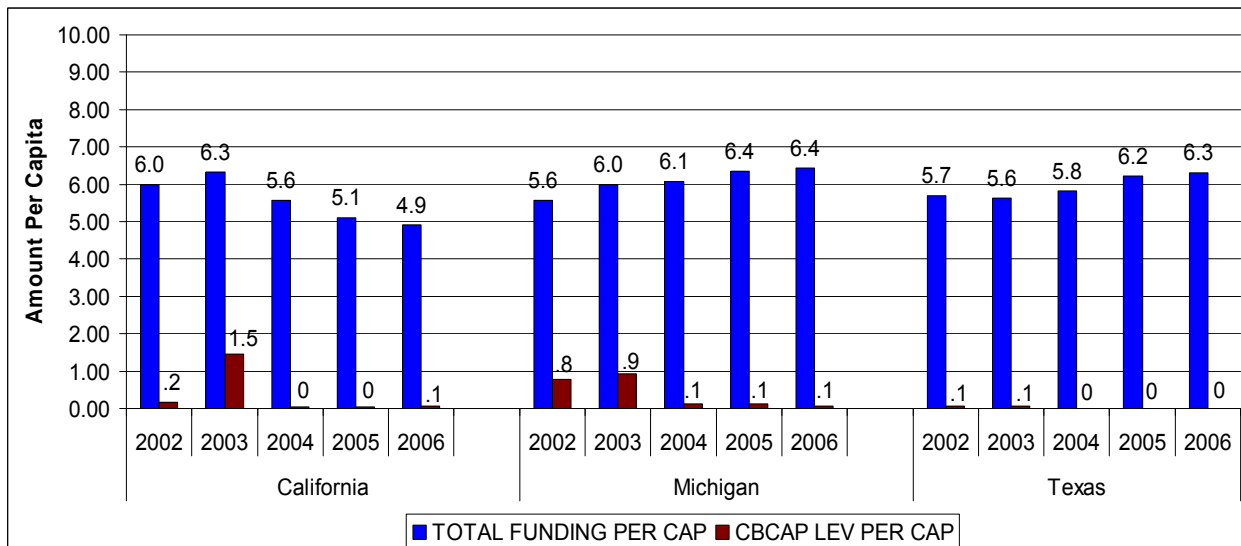
Data source: Administration for Children and Families, Program Instructions, 2002-2006

Although there are a multitude of factors that tax the states' resources, two will be considered here and are displayed in Figure 12. Poverty rate was chosen because it is a well documented risk factor for child maltreatment (Drake & Pandy, 1996; Sedlak & Broadhurst, 1996). Poverty increases family stress and decreases the resources that families have at their disposal to provide for their children. The rate of child abuse and neglect was also included because it is one of the primary outcomes state child welfare departments are trying to affect.

Figure 12: Child Abuse and Poverty Rates: California, Michigan, and Texas, 2002-2006
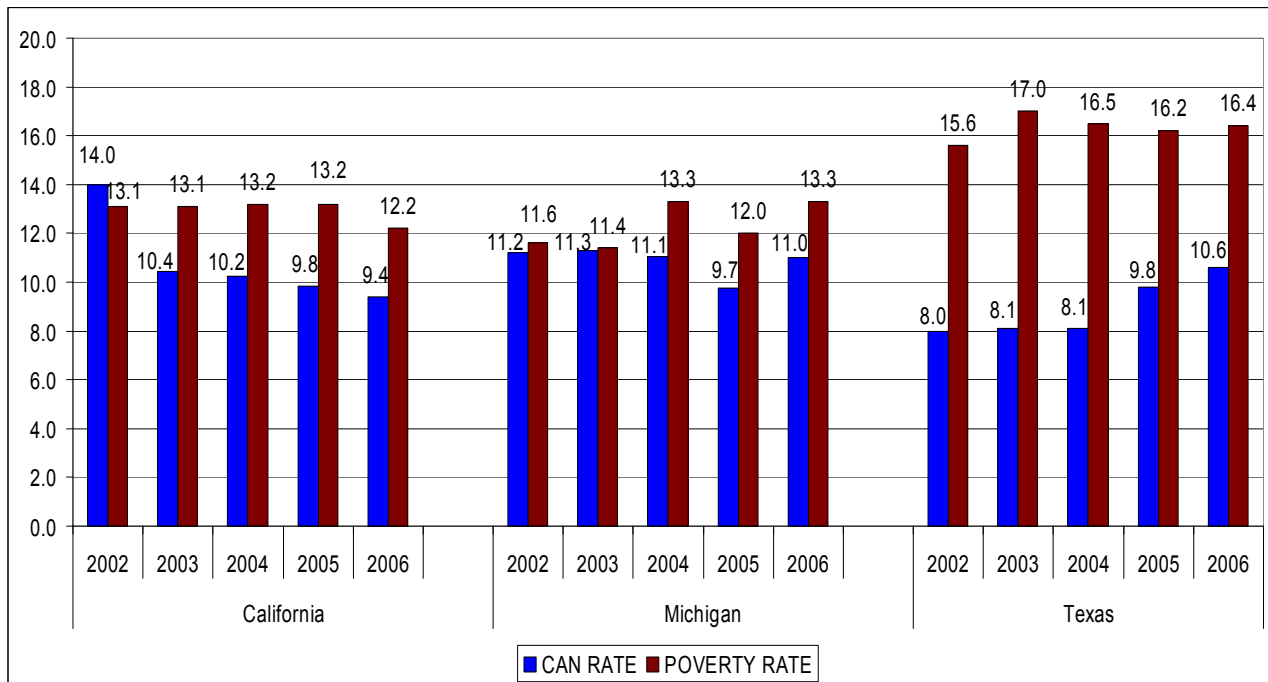
Data source: (Child Abuse) Administration for Children and Families, Statistics and Research 2002-2006; (Poverty Rates) US Census

The national poverty rate has steadily risen since 2001 only recently dropping from 12.6 to 12.3 of the total population in 2006 (Census Bureau, 2008). California has consistently remained above the national poverty rate for the past five years except in 2006 when California dropped only slightly below at a rate of 12.2 compared to the national average of 12.3. Michigan also rose above the national average in both 2004 and 2006. Texas' poverty rates have remained well above the national rate for several years. In terms of child abuse rates, California has seen a rather steady drop over the

time period under analysis. Michigan and Texas on the other hand have not, instead being faced with rather static and rising rates, respectively.

Not all of the factors that impact child maltreatment or the states ability to address it are presented here. However, what is evident is that although California's poverty rate appears to be rather static over the period of time considered here, the state has seen a drop in child maltreatment rates. Proceeding under the caveats mentioned earlier it is therefore important to look more in-depth at the way their child abuse prevention efforts are structured.

California allocates the great majority of its child maltreatment prevention funding to counties with regional and local child abuse prevention councils that are responsible for programming development and planning. These networks were established in the early 1980s to coordinate services and ultimately report to the Office of Child Abuse Prevention at the state level which is a collaborative effort with other state agencies. The state provides the regional and local councils with technical assistance and support as well as CBCAP grants (60% of which go to the counties with the rest remaining at the state level) and Title IV-B, Part 2 (85% of which is allocated to the counties). The state office uses its political leadership to develop a comprehensive plan first and then coordinate funding at the state level and then down through to local efforts. They work primarily to partner with other efforts currently in progress rather than trying to always create something new with limited resources. They are also pursuing the Pathways to Prevention approach which takes a global view of child abuse prevention including individual, family, and environmental factors that can increase risk or strengthen family resiliency. They partner with other state agencies as well as private groups and local service providers in an effort to make the best use of existing resources as opposed to creating new collaborations or programs.

Conclusion

There are two important elements surrounding state initiated child abuse prevention and early intervention programming and services. The first involves the resources that are available for effective development and implementation and the second is the way in which these resources are used. These concerns are at the center of the Department of Family and Protective Services (DFPS) statewide, long-range strategic plan for child abuse and neglect prevention services. Specifically, one of the identified threats to implementation of the strategic plan is the availability of adequate resources (Department of Family and Protective Services Statewide Child Abuse and Neglect Prevention Draft Plan, 2008). This concern is shared by many states and is due primarily to the complex and dynamic nature of child maltreatment where a number of risk factors come into play, increasing the probability of its occurrence. This is compounded in a state such as Texas that is expansive in terms of geography as well as the diversity of its population. These factors demand a variety of lasting resources in order to alleviate risk and build protective factors. Underlying all of these resources, of course, is funding.

The second element that is essential to strengthening child abuse prevention and early intervention strategies is the way in which resources are used. This idea is at the heart of state capacity or the ability of a state to achieve its public policy objectives. Although little can be done with a small amount of funding, it also must be understood that the connection between funding and policy outcomes is tenuous. The mechanism that translates those funds into substantive results is the way in which the state department responsible for child abuse prevention and its policies and programs function and are structured. It is here that all of the elements impacting both resources and outcomes merge.

The qualitative interviews that were conducted for this evaluation revealed more flexibility in child abuse prevention funding for those states that were able to procure larger sources of leveraged funds. This relates to the variety of state and local public and private funds that help ameliorate barriers of restricted funding whose effects are exacerbated when there are a limited number of funding streams.

States were also not as confined to restricted funds when they partnered with other state departments and current collaborative efforts in order to make the most efficient use of existing resources. Although several difficulties were identified and detailed earlier in this report, these challenges were not insurmountable at the local, county or state levels. As stated earlier under Element 1, one key to success in this area is the active promotion of collaboration and coordinated funding by leadership. More detailed information on the interviews is contained in *Appendices A and C*.

Opportunities for the ICC & DFPS to increase funding for child abuse prevention include:

1) Establish a work group comprised of the fiscal officers from each state agency that provide funding to programs serving children and families in the state of Texas. Establish commonalities among funding sources as well as opportunities for collaboration.

2) Use available resources in order to determine if more state funding can be leveraged to draw down a larger amount of federal CBCAP dollars. The FRIENDS network would be a source given that it is established as the National Resource Center for CBCAP by the US Department of Health and Human Services' Children's Bureau.

3) Investigate the possibility of partnering to a greater degree with existing collaborations such as Raising Texas or TIFI in order to further collaborative funding opportunities for all groups.

Appendix A

EVALUATION ELEMENT 1

Identify and evaluate streamlined funding mechanisms for programs and services for the prevention of and early intervention in child abuse and neglect

Texas Community Based Organization Interviews

Qualitative interviews were conducted with executive directors or their designee to understand how effective community based organizations are maximizing funding streams to support prevention services. United Way organizations, prevention advocates and other experts were asked to identify child abuse and neglect providers who they considered to be effective and efficient service providers. Nineteen agencies were contacted and 11 agreed to participate.

Table 58: Characteristics of Participating Agencies

Agency Characteristics	Number of Agencies
Service Area • Urban • Medium Size Cities • Rural/ Small Town	4 4 3
Services Provided • Prevention Only • Multiple Children's Programs	5 6
Agencies Annual Budget • Less than $1 million • $1.1 Million to $3 Million • Greater than $3 Million	4 5 2
Number of Employees • Less than 20 • 20-50 • More than 50	4 4 3

As can be seen in Table 58, the agencies interviewed were diverse in terms of the communities served, services provided, and financial and human resources accessed. Staff size ranged from 4.5 full time staff to 278 (Median=32) and fiscal budgets ranged from $158,000 to 33 million (Median=1.7 million). Agencies which provide multiple children's services tend to be larger than those that focus only on prevention. All of the agencies with more than 50 staff and budgets greater than $3 million offered a continuum of children's services.

Funding Sources

Table 59 illustrates that all of the respondent agencies received funding from foundations or corporate grants as well as individual donations and fundraising events. Most respondents (9) had received United Way funds. Two agencies which serve rural communities and small towns receive funding from county governments. Few (4) charged a fee for services and those that did reported that fees were limited to counseling and special education programs such as divorcee training.

Table 59: Funding Sources Used by Participating Agencies

Funding Sources	Number of Agencies
Foundation /Corporate Donations/Grants	11
Individual Donations/Fundraisers	11
United Way	9
State Grants/Contracts	9
Federal Grants	7
Fee for Service	4
County Appropriation	2

Nine agencies reported receiving state funds from 1 to 3 different state agencies. The Texas state grantors include Department of Family and Protective Services (DFPS) (N=6), Office of the Attorney General (OAG) (N=5), Community Development Block Grants (CDBG) (N=4), Texas Workforce Commission (TWC) (N=2) Texas Education Agency (TEA) (N=1), Juvenile Probation Commission (N=1), Health and Human Services Commission (HHSC) (N=1) and Texas Juvenile Probation Commission (TJPC) (N=1). There did not appear to be a relationship between the number of grantors and

the community environment in which the agency operates. However, larger agencies and those with multiple programs and services tend to have relationships with more state grantors compared to smaller more focused organizations.

Seven agencies stated they funded services in part through federal grants. Respondents reported relationships with one to five federal grantors (Median =2). All of the agencies who receive federal funding had at least one grant through the Administration on Children Youth and Families (ACYF). Four reported funding through Housing and Urban Development (HUD), two from the Department of Justice, one from the Substance Abuse Mental Health Services Administration (SAMHSA), one from the Department of Education, and one from other departments within the ACYF and the Department of Health and Human Services. Again as with state funding, agencies with a greater variety of services had a relationship with a greater number of federal funding sources.

Program Funding Strategies

Seven agencies reported blending or pooling funds from different sources to fund specific programs. However, they also reported that blending was possible only with unrestricted funds. For example, they may have grant funds (restricted funds) to provide a parenting program. They may add a special fathers' training event or provide child care during the training using funds generated by agency fund raising events. Blending in this way is used by agencies regardless of size, services mix or community.

Another strategy used by responding agencies was braiding funds. In braiding, funds from two or more sources are used to fund a program. Funds support different client groups or components of the program. In braiding, separate accountability records including financial and utilization records are maintained for each funding stream, but the program appears seamless to the community and participants. Nine agencies reported that they used braiding. Again there did not appear to be a relationship between agency size, services or community type and the use of braiding in this sample. Several factors promoted the braiding of funding including:

- Having an adequate administrative infrastructure including the staff and software for tracking of services and financial accounting
- Generalizing program components, implementation and outcomes

- Finding a variety of funding sources for child abuse and neglect prevention
- Training staff to find sources that can be braided and tracking them once they are obtained
- Locating funding sources that target similar populations and or services
- Dialoguing with foundations to increase compatibility of funding streams, in terms of reporting requirements and schedules

Maximizing Resources through Collaboration

All of the responding agencies have participated in collaborations to maximize resources and increase the effect of their efforts. One agency had only collaborated with other private agencies while all other agencies (N=11) collaborated with both public and private organizations. The vast majority (N=11) formally specified their agreed upon responsibilities using memorandums of agreement.

Table 60 details the strategies used in the collaborations that were interviewed, including staff cross training (N=10) and the use of common client intake forms (N=7) to reduce duplication.

Table 60: Coordinating Strategies

Coordination Strategies	Number of Agencies
Staff cross-training	10
Shared information/tracking systems	10
Common intake forms	7
Co-location of staff	5
Coordinated funding (braiding, blending)	5
Administrative integration	3
Regular face to face meetings	7
Sub-contract	3

There are several factors that made these collaborations efforts successful. These include:

- Agencies perceive a benefit to participation that is specific to their organization
- Agencies subscribe to the overall goals of the collaboration
- All participating agencies have a clear understanding of the goals, services and responsibilities
- An identified leader coordinates the efforts of the collaboration. Sometimes this takes the form of a lead agency
- Taking time to build trust among members through regular meetings to track progress and focusing on shared outcomes and the benefits of collaboration

The agencies that were interviewed also expressed several common barriers to successful collaboration. These include:

- Insufficient funding
- Funders of collaborations specify objectives, tasks and activities rather than allowing a local response
- Agencies have different personnel policies and procedures, structures, culture and philosophies

Texas Regional/County Based Partnership Interviews

TRIAD

The TRIAD Prevention Program is a program of the TRIAD Consortium. While TRIAD is not a legal entity in itself, it is a consortium of the three county agencies serving children in working together to support the public child care resources of Harris County. The Consortium was established in January 1974 and is overseen by the Executive Directors of the three TRIAD agencies (Harris County Children's Protective Services, Mental Health Mental Retardation Authority of Harris County, and Harris County Juvenile Probation Department). The current TRIAD consortium budget funded from Harris County Commissioner's Court is 1.25 million. The Mental Health and Mental Retardation Authority of Harris County (MHMRA) serves as the fiscal agent of the Consortium. The Consortium currently funds forensic services in the juvenile justice institutions, the TRIAD Mental Health Program, the Community Resource Coordination Group (CRCG) Coordinator and community based flexible funding for residential and in-home services.

The TRIAD Executives started the TRIAD Prevention Program in March, 1998 to coordinate prevention services among the three agencies. Harris County Children's Protective Services (HCPS) was named the administrative agent for this program. TRIAD Consortium funds are used for TRIAD MH which includes a percentage of the funding for Parenting with Love and Limits Evidence Based Program. The prevention program is also funded with dedicated staff from the Juvenile Program and MHMRA departments placed under the supervision of the TRIAD Prevention Program Director, an HCPS employee, additional funds budgeted by HCPS in their Commissioner's Court target request, state and local grants, and fees collected through the Family Protection

Fee and Juvenile case manager funds are also used. The TRIAD Consortium was also instrumental in the SAMHSA application for Children's Mental Health. HCPS is the fiscal and lead agency for this project. The eight main programs that comprise TRIAD are:

- JP Court Family Service Case Managers
- Truancy Learning Camp
- Community Youth Development Program (CYD)
- Intake/Diversion Program
- Services to At-Risk Youth (STAR)
- Community Resource Coordination Group (CRCG)
- TRIAD Mental Health
- Parenting with Love and Limits

TRIAD works with HCPS' Program Improvement Technical Assistance (PITA) system. HCPS is accredited by the Council on Accreditation (COA) and, therefore, must continuously be reviewed to ensure they are meeting COA standards. In addition, there is on-going program improvement and technical assistance (i.e. provision of logic models, etc.) from PITA. The PITA staff of three individuals meets quarterly with the program directors and quarterly and annual reports are provided to the board. There is continual feedback into the system where all stakeholders have access to the team and are part of case review and other information gathering processes.

Collaboration also occurs in terms of service provision, staff sharing, and funding. In terms of the latter, multiple programs and services that are provided under the TRIAD umbrella and extend into the community are funded through a variety of federal, state, and local sources. Determination of what projects will be pursued, as well as how grants and other funding will be spent is pursued at the program level but the budget is determined by the individuals who represent the executive directors of HCPS, MHMRA, and Juvenile Probation. This applies to how funding is tracked as well as the assignment of different fiduciary agents.

Funding and programmatic opportunities come from a number of sources including a HCPS grant writer and program managers. After these opportunities have been identified, the program director and representatives of the three agencies meet and make a joint decision as to where the funding and/or program would best fit.

There is limited blending of the funds that support TRIAD's work given that there is a great deal of tracking that needs to take place. Therefore, it is necessary to keep them separate despite the fact that a number of funding sources will be used to fund one particular initiative. For example, funding for CRCG has gone into the Systems of Hope grant that was combined with SAMHSA funding as well as some money from TRIAD.

Federal funding was reported to have the least amount of barriers to funding the collaborative efforts given that the federal government seems to have an understanding of the use of evidence based practice. In addition, it tends to set clear and consistent expectations up front and support community based initiatives as opposed to using a top down approach.

State funding was described as more problematic due to the need for the legislature to at times refocus its priorities on other important policy areas. At times the legislature has changed outcome measures mid stream and made additions that shift funding for program services. An example of the latter was when evidence based practice was required of the CYD programs and then 5 months later the requirement was retracted because it was too difficult to implement. This caused a great deal of confusion and credibility problems with funders. It was indicated that what would work to alleviate this problem is to create an understanding with the legislature regarding the need for gradual change that works with communities in determining what is best as opposed to imposing it with little warning. In addition, a need was expressed for an understanding of the difficulty of data collection in social services in addition to the differences between communities and the need to use what they are doing rather than imposing something completely new on them.

The challenge with county level funding has been obtaining enough. There are a number of different programs and organizations that need the money and there are shifting priorities that come with changes on Commissioner's Court and in the social and political environments that impact the distribution of funds. It was reported that Commissioner's Court seems to be shifting its emphasis to look at where the money is going and if it is being used effectively, but it has not reached that point as of yet.

The collaborative efforts of TRIAD are held together by what is essentially an informal arrangement outlined in a white paper. What has made the collaboration successful is top-down leadership that established a collaborative culture early on and has sustained it through changes in program directors and executive leadership. There is also an element of trust, an understanding of objectives, and a willingness to share power that helps to make the collaboration successful. Essentially, it is understood that collaboration is part of doing what is best for the children and families of Harris County.

Austin Children's Partnership

The Children's Partnership was established in 1998 by a group of community providers who recognized that money could be used more efficiently for children with severe mental health needs through a collaborative effort. The Partnership exists now as a "virtual agency" with no staff exclusively dedicated to its work, but at least 44 community partners who work to provide a system of care for children and their families in Austin/Travis County. The board of the Children's Partnership meets quarterly and the Executive Committee meets once a month. The community representatives include:

- Community Resource Coordination Group
- Austin Travis County Mental Health and Mental Retardation
- Travis County Juvenile Probation Department
- Texas Health and Human Services Commission
- Austin Travis County Health and Human Services and Veteran Services
- Texas Department of Family and Protective Services
- Pflugerville Independent School District
- Manor Independent School District
- Austin Independent School District
- Casey Family Programs

The ultimate goal of the collaborative is to bring community providers together to serve the complex needs of children and youth with serious emotional disturbances as well as to educate other community partners on how to reach their goals by taking a different focus. For example, the school district's primary focus is providing education and meeting federal and state standards, but the partnership has helped them to understand how providing mental health services can actually help students attend and be successful in school.

The direct budget for the Partnership involves money from four partners that is put into a flexible pool and tracked individually by a Managed Service Organization (MSO) which reports to the individual partners. The county child protective services agency provides approximately $400,000, Austin/Travis MHMR $700,000, juvenile justice $400,000 and county health and human services $1.2 million. These sources were determined in the original memorandum of understanding; however, the amounts are contributed as needed. The Children's Partnership also conducts fundraising, charges for community trainings, and receives a small amount in donations. There are also resources that extend beyond these specific dollar amounts, including staff resources that are extended to community efforts and individual work with families through the child and family team.

As stated earlier, the MSO tracks the money that is directed toward specific services based on the need of the family. If a child is referred to the Children's Partnership because of juvenile justice issues, then he/she receives funding from that partner until he/she is no longer in need of those services. Then, funding will come from another area. All of the funding authorizations occur at the service level so the Partnership can more easily get around categorical funding. They have also addressed funding challenges through innovative work with community partners to address what areas of non-restricted funding can be used to service the needs of families.

There have been challenges to the coordination of funding including other community members not seeing mental health as "their business" and concerns regarding using their money for anything outside their expressed purpose. The Partnership has addressed this by trying to educate other organizations on how they can use their resources more effectively through a collaborative structure. Often the Partnership has convinced other organizations that it isn't always about getting more money, but using what you have more efficiently.

TIFI Community- LEAF

The TIFI community in the panhandle has recently become a 501c3 and has changed their name from the West Texas Community Coalition to the Llano Estecado Alliance for Families (LEAF). They began approximately 10 years ago, starting out as a

small local CRCG and eventually growing into a diverse and formal advisory group with 21 board members plus a number of community stakeholders.

The current members of the collaborative include the county CPS, juvenile justice, school districts, faith based partners, families, and Texas Tech University. They cover 11 counties, ten of which are classified as frontier and one as rural. They target children ages 3-18 with severe emotional disturbances. They operate under a set of bi-laws and a memorandum of understanding (MOU). Their budget consists of a flexible funding pool that contains both state and local funding. The amount each partner contributes is only loosely outlined in the MOU with each member contributing what they can. For example, one partner can only contribute money they fundraise while others can pull from county funding. For the most part, small expenditures come out of the flex pool and otherwise the members contribute resources as needed. More structured collaborative funding was one of their original goals, but so far they have not found the need for a more formal collaborative funding agreement.

One of the challenges for the collaboration has included the diverse nature of its membership. Various partners have their own guidelines and mandates that they are trying to adhere to while trying to be a part of the collaborative. In addition, partners play multiple roles in their small community, which diverts their attention from the collaboration's goals. However, what has made the collaborative successful up to this point has been consistent core leadership that has a "can do attitude" and is motivated to be a part of the collaborative. The collaborative has made it possible to be supportive and helpful in reaching each partners' goals by being more informed about what everyone does and how they can partner together to reduce duplication of efforts and support the grant projects of the partners.

It was reported that there is less of this collaboration at the state level where departments seem to work in separate silos, duplicating the same efforts in different departments. This sort of fragmentation extends to various offices within the departments where contracts and budgets are often not aware of the programmatic side and end up impeding the work of the collaborative. This also permeates the work of the individual partners as they often cannot participate in or put forward funding for particular initiatives because of the restrictions of their individual state funders. It would

be helpful if there could be more of a coordinated effort at the state level as well as more alignment between the designated regions of each department.

Out of State Interviews

The purpose of this part of Element 1 was to inform the Texas Interagency Coordinating Council (ICC) and the Department of Family and Protective Services (DFPS) of coordinated child abuse and neglect prevention efforts in other states. Primary areas of interest included the structure, policies and practices, and coordination efforts that are employed especially in the area of the coordination (braiding and blending) of funding.

Selection Method

States were identified through three different strategies. The first was a review of state child maltreatment department web pages. This proved minimally successful in identifying contacts. Therefore, we obtained the lead agency contact list from the FRIENDS National Resource Center for Community Based Child Abuse Prevention. A third strategy was to use the Title IV-E list serve in order to arrange interviews with the appropriate individuals. Contact was attempted with every state (N=50) resulting in qualitative interviews with 17 states from diverse regions of the country. The collaborations in the interviewed states are primarily focused on child abuse prevention except for Colorado and Oregon whose collaborations house all prevention efforts in the state. Funding information for all states relates directly to child abuse prevention programming and services.

Background

There are a number of different service areas provided by disparate state departments as well as private organizations that contribute to the prevention of child maltreatment. However, collaboration is a commonly suggested strategy in the area of child abuse prevention (FRIENDS, 2007; Gray & Szekely, 2006; Westat & Chapin Hall, 2003) given the cost and complexity of delivering primary and secondary prevention services to the population at-large and those at-risk. It often makes intuitive and

practical sense to combine efforts in this area to reduce duplication of services and funding. There are many opportunities for collaboration including shared intake/assessment forms, staff cross-training, common information and tracking systems and coordination of funding streams through braiding or blending/pooling (Bryant & Cohen, 2003; FRIENDS, 2007; Gray & Szekely, 2006; O'Brien, 1996; Szekely, 2005).

Braiding involves money from several sources being used for one purpose, but requires both separate and collective tracking to its source. On the other hand, blending or pooled funding consists of integrating several funding sources into a single fund from which multiple initiatives can be supported (Szekely, 2005). This allows states the most flexibility and a reduced need for a complex administrative structure in order to participate in collaboratively funded projects. Finally, there is separated funding that involves specific sources being allocated for particular purposes without shared administration of the funding (Szekely, 2005). This is often necessary given the restrictions that exist with a number of federal, state, and private funding sources. However, it limits opportunities for coordination among different entities that are working in the area of child abuse prevention.

Several challenges to coordinated funding exist including the issue of flexibility that was just mentioned. This involves not only regulations that emanate from the funding source, but from the state agency that would be responsible for allocating those funds. In addition, different fiscal and procurement rules can restrict use of a common language through which joint funding can be pursued. Sometimes there are also turf issues as well as fears regarding how allocating money to a collaborative effort will detract from funding the primary activities of an agency. In this scenario, it would be essential to educate agencies as well as legislatures regarding the importance of collaboration towards meeting goals of efficiency and appropriate service delivery.

Despite these challenges, coordinated funding can become a reality; however, several factors are necessary for success (O'Brien, 1996; FRIENDS, 2007; Gray & Szekely, 2006). These include:

- Leadership from within state agencies and government (governor and legislature)

- Knowledge of different funding streams, procurement rules, and restrictions on funding sources
- A clear vision and plan for coordinated funding including delineation of how money will be procured, divided, and tracked
- When possible, building on existing collaborations as opposed to creating new structures that further decentralize efforts

Of the states that were interviewed there were several efforts to build a strong collaborative funding structure in order to reduce duplication of funding and services as well as participate in efforts that would draw down larger pools of money from federal and private sources. Those that seemed most successful had the necessary structures and support in place. They also understood and attempted to overcome known challenges to collaboration.

Structure

The collaborative structures in the states that were interviewed were primarily Children's Trust Funds and most were part of a state department (i.e. Department of Human Services, Department of Children and Family Services). One exception was the North Carolina collaboration that although dominated by state departments, was housed in the Prevent Child Abuse America chapter of that state. Other collaborative structures included:

- Part of the governor's office (Florida, Alaska)
- Umbrella organization for all prevention efforts involving children and families in the state (Colorado and Oregon)
- Collaboration of legislators and private agencies that was part of a separate larger prevention collaboration of state and public agencies (Missouri)

Three states did not have formal collaborative arrangements (Nevada, Iowa, and Minnesota). However, Iowa in particular provides an interesting case given that all of their prevention services are contracted out to their state chapter of Prevent Child Abuse America (PCA). PCA Iowa is the fiscal agent for the county grants and they are the Community Based Child Abuse Prevention (CBCAP) grant lead agency in the state. This arrangement has existed since 1998 and includes contract monitoring and evaluation although the state still retains administrative and oversight responsibilities.

Delaware also has an informal collaborative arrangement with their state PCA chapter that is also the Community Based Child Abuse Prevention (CBCAP) grant lead agency in the state. The choice was given to Delaware's Department of Prevention and Early Intervention to take on this grant after it was removed from the Children's Trust Fund. However, in an effort to incorporate community based organizations, the state recommended to the governor that PCA Delaware take the lead. This helped to ensure there was a focus on community level change as well as pursuit of resources at the local level. In terms of formal collaborations, Delaware's Department of Prevention and Early Intervention is part of the Family Support Coordinating Council. It is supported by the PCA chapter that was legislatively mandated a year ago to ensure that high-quality, research-based, outcome-measured family education, support and early care and education programs are available statewide. The council is also responsible for reviewing the work of the CBCAP grantees.

North Carolina also stands out in terms of the placement of its collaborative structure (Alliance for Evidence Based Family Strengthening Programs) within a nationally recognized non-profit, Prevent Child Abuse America (PCA). The collaborative grew out of a task force for child abuse prevention and other recommendations that were part of a report from the North Carolina Institute for Medicine. Eventually, this grew into an effort to coordinate funding as well as implement evidence based practice. PCA North Carolina is provided funding by the Duke Endowment to host the collaborative and will house the collaboration's infrastructure including common evaluation, quality assessment, and a shared database. When coordinated funding becomes more of a regular practice for the Alliance, this will also be organized by PCA North Carolina with the input of all of the members of the collaboration.

Colorado is another alternative example. Within the Department of Public Health and the Environment there is the Prevention Leadership Council (PLC) that serves as the umbrella organization for all prevention efforts related to children and families in the state. This includes the Children's Trust Fund that focuses specifically on the prevention of child maltreatment. The purpose of the PLC is to carry out legislation passed in 2000 that mandated the streamlining of prevention services, funding, training, and evaluation as well as the development of a state plan to facilitate these efforts. This

structure attempts to reduce duplication of funding and services for children and families. It is supported by a MOU between the departments. A more detailed listing of each state's formal collaborative structure is in Table 61.

Membership

States have representatives from a wide-range of state agencies as well as community organizations (i.e. hospitals, etc) on their collaborations. Oregon, Washington, and Missouri were the only states where legislators sat on the collaboration. In the case of Oregon there is one legislator from each house and in Washington and Missouri there were four seats, two from each house. Oklahoma and Michigan were the only collaborations that formally included parent representatives at the state level although all states indicated this was a goal. Missouri was the only state where the child abuse prevention collaboration in the form of the Children's Trust Fund did not have state department representation but belonged to a larger collaborative prevention effort, the Prevention Partners Group. Missouri's Department of Social Services was also responsible for some prevention efforts and was a member of the Prevention Partners Group. Of the states interviewed the longest running collaborations are California and Missouri each at 28 years and the shortest is Florida which is only a year old. All the collaborations were established by statute. The members of the formal collaborations hold meetings ranging from monthly to quarterly.

Table 61: Collaborations of Interviewed States

State	Date Estab	Structure	Members	Duties
Alaska	1996	Governor's Office	Dept. of Health & Social Services Dept. of Education & Early Dev. Governor or designee 4 members of the public	Plan & develop services Fund & advise programs
California	1983	Department of Social Services	Dept. of Health Services Dept. of Mental Health Dept. of Alcohol and Drug Programs Dept. of Developmental Services Dept. of Education Employment Development Department First 5 Commission Workforce Investment Board Dept. of Justice Judicial Council/Admin Office of the Courts Foundation Consortium	Fund child abuse prevention initiatives Educate community Provide technical assistance & support
Colorado (CTF)	1989	Department of Public Health & Environment	Dept. of Education Dept. of Human Services Dept. of Public Safety Dept. of Transportation Dept. of Public Health & Environment Non-Profit representation	Fund child abuse prevention initiatives Educate community Provide technical assistance & support
Colorado Prevention Leadership Council	2000	Department of Public Health & Environment	Dept. of Education Dept. of Human Services Dept. of Public Safety Dept. of Transportation Dept. of Public Health & Environment	Data collection & management Develop & implement state plan Coordinate training & evaluation
Delaware	2007	Prevent Child Abuse America Chapter	Dept. of Education Dept. of Prevention & Early Intervention United Way Dept. of Public Health Dept. of Health and Social Services Family representatives University of Delaware	Review work of CBCAP grantees Plan for and develop statewide prevention initiatives

Table 61: Collaborations of Interviewed States (continued)

State	Date Estab	Structure	Members	Duties
Florida	2007	Governor's Office	Dept. of Children & Families Dept. of Corrections Dept. of Education Dept. of Health Dept. of Juvenile Justice Dept. of Law Enforcement Agency for Persons w/ Disabilities Agency for Workforce Innovation Parent Representative 8 community based & 1 faith organization Guardian Ad Litem Office School Board Association Statewide Advocacy Council Prevent Child Abuse Florida Private therapist Head Start Early Childhood Association Sherriff's Office Judge Office of Adoption & Child Protection Community Advocate Doctor State Court	Fund child abuse prevention initiatives Educate community Provide technical assistance & support
Kentucky	2002	Cabinet for Health and Family Services	Dept. of Education Dept. of Human Support Services Dept. of Mental Health & Mental Retardation Community Based Organizations Parent Representation Law Enforcement representation	Plan and develop services Advise CBCAP grantees

Table 61: Collaborations of Interviewed States (continued)

State	Date Estab	Structure	Members	Duties
Michigan (CTF)	1982	Department of Human Services	State Police Dept. of Human Services Dept. of Education Parent Representation	Fund child abuse prevention initiatives Educate community & promote awareness of prevention
Michigan (0-3)	1997	Department of Human Services	Dept. of Human Services Dept. of Education Dept. of Community Health	Provide technical assistance & support
Missouri (CTF)	1983	Office of Administration	House of Representatives (2) Senate (2) 17 public members	Integrate statewide prevention efforts Fund prevention initiatives Public awareness & education
Missouri Prevention Partners	2006	Staffed by Prevent Child Abuse America Chapter	CTF Private organization representation University of Missouri Prevent Child Abuse Missouri Juvenile Justice Association Dept. of Mental Health Dept. of Senior Services Dept. of Corrections Dept. of Public Safety Dept. of Health Dept. of Social Services	Develop statewide plan Promote collaboration among public and private agencies
North Carolina	2006	Prevent Child Abuse North Carolina	Dept. of Social Services Dept. of Public Health Dept. of Public Instruction Duke University Duke Endowment	Develop coordinated funding efforts Provide technical assistance & support

Table 61: Collaborations of Interviewed States (continued)

State	Date Estab	Structure	Members	Duties
Ohio	1983	Department of Children & Family Services	House of Representatives (2) Senate (2) 8 public members Dept. of Job & Family Services Dept. of Job & Alcohol Services Dept. of Health	Educate community Fund prevention initiatives Develop state plan
Oklahoma	1984	Office of Child Abuse Prevention	Dept. of Human Services, Child Welfare Dept. of Health Dept. of Education Dept. of Mental Health & Substance Abuse Office of the Attorney General Chapter of American Academy of Pediatrics Law enforcement representative Private child welfare experts (2) Faith based representative Partnership for School Readiness Commission on Children & Youth Parent representatives (3)	Plan and coordinate services & funding Fund child abuse prevention initiatives Provide technical assistance & support
Oregon	1994	Separate commission	Dept. of Human Services Dept. of Education Youth Authority Dept. of Corrections Child Care Division Dept. of Employment Private Business representation Legislative Representation	Provide funding to local commissions Statewide planning Standard setting & policy dev. Guidance regarding researched based practice
Tennessee	1984	Department of Children's Services	Court Appointed Special Advocates Dept. of Maternal and Child Health Child Care Resource and Referral Network Dept of Health Commission on Children and Youth Private Hospital Representative w/ legislative committee on children & youth	Leadership role in child abuse prevention planning Promotion of evidence based practice Fund child abuse prevention initiatives

Table 61: Collaborations of Interviewed States (continued)

State	Date Estab	Structure	Members	Duties
Texas	2005	Health and Human Services Commission	Dept. of Family and Protective Services Health and Human Services Commission Dept. of State Health Services Dept. of Aging and Disability Services Texas Youth Commission Texas Workforce Commission Office of the Attorney General Texas Juvenile Probation Commission Texas Dept of Housing & Community Affairs Dept. of Assistive and Rehabilitative Services	Facilitate communication & collaboration among state agencies concerning policies for prevention & early intervention of child maltreatment
Washington	1982	State Government Council	Dept. of Health Dept. of Social and Health Services Dept. of Early Learning Office of Public Instruction Governor Appointees (7) State Representatives (2) State Senators (2)	Manage Children's Trust Fund Statewide program development Coordinate services & funding Provide technical assistance & support

The members of the formal collaborations are also primarily appointed by the governor or are required to participate given their position as indicated in the statute which created the collaboration. Although this appears to be one of the successful elements in terms of establishing buy-in, it also is not sufficient for a successful collaboration as was stated by the representative from Oklahoma. This individual indicated that it is still difficult to hold people accountable due to a lack of enforcement or accountability for actions. This could partially be resolved by who the collaboration reports to or the placement of the collaboration within the state. In the example of Florida, the Child Abuse Prevention and Permanency Council is part of the Children's Cabinet which is chaired by the Lieutenant Governor. The council itself is headed by the Chief Child Advocate who reports to the Lieutenant Governor. In the case of Oklahoma there is a Commission on Children and Youth that has oversight of all children and youth activities; however there is apparently little in the way of an accountability mechanism in place. They are currently trying to resolve this by developing more specific goals and objectives to be placed in the state child abuse prevention plan.

Some states indicated that detailed responsibilities of the collaboration as a whole as well as for the individual representatives were outlined in the statute. Others such as Ohio developed a memorandum of agreement (MOA) among the members that was based on the more general points of the legislation that originally established the collaboration. An MOU or MOA, formal statements of commitment and purpose applicable to each individual member, was a common tool across collaborations and was often stated as the instrument that helped the collaboration to function.

Role of Collaboration

The roles of the collaborations were fairly consistent. All of the states reported the coordination of child abuse prevention services among state agencies including planning statewide child abuse prevention efforts and providing assistance and support to local organizations and grantees. There were a number of collaborations whose role it was to coordinate funding among state agencies and all played a part in deciding how money specific for the collaboration was to be spent (i.e. grants, services, etc.). At least

four states (Oklahoma, Florida, Washington, and California) reported being responsible for developing and submitting a statewide child abuse prevention strategic plan.

Coordination Strategies

Several states (Colorado, Tennessee, Oklahoma, Alaska, and Michigan) indicated that they utilize the coordination strategy of a shared information/tracking system and three (Florida, North Carolina, and Washington) indicated they are working towards developing one. Colorado's shared data system consists of client specific information, population-based data, and resource information for providers in terms of who receives funding as well as research information on particular issue areas. Another strategy common across states was staff cross training ranging from topics regarding prevention to quality assurance and program improvement. Colorado has devised a system that brings together information on all of the training opportunities that exist across departments. Of the states that were interviewed, only two (Missouri and Alaska) indicated that co-location of staff and administrative integration are employed. More commonly, the collaborations have staff specific to the coordinating entity that perform administrative functions.

Barriers to Coordinated Funding

Our analysis of the interviews revealed several barriers to the coordination of funding:

- Inflexibility of restricted funding
- Reporting requirements
- Turf Issues
- Lack of top-down support/leadership

A consistent theme among states in regards to braiding and blending funding was the inability to use restricted funding and the cumbersome reporting requirements attached to it. Challenges associated with the coordination of funding also included turf issues as well as having the available resources in order to administer and track these efforts. Colorado commented that often state fiscal officers are concerned about collaborative funding efforts because the legislature might see the transfer of that

money as a sign that the individual department doesn't need it. Colorado is currently embarking on an effort to determine the different fiscal and procurement regulations across departments in order to see if it is the rules or the interpretation of them that is standing in the way of these efforts. Also mentioned by all of the states interviewed was the essential element of communication among collaborative partners in overcoming these challenges. Another key was leadership. More specifically, several states mentioned that high level officials must make the decision to value and fund prevention efforts, especially in the area of universal prevention.

Benefits to Collaboration

Responses regarding the overall benefits of collaboration included resource maximization, shared expertise, and a reduction in the duplication of child abuse prevention services across state agencies. A number of the states that were interviewed also indicated that their efforts helped to bring child abuse prevention more to the forefront among the member agencies and statewide. Florida in particular indicated that the collaboration had served to frame child abuse prevention as a public health issue and make child abuse prevention more of an issue that agencies own as opposed to passing it off as something "only social service agencies do." Colorado mentioned several benefits including the fact that when the state experienced a recent recession, the collaboration was able to keep programs running because people didn't retreat into their individual silos, but worked together to maintain services despite a loss in funding. In addition, the collaboration has helped to increase funding as joint pursuit of grant opportunities has become a part of the state plan for prevention. North Carolina commented that opportunities for collaborative funding have become clearer through the collaboration as participants were able to communicate regularly and discover what programs they were jointly funding.

Larger States

Three states (Florida, California, and Michigan) with comparable populations to Texas were interviewed. Here, the collaborative structures included both state level networks as well as local collaborations that reported to the state. In Florida, there are

twenty local planning teams corresponding to the twenty judicial circuits throughout the state. Twenty-five people, consisting of community based child abuse prevention and general children's services organizations, are on each team. They are responsible for creating local action plans that, although in line with the state objectives, are based on the specific needs of each community.

In California, there are 58 local child abuse prevention networks that correspond to the number of counties in the state. These are then divided into 8 regional child abuse prevention networks. The state collaboration is the State Interagency Team (SIT) that is chaired by the California Department of Social Services, Children and Family Services Division's Deputy Director, and is comprised of representatives overseeing programs effecting children from departments within the California Health and Human Services Agency (CHHS), such as the California Department of Health Services, the California Department of Mental Health, the California Department of Alcohol and Drug Programs and the California Department of Developmental Services. In addition to those agencies, the California Department of Education, the California Employment Development Department, the California First 5 Commission, the California Workforce Investment Board, the California Department of Justice, the Judicial Council/Administrative Office of the Courts, and the Foundation Consortium also participated. The purpose of the SIT is to provide leadership and guidance to facilitate implementation of improved systems that benefit the common population of children, youth and families served by SIT agencies. The SIT promotes shared responsibility and accountability for the welfare of children, youth and families by promoting the alignment of planning, funding and policy across state departments and philanthropy. SIT disseminates both money and information through the regional networks that in turn filter these resources down to the local entities. Each region has a choice in how they are structured (i.e. 501c3, government agency).

Michigan provides a different case. Although all of Michigan's efforts are housed within the Children's Trust Fund (CTF) there are two separate initiatives within the department. The first is the "Zero to Three" component that focuses on funding and services in the area of secondary prevention for children zero to three years of age. They are funded by three state departments one of which puts forward its TANF funding

to support the efforts of the collaboration. The second is the Michigan CTF, which is the administrative and fiduciary agent for Zero to Three, but is also responsible for separate activities and is funded through a mix of state, federal, and private funds. The efforts of the CTF focus on secondary and primary prevention. The CTF funds 72 county-based councils to conduct primary prevention activities. The funding they receive is not to be used for direct service except through local interagency collaborations. They base their funding on a non-competitive tier system with smaller organizations receiving smaller pots of money as well as being held to less rigorous requirements. They also fund direct service projects that focus on both primary and secondary prevention; however, this funding is awarded on a competitive and declining basis.

Future Efforts

A number of states mentioned future or ongoing efforts that were intended to strengthen the work of their collaborations. The Child Abuse Prevention and Permanency Advisory Council in Florida, a relatively new collaboration, is moving toward the development and utilization of a web based system that will allow the members of the collaboration to share information and prevent duplication of services. In Oklahoma, the State Interagency Child Abuse Prevention Task Force is hiring a consultant to help develop more specific goals and objectives for their child abuse prevention strategic plan. Finally in California, the Children's Trust Fund is part of the Office of Child Abuse Prevention's effort to encourage widespread use of the Pathway to Prevention of Child Abuse and Neglect among the members of the collaboration. This framework, developed by the Harvard University Pathways Mapping Initiative, California State University Monterey Bay, and the California Office of Child Abuse Prevention is a comprehensive strategic action plan for use by policymakers, community members, and service providers towards the prevention of child maltreatment.

Appendix B

EVALUATION ELEMENT 2

Determine how to best evaluate the cost-effectiveness of state-funded programs and services for the prevention of and early intervention in child abuse and neglect

Literature Review

Cost-benefit analysis of social policies answers the important question of what returns society receives in return for or beyond the funding that is dedicated to these efforts (Foster & Holden, 2002; Lynn et al., 1998; Masse & Barnett, 2002; Plotnick et al., 1998; Plotnick & Deppman, 1999). This question is frequently posed by legislators as well as other funding sources in order to justify allocating scarce resources to one program as opposed to another arguably important endeavor. It is often an analysis of benefit over cost that more clearly points to the appropriate choice of one alternative over another especially when similar goals are involved (Lillie-Blanton et al., 1998). This is essentially the concept of opportunity costs in which is the cost associated with resources allocated for one purpose not being available for another.

Six steps in cost-benefit analysis can be identified. They include (Foster & Holden, 2002):

- Step 1: Define the program, policy of intervention being evaluated
- Step 2: Specify the study perspectives
- Step 3: Select time frame and analytic horizon
- Step 4: Identify relevant benefits and costs
- Step 5: Measure those effects in dollar terms
- Step 6: Produce a summary measure of the policy's net benefits

In order to follow this framework, evaluators must have a firm idea of the theory of change specified in the program's logic model. This includes program inputs and outputs and how these are expected to affect the phenomenon in question in terms of immediate, intermediate, and long-term outcomes. The program and the analysis of its costs and benefits should also specify to whom these benefits and costs will incur. This can include the parents/caregivers, children, public and private agencies, and society as a whole (Foster & Holden, 2002). This can be a challenge in the field of child abuse prevention given the number of agencies and organizations that are often involved in

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the process. There are a number of different perspectives to be considered regarding perceived costs and benefits. Several stakeholders experience reductions in cost when child abuse is prevented and varying levels of benefits accrue to different members of the family as well as families that are at varying levels of risk in the first place (Plotnick & Deppman, 1999).

Obtaining this information and using it to make choices regarding the efficient use of funds is often difficult in the area of social services because a number of the goods involved violate market assumptions such as willingness to pay, symmetry of information, and the absence of externalities. The area of child abuse prevention is a perfect example in this regard in that it is difficult to calculate costs and benefits using the end result of the traditional framework (Caldwell 1992). This stands as a point of fact for three reasons (Daro 1988):

- The intangible nature of a number of the goals involved in this work
- The use of discounting does not take into account the prolonged nature of the efforts involved in child abuse prevention
- The lack of consensus regarding what benefits and costs to include

Although cost-benefit analysis is desirable in relation to child abuse prevention its calculation and interpretation is not as clear cut as in other fields. Therefore it is necessary that in addition to a direct determination of benefit over cost, costs exceeding benefits in dollar value, a situation in which a system will not break even, must be justified in other ways (ACF, 1993).

One more general alternative that still provides an empirical picture about the costs associated with child abuse and the benefits of prevention is a model of skill formation based on human capital development. The term human capital describes the set of skill, experiences, and other positive characteristics that contribute to the productivity of individuals (Kilburn & Karolyn, 2008).

This strategy, or other tools of cost benefit analysis, ultimately should help policymakers to determine if a program is achieving desired outcomes. More specifically, ACF recommends that two questions are important and possible to answer when conducting cost benefit analysis in child welfare. The first is "what am I buying in terms of outcomes" and the second is "is the cost of achieving those outcomes reasonable."   The purpose of answering these questions is four fold:

- "Evaluate alternative mixes of financial, human, and information resources
- Support wise economic decisions on proposed information system investments
- Establish a performance baseline against which to measure the success of projects
- Provide fundamental management tools that maximize benefits and minimize costs" (ACF, 1993)

This can be done by examining outcomes or benefits by program function such as intake and assessment and family services or by outcome domains such as child and family well-being. However, a challenge in relation to answering both questions relates to the time frame of intervention as well as the duration of effect (Lillie-Blanton et al., 1998). This is especially true in terms of long-term benefits that programs contend are part of their outcomes. It is therefore important that reasonable expectations, based on research if possible, be created regarding program effects.

After the benefits of the program have been identified then values and/or costs can be assigned and projections can be made over a number of years for various target populations. This can be done in order to analyze the status quo or to determine if an alternative specification of the system would be more beneficial. The latter involves a layout of the status quo of costs as well as benefits in addition to those that apply to the alternative structure. A model for this sort of analysis in child welfare systems is outlined by the Administration for Children and Families (ACF). Total present value of benefits, less total present value costs, net benefits, and the benefit/cost ratio are set in a matrix against the status quo and available alternatives. Costs involve all aspects of the present system including equipment and software, personnel, travel, overhead and indirect costs, services and goods provided to clients, and quality assurance and continuous program activities (Plotnick & Deppman, 1999) and a determination of whether these are one time or recurring costs (ACF, 1993).

Another option is to set the benefits and costs of prevention against the costs of treatment or intervention. This includes a delineation of causal factors and consequences of maltreatment along with the immediate and long-term costs that have been highlighted in the literature (Daro, 1988). These costs involve a comprehensive approach to child maltreatment (Bonomi et al. 2008; Reed 2007; Rovi et al 2004; Wang & Holton 2007). Immediate or direct costs are those associated with actual intervention

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by the child welfare and adjoining systems and the immediate impact of child maltreatment. This includes:

- hospitalization
- medical treatment
- mental health care systems
- child welfare/social service provision
- foster care
- law enforcement response
- judicial system

Indirect costs are those that result from the negative consequences of maltreatment including those that impact the individual as well as those that carry over to affect society at large. These include:

- special education
- juvenile delinquency facility costs
- mental health and health care
- adult criminal justice system
- lost productivity to society
- treatment of substance abuse
- interventions of domestic violence resulting for child maltreatment
- chronic health problems

One model utilizing these indicators (Conrad, 2006) projects direct and indirect costs according to the base year value, followed by current values, the probability of incurred cost, and the average cost per case of child abuse. In this case, costs involving loses of lifetime income as well as federal and state income tax payments were separated out as opportunity costs or an indicator of revenues and productivity that were diverted from other more beneficial uses because of the occurrence of child maltreatment. In order to illustrate the efficacy of prevention in alleviating the onset of these costs, Conrad suggests separating prevention programs out into general categories and highlighting observed changes in the populations that received services.

In analyzing the costs and benefits of the Abecedarian Early Childhood (AEC) Intervention program, researchers followed a control group and subjects participating in an intensive pre-school program for children birth to five years (Masse & Barnett, 2002). In looking at program costs they examined labor resources such as staff and non-labor costs associated with equipment, supplies, etc. The marginal cost of the program was

then determined by calculating the difference between the cost of the intervention and the cost of care of the control group. Both these associated costs as well as the benefits of the program were converted into constant dollars and discounted for a range of rates (Masse & Barnett, 2002). Benefits included improved health, educational attainment, reduced welfare use, and earnings. The latter was estimated according to different demographics and educational attainment as well as life expectancy.

Another way to combine quantitative such as that in the AEC study and qualitative information is through the use of a policy scorecard that outlines the different program options available as well as the cost of each in relation to the baseline cost of the problem at hand (Karoly et al. 2003). This technique allows for qualitative measurements to be included in the analysis and decision-making process regarding benefits and costs.

Cost-effectiveness analysis is another technique that allows for difficult to quantify information to contribute to allocation decisions. As opposed to converting costs into the same metric, different alternatives and the degree to which they each result in a reduction in the phenomenon in question can be considered. This particular method recognizes that it is often challenging to assign a worth to particular social benefits such as increased self-esteem or parent-child bonding. However, it does not support the conclusion that these interventions cannot be measured rather the costs associated with providing varying alternatives are measured and then their effect on the desired outcome is determined (Weiss, 1998).

Regardless of the technique chosen, budgetary considerations as well as the desire for parsimony, necessitate the careful selection of a limited number of outcomes. This should be based, as mentioned earlier, on the programs theory of change, focusing on those outcomes that can in some way be calculated (Karoly et al., 1998). In addition to these criteria, Karoly et al. (1998) recommend that four others must be met:

- Use of experimental design
- Adequate sample size
- Small rate of attrition
- Long-term follow up

These criteria ensure that the cost-benefit analysis is rigorous and can be used to confidently argue that a particular program is saving the government money even if not

all costs or benefits can be monetized. Examples of non-monetary benefits included reduced personal and family stress, better parenting, and improved mental health (Plotnick & Deppman, 1999).

Another way of including both qualitative and quantitative techniques is through holistic cost-benefit analysis presented by Henry et al. (2007). In this model, a collaborative process is used in order to determine all of the costs and benefits recognized by all the important stakeholders. The result attempts to "holistically assess the perspectives and experiences of all parties directly involved with the interventions and outcomes of services" (Henry et al., 2007). This includes parental assessment, facilitator/service provider involvement, cost comparison of services, assessment of cost avoidance, and participant-observation of services (Henry et al., 2007). Tools that are used include:

- Integrated structured surveys
- Historical cost-comparisons of services
- In-depth interviews
- Retrospective case studies
- Participant-observation

This approach certainly provides a more comprehensive analysis of the costs and benefits associated with a particular program and may fit well within the complex and dynamic systems associated with child abuse prevention. However, it can also be cost and time prohibitive due to the number of resources that must be devoted to the activities involved.

One approach to measuring the benefits of a child abuse prevention program can be found in an analysis of parent education intervention for at-risk families (Cowen, 2001). First, the basic components of the program were defined with categories for target behaviors including strong parental belief in the value of punishment and the inability of the parent to be empathetically aware of the child's needs. Then the intended outcomes were delineated into subcategories. Finally, the outcome measurements were detailed. In this case the tool used to determine if the program was of benefit was the AAPI. Both low and high score descriptions were included. The researchers looked at data from 15 counties over a one year time frame. Their sample included a range of families including those who could be categorized as "at-risk" as

well as those that had self-selected. The AAPI, a 32-item questionnaire, was administered both prior to and after the intervention and was supplemented with a form eliciting information on socio-demographics including sex, age, ethnicity, education etc (Cowen, 2001).

An interview garnering these variables was also used to evaluate the impact of statewide home visiting programs (Caldera et al., 2007). These baseline characteristics were supplemented with several other measures such as substance abuse and mental health issues in addition to incidents of domestic violence. Substance abuse was self-reported, but mental health problems were measured using a Center for Epidemiological Studies Depression Scale and incidence of domestic violence through a Revised Conflict Tactics Scale. In terms of outcomes, those for the children included development (Bayley Scales of Infant Development) and behavior (Child Behavior Checklist [CBCL]). The parents' focused on knowledge, attitudes, and self-ratings that were measured through a number of diverse instruments.

Understanding the core components of the program under consideration is an essential first step to this sort of analysis. An analysis of the cost-effectiveness of the Family Connections program used the logic model to evaluate benefits related to child safety and behavior (DePanfilis et al., 2008). Risk and protective factors were measured as well as child safety (physical and psychological care) and child behavior (caregiver reports through the CBCL. Some families were served over a three month period and others over a nine month period. Measures of each area were taken at the beginning and ending of the intervention as well as six months later. The researchers indicated that the cost-effectiveness analysis was comprised of three parts (DePanfilis et al., 2008):

- Calculated the costs of the group that received a 3-month intervention and the group that was part of a 9-month intervention
- The magnitude of change in child behavior for each of the two groups was determined
- Cost-effectiveness ratios were calculated to determine which group achieved a given amount of change at what cost

Another approach was taken by the Washington State Institute for Public Policy in an analysis of evidence-based programs to prevent child abuse and to reduce the

amount of time children remained in the child welfare system. This cost-benefit analysis of programs in the state of Washington included the following outcomes (Lee et al., 2008):

- Child abuse and neglect
- Out-of-home placement
- Crime
- High school graduation
- Standardized K–12 test scores
- K–12 grade repetition
- K–12 special education
- Alcohol and drug abuse

An earlier report by one of the authors focused mostly on future economic earnings, health care, lower incidence of crime (Aos et al., 2006). However, for this study the authors took the above benefits and divided them by different classes of recipients. Primary was the program participant followed by the non-program participant group that was broken into taxpayers and non-taxpayers. They then calculated the total benefits for each group. Across the bottom of the matrix they calculated the net program benefit as well as a total benefit-to-cost ratio. They did this for a series of prevention programs as well as intervention programs and administrative policies such as subsidized guardianship. They also included a matrix of program costs per participant in the present value of 2007 dollars as well as costs for comparison groups that had not gone through that specific program, but had used some other service. For the programs included in the analysis they also calculated the difference between the children eligible to participate in the programs and those who were already enrolled. They then took a portion of this population and calculated how much over a five year period the state of Washington would see in benefits and costs based on the individual program calculations.

Regardless of the challenges, what holistic cost benefit analysis highlights is the need to make more than just an economic case for prevention. On the one hand economic analysis is essential especially given the budgetary constraints that put program funding in jeopardy from one fiscal year to the next. On the other hand it cannot substitute for evaluating the impact programs are having on stated outcomes (National Clearinghouse on Child Abuse and Neglect Information, 2004). Therefore

funders, both legislative and private, need a comprehensive understanding of not only the impact of the problem on individuals and society as a whole, but the theory of change that will be translated into specific activities and result in the most efficient use of the scare resources that are available.

Appendix C

EVALUATION ELEMENT 3
Evaluate the effectiveness of state-funded child maltreatment prevention programs and services in achieving their intended outcomes

Program Type and Agency Descriptions[12]

Each unique program implements services and curricula aimed at strengthening families, reducing the risk of child abuse, and increasing the type and nature of vital protective factors to prevent the occurrence of abuse. Of the agencies that administer these programs, eight are part of the Texas Families: Together and Safe Program, twelve are Family Strengthening Services, and four are Community Based Child Abuse Prevention programs. The code specified in front of each of the program names below refers to the program identifier for each of the funded programs in the PEI data base.

Texas Families: Together and Safe (TFTS)

The goals of TFTS programs are to enhance the collaboration of local government, agencies, and families; to ensure the accessibility of family support services; to provide preventative services that allow children to reside in their own homes; and to increase the effectiveness of family support services. TFTS programs serve approximately 30 counties throughout 11 areas of the state by helping families work towards self-sufficiency. TFTS funds programs that promote familial stress reduction and integrate educative opportunities for families to develop competent behaviors that maintain and expand the abilities to successfully nurture children.

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[12] Although PEI funded a large number of child maltreatment prevention programs from 2006 to 2008, the data sent by DFPS to the contractor only included a total of 24. All program descriptions are taken from 2008 proposals submitted to PEI. A proposal for Family Outreach of America was not provided.

Family Strengthening Services (FS)

Available across the state of Texas, these services are designed to build the resiliency of the family by increasing protective factors. Programs are based on the utilization of best practices. Community collaboration is also a necessary component in providing an effective continuum of services for the target populations.

Community-Based Child Abuse Prevention (CBCAP)

One of the aims of the CBCAP program is to raise awareness of prevention services that already exist within the community in order to encourage families to access those services which are currently available. Several community partnerships consisting of parents, organizations, government agencies, and community members have been developed to usher in much needed improvements in outcomes for families, children, and youth. Parental participation and involvement are key elements in the effectiveness of CBCAP programs.

Texas Families: Together and Safe (TFTS) Agencies
10073: Catholic Charities Diocese of Fort Worth, Inc.

Catholic Charities Diocese of Fort Worth, Inc (Catholic Charities) has served children and families from an array of backgrounds in Tarrant and the surrounding counties for the last century. Within Tarrant County, Catholic Charities focuses specifically on low-income neighborhoods where there have been higher reported cases of child abuse and/or neglect. Primarily, Catholic Charities targets families with children (0-18) who are at risk of experiencing neglect or abuse and seeks to provide case management and support services. Families are assessed throughout program participation to determine acuity of need, and are supported through a strengths-based, wrap-around model consisting of in-home case management, therapeutic services, education, immunizations, emergency assistance, childcare, mentoring, transportation, and recreation.

Catholic Charities implements four unique programs to increase the effectiveness of family functioning in the respective service area:

- Homebuilders is a brief service intervention for families where children are at imminent risk for removal. There are no charges for these services, and families

are offered counseling and education to ensure the safety of the child/ren within the home.

- 1-2-3 Magic is an appropriate disciplinary approach that consists of counting negative (stop) and positive (start) behaviors. Through this program, parents are taught effective ways of redirecting children's behavior and building self-esteem.

- Love and Logic is a program designed to minimize the stress of parenting by teaching techniques that can be viewed as fun and rewarding. Adults and children are taught to maintain healthy, respectful relationships. Through the use of humor, hope, and empathy, children are encouraged to make choices when given a task, even if their choices include failure (when the cost is minimal), and parents are encouraged to pair these failures with loving and empathic responses. Parents are taught to provide real limits for their children in loving ways with an emphasis on dignity, respect, healthy decision-making, and behavioral consequences.

- Effective Black Parenting emerged as a method of reaching parents with children ages birth to eighteen years of age. The complete format consists of fourteen training sessions (three hours each) taught for eight to twenty parents recruited from the institutions that run the program. The program utilizes role playing, demonstrations, lectures, and homework activities that are supported by a fully-scripted Instructor's Manual and the Parent Handbook. The content includes Culturally Specific Parenting Strategies (Pyramid of Success for Black Children and cultural pride), traditional versus modern discipline, talking time with children, general parenting strategies, parenting skills with cultural guidance (i.e. use of African American language expressions and proverbs), and special topics like single parenting and/or drug abuse prevention.

10074: DePelchin Children's Center: Families Count

DePelchin Children's Center has served the Houston area for more than 116 years by offering interventions and programs with the purpose of empowering children, their families, and the community with the necessary resources that promote healthy family functioning. DePelchin, a private non-sectarian United Way agency, serves more than 26,000 individual people annually. Since the 1980's, DePelchin has focused efforts on the prevention of bullying, teenage pregnancy, violence, and homelessness. For over ten years, DePelchin has also focused on the prevention of child abuse through therapeutic intervention and prevention education, predominantly with children and families in Northwest Houston. One of the goals of DePelchin is to increase the

efficiency and the effectiveness of community-based family support services, to enable children to remain in their homes, and to collaborate with the community

The specific prevention program funded by PEI, Families Count, uses Nurturing Parenting and/or the STEP curriculum.

- The Nurturing Parenting program centers on the constructs of appropriate expectations, empathy, non-violent discipline, appropriate family roles, and power and independence. Every activity that is explored reinforces a construct, and each construct has a cognitive and affective component that can be measured in terms of change. There are eighty lessons (60-90 minutes each) in 15 concentrated parenting skill areas that can be structured for the specific needs of families. However, there is a patterned structure to the activities that is designed to create predictability for the families. Each session concentrates on one or two topics taught through the prescribed Activities Manual. Parent and child groups focus on the same topics, and each session is reinforced with home practice exercises outlined in the parent handbook where families are given a log to track activities and progress. Programs are divided for different age groups: infants, toddlers and preschoolers, children (5-11), and adolescents (12-18).

- Systematic Training for Effective Parenting (STEP) has parent education study groups for early childhood, seven to twelve year olds, and teens. Each program has a leader's resource guide, promotional tools, and parent handbooks. Based on the goals of misbehavior (attention, power, revenge, or inadequacy), parents are taught to understand child development and effective strengths-based discipline. Homework components involve activities from the handbook and skills learned within the group, which generally has 12 to 15 participants. The program includes weekly family counseling, biweekly home visits, and biweekly parenting education for three months. Support groups are available once a quarter.

10075: Family Services Center, Inc.

Family Services Center has worked to promote the safety and well being of children and families since 1995. Their community-based, family-focused support services include: family assessment, family service planning, information and referral, parenting education, counseling, stress management, anger management, life skills training, support groups, case management, visitation services, basic needs support, job training, transportation, and childcare. Family Services Center has continually focused efforts on providing affordable and accessible services to families in the following Texas counties: Brown, Coleman, Comanche, Eastland, McCullough, Mills, and San Saba. Concerted efforts are made to reach minority families, to provide services in both Spanish and English, to contact populations that are disproportionately

represented, and to identify those families with the highest risk for abuse and those with the highest vulnerability.

In support of the goal to build healthy families and prevent the maltreatment of children, the Center utilizes seven curricula aimed at abuse prevention and education to provide families means of coping with risk factors and establishing viable protective factors.

- Brief Strategic Family Therapy is used with those who exhibit conduct problems, associate with antisocial peers, use drugs at an early age, and/or participate in maladaptive family interactions. Focused interventions are used to improve the patterns of interaction and to build strategies to strengthen the families. It does not rely on the family's ability to come to a session rather outreach strategies are implemented to ensure program participation. This intervention works with every member of the nuclear family and is often scheduled in the afternoon and evening or on Saturdays.

- Nurturing Parenting Program

- Inside-Out Parenting aims to help children become self-reliant and capable of good decision-making. This program provides tools that help adults handle difficult situations to ensure that children become responsible in their behaviors and actions.

- Children in the Middle is meant to focus primarily on children rather than parents' reactions to divorce. Information is focused on how divorce affects children differently in terms of age, especially akin to the stressors of parental conflict. Another essential element is the discussion of various parenting plans as well as continued involvement of the non-custodial parent if possible. The content of this program can be presented in individual or group format, ideally 6-12 group members. Curriculum topics include: introduction to divorce, children's reactions to divorce, moderators of harm, skills training, closing, and supplemental information for parents to take home.

- Common Sense Parenting is a program that helps parents to recognize both the positive and negative consequences that stem from decision-making and teaches the implementation of discipline strategies, appropriate consequences, and reward systems. The program focuses on practical techniques that are logical, sensible, and easy for parents to initiate with their children.

- Active Parenting offers insight into ways to develop positive parenting techniques. Parents are taught to instill confidence in their children through the use of mutual respect and nonviolent strategies. The goal of this program is to help parents raise happy, healthy, and successful children.

- Nurturing Parenting Skills in African American Families is focused on integrating contemporary concepts of parenting with successful historical approaches to working with African American families based on four content areas: difference and its place in America, transcending oppression and teaching dual consciousness, spirituality and the Black church, and teaching children to access resources. Activities within groups are intended to last between one and two hours, and the group is intended to incorporate 12-15 adults with two facilitators, who must be African American.

10076: Healthy Families San Angelo

Since 1994, Healthy Families San Angelo has provided services for families in San Angelo, Texas, to create a family environment where parents become effective guides and role models for children based on familial strengths. Healthy Families San Angelo provides parent education and training, home visitation, fatherhood services, child school readiness training, support groups, resource and referrals, basic needs support, childcare, and transportation to its target population consisting of teen parents, first-time parents, parents with young children, and parents with children determined to be at high risk (of abuse, neglect, developmental delay, disability, emotional challenges, school challenges, or health challenges) in and around San Angelo. The majority of participants served are Hispanic, and the two programs developed and implemented focus on newborns and children.

- Healthy Families program focuses on newborns and initiates services either prenatally or at birth. The program has two aspects, family assessment (intake) and family support (home visits). A standardized assessment tool (generally the Kempe Family Stress Checklist) is used to systematically identify families in need of services by assessing the presence of various factors associated with an increased risk for child abuse and neglect or other poor childhood outcomes. Although the services are voluntary, Healthy Families San Angelo uses persistent outreach efforts to provide weekly services that begin with the development of an Individual Family Support Plan. The Healthy Families program provides culturally competent services that focus on supporting parent(s), parent-child interaction, and child development. At minimum, families are linked to a medical provider (depending on the unique family needs) and to other social services that will assist in meeting basic needs.

- Dads Make a Difference aims to promote healthy child growth and development, to encourage positive father-child interaction, to support responsible fatherhood, and to enhance family functioning regardless of parental living situation. Through developmental assessments and weekly home visits, the program encourages positive father-child relationships. Fathers are given the opportunity to attend

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support groups and bimonthly father-child play groups to learn how play can stimulate brain development. The program also encourages development of education opportunities, effective job skills, paternity establishment, elimination of high-risk behaviors, and taking responsibility of fatherhood through the use of various training programs and coursework. Dads Make a Difference also has a public campaign strategy to promote responsible fatherhood.

10077: The Parenting Cottage, Inc.

The Parenting Cottage has served at-risk families in the Lubbock area for over 25 years. The Parenting Cottage seeks to provide a warm, comfortable atmosphere to parents when they are accessing one of the many services or programs offered: home visitation, groups, resources, referrals, Sunny Beginnings, the Fetal Alcohol Spectrum Disorder Program, the ECI-Debt Program, and the Healthy Families Program. The population, served within a thirty-mile radius of Lubbock and Crosby County, includes prenatal families and at-risk families, most specifically with children under the age of six. At-risk families are identified as having separated parents, divorced parents, parental conflict, teen parents, poor parent-child interaction, limited knowledge of child development, lack of social support, high stress levels, high number of children, negative parental attitudes, and/or homelessness.

- Parents as Teachers (PAT) is implemented through the provision of thorough developmental, hearing, vision, dental, and health screenings once a year with summaries of all screenings provided to parents. The screening provides the developmental data necessary to identify children who are off target. An individualized service plan is developed based on the results, which may warrant personal home visits involving the whole family on a monthly basis. Home visits last a minimum of 50 minutes and often cover a range of learning modules about parenting skills and child development. The program utilizes role-playing, modeling, and hands-on demonstrations rather than lecture. Group meetings are also offered on a monthly basis regarding parent education training, mentoring, familial support, and/or father support. Additionally, this particular child abuse prevention program offers child-school readiness training, booster sessions, basic needs support, resources, and referrals.

10078: United Way of San Antonio and Bexar County

United Way is the lead/fiscal agent and employs the Program Coordinator for the collaborative effort of Baptist Children's Home Ministries, Catholic Charities Archdiocese of San Antonio, and Family Service Association to provide in-home and group-based services for families who are expecting children or who have children

(ages 0-18) in Bexar, Uvalde, and Zavala Counties. United Way is able to train parents to be more effective through Parents As Teachers (PAT), Nurturing Parenting, Middle Way, and Effective Black Parenting.

- Middle Way includes classes for parents and teens and three levels of children's programming. It is a fifteen week program combining ten weeks of structured learning (2.5 hours each) with five weeks of support group participation (1.5 hours per week) to impede the further abuse and neglect of children.

10093: Unity Partners dba Project Unity

Two of the main goals of Project Unity are to decrease the risk factors and increase the protective factors associated with the prevention of child abuse. The program serves children and families residing in Brazos, Burleson, Leon, Grimes, Madison, Roberson, or Washington County who are identified as being at-risk for the presence of child abuse and/or neglect. Project Unity implements the Family Connections (FC) program to successfully serve families with children (0-18) and to minimize the likelihood of the future maltreatment of children.

- FC uses clinically tested instruments to guide the identification of risk and protective factors associated with child neglect (or maltreatment) as part of the comprehensive family assessment. A practitioner is assigned to work with the family and provides services for a minimum of one hour weekly face-to-face FC contact over at least three months. FC provides the majority of services in the community by meeting the families where the families live. The development and implementation of marketing and recruitment procedures targeted towards potential program clients is an integral part of the successful functioning of the program as well as the establishment and management of referral procedures. Consumer input is utilized through a community advisory panel, and emergency services are provided to address the initial concrete needs that a family may present. The development of outcome-driven service plans is geared towards decreasing the risk and increasing the protective factors associated with child maltreatment. Finally, FC implements a process for evaluation of client change over time and at case closing to ensure that clients' lives are being positively affected and to maintain the program's overall effectiveness.

10050: AVANCE, INC. (McAllister)

One of the aims of AVANCE is to address the issue of child abuse through prevention and early intervention. The Mission of the AVANCE Parent Child Education Program is to provide strength and support for at-risk families to become better

advocates, nurturers, and protectors of their children to reduce the probability of abuse. The long term goal is to prevent abuse within the target population by providing support services and increasing family protective factors. AVANCE targets families within the community that include low priority CPS clients with babies and/or young preschool age children who manifest the risk factors for child abuse. Through the implementation of the AVANCE Parent Child Education Program, which consists of weekly center-based parenting education classes that continue for nine months, parental resiliency, attachment patterns, problem-solving, communication, and social support are addressed. Classes are three hours long, and parent self-enhancement is encouraged through home visitation once a month for nine months and through case management. In addition to Parent Education and accountability, the program provides mentoring, child-school readiness, childcare, transportation, resource acquisition, and referral services.

Family Strengthening Agencies
10051: AVANCE, Inc. (Cameron County)

AVANCE, Inc. - Cameron County offers valuable educational and enrichment opportunities to parents and children to assist at-risk families in becoming better advocates, nurturers, and protectors of their children. The long term goal is to prevent abuse within the target population by providing support services and increasing family protective factors. AVANCE targets families that include low priority CPS clients with babies and/or young preschool age children and families meeting risk factors for child abuse who live in community sites throughout the Rio Grande Valley in Cameron County.

- AVANCE Parent Child Education Program, which consists of weekly center-based parenting education classes that continue for nine months, parental resiliency, attachment patterns, problem-solving, communication, and social support are addressed. Classes are three hours long, and parent self-enhancement is encouraged through home visitation once a month for nine months and through case management. In addition to parent education and accountability, the program provides mentoring, child-school readiness, childcare, transportation, resource acquisition, and referral services.

10052: AVANCE, Inc. (Hidalgo County)

AVANCE - Hidalgo County targets families that include low priority CPS clients in twelve community sites throughout the Rio Grande Valley in the counties of Willacy, Hidalgo, and Starr who have babies and/or young preschool age children or who meet the risk factors for child abuse.

10053: AVANCE, Inc. (Dallas)

This agency's service area includes twenty-one census tracts at fourteen low-income elementary schools within the following five regions of Dallas: Bachman Lake, East Dallas, Love Field, Oak Cliff, and West Dallas. This population is characteristically impacted by poverty that is often interrelated to the occurrence of abuse and/or neglect.

10054: Big Brothers Big Sisters of South Texas

Big Brothers Big Sisters of South Texas (BBBS) provides services through community-based and school-based mentoring programs. Volunteers are matched with children to provide needed support and guidance. Mentors assist children in successful development and in the avoidance of risky and/or delinquent behaviors. The target population for this project is primarily minority children from low-income, single parent families who are recruited through cooperation with faith-based groups, other programs, CPS offices, schools, and media advertisements. The population being served resides in Bexar County and benefits from the one-to-one mentoring relationships that are available. The goal is to assist children in developing protective assets such as self-confidence, relationships with family, relationships with peers, etc. Children are evaluated annually on the development of these assets.

The BBBS Mentoring Program is integral in developing these assets and mitigating the presence of risky behavior. After volunteers are recruited, screened, trained, and matched with children, mentors begin to interact with parents and children. Mentors act as a resource for parents who need additional support. On average, mentors meet with children approximately three times a month for an average of twenty-two months. In addition to mentoring, the BBBS program offers parenting education

and other resources and referrals that are invaluable to the fight to end child abuse and/or neglect.

10055: DePelchin Children's Center: Family Connections (FC Gulfton)

In addition to Families Count, DePelchin Children's Center also operates Family Connections, which provides services for families in Gulfton (Southwest area of Houston). Families residing in Gulfton are in a high risk environment often attributed to immigration status that may contribute to unemployment, low education level, or stressors due to poverty and immigration-related trauma. The program was developed to combat these factors that may contribute to the likelihood of child abuse and the breakdown of healthy familial structure. Some of the program's goals include: enhancing well-being among children and their families, strengthening positive family interactions, assisting families in meeting basic needs, decreasing risk factors for abuse, and child maltreatment in the target community. To meet the unique characteristics of the population, FC-Gulfton maintains a high level of communication with DFPS, works to collaborate with community organizations, and partners with various schools in the area. The program cultivates social networks built through multi-family events that provide daily nurturance and reinforcement, and weekly "Charlas" or chats are informational groups that offer discussion and support to community members.

10061: Family Service Association of San Antonio, Inc.

Family Service Association serves families in rural areas in the counties of Dimmit, Maverick, Uvalde, and Zavala. Three of the targeted counties are designated as border counties, which makes the residents vulnerable to unique challenges and issues. The majority of residents in these counties are Hispanic, and the program targets families living in abject poverty. Many of the children in these areas are identified as being at risk for school failure, and the rates of teen pregnancy are often high. Parents and children that are targeted often have a high risk for drug and/or alcohol use and are at a great risk for displacement. Parenting skills are low, and survival skills or survival efforts often consume much of the families' energy.

In response to the unique needs observed in these rural counties, Family Service Association provides assistance and education through the Nurturing Parent program, Parents As Teachers (PAT), and Middle Way.

10056: Family Care Connection

Family Care Connection operates in three zip codes in Dallas County and focuses primarily on case management and parent education for low income African American teen and young adult parents. Preference is given to youth who are pregnant and/or parenting and are aging out of foster care. Family Care Connection implements the Success for Life Program to decrease the risk factors, increase the protective factors, and build resiliency against child abuse and/or neglect in low-income young adult parents.

The protective factors addressed are supportive social/familial environment, parenting competency, access to support services, the ability to advocate for needs, secure attachment, and the nurturing parent-child relationship. Group parenting is held in daycare centers to provide care for children of these young parents in an ongoing format. Group parenting is available for up to fifty parents, and in-home parent education and case management are provided for those (up to 20 years old) who are in crisis. Clients who receive services within the home are encouraged to participate in group parenting beyond their discharge from services. Families are encouraged to remain in parenting groups for up to two years. The Success for Life Program also utilizes the Parents as Teachers (PAT) curriculum.

10057: New Horizons Ranch & Center, Inc.

New Horizons, in collaboration with United Way of Abilene, 2-1-1 Texas A Call for Help, Texas Family Institute, Parents as Teachers, and the Community Based Child Abuse Prevention coalition, created a community-based project called Family Link to serve Taylor County. Family Link is designed to reduce the number of reported child maltreatment cases in Taylor County, form long-term supportive relationships between resources and families at-risk, increase families' support systems, and enhance the collaborative spirit among organizations serving at-risk families. In addition to these basic goals, Family Link's primary activities and assistance that lead to the achievement

of the stated goals are developing services (including emergency services) for at-risk families, providing a Family Guide to enhance family-community interaction, providing voucher-based emergency respite and childcare for families needing immediate relief, teaching parent education courses in a variety of settings to promote optimal accessibility, and counseling with the intent to foster better communication and problem-solving skills. The specific programs that this agency uses to promote these goals and activities are Parents as Teachers (PAT) and Family Connections (FC).

10058: The Children's Shelter

The Children's Shelter created a program called Project MAS-South (Mothers and Schools) to help at-risk families by way of child abuse prevention and early intervention. It targets underserved families living in the rural southern portions of San Antonio and Bexar County. Primarily, the Children's Shelter provides intensive case management (in-home) that targets the teen parent population residing within the Southside Independent School District of San Antonio, Texas. In addition to intensive in-home case management, this often overlooked and underserved population is given the opportunity to participate in weekly support groups that focus on effective parenting. Healthy Families and Nurturing Parenting are two programs that support the program objectives of decreasing child abuse and maltreatment, drop-out rates, and pregnancy rates.

10059: The Parenting Center

The Parenting Center serves residents of Tarrant County, primarily those who are first-time teenage parents from low-income, minority neighborhoods by providing intensive home visitation and support services. The program is participant- driven, in that participants have the ability to design their own programs and goals that are supported by a Family Support Worker. The aim is to increase the factors that protect against abuse and/or neglect: parental resilience, knowledge of parenting and child development, nurturing and attachment, healthy marriage, social connections, concrete support in times of need, effective problem solving, and effective communication skills.

The Parenting Center uses the Healthy Families program to facilitate the growth and sustenance of these protective factors.

10060: YWCA of Metropolitan Dallas

The YWCA (Young Women's Christian Association) houses and manages the Nurse-Family Partnership (NFP) in the metropolitan Dallas area to prevent and intervene in child abuse cases by producing enduring improvements in the health and well-being of first-time parents and their children. Although age and ethnicity are not eligibility requirements, most families identified for participation in the NFP are young African American or Hispanic women who are first-time mothers with low incomes. NFP uses home visitation up through the child's second birthday, to increase protective factors (secure attachment, stable relationships, coping skills, parental monitoring, and social support) in five domains: personal health, environmental health, life course development, maternal role, and family and friends. The home visits generally begin in early pregnancy, occur approximately every one to two weeks, and are made by registered nurses who carry a maximum of twenty-five cases.

During the prenatal period, 24-hour diet histories, weight gain, and health issues are documented and reviewed. A specific set of protocols that can be adapted to the needs of the family is followed by the caregivers. Activities are based on three program goals that are further developed into short, immediate, and long-term outcomes. The NFP is grounded in theories of human ecology, attachment, and self-efficacy. To assist in preventing child abuse, the program also offers fatherhood services, mentoring, parent education, training, resources, referrals, and basic needs support.

Community Based Child Abuse Prevention Agencies
10097: Children's Advocacy Center of Tom Green County, Inc.

The Children's Advocacy Center of Tom Green County, Inc (CAC) applies three strategies to ensure its continued effectiveness in the prevention of child abuse and neglect: forming comprehensive collaborative partnerships, participating as partners in prevention efforts with parents and community stakeholders, and developing services that enable families to receive assistance. Nurturing Parenting, Parent's Anonymous,

and Family Forward are the three programs utilized to effectively prevent child abuse and neglect.

- Parent's Anonymous (PA) is a specific support group that encourages parents to play active roles in the development of their children through support and educative knowledge. Parents meet in a group run by a PA facilitator. Parents practice new behaviors at home and discuss results in the group each week. The group is free, open-ended, and ongoing (once weekly). Parents with children of any age can join, and they can help lead a group, plan new program development, volunteer on hotlines, serve on boards, and/or determine their own learning goals. The PA group leader and facilitator are available between meetings, and all leaders and facilitators receive the *Best Practices for Parents Anonymous Group Facilitators* handbook. Parents receive their own handbook entitled, *I Am a Parents Anonymous Parent*. The collaboration of parents provides a rich environment that fosters learning and growth through shared experience.

- Family Forward offers twelve-week family education classes that include formal, shared leadership components. Parents also have the opportunity to continue meeting on a weekly basis through support groups that utilize the Parent's Anonymous model. Home visits are 1.5 hours per week for three to six months. Support groups are once a week for 1.5 hours for as long as a year (52 weeks). Support groups designed for children follow the same guidelines mentioned above. Parent education classes are 1.5 hour sessions that meet weekly for up to ten weeks. This community partnership for strengthening families includes engaging communities (parents and agencies) in assessing community child abuse prevention needs and implementing services which include parent mentorship and ancillary support services.

10096: Family Connections (Austin)

Family Connections was created over five years ago from the merger of Austin Families, Inc (previously 26 year experience) and Connections Resource Center (11 years experience) to assist families and children in the Austin area. To serve the at-risk families in the Austin-area, Family Connections facilitates, promotes, and sustains community-based, family-focused processes. These processes, aimed at strengthening families through community resources and support, are maintained by CALMS and Parenting Counts.

- CALMS is a mentoring program that informs participants about child development and promotes the participants' cultivation of healthy connections with their infants. The acronym CALMS is a tool that instructs caregivers to participate in the following ways: Check in with yourself and assess your feelings; Allow a breath, relax your body; Listen to your baby, be aware; Mirror

and reflect your baby's feelings; and <u>S</u>oothe your baby. The program consists of eight contact visits in the home, and mentoring takes place for half an hour, four times a month. Parenting classes are offered once a week for up to eight weeks, and playgroups meet twice a month for up to four months. Each of these events lasts for approximately 1.5 hours. Two hour parent leadership support groups meet once a week for up to a year, and father support groups meet monthly for 1.5 hours up to eleven months. This particular community partnership includes engaging the community in assessment, prevention, and the implementation of services (i.e. parent mentoring, home visitation, education and training, and ancillary support services).

- Parenting Counts implements play groups within the community for children ages birth to five years old. Core concepts include: attachment and emotions, communication, handling stress, learning, and literacy. Each of the five two-hour workshops and 15 twenty-minute sessions (combined with the workshops) consist of multimedia presentations and activities that enhance parental understanding and involvement as an avenue to protecting children from the occurrence of maltreatment.

10094: Greater Port Arthur Chamber of Commerce

The Greater Port Arthur Chamber of Commerce (GPACC) assists families and parents in understanding the services and resources available to them and enlightens community leaders about familial challenges. Clinical assessment instruments guide the identification of the risk factors and the protective factors associated with child neglect (or maltreatment) as part of the comprehensive family assessment. The development and implementation of marketing and recruitment procedures is targeted towards potential program clients. GPACC establishes and manages referral procedures for actively reaching eligible families with offers of service. The formation and utilization of a community advisory panel ensures that consumer input is incorporated in program development. A provision for emergency services addresses initial concrete needs and resources or ongoing services needed. GPACC conducts comprehensive family assessments to guide the service delivery process and develops outcome driven service plans geared towards decreasing risk and increasing the protective factors associated with child maltreatment.

GPACC advocates on behalf of clients in the community, facilitates service provision by other organizations and/or individuals, and implements processes for client-change evaluation over time. The community partnership for strengthening

families includes active engagement of the community (parents and agencies) to assess child abuse prevention needs and the services, which include parent education classes that utilize the Parenting Wisely curriculum.

- Parenting Wisely focuses on teaching caregivers fair and effective methods of discipline, which includes developing desired child behaviors through the use of appropriate corrections and rewards. Additionally, caregivers learn how to stay calm while communicating the affects of behavior to their children. Specifically, the curriculum develops assertive discipline reinforcement, communication sills, problem-solving strategies, chore/homework compliance, good listening skills, and the ability to deal with peer pressure. The program is to be utilized with caregivers who have young children (ages 3 to 9).

Protective Factors Survey

This instrument contains 44 items. Each item is ranked on a Likert scale with 1 indicating the least amount of the particular protective factor and 7 indicating the greatest amount of the particular protective factor. This self-administered survey that takes approximately 10-15 minutes to complete is designed as a pre-post evaluation tool for caregivers who are utilizing child maltreatment prevention services. The survey is designed to be administered in person, and a participant ID number is used to ensure staff administer the survey to the same participants at different intervals. It is suggested that the survey be administered by following a set of procedural steps outlined within the manual safeguards in order to avoid a biased interpretation of the data. The *Protective Factors Survey* provides a snapshot of the protective factors evidenced within a family. The survey's purpose is to give necessary feedback to programs to evaluate the effectiveness of their services and to develop continuous improvements - not to assess, diagnose, or place individuals being served within the program. It was designed to help prevention-focused programs to better assess changes in protective factors within the family and identify areas where workers can focus on strengthening and/or developing individual family protective factors. Five protective factors are measured by this survey: social support, concrete support, knowledge of parenting/child development, nurturing and attachment, and family functioning/resiliency.

Protective Factor Survey

1	Setting limits (ex. Rules, guidelines, structure) keeps kids safe.
2	I have neighbors, friends, or relatives that help me when I need it.
3	My family members feel closer to people outside the family than to our own family members
4	I know where to go in my community to get help with family needs.
5	My child/ren misbehave just to upset me.
6	More bad things happen to my family than to other families
7	My family enjoys spending time together.
8	When I am worried about my child/ren, I have someone to talk to.
9	I don't think my family can survive if another problem hits us.
10	Children learn more from watching what you do than from hearing what you say.
11	I can usually tell when my child/ren are upset.
12	Boys who cry are weak.
13	I praise my children when they behave well.
14	My family shows each other love and affection.
15	My family is able to solve our problems.
16	When we have disagreements, family members listen to both sides of the story.
17	When I discipline my child/ren, I have a hard time keeping my feelings under control.
18	I try to comfort my child/ren when something is bothering them.
19	My family members discuss problems with each other.
20	Some members of my family lose their temper.
21	I make rules and stick to them.
22	I feel proud of my children.
23	In my family, we take time to listen to each other.
24	I feel like I am struggling to be a good parent.
25	I try to take a break when I am frustrated by my child/ren's behavior.
26	In my family, we support one another when something goes wrong.
27	I look for information to make sure what I expect from my child is fair (i.e. internet, hotlines, TV, talking to others.)
28A	I use timeout.
28B	I hit.
28C	I spank.
28D	I ground.
29	I take away privileges.
30	(no data)
31	(no data)
32	(no data)
33	It is important to talk to babies even if they don't understand your words.
34	It is best to keep babies in a crib or playpen for most of the day so they will be safe.
35	Most children are not ready for toilet training by age one.
36	Picking up a baby every time they cry will spoil them.
37	You should never shake a baby.
38	Temper tantrums are common in children between one and four years of age.
39	When my baby won't stop screaming or crying, I can control my emotions.
40	All children should be toilet trained by the age of two.
41	I know how to teach my child/ren to resist pressure from friends to break the rules (such as to drink, do drugs).

Protective Factor Survey (continued)

42	A common part of being a teenager is going against the rules.
43	I teach my child/ren to take responsibility for their actions.
44	I don't know how to handle my child/ren when they go against the rules.

Prevention and Early Intervention Protective Factors Survey for Caregivers

The *Prevention and Early Intervention Protective Factors Survey for Caregivers* (FRIENDS National Resource Center, 2008) is an updated version of *the Protective Factors Survey*. It is also used at both pre-test and post-test intervals (before and after participation in prevention programs). Participants are encouraged to respond to each statement personally and honestly without trying to answer for other family members and the participants are encouraged to ask program staff when questions arise about the statements or about any other portions of the survey. The entire survey is comprised of twenty-nine items that are divided into five parts. Of the twenty-nine items, Part One contains five statements that are ranked on a Likert scale corresponding to the frequency at which a particular statement occurs within the participant's family (7= *always*; 1=*never)*. Part Two contains six items that are viewed in terms of agreement with the items, also ranked on a scale of one to seven, where one indicates strong disagreement and seven indicates strong agreement with the statements. Part Three is comprised of three statements that ask about parenting and the nature of the caregiver-child relationship and are ranked on a Likert scale from one to seven with seven indicating strong agreement. The participant is asked to focus on the child that is expected to benefit most from caregiver participation in the program. Part Four, also ranked from one (*never*) to seven (*always*), includes six items that relate to the frequency of behaviors within the family. Finally, the fifth part of the survey is titled, Other Items. Other Items includes the final nine items of the survey which are scored from one to seven based on the participant's level of agreement with the statement (1-*Strongly Disagree*; 4-*Neutral*; 7-*Strongly Agree*).

Prevention and Early Intervention Protective Factors Survey for Caregivers

Part One: Please circle the number that best describes how often the statements are true for you or your family. The numbers represent a scale from 1 to 7 where each of the numbers represents a different amount of time. The number 4 means that the statement is true about half the time.

	1	2	3	4	5	6	7
1. In my family, we talk about problems.	Never	Very Rarely	Rarely	About Half the Time	Frequently	Very Frequently	Always
2. When we argue, my family listens to "both sides of the story."	Never	Very Rarely	Rarely	About Half the Time	Frequently	Very Frequently	Always
3. In my family, we take time to listen to each other.	Never	Very Rarely	Rarely	About Half the Time	Frequently	Very Frequently	Always
4. My family pulls together when things are stressful.	Never	Very Rarely	Rarely	About Half the Time	Frequently	Very Frequently	Always
5. My family is able to solve our problems.	Never	Very Rarely	Rarely	About Half the Time	Frequently	Very Frequently	Always

Part Two: Please *circle* the number that best describes how much you agree or disagree with the statement.

	1	2	3	4	5	6	7
6. I have others who will listen when I need to talk about my problems.	Strongly Disagree	Strongly Disagree	Slightly Disagree	Neutral	Slightly Disagree	Mostly Agree	Strongly Agree
7. When I am lonely, there are several people I can talk to.	Strongly Disagree	Strongly Disagree	Slightly Disagree	Neutral	Slightly Disagree	Mostly Agree	Strongly Agree
8. I would have no idea where to turn if my family needed food or housing.	Strongly Disagree	Strongly Disagree	Slightly Disagree	Neutral	Slightly Disagree	Mostly Agree	Strongly Agree

9. I wouldn't know where to go for help if I had trouble making ends meet.	1 Strongly Disagree	2 Strongly Disagree	3 Slightly Disagree	4 Neutral	5 Slightly Disagree	6 Mostly Agree	7 Strongly Agree
10. If there is a crisis, I have others I can talk to.	1 Strongly Disagree	2 Strongly Disagree	3 Slightly Disagree	4 Neutral	5 Slightly Disagree	6 Mostly Agree	7 Strongly Agree
11. If I needed help finding a job, I wouldn't know where to go for help.	1 Strongly Disagree	2 Strongly Disagree	3 Slightly Disagree	4 Neutral	5 Slightly Disagree	6 Mostly Agree	7 Strongly Agree

Part Three: **This part of the survey asks about parenting and your relationship with your child. For this section, please focus on the child that you hope will benefit most from your participation in our services. Please write the child's age or date of birth and then answer questions with this child in mind.**

12. There are many times when I don't know what to do as a parent.	1 Strongly Disagree	2 Strongly Disagree	3 Slightly Disagree	4 Neutral	5 Slightly Disagree	6 Mostly Agree	7 Strongly Agree
13. I know how to help my child learn.	1 Strongly Disagree	2 Strongly Disagree	3 Slightly Disagree	4 Neutral	5 Slightly Disagree	6 Mostly Agree	7 Strongly Agree
14. My child misbehaves just to upset me.	1 Strongly Disagree	2 Strongly Disagree	3 Slightly Disagree	4 Neutral	5 Slightly Disagree	6 Mostly Agree	7 Strongly Agree

Part Four: **Please tell us how often each of the following happens in your family.**

15. I praise my child when he/she behaves well.	1 Never	2 Very Rarely	3 Rarely	4 About Half the Time	5 Frequently	6 Very Frequently	7 Always
16. When I discipline my child, I lose control.	1 Never	2 Very Rarely	3 Rarely	4 About Half the Time	5 Frequently	6 Very Frequently	7 Always

	1	2	3	4	5	6	7
17. I am happy being with my child.	Never	Very Rarely	Rarely	About Half the Time	Frequen tly	Very Frequen tly	Always
18. My child and I are very close to each other.	Never	Very Rarely	Rarely	About Half the Time	Frequen tly	Very Frequen tly	Always
19. I am able to soothe my child when he/she is upset.	Never	Very Rarely	Rarely	About Half the Time	Frequen tly	Very Frequen tly	Always
20. I spend time with my child doing what he/she likes to do.	Never	Very Rarely	Rarely	About Half the Time	Frequen tly	Very Frequen tly	Always

Other items:

	1	2	3	4	5	6	7
21. When I am worried about my children, I have someone to talk to.	Strongly Disagree	Strongly Disagree	Slightly Disagree	Neutral	Slightly Disagree	Mostly Agree	Strongly Agree
22. I have family, friends, or neighbors I could talk to if I am feeling down.	Strongly Disagree	Strongly Disagree	Slightly Disagree	Neutral	Slightly Disagree	Mostly Agree	Strongly Agree
23. When something goes wrong in our family, we are there to help each other.	Strongly Disagree	Strongly Disagree	Slightly Disagree	Neutral	Slightly Disagree	Mostly Agree	Strongly Agree
24. In times of need, I know where to get help for my family with things like food or clothing.	Strongly Disagree	Strongly Disagree	Slightly Disagree	Neutral	Slightly Disagree	Mostly Agree	Strongly Agree
25. My family can talk about almost anything.	Strongly Disagree	Strongly Disagree	Slightly Disagree	Neutral	Slightly Disagree	Mostly Agree	Strongly Agree

26. My family feels close to one another.	1 Strongly Disagree	2 Strongly Disagree	3 Slightly Disagree	4 Neutral	5 Slightly Disagree	6 Mostly Agree	7 Strongly Agree
27. No data	1 Strongly Disagree	2 Strongly Disagree	3 Slightly Disagree	4 Neutral	5 Slightly Disagree	6 Mostly Agree	7 Strongly Agree
28. My child has a lot of friends in his/her same age group.	1 Strongly Disagree	2 Strongly Disagree	3 Slightly Disagree	4 Neutral	5 Slightly Disagree	6 Mostly Agree	7 Strongly Agree
29. My child comes to me when he/she is feeling upset.	1 Strongly Disagree	2 Strongly Disagree	3 Slightly Disagree	4 Neutral	5 Slightly Disagree	6 Mostly Agree	7 Strongly Agree

Adult-Adolescent Parenting Inventory

The *Adult-Adolescent Parenting Inventory (AAPI-2)* is used to assess the child-rearing and parenting attitudes of parent (adult and adolescent) and non-parent populations (Bavolek & Keene, 2007). The inventory is intended to provide an index of risks based on the known behaviors of abusive parents that contribute to the abuse and/or neglect of children. The index of risk pertains to five specific behaviors that are categorized as the following constructs: inappropriate expectations of children, parental lack of empathy, strong belief in the use of corporal punishment, reversing parent-child roles, and oppressing children's power and independence. The AAPI-2 consists of 40 items that are presented in a five-point Likert scale from strongly agree to strongly disagree. The survey can be administered and scored online. After the demographic data and item responses have been entered, the scores are automatically stored and saved, which eliminates a degree of scoring error. In interpreting the scores for the AAPI-2, one must be mindful that lower scores indicate a lower risk of child abuse.

Adult-Adolescent Parenting Inventory (AAPI-2)[13]

	Strongly Agree	Agree	Disagree	Strongly Disagree	Uncertain
1. Children need to be allowed freedom to explore their world in safety.	SA	A	D	SD	U
2. Time-out is an effective way to discipline children.	SA	A	D	SD	U
3. Children who are one-year-old should be able to stay away from things that could harm them.	SA	A	D	SD	U
4. Strong-willed children must be taught to mind their parents.	SA	A	D	SD	U
5. The sooner children learn to feed and dress themselves and use the toilet, the better off they will be as adults.	SA	A	D	SD	U
6. Spanking teaches children right from wrong.	SA	A	D	SD	U
7. Babies need to learn how to be considerate of the needs of their mother.	SA	A	D	SD	U
8. Strict discipline is the best way to raise children.	SA	A	D	SD	U
9. Parents who nurture themselves make better parents.	SA	A	D	SD	U
10. Children can learn good discipline without being spanked.	SA	A	D	SD	U
11. Children have a responsibility to please their parents.	SA	A	D	SD	U
12. Good children always obey their parents.	SA	A	D	SD	U
13. In father's absence, the son needs to become the man of the house.	SA	A	D	SD	U
14. A good spanking never hurt anyone.	SA	A	D	SD	U
15. Parents need to push their children to do better.	SA	A	D	SD	U
16. Children should keep their feelings to themselves.	SA	A	D	SD	U
17. Children should be aware of	SA	A	D	SD	U

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[13] (Bavolek & Keene, 2007)

ways to comfort their parents after a hard day's work.					
18. Children learn respect through strict discipline.	SA	A	D	SD	U
19. Hitting a child out of love is different than hitting a child out of anger.	SA	A	D	SD	U
20. A good child sleeps through the night.	SA	A	D	SD	U
21. Children should be potty trained when they are ready and not before.	SA	A	D	SD	U
22. A certain amount of fear is necessary for children to respect their parents.	SA	A	D	SD	U
Spanking teaches children it's alright to hit others.	SA	A	D	SD	U
23. Children who feel secure often grow up expecting too much.	SA	A	D	SD	U
24. There is nothing worse than a strong-willed two-year-old.	SA	A	D	SD	U
25. Sometimes spanking is the only thing that will work.	SA	A	D	SD	U
26. Children who receive praise will think too much of themselves.	SA	A	D	SD	U
27. Children should do what they're told to do, when they're told to do it. It's that simple.	SA	A	D	SD	U
28. Children should be taught to obey their parents at all times.	SA	A	D	SD	U
29. Children should know what their parents need without being told.	SA	A	D	SD	U
30. Children should be responsible for the well-being of their parents.	SA	A	D	SD	U
31. It's OK to spank as a last resort.	SA	A	D	SD	U
32. Parents should be able to confide in their children.	SA	A	D	SD	U
33. .Parents who encourage their children to talk to them only end up listening to complaints.	SA	A	D	SD	U
34. Children need discipline, not spanking.	SA	A	D	SD	U

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35. Letting a child sleep in the parents' bed every now and then is a bad idea.	SA	A	D	SD	U
36. A good spanking lets children know parents mean business.	SA	A	D	SD	U
37. A good child will comfort both parents after they have argued.	SA	A	D	SD	U
38. "Because I said so" is the only reason parents need to give.	SA	A	D	SD	U
39. Children should be their parents' best friend.	SA	A	D	SD	U

Prevention and Early Intervention Family Satisfaction Survey[14]

INSTRUCTIONS							
On a scale from 1-7, with 1 as 'strongly disagree' and 7 as 'strongly agree', please rate how much you agree with the following statements based on the program you just completed. In addition, questions 6 and 7 are fill-in the blank, where you can write in your opinions. Each statement should have only one score.							
1. This program has helped me improve my parenting skills.	1 Strongly Disagree	2	3	4 In Between	5	6	7 Strongly Agree
2. This program has helped me reduce stress in my life.	1 Strongly Disagree	2	3	4 In Between	5	6	7 Strongly Agree
3. My ideas and opinions are welcomed and included in the program	1 Strongly Disagree	2	3	4 In Between	5	6	7 Strongly Agree
4. I feel that the program staff respects me.	1 Strongly Disagree	2	3	4 In Between	5	6	7 Strongly Agree
5. This program is helping me reach my goals for my family and me.	1 Strongly Disagree	2	3	4 In Between	5	6	7 Strongly Agree
6. What do you like most about this program?							
7. What suggestions do you have for program improvement?							

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[14] (Texas Department of Family and Protective Services, 2008, p. 173)

Paired Sample t tests of the Protective Factor Survey by Agency

Table 62: Paired Sample t tests AVANCE, Inc. (RGV- MCAL)

Item	1**		2		3		4		5	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.26	6.48	5.66	6.01	3.16	3.09	4.95	5.78	2.67	2.69

Item	6		7		8*		9*		10	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	2.60	2.61			5.62	5.99	3.25	2.77	5.53	5.72

Item	11*		12		13		14		15***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.05	6.43	2.43	2.23	5.97	6.27	5.87	6.39	5.71	6.26

Item	16***		17**		18		19***		20**	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.07	5.66	4.24	3.85	6.05	6.33	4.95	5.53	4.32	3.82

Item	21***		22*		23*		24***		25	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.98	5.82	6.61	6.81	5.52	5.97	4.31	3.47	4.79	5.13

Item	26		27		28A		28B***		28C**	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.77	6.22	4.87	5.41	4.56	4.73	2.45	1.94	3.07	2.70

Item	28D***		29		30		31		32	
Period	Pre	Post	Pre	Pre	Post	Pre	Post	Post	Pre	Post
Mean	4.86	5.46	4.99	5.65						

Item	33		34		35		36**		37	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean			3.75	3.74	4.59	4.36	4.53	3.72	5.43	5.66

Item	38		39		40**		41		42	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.69	5.70	5.08	5.61	5.21	4.42				

Item	43		44						Average***	
Period	Pre	Post	Pre	Post					Pre	Post
Mean									4.59	4.85

N=671   * p< 0.05, ** p<0.01, ***p<0.001

Table 63: Paired Sample t tests AVANCE, Inc. (RGV-Cameron)

Item	1		2		3		4**		5	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.49	6.36	5.28	5.43	2.81	2.66	4.70	5.42	2.02	2.11
Item	6		7		8**		9		10	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	2.17	1.98			5.57	6.02	2.52	2.30	5.37	5.39
Item	11		12		13		14		15	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.13	6.20	1.93	1.96	6.10	6.42	6.19	6.31	5.70	5.79
Item	16***		17		18		19		20	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.05	5.75	3.26	3.32	6.51	6.33	5.23	5.41	3.38	3.30
Item	21		22		23		24		25***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.27	5.53	6.83	6.80	5.82	6.06	3.24	3.37	4.20	4.93
Item	26		27**		28A		28B		28C	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.83	6.14	4.84	5.28	3.94	4.26	1.43	1.45	2.31	2.10
Item	28D		29		30		31		32	
Period	Pre	Post	Pre	Pre	Post	Pre	Post	Post	Pre	Post
Mean	5.04	5.12								
Item	33		34		35		36		37	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.64	6.41	4.04	3.85	5.09	4.79	4.13	3.40	5.74	6.15
Item	38		39**		40		41		42	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.52	5.96	6.00	5.60	5.43	4.79	5.96	6.17	2.87	3.22
Item	43		44						Average**	
Period	Pre	Post	Pre	Post					Pre	Post
Mean	6.32	6.00	3.94	3.30					4.59	4.72

N=301   * p< 0.05, ** p<0.01, ***p<0.001

Table 64: Paired Sample t tests AVANCE, Inc. (RGV-Hidalgo)

Item	1		2		3		4***		5	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean			5.53	5.72	2.72	2.72			2.45	2.27
Item	6		7		8		9		10	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	3.15	2.46			5.08	5.67	3.12	2.88	5.67	6.04
Item	11**		12		13		14		15	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.04	6.58	2.11	1.96	5.83	6.10	5.94	6.23	5.32	5.66
Item	16		17		18**		19		20*	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.39	5.57	3.27	3.15	5.77	6.35	5.14	5.20	3.88	3.35
Item	21*		22		23		24		25**	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.94	5.50	6.57	6.80	6.02	6.08	3.67	3.31	4.17	4.90
Item	26		27*		28A		28B		28C	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.53	6.00	4.92	5.57	4.19	4.66	1.52	1.34	2.28	2.04
Item	28D*		29		30		31		32	
Period	Pre	Post	Pre	Pre	Post	Pre	Post	Post	Pre	Post
Mean	4.92	5.38	4.91	5.41						
Item	33		34		35		36		37	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.52	6.66	3.83	3.80	5.23	5.60	3.34	3.62	5.07	5.86
Item	38		39		40		41		42	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.59	5.48	5.50	5.79	4.75	4.54	5.61	5.52	3.82	3.18
Item	43*		44**						Average	
Period	Pre	Post	Pre	Post					Pre	Post
Mean	5.95	6.55	3.91	3.05					4.34	4.47

N=530   * p< 0.05, ** p<0.01, ***p<0.001

Table 65: Paired Sample t tests AVANCE, Inc. (Dallas)

Item	1		2		3		4***		5	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.37	5.49	4.59	5.18	3.31	3.45	4.29	5.59	2.73	2.12

Item	6*		7		8***		9		10	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	2.51	1.78			4.71	5.73	3.63	2.94	5.59	6.04

Item	11		12		13**		14*		15	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.39	5.29	2.31	1.73	4.90	5.39	5.00	5.44	4.96	5.63

Item	16***		17		18*		19**		20***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.15	5.52	4.18	3.53	5.29	5.63	4.21	5.13	3.96	2.92

Item	21		22		23		24		25	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.69	4.96	5.63	5.67	4.94	5.21	3.65	3.16	4.56	5.04

Item	26		27**		28A		28B		28C	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.00	5.46	4.73	5.52	4.57	5.22	2.28	1.46	2.92	2.39

Item	28D***		29		30		31		32	
Period	Pre	Post	Pre	Pre	Post	Pre	Post	Post	Pre	Post
Mean	5.33	6.18	4.65	5.22						

Item	33		34		35		36		37	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.50	5.69	3.19	2.56	4.69	4.43	3.30	2.49	4.95	5.33

Item	38		39*		40		41**		42	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.14	5.48	4.98	5.67	4.71	3.98	5.53	6.59	2.59	2.09

Item	43**		44						Average	
Period	Pre	Post	Pre	Post					Pre	Post
Mean	6.16	6.75							4.33	4.48

N=133   * p< 0.05, ** p<0.01, ***p<0.001

Table 66: Paired Sample t tests Big Brother/Big Sister of South Texas

Item	1		2		3*		4		5	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.16	6.76	4.56	4.76	2.88	3.80	4.40	4.76	2.68	2.44
Item	6		7		8		9		10	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	2.40	2.64			5.24	5.52	2.68	1.92	5.36	5.76
Item	11		12		13		14		15	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.48	6.40	1.64	1.72	6.56	6.40	6.12	5.80	5.33	5.38
Item	16		17		18		19		20	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.25	5.08	3.24	3.16	6.40	6.68	5.16	5.52	3.92	4.04
Item	21		22*		23		24		25	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.28	5.28	6.60	6.92	6.12	5.80	4.64	4.48	5.12	5.16
Item	26		27		28A		28B		28C	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.92	6.20	5.68	5.64	5.41	5.14	1.71	1.29	2.38	2.03
Item	28D		29		30		31		32	
Period	Pre	Post	Pre	Pre	Post	Pre	Post	Post	Pre	Post
Mean	5.11	4.39	6.00	6.08						
Item	33		34		35		36		37	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean										
Item	38		39		40		41		42	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean										
Item	43		44						Average	
Period	Pre	Post	Pre	Post					Pre	Post
Mean									4.62	4.43

N=56   * p< 0.05, ** p<0.01, ***p<0.001

Table 67: Paired Sample t tests DePelchin Children's Center (Family Connections - Gulfton)

Item	1		2*		3		4***		5	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.82	6.54	4.21	5.64	2.68	2.89	3.93	6.11	3.50	3.04

Item	6		7		8**		9**		10	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	2.61	2.32			4.96	6.52	3.81	2.51	4.86	5.57

Item	11		12*		13*		14		15	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.36	6.39	3.61	2.71	5.64	6.39	5.78	6.04	4.86	5.61

Item	16**		17		18		19		20	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	3.96	5.43	4.29	3.93	5.75	6.29	5.29	5.75	4.43	4.14

Item	21***		22		23		24**		25	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.46	6.14	6.39	6.71	5.04	6.11	5.00	3.75	4.75	4.86

Item	26*		27***		28A*		28B*		28C**	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.60	6.36	4.04	5.71	4.07	5.55	2.79	1.83	3.90	2.76

Item	28D		29		30		31		32	
Period	Pre	Post	Pre	Pre	Post	Pre	Post	Post	Pre	Post
Mean	4.07	4.80								

Item	33		34		35		36		37	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.33	6.87	5.21	4.64	5.00	3.71	3.64	3.86	6.20	6.53

Item	38		39		40		41*		42	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.47	5.87	5.53	5.60	5.33	4.80	4.91	6.17	3.17	2.43

Item	43*		44**						Average	
Period	Pre	Post	Pre	Post					Pre	Post
Mean	6.00	6.50	5.26	3.39					4.66	4.92

N=42   * p< 0.05, ** p<0.01, ***p<0.001

Table 68: Paired Sample t tests Family Care Connections

Item	1*		2**		3		4**		5**	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.92	6.43	4.95	5.93	2.91	2.65	4.58	5.56	1.84	1.29

Item	6		7		8**		9		10***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	2.36	2.10			5.21	5.89	2.27	1.83	4.42	5.66

Item	11***		12*		13		14*		15	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.77	6.49	2.16	1.64	5.71	5.98	5.21	5.78	4.90	5.40

Item	16		17		18		19**		20*	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.30	4.80	1.98	2.00	6.20	6.32	4.58	5.38	3.74	3.21

Item	21***		22*		23***		24		25**	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.88	6.16	6.11	6.72	4.51	5.56	3.28	3.03	4.40	5.33

Item	26		27		28A		28B		28C	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.05	5.52	4.82	4.98	2.92	2.70	1.38	1.17	1.91	1.98

Item	28D		29		30		31		32	
Period	Pre	Post	Pre	Pre	Post	Pre	Post	Post	Pre	Post
Mean	4.13	4.70								

Item	33**		34		35		36**		37	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.89	7.00	4.42	4.42	4.37	5.84	5.53	2.58	6.74	6.68

Item	38		39		40		41		42	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.00	5.39	4.83	5.33	5.68	5.16	5.86	6.50	3.53	3.33

Item	43		44						Average	
Period	Pre	Post	Pre	Post					Pre	Post
Mean	5.93	6.50	2.71	1.79					4.29	4.42

N=97   * p< 0.05, ** p<0.01, ***p<0.001

Table 69: Paired Sample t tests New Horizon Ranch & Center, Inc.

Item	1		2**		3		4***		5***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.48	6.51	4.87	5.30	3.38	3.27	4.38	5.72	3.21	2.64

Item	6***		7		8***		9***		10	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	3.09	2.59			4.85	5.64	3.20	2.61	5.58	5.85

Item	11		12*		13***		14***		15***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.17	6.31	1.55	1.33	5.88	6.22	5.68	6.10	4.51	5.25

Item	16***		17***		18*		19***		20**	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.53	5.28	3.78	3.22	6.20	6.37	4.68	5.41	4.49	4.12

Item	21***		22*		23***		24***		25	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.36	5.15	6.48	6.68	5.11	5.66	4.88	4.30	4.96	5.22

Item	26***		27***		28A		28B		28C***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.33	5.83	4.85	5.68	3.82	4.05	1.45	1.29	3.00	2.26

Item	28D***		29		30		31		32	
Period	Pre	Post	Pre	Pre	Post	Pre	Post	Post	Pre	Post
Mean	4.38	4.83								

Item	33		34		35		36		37	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.56	6.56	2.27	2.54	5.05	5.20	3.79	3.55	6.59	6.83

Item	38*		39		40		41***		42	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.81	5.40	5.33	5.71	4.19	4.07	5.16	6.11	3.63	3.21

Item	43***		44						Average***	
Period	Pre	Post	Pre	Post					Pre	Post
Mean	5.60	6.14	3.81	3.56					4.52	4.72

N=242   * p< 0.05, ** p<0.01, ***p<0.001

Table 70: Paired Sample t tests The Children's Shelter of San Antonio

Item	1		2*		3*		4**		5	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.18	6.38	5.72	6.19	2.67	3.20	4.63	5.33	1.72	1.63

Item	6		7		8		9		10**	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	2.38	2.48			5.66	6.09	2.47	2.90	5.00	5.78

Item	11		12		13***		14		15	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.63	6.13	1.71	1.47	5.54	6.37	5.51	5.43	5.10	5.28

Item	16		17		18**		19		20*	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.54	4.75	3.11	2.66	5.99	6.54	4.86	4.91	4.52	3.91

Item	21**		22		23*		24		25	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.58	5.14	6.47	6.75	4.72	5.10	3.44	3.08	4.99	5.49

Item	26		27		28A***		28B*		28C***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.15	5.51	4.97	5.32	2.36	3.29	1.09	1.41	1.35	1.97

Item	28D**		29		30		31		32	
Period	Pre	Post	Pre	Pre	Post	Pre	Post	Post	Pre	Post
Mean	3.44	4.50								

Item	33		34*		35		36**		37	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.73	6.86	3.59	2.27	4.86	4.05	3.82	2.36	6.95	6.71

Item	38		39		40		41		42	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.86	5.68	5.68	5.64	4.82	2.68				

Item	43		44						Average*	
Period	Pre	Post	Pre	Post					Pre	Post
Mean									4.36	4.50

N=180　　　* p< 0.05, ** p<0.01, ***p<0.001

Table 71: Paired Sample t tests The Parenting Center

Item	1*		2*		3		4***		5	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.46	6.83	4.65	5.42	2.88	3.39	3.69	5.31	2.34	2.38

Item	6		7		8		9		10	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	2.63	2.65			5.41	5.90	3.02	3.10	5.19	5.56

Item	11**		12*		13		14		15**	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.90	6.54	1.92	1.37	6.15	6.20	6.04	5.92	4.50	5.27

Item	16		17		18		19		20	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.55	5.17	3.58	3.44	6.28	6.48	4.76	5.18	4.76	4.39

Item	21***		22		23*		24		25	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.43	5.39	6.73	6.88	4.96	5.49	4.55	3.98	4.51	5.19

Item	26		27		28A		28B*		28C	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.25	5.46	4.63	5.14	4.60	4.15	1.80	1.26	2.96	2.49

Item	28D		29		30		31		32	
Period	Pre	Post	Pre	Pre	Post	Pre	Post	Post	Pre	Post
Mean	4.45	4.45								

Item	33		34		35		36		37	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.67	6.79			5.48	4.48	4.25	4.21	6.04	6.00

Item	38		39		40		41*		42	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.43	5.86	5.83	6.00	4.54	4.50	4.47	5.53	2.78	4.06

Item	43		44						Average	
Period	Pre	Post	Pre	Post					Pre	Post
Mean	5.50	5.94	3.44	2.78					4.63	4.76

N=77   * p< 0.05, ** p<0.01, ***p<0.001

Table 72: Paired Sample t tests YWCA of Metropolitan Dallas

Item	1		2		3		4		5	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.41	6.59	5.91	6.41	2.71	2.14	5.27	5.68	1.50	2.14

Item	6		7		8**		9		10	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	2.48	1.81			5.50	7.00	1.95	1.86	5.36	5.36

Item	11*		12		13		14		15	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.63	6.69	1.77	1.64	5.81	6.06	6.18	6.50	5.91	5.95

Item	16*		17		18		19		20	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.95	6.00	2.53	2.93	6.60	6.87	5.77	6.14	4.27	3.64

Item	21		22		23		24		25	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.36	5.27	6.41	6.76	5.86	6.36	2.80	3.13	4.46	4.69

Item	26		27		28A*		28B		28C	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.23	6.64	5.44	4.69	4.56	2.81	1.41	1.41	2.82	2.35

Item	28D		29		30		31		32	
Period	Pre	Post	Pre	Pre	Post	Pre	Post	Post	Pre	Post
Mean	4.69	3.63								

Item	33		34		35**		36*		37	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.81	7.00	3.50	3.13	3.67	5.27	5.63	3.44	6.56	6.81

Item	38		39		40		41		42	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.06	5.56	6.45	6.91	5.06	4.94	5.44	6.78	4.22	3.67

Item	43		44						Average	
Period	Pre	Post	Pre	Post					Pre	Post
Mean	6.33	6.89	2.44	2.33					4.67	4.58

N=43   * p< 0.05, ** p<0.01, ***p<0.001

Table 73: Paired Sample t tests Family Service Association of San Antonio, Inc.

Item	1		2		3		4***		5*	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.22	6.45	5.45	5.79	2.88	3.02	4.70	5.91	2.28	1.67

Item	6		7		8**		9**		10	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	2.13	2.13			5.26	6.02	2.73	1.98	5.23	5.45

Item	11		12		13**		14		15	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.35	6.46	1.69	1.16	6.09	6.22	5.91	6.21	5.09	5.43

Item	16		17		18		19		20	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.71	5.00	3.15	2.87	6.32	6.43	5.05	5.22	3.78	3.36

Item	21		22		23		24		25	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.57	4.98	6.76	6.94	5.39	5.55	3.87	3.58	4.92	4.62

Item	26		27		28A		28B		28C***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.73	5.85	5.24	5.19	3.30	3.47	1.13	1.13	2.49	1.64

Item	28D		29		30		31		32	
Period	Pre	Post	Pre	Pre	Post	Pre	Post	Post	Pre	Post
Mean	4.58	4.98								

Item	33		34**		35		36		37	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.82	6.58	3.45	2.52	5.36	5.24	3.48	2.85	5.88	6.45

Item	38		39		40*		41		42	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.64	5.45	5.30	5.76	4.45	3.85	4.81	5.52	4.25	3.50

Item	43		44						Average	
Period	Pre	Post	Pre	Post					Pre	Post
Mean	5.75	5.85	3.30	2.80					4.41	4.51

N=197   * p< 0.05, ** p<0.01, ***p<0.001

Table 74 Paired Sample t tests: Family Outreach of America

Item	1		2		3		4***		5	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.68	6.59	5.43	5.71	2.50	2.52	4.72	5.47	2.34	2.25

Item	6		7		8		9		10	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	2.25	2.02			5.88	6.08	1.95	1.90	5.86	5.77

Item	11		12*		13		14		15	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.57	6.51	1.70	1.41	6.32	6.48	6.35	6.36	5.59	5.74

Item	16		17		18		19		20	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.03	5.26	3.07	2.80	6.5	6.61	5.35	5.59	3.85	3.91

Item	21		22		23		24		25***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.13	5.50	6.73	6.85	5.84	5.91	3.59	3.42	4.98	5.66

Item	26		27		28A		28B		28C	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.90	5.96	4.84	5.18	3.84	4.03	1.47	1.22	2.83	2.52

Item	28D		29		30		31		32	
Period	Pre	Post	Pre	Pre	Post	Pre	Post	Post	Pre	Post
Mean	4.80	4.97								

Item	33		34		35		36		37*	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.62	6.81	2.67	2.69	4.77	4.94	4.28	3.92	6.43	6.80

Item	38		39		40*		41		42	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.54	5.69	5.63	5.54	4.39	3.94	5.64	5.80	4.11	3.91

Item	43		44						Average*	
Period	Pre	Post	Pre	Post					Pre	Post
Mean	6.44	6.26	2.46	2.40					4.68	4.76

N=168   * p< 0.05, ** p<0.01, ***p<0.001

Table 75: Paired Sample t tests Catholic Charities Diocese of Fort Worth, Inc.

Item	1		2***		3		4***		5**	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.33	6.43	4.69	5.28	3.71	3.85	4.28	5.49	3.10	2.72

Item	6***		7		8***		9***		10**	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	3.21	2.51			4.91	5.78	3.09	2.56	5.68	5.97

Item	11		12**		13*		14***		15***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.25	6.37	2.11	1.85	6.04	6.21	5.45	5.85	4.55	5.30

Item	16***		17***		18		19***		20***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.54	5.24	3.92	3.41	6.05	6.14	4.84	5.21	4.54	4.06

Item	21***		22**		23***		24***		25*	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.84	5.21	6.23	6.44	4.97	5.55	4.66	3.97	4.87	5.13

Item	26***		27***		28A		28B**		28C***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.05	5.65	4.78	5.63	4.54	4.92	1.76	1.49	2.90	2.47

Item	28D***		29		30		31		32	
Period	Pre	Post	Pre	Pre	Post	Pre	Post	Post	Pre	Post
Mean	4.35	4.85								

Item	33		34		35		36		37	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.39	6.43	3.33	3.24	4.60	4.69	3.86	3.71	6.24	6.56

Item	38		39		40		41*		42	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.81	5.76	5.52	5.49	4.42	4.53	5.10	5.44	2.96	2.92

Item	43		44						Average***	
Period	Pre	Post	Pre	Post					Pre	Post
Mean	5.91	5.99	3.65	3.45					4.59	4.74

N=422   * p< 0.05, ** p<0.01, ***p<0.001

Table 76: Paired Sample t tests DePelchin Children's Center (Families Count)

Item	1		2***		3		4***		5	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean			4.64	5.31	3.31	3.53			3.09	3.01
Item	6		7		8***		9		10*	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	2.91	2.80			4.54	5.75	3.16	2.78	5.27	5.60
Item	11		12		13		14***		15*	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.06	6.29	2.44	2.17	6.07	6.02	5.43	5.91	4.98	5.25
Item	16***		17		18		19***		20	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.70	5.23	4.11	3.91	6.00	6.15	4.43	5.27	4.21	4.20
Item	21***		22		23***		24**		25	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.84	5.47	6.49	6.64	5.20	5.65	4.76	4.31	4.79	4.87
Item	26*		27		28A		28B		28C	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.34	5.70	4.69	5.03	4.26	4.38	2.90	2.79	3.72	3.77
Item	28D		29		30		31		32	
Period	Pre	Post	Pre	Pre	Post	Pre	Post	Post	Pre	Post
Mean	4.67	4.89								
Item	33		34		35		36		37	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.23	6.48	3.97	3.15	4.64	4.27	4.41	4.28	5.91	5.97
Item	38		39		40		41**		42	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.81	5.59	4.69	5.50	4.28	4.31	5.29	6.06	3.71	3.06
Item	43		44*						Average***	
Period	Pre	Post	Pre	Post					Pre	Post
Mean	3.71	3.06	3.77	2.83					4.61	4.88

N=410   * p< 0.05, ** p<0.01, ***p<0.001

Table 77: Paired Sample t tests Family Service Center, Inc

Item	1		2*		3		4***		5	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.62	6.72	5.75	5.92	2.67	2.60	5.23	5.87	2.29	2.14
Item	6*		7		8**		9***		10*	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	2.36	2.14			5.72	6.03	2.39	2.02	5.58	5.79
Item	11		12		13**		14***		15***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.36	6.33	1.53	1.47	6.26	6.42	5.97	6.19	5.14	5.47
Item	16***		17		18		19***		20	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.94	5.23	3.17	3.09	6.37	6.42	5.17	5.46	4.05	3.91
Item	21***		22*		23***		24**		25**	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.05	5.35	6.75	6.83	5.46	5.78	4.00	3.69	5.00	5.30
Item	26**		27***		28A**		28B		28C**	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.83	6.05	4.89	5.31	4.34	4.65	1.36	1.24	2.73	2.51
Item	28D***		29		30		31		32	
Period	Pre	Post	Pre	Pre	Post	Pre	Post	Post	Pre	Post
Mean	4.49	4.88								
Item	33		34		35		36**		37	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.61	6.70	2.14	2.01	4.43	4.52	4.08	3.74	6.76	6.75
Item	38*		39		40		41		42	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.19	5.40	5.53	5.61	3.91	3.87	5.52	5.69	3.77	3.69
Item	43		44						Average**	
Period	Pre	Post	Pre	Post					Pre	Post
Mean	6.22	6.35	2.75	2.65					4.62	4.67

N=528   * p< 0.05, ** p<0.01, ***p<0.001

Table 78: Paired Sample t tests Healthy Families San Angelo

Item	1		2*		3		4***		5	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.54	6.64	5.77	6.06	2.47	2.31	4.97	5.74	2.09	2.24
Item	6		7		8**		9		10	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	2.28	2.03			5.98	6.33	2.08	2.22	5.31	5.34
Item	11***		12		13***		14		15	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.21	6.65	1.44	1.47	6.24	6.58	6.17	6.29	5.39	5.58
Item	16		17		18*		19		20	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.86	5.03	2.78	2.85	6.48	6.68	5.13	5.27	4.02	4.18
Item	21		22		23		24		25*	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.90	4.82	6.80	6.88	5.49	5.49	3.42	3.26	4.85	5.17
Item	26*		27		28A		28B		28C	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.04	6.26	4.99	5.15	3.19	3.22	1.20	1.13	3.16	3.06
Item	28D		29		30		31		32	
Period	Pre	Post	Pre	Pre	Post	Pre	Post	Post	Pre	Post
Mean	3.99	4.04								
Item	33		34		35		36		37	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.92	6.88	2.67	2.27	4.59	4.59	3.00	2.83	6.88	6.88
Item	38		39		40		41		42	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.65	5.87	5.88	6.19	4.40	3.91				
Item	43		44						Average	
Period	Pre	Post	Pre	Post					Pre	Post
Mean									4.59	4.64

N=332   * p< 0.05, ** p<0.01, ***p<0.001

Table 79: Paired Sample t tests The Parenting Cottage, Inc

Item	1		2*		3		4***		5	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.59	6.58	5.74	6.06	2.51	2.59	4.92	5.74	2.16	2.08

Item	6		7		8		9*		10	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	2.11	1.94			6.07	6.27	2.20	1.88	5.32	5.44

Item	11**		12		13		14		15***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.30	6.57	1.35	1.28	6.38	6.39	6.32	6.48	5.50	5.87

Item	16***		17		18		19***		20***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.96	5.52	3.34	3.13	6.47	6.61	5.30	5.82	3.95	3.40

Item	21***		22		23***		24***		25***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.82	5.21	6.78	6.84	5.66	6.02	3.73	3.19	4.97	5.41

Item	26***		27*		28A		28B*		28C**	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.06	6.35	5.28	5.63	3.36	3.47	1.41	1.21	3.10	2.69

Item	28D*		29		30		31		32	
Period	Pre	Post	Pre	Pre	Post	Pre	Post	Post	Pre	Post
Mean	4.55	4.87								

Item	33		34		35		36		37	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.74	6.74	2.74	2.86	4.38	4.35	3.82	3.63	6.54	6.63

Item	38		39		40		41		42	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.60	5.60	5.23	5.45	4.19	4.15				

Item	43		44						Average***	
Period	Pre	Post	Pre	Post					Pre	Post
Mean									4.61	4.92

N=360   * p< 0.05, ** p<0.01, ***p<0.001

Table 80: Paired Sample t tests United Way of San Antonio & Bexar County

Item	1		2		3		4***		5	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.40	6.17	5.49	5.68	2.86	2.83	5.04	5.62	2.06	2.04
Item	6		7		8		9		10***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	2.17	2.19			5.88	6.12	2.32	2.20	5.35	5.85
Item	11		12		13		14		15**	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.21	6.28	1.61	1.46	6.17	6.37	6.17	6.21	5.33	5.63
Item	16		17		18		19		20	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.15	5.25	3.21	3.08	6.43	6.44	5.29	5.38	3.86	3.72
Item	21***		22		23		24		25**	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.88	5.25	6.81	6.81	5.62	5.81	3.81	3.55	4.82	5.24
Item	26		27**		28A		28B		28C***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.99	5.95	5.20	5.59	4.26	4.50	1.34	1.33	2.30	1.94
Item	28D*		29		30		31		32	
Period	Pre	Post	Pre	Pre	Post	Pre	Post	Post	Pre	Post
Mean	5.05	5.36								
Item	33		34		35**		36*		37**	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.60	6.84	2.49	2.25	4.58	5.10	3.40	2.94	6.38	7.00
Item	38		39		40**		41		42	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.73	5.61	5.48	5.30	4.16	3.70	5.71	5.77	3.47	3.34
Item	43		44						Average	
Period	Pre	Post	Pre	Post					Pre	Post
Mean	6.04	6.26	2.77	2.64					4.64	468

N=494   * p< 0.05, ** p<0.01, ***p<0.001

Table 81: Paired Sample t tests Family Outreach of America

Item	1		2		3		4**		5	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.63	6.59	5.33	5.55	2.65	2.63	5.08	5.74	2.15	2.15
Item	6		7		8		9		10	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	2.44	1.87			5.70	5.70	2.10	2.36	5.62	5.15
Item	11		12		13		14*		15**	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.60	6.35	1.64	1.56	6.50	6.48	5.87	6.26	4.90	5.50
Item	16		17		18		19**		20	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.90	5.46	3.41	2.95	6.38	6.46	5.20	5.78	4.13	3.59
Item	21		22		23***		24		25	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.83	4.93	6.73	6.68	5.34	6.02	3.77	3.85	4.95	5.05
Item	26		27		28A		28B		28C	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.82	5.90	4.95	5.33	3.89	4.48	1.49	1.51	2.89	2.73
Item	28D		29		30		31		32	
Period	Pre	Post	Pre	Pre	Post	Pre	Post	Post	Pre	Post
Mean	5.24	5.08								
Item	33		34		35**		36		37	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.68	6.62	2.49	3.05	3.81	4.92	3.70	3.27	6.62	6.54
Item	38		39		40		41		42	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.73	5.70	5.08	5.62	4.16	4.08	5.68	5.86	3.98	3.61
Item	43		44						Average	
Period	Pre	Post	Pre	Post					Pre	Post
Mean	6.28	6.10	2.41	2.79					4.59	4.74

N=66   * p< 0.05, ** p<0.01, ***p<0.001

Table 82: Paired Sample t tests Unity Partners, DBA Project Unity

Item	1*		2***		3		4***		5	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.55	6.73	4.70	5.20	2.84	2.86	4.36	5.75	2.34	2.19

Item	6		7		8***		9**		10*	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	2.65	2.34			5.28	5.85	3.09	2.69	5.61	5.86

Item	11		12		13**		14**		15***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.54	6.59	1.57	1.41	6.40	6.60	6.24	6.43	4.94	5.54

Item	16***		17		18		19**		20***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.02	5.58	3.12	2.88	6.53	6.63	5.21	5.51	3.79	3.26

Item	21		22**		23***		24***		25	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.19	5.36	6.77	6.90	5.64	5.99	4.22	3.72	5.04	5.15

Item	26***		27***		28A		28B**		28C***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.82	6.09	5.14	5.55	4.19	4.28	1.46	1.25	2.80	2.48

Item	28D*		29		30		31		32	
Period	Pre	Post	Pre	Pre	Post	Pre	Post	Post	Pre	Post
Mean	4.03	4.30								

Item	33		34		35		36		37	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.62	6.66	2.79	2.67	4.62	4.89	3.99	3.67	6.55	6.83

Item	38		39		40		41		42	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.79	5.87	5.78	5.93	4.43	4.51	5.66	5.98	3.63	3.25

Item	43		44						Average***	
Period	Pre	Post	Pre	Post					Pre	Post
Mean	6.33	6.36	2.41	2.51					4.64	4.78

N=459   * p< 0.05, ** p<0.01, ***p<0.001

Table 83: Paired Sample t tests Children's Advocacy Center of Tom Green Co.

Item	1		2**		3		4***		5	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.07	6.43	4.72	5.39	4.60	4.67	4.41	5.64	4.93	5.25
Item	6		7		8		9**		10	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.44	5.87					5.16	5.87	5.62	5.72
Item	11		12		13		14		15	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.02	6.28	6.46	6.52	5.82	5.98	5.56	5.85	4.85	5.21
Item	16**		17		18		19		20	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.85	5.21	3.84	4.17	5.97	6.30				
Item	21		22		23		24		25	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean										
Item	26		27		28A		28B		28C	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean					4.74	4.74	1.58	1.63	1.58	1.63
Item	28D		29		30		31		32	
Period	Pre	Post	Pre	Pre	Post	Pre	Post	Post	Pre	Post
Mean	4.68	4.25								
Item	33		34		35		36		37	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean										
Item	38		39		40		41		42	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean										
Item	43		44						Average***	
Period	Pre	Post	Pre	Post					Pre	Post
Mean									4.91	5.23

N=203   * p< 0.05, ** p<0.01, ***p<0.001

Table 84 : Protective Factors Survey Paired Sample t tests All Participating Programs

Item	1***		2***		3		4***		5***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.49	6.36	5.23	5.63	2.97	3.00	4.70	5.42	2.51	2.36

Item	6***		7***		8***		9***		10***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	2.61	2.37			5.43	5.97	2.76	2.46	5.46	5.72

Item	11***		12***		13***		14***		15***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.22	6.39	1.91	1.73	6.11	6.32	5.91	6.15	5.11	5.54

Item	16***		17***		18***		19***		20***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.84	5.32	3.41	3.19	6.27	6.41	5.03	5.41	4.08	3.77

Item	21***		22***		23***		24***		25***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.90	5.34	6.61	6.75	5.40	5.76	4.06	3.65	4.85	5.18

Item	26***		27***		28A		28B		28C	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.65	5.96	4.95	5.41	4.08	4.32	1.63	1.44	2.77	2.47

Item	28D		29***		30		31		32	
Period	Pre	Post	Pre	Pre	Post	Pre	Post	Post	Pre	Post
Mean	4.54	4.88	5.01	5.56						

Item	33**		34**		35		36***		37***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.56	6.65	2.93	2.77	4.64	4.73	3.94	3.50	6.31	6.54

Item	38		39**		40***		41***		42**	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.55	5.63	5.47	5.64	4.43	4.15	5.46	5.84	3.53	3.34

Item	43**		44***						Average***	
Period	Pre	Post	Pre	Post					Pre	Post
Mean	6.01	6.12	3.11	2.83					4.58	4.74

* p< 0.05, **p<0.01, ***p<.001

Protective Factor Survey Items with Significant Increase from Pre to Post-Test by Agency

Table 85: Protective Factor Survey Items with Significant Increase AVANCE, Inc. (McAllen)

Item (#)	Pre-Test Score	Post-Test Score	Significance Level
Setting limits keeps kids safe (1)	6.26	6.48	p<.01
When I am worried about my child/ren I have someone to talk to (8)	5.62	5.99	p<.05
I can usually tell when my child/ren are upset (11)	6.05	6.43	p<.05
My family is able to solve our problems (15)	5.71	6.26	p<.001
When we have disagreements, family members listen to both sides of the story (16)	5.07	5.66	p<.001
My family members discuss problems with each other (19)	4.95	5.53	p<.001
I make rules and stick to them (21)	4.98	5.82	p<.001
I feel proud of my children (22)	6.61	6.81	p<.01
In my family, we take time to listen to each other (23)	5.52	5.97	p<.05
I ground (28D)	4.86	5.46	p<.001

Table 86: A Protective Factor Survey Items with Significant Increase VANCE, Inc. (Cameron)

Item (#)	Pre-Test Score	Post-Test Score	Significance Level
I know where to go in my community to get help with family needs (4)	4.70	5.42	p<.01
When I am worried about my child/ren, I have someone to talk to (8)	5.57	6.02	p<.01
When we have disagreements, family members listen to both sides of the story (16)	5.05	5.75	p<.001
I try to take a break when I am frustrated by my child/ren's behavior (25)	4.20	4.93	p<.001
I look for information to make sure what I expect from my child is fair (27)	4.84	5.28	p<.01

Table 87: Protective Factor Survey Items with Significant Increase AVANCE, Inc. (Hidalgo)

Item (#)	Pre-Test Score	Post-Test Score	Significance Level
I can usually tell when my child/ren are upset (11)	6.04	6.58	p<.01
I try to comfort my child/ren when something is bothering them (18)	5.77	6.35	p<.01
I make rules and stick to them (21)	4.94	5.50	p<.05
I try to take a break when I am frustrated by my child/ren's behavior (25)	4.17	4.90	p<.01
I look for information to make sure what I expect from my child is fair (27)	4.92	5.57	p<.05
I ground (28D)	4.92	5.38	p<.05
I teach my child/ren to take responsibility for their actions (43)	5.95	6.55	p<.05

Table 88: Protective Factor Survey Items with Significant Increase AVANCE, Inc. (Dallas)

Item (#)	Pre-Test Score	Post-Test Score	Significance Level
I know where to go in my community to get help with family needs (4)	4.29	5.59	p<.001
When I am worried about my child/ren, I have someone to talk to (8)	4.71	5.73	p<.001
I praise my children when they behave well (13)	4.90	5.39	p<.01
My family shows each other love and affection (14)	5.00	5.44	p<.05
When we have disagreements, family members listen to both sides of the story (16)	4.15	5.52	p<.001
My family members discuss problems with each other (19)	4.21	5.13	p<.01
I look for information to make sure what I expect from my child is fair (27)	4.73	5.52	p<.01
I ground (28D)	5.33	6.18	p<.001
When my baby won't stop screaming or crying, I can control my emotions (39)	4.98	5.67	p<.05
I know how to teach my child/ren to resist pressure from friends to break the rules (41)	5.53	6.59	p<.01
I teach my child/ren to take responsibility for their actions (43)	6.16	6.75	p<.01

Table 89: Protective Factor Survey Items with Significant Increase Big Brothers Big Sisters of South Texas

Item (#)	Pre-Test Score	Post-Test Score	Significance Level
My family members feel closer to people outside the family than to our own family members (3)[15]	2.88	3.80	p<.05
I feel proud of my children (22)	6.60	6.92	p<.05

Table 90: Protective Factor Survey Items with Significant Increase DePelchin Children's Center: Family Connections

Item (#)	Pre-Test Score	Post-Test Score	Significance Level
I have neighbors, friends, or relatives that help me when I need it (2)	4.21	5.64	p<.05
I know where to go in my community to get help with family members (4)	3.93	6.11	p<.001
When I am worried about my child/ren, I have someone to talk to (8)	4.96	6.52	p<.01
I praise my children when they behave well (13)	5.64	6.39	p<.05
When we have disagreements, family members listen to both sides of the story (16)	3.96	5.43	p<.01
I make rules and stick to them (21)	4.46	6.14	p<.001
In my family, we support one another when something goes wrong (26)	5.60	6.36	p<.05
I look for information to make sure what I expect from my child is fair (27)	4.04	5.71	p<.001
I use timeout (28A)	4.07	5.55	p<.05
I know how to teach my child/ren to resist pressure from friends to break the rules (41)	4.91	6.17	p<.05
I teach my child/ren to take responsibility for their actions (43)	6.00	6.50	p<.05

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[15] Reversed item with higher score indicating the respondent feels closer to family members than to outsiders

Table 91: Protective Factor Survey Items with Significant Increase Family Care

Connections

Item (#)	Pre-Test Score	Post-Test Score	Significance Level
Setting limits keeps kids safe (1)	5.92	6.43	p<.05
I have neighbors, friends, or relatives that help me when I need it (2)	4.96	5.93	p<.01
I know where to go in my community to get help with family needs (4)	4.58	5.56	p<.01
When I am worried about my child/ren, I have someone to talk to (8)	5.21	5.89	p<.01
Children learn more from watching what you do than from hearing what you say (10)	4.42	5.66	p<.001
I can usually tell when my children are upset (11)	5.77	6.49	p<.001
My family shows each other love and affection (14)	5.21	5.78	p<.05
My family members discuss problems with each other (19)	4.58	5.38	p<.01
I make rules and stick to them (21)	4.88	6.16	p<.001
I feel proud of my children (22)	6.11	6.72	p<.05
In my family, we support one another when something goes wrong (23)	4.51	5.56	p<.001
I try to take a break when I am frustrated by my child/ren's behavior (25)	4.40	5.33	p<.01
It is important to talk to babies even if they don't understand your words (33)	5.89	7.00	p<.01

Table 92: Protective Factor Survey Items with Significant Increase New Horizon Ranch and Center

Item (#)	Pre-Test Score	Post-Test Score	Significance Level
I have neighbors, friends, or relatives that help me when I need it (2)	4.87	5.30	p<.01
I know where to go in my community to get help with family needs (4)	4.38	5.72	p<.001
When I am worried about my child/ren, I have someone to talk to (8)	4.85	5.64	p<.001
I praise my children when they behave well (13)	5.88	6.22	p<.001
My family shows each other love and affection (14)	5.68	6.10	p<.001
My family is able to solve our problems (15)	4.51	5.25	p<.001
When we have disagreements, family members listen to both sides of the story (16)	4.53	5.28	p<.001
I try to comfort my child/ren when something is bothering them (18)	6.20	6.37	p<.05
My family members discuss problems with each other (19)	4.68	5.41	p<.001
I make rules and stick to them (21)	4.36	5.15	p<.001
I feel proud of my children (22)	6.48	6.68	p<.05
In my family, we support one another when something goes wrong (23)	5.11	5.66	p<.001
In my family, we support one another when something goes wrong (26)	5.33	5.83	p<.001
I look for information to make sure what I expect from my child is fair (27)	4.85	5.68	p<.001
I ground (28D)	4.38	4.83	p<.001
I know how to teach my child/ren to resist pressure from friends to break the rules (41)	5.16	6.11	p<.001
I teach my child/ren to take responsibility for their actions (43)	5.60	6.14	p<.001

Table 93: Protective Factor Survey Items with Significant Increase The Children's Shelter of San Antonio

Item (#)	Pre-Test Score	Post-Test Score	Significance Level
I have neighbors, friends, or relatives that help me when I need it (2)	5.72	6.19	p<.05
My family members feel closer to people outside the family than to our own family members (3)[16]	2.67	3.20	p<.05
I know where to go in my community to get help with family needs (4)	4.63	5.33	p<.01
Children learn more from watching what you do than from hearing what you say (10)	5.00	5.78	p<.01
I praise my children when they behave well (13)	5.54	6.37	p<.001
I try to comfort my child/ren when something is bothering them (18)	5.99	6.54	p<.01
I make rules and stick to them (21)	4.58	5.14	p<.01
In my family, we take time to listen to each other (23)	4.72	5.10	p<.05
I use timeout (28A)	2.36	3.29	p<.001
I hit (28B)[17]	1.09	1.41	p<.05
I spank (28C)[18]	1.35	1.97	p<.001
I ground (28D)	3.44	4.50	p<.01

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[16] Reversed item with higher score indicating the respondent feels closer to family members than to outsiders
[17] Reversed item with higher score indicating the respondent rarely, never or very rarely hits
[18] Reversed item with higher score indicating the respondent rarely, never or very rarely spanks

Table 94: Protective Factor Survey Items with Significant Increase The Parenting Center

Item (#)	Pre-Test Score	Post-Test Score	Significance Level
Setting limits keeps kids safe (1)	6.46	6.83	p<.05
I have neighbors, friends, or relatives that help me when I need it (2)	4.65	5.42	p<.05
I know where to go in my community to get help with family needs (4)	3.69	5.31	p<.001
I can usually tell when my children are upset (11)	5.90	6.54	p<.01
My family is able to solve our problems (15)	4.50	5.27	p<.01
I make rules and stick to them (21)	4.43	5.39	p<.001
In my family, we take time to listen to each other (23)	4.96	5.49	p<.05
I know how to teach my child/ren to resist pressure from friends to break the rules (41)	4.47	5.53	p<.05

Table 95: Protective Factor Survey Items with Significant Increase YWCA of Metropolitan Dallas

Item (#)	Pre-Test Score	Post-Test Score	Significance Level
When I am worried about my child/ren, I have someone to talk to (8)	5.50	7.00	p<.01
I can usually tell when my child/ren are upset (11)	5.63	6.69	p<.05
When we have disagreements, family members listen to both sides of the story (16)	4.95	6.00	p<.05
Most children are not ready for toilet training by age one (35)	3.67	5.27	p<.01

Table 96: Protective Factor Survey Items with Significant Increase Family Service Association of San Antonio

Item (#)	Pre-Test Score	Post-Test Score	Significance Level
I know where to go in my community to get help with family needs (4)	4.70	5.91	p<.001
When I am worried about my child/ren, I have someone to talk to (8)	5.26	6.02	p<.01
I praise my children when they behave well (13)	6.09	6.22	p<.01

Table 97: Protective Factor Survey Items with Significant Increase Family Outreach of America

Item (#)	Pre-Test Score	Post-Test Score	Significance Level
I know where to go in my community to get help with family needs (4)	4.72	5.47	p<.001
I try to take a break when I am frustrated by my child/ren's behavior (25)	4.98	5.66	p<.001
You should never shake a baby (37)	6.43	6.80	p<.05

Table 98: Protective Factor Survey Items with Significant Increase Catholic Charities Diocese of Fort Worth

Item (#)	Pre-Test Score	Post-Test Score	Significance Level
I have neighbors, friends, or relatives that help me when I need it (2)	4.69	5.28	p<.001
My family members feel closer to people outside the family than to our own family members (3)[19]	4.28	5.49	p<.001
When I am worried about my child/ren, I have someone to talk to (8)	4.91	5.78	p<.001
Children learn more from watching what you do than from hearing what you say (10)	5.68	5.97	p<.01
I praise my children when they behave well (13)	6.04	6.21	p<.05
My family shows each other love and affection (14)	5.45	5.85	p<.001
My family is able to solve our problems (15)	4.55	5.30	p<.001
When we have disagreements, family members listen to both sides of the story (16)	4.54	5.24	p<.001
My family members discuss problems with each other (19)	4.84	5.21	p<.001
I make rules and stick to them (21)	4.84	5.21	p<.001
I feel proud of my children (22)	6.23	6.44	p<.01
In my family, we take time to listen to each other (23)	4.97	5.55	p<.001
I try to take a break when I am frustrated with my children's behavior (25)	4.87	5.13	p<.05
In my family, we support one another when something goes wrong (26)	5.05	5.65	p<.001
I look for information to make sure what I expect from my child is fair (27)	4.78	5.63	p<.001
I ground (28D)	4.35	4.85	p<.001
I know how to teach my child/ren to resist pressure from friends to break the rules (41)	5.10	5.44	p<.05

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[19] Reversed item with higher score indicating the respondent feels closer to family members than to outsiders

Table 99: Protective Factor Survey Items with Significant Increase DePelchin Children's Center (Families Count)

Item (#)	Pre-Test Score	Post-Test Score	Significance Level
I have neighbors, friends, or relatives that help me when I need it (2)	4.64	5.31	p<.001
When I am worried about my child/ren, I have someone to talk to (8)	4.54	5.75	p<.001
Children learn more from watching what you do than from hearing what you say (10)	5.27	5.60	p<.05
My family shows each other love and affection (14)	5.43	5.91	p<.001
My family is able to solve our problems (15)	4.98	5.25	p<.05
When we have disagreements, family members listen to both sides of the story (16)	4.70	5.23	p<.001
My family members discuss problems with each other (19)	4.43	5.27	p<.001
I make rules and stick to them (21)	4.84	5.47	p<.001
In my family, we take time to listen to each other (23)	5.20	5.65	p<.001
In my family, we support one another when something goes wrong (26)	5.34	5.70	p<.05
I know how to teach my child/ren to resist pressure from friends to break the rules (41)	5.29	6.06	p<.01

Table 100: Protective Factor Survey Items with Significant Increase Family Service Center, Inc

Item (#)	Pre-Test Score	Post-Test Score	Significance Level
I have neighbors, friends, or relatives that help me when I need it (2)	5.75	5.92	p<.05
I know where to go in my community to get help with family needs (4)	5.23	5.87	p<.001
When I am worried about my child/ren, I have someone to talk to (8)	5.72	6.03	p<.01
Children learn more from watching what you do than from hearing what you say (10)	5.58	5.79	p<.05
I praise my children when they behave well (13)	6.26	6.42	p<.01
My family shows each other love and affection (14)	5.97	6.19	p<.001
My family is able to solve our problems (15)	5.14	5.47	p<.001
When we have disagreements, family members listen to both sides of the story (16)	4.94	5.23	p<.001
My family members discuss problems with each other (19)	5.17	5.46	p<.001
I make rules and stick to them (21)	5.05	5.35	p<.001
I feel proud of my children (22)	6.75	6.83	p<.05
In my family, we take time to listen to each other (23)	5.46	5.78	p<.001
I try to take a break when I am frustrated by my child/ren's behavior (25)	5.00	5.30	p<.01
In my family, we support one another when something goes wrong (26)	5.83	6.05	p<.01
I look for information to make sure what I expect from my child is fair (27)	4.89	5.31	p<.001
I use timeout (28A)	4.34	4.65	p<.01
I ground (28D)	4.49	4.88	p<.001
Temper tantrums are common in children between one and four years of age (38)	5.19	5.40	p<.05

Table 101: Protective Factor Survey Items with Significant Increase Healthy Families San Angelo

Item (#)	Pre-Test Score	Post-Test Score	Significance Level
I have neighbors, friends, or relatives that help me when I need it (2)	5.77	6.06	p<.05
I know where to go in my community to get help with family needs (4)	4.97	5.74	p<.001
When I am worried about my child/ren, I have someone to talk to (8)	5.98	6.33	p<.01
I can usually tell when my child/ren are upset (11)	6.21	6.65	p<.001
I praise my children when they behave well (13)	6.24	6.58	p<.001
I try to comfort my child/ren when something is bothering them (18)	6.48	6.68	p<.05
I try to take a break when I am frustrated by my child/ren's behavior (25)	4.85	5.17	p<.05
In my family, we support one another when something goes wrong (26)	6.04	6.26	p<.05

Table 102: Protective Factor Survey Items with Significant Increase The Parenting Cottage, Inc

Item (#)	Pre-Test Score	Post-Test Score	Significance Level
I have neighbors, friends, or relatives that help me when I need it (2)	5.74	6.06	p<.05
I know where to go in my community to get help with family needs (4)	4.92	5.74	p<.001
I can usually tell when my child/ren are upset (11)	6.30	6.57	p<.01
My family is able to solve our problems (15)	5.50	5.87	p<.001
When we have disagreements, family members listen to both sides (16)	4.96	5.52	p<.001
My family members discuss problems with each other (19)	5.30	5.82	p<.001
I make rules and stick to them (21)	4.82	5.21	p<.001
In my family, we take time to listen to each other (23)	5.66	6.02	p<.001
I try to take a break when I am frustrated by my child/ren's behavior (25)	4.97	5.41	p<.001
In my family, we support one another when something goes wrong (26)	6.06	6.35	p<.001
I look for information to make sure what I expect from my child is fair (27)	5.28	5.63	p<.05
I ground (28D)	4.55	4.87	p<.05

Table 103: United Way of San Antonio and Bexar County:

Item (#)	Pre-Test Score	Post-Test Score	Significance Level
I know where to go in my community to get help with family needs (4)	5.04	5.62	p<.001
Children learn more from watching what you do than from hearing what you say (10)	5.35	5.85	p<.001
My family is able to solve our problems (15)	5.33	5.63	p<.01
I make rules and stick to them (21)	4.88	5.25	p<.001
I try to take a break when I am frustrated by my child/ren's behavior (25)	4.82	5.24	p<.01
I look for information to make sure what I expect from my child is fair (27)	5.20	5.59	p<.01
I ground (28D)	5.05	5.36	p<.05
Most children are not ready for toilet training by age one (35)	4.58	5.10	p<.01
You should never shake a baby (37)	6.38	7.00	p<.01

Table 104: Protective Factor Survey Items with Significant Increase Family Outreach of America

Item (#)	Pre-Test Score	Post-Test Score	Significance Level
I know where to go in my community to get help with family needs (4)	5.08	5.74	p<.01
My family shows each other love and affection (14)	5.87	6.26	p<.05
My family is able to solve our problems (15)	4.90	5.50	p<.01
My family members discuss problems with each other (19)	5.20	5.78	p<.01
In my family, we take time to listen to each other (23)	5.34	6.02	p<.001
Most children are not ready for toilet training by age one (35)	3.81	4.92	p<.01

Table 105: Protective Factor Survey Items with Significant Increase Unity Partners, DBA Project Unity:

Item (#)	Pre-Test Score	Post-Test Score	Significance Level
Setting limits keeps kids safe (1)	6.55	6.73	p<.05
I have neighbors, friends, or relatives that help me when I need it (2)	4.70	5.20	p<.001
I know where to go in my community to get help with family needs (4)	4.36	5.75	p<.001
When I am worried about my child/ren, I have someone to talk to (8)	5.28	5.85	p<.001
Children learn more from watching what you do than from hearing what you say(10)	5.61	5.86	p<.05
I praise my children when they behave well (13)	6.40	6.60	p<.01
My family shows each other love and affection (14)	6.24	6.43	p<.01
My family is able to solve our problems (15)	4.94	5.54	p<.001
When we have disagreements, family members listen to both sides of the story (16)	5.02	5.58	p<.001
My family members discuss problems with each other (19)	5.21	5.51	p<.01
I feel proud of my children (22)	6.77	6.90	p<.01
In my family, we take time to listen to each other (23)	5.64	5.99	p<.001
In my family, we support one another when something goes wrong (26)	5.82	6.09	p<.001
I look for information to make sure what I expect from my child is fair (27)	5.14	5.55	p<.001
I ground (28D)	4.03	4.30	p<.05

Table 106: Protective Factor Survey Items with Significant Increase Children's Advocacy Center of Tom Green County:

Item (#)	Pre-Test Score	Post-Test Score	Significance Level
I have neighbors, friends, or relatives that help me when I need it (2)	4.72	5.39	p<.01
I know where to go in my community to get help with family needs (4)	4.41	5.64	p<.001
I don't think my family can survive if another problem hits us (9)[20]	5.16	5.87	p<.01
When we have disagreements, family members listen to both sides of the story (16)	4.85	5.21	p<.01

[20] Reversed item with higher scores indicating greater disagreement with this statement

Paired Sample t test of the Prevention and Early Intervention Protective Factors Survey for Caregivers *by Agency*

Table 107: Paired Sample t test Family Service Association of San Antonio

Item	1		2		3		4		5	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.33	5.556	5.00	5.11	4.89	5.33	4.33	5.56	5.00	5.33

Item	6		7		8		9		10	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.56	5.67	5.44	5.89	3.00	2.78	2.56	2.78	6.33	6.22

Item	11		12		13		14		15	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	3.89	3.44	3.22	3.00	5.89	5.67	2.89	3.00	6.11	5.78

Item	16		17		18		19		20	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	2.67	2.22	6.11	6.78	6.67	6.67	5.78	5.89	6.00	5.67

Item	21		22		23		24		25	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean										

Item	26		27		28		29		Average	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean									4.78	4.92

N=9
* p< 0.05, **p<0.01, ***p<0.001

Table 108: Paired Sample t test Greater Port Arthur Chamber of Commerce

Item	1**		2		3		4*		5	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.77	6.00	5.15	5.62	5.23	5.92	4.85	6.00	5.23	5.77
Item	6		7		8		9		10	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.08	6.69	6.31	6.62	2.62	3.00	2.46	2.54	5.31	5.85
Item	11		12		13		14		15	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	3.77	3.54	3.69	3.92	6.46	6.46	2.77	2.69	6.23	6.62
Item	16		17		18		19		20	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	1.92	2.62	6.92	7.00	6.92	7.00	6.62	6.92	6.15	6.38
Item	21		22		23		24*		25**	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.67	6.17	6.08	6.00	6.00	6.25	5.42	6.58	5.75	6.42
Item	26		27		28		29		Average**	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.50	6.75			5.33	5.83	6.75	6.75	5.22	5.61

N=13
* p< 0.05, **p<0.01, ***p<0.001

Table 109: Paired Sample t test Family Connections

Item	1***		2***		3***		4***		5*	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.90	5.56	4.96	5.39	5.10	5.68	5.41	5.99	5.33	5.70
Item	6***		7***		8		9		10***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.90	5.56	4.70	5.39	3.56	3.63	3.67	3.58	4.94	5.60
Item	11		12		13*		14		15	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	3.92	4.27	4.67	4.65	5.04	5.48	3.50	3.17	5.84	5.98
Item	16		17		18		19		20	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	3.22	3.19	6.38	6.45	6.43	6.37	5.85	5.95	5.53	5.54
Item	21*		22***		23		24**		25	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.35	5.84	4.79	5.68	5.82	6.16	4.22	5.01	5.36	5.77
Item	26		27		28		29		Average***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.87	6.21			5.07	5.34	5.48	5.90	4.99	5.20

N=206
* p< 0.05, **p<0.01, ***p<0.001

Table 110: Paired Sample t test Children's Advocacy Center of Tom Green County

Item	1*		2		3		4*		5	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.42	5.89	4.90	5.45	5.30	5.45	5.25	5.60		
Item	6*		7		8		9		10	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.40	6.20			2.15	2.45	1.90	1.95	6.17	6.00
Item	11		12		13		14		15	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	3.17	2.94	3.72	2.94	5.47	5.88	4.11	3.67	6.18	5.82
Item	16		17		18		19		20	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	2.28	2.61	6.72	6.33	6.00	6.06	5.56	5.94	5.83	5.28
Item	21*		22		23		24		25*	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.00	5.70	5.80	5.60	6.10	5.70	5.60	6.30	6.40	6.40
Item	26		27		28*		29		Average	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	6.00	6.22			5.88	5.75	5.50	5.00	5.01	5.09

N=51
* p< 0.05, **p<0.01, ***p<0.001

Table 111: Protective Factors Survey for Caregivers *Paired Sample t test All Participating Programs*

Item	1***		2***		3***		4***		5***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	4.92	5.64	4.78	5.40	5.12	5.65	5.27	5.91	5.29	5.68
Item	6***		7***		8**		9***		10***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.24	5.75	4.92	5.55	3.25	3.36	3.25	3.21	5.23	5.72
Item	11**		12***		13***		14***		15***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	3.80	3.97	4.36	4.24	5.29	5.64	3.47	3.18	5.94	5.95
Item	16***		17***		18***		19***		20***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	2.91	2.98	6.46	6.51	6.44	6.41	5.88	6.04	5.66	5.60
Item	21**		22***		23***		24***		25***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.45	5.87	5.05	5.71	5.87	6.12	4.51	5.34	5.51	5.91
Item	26***		27		28**		29*		Average***	
Period	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mean	5.96	6.28			5.19	5.46	5.68	5.94	5.00	5.20

* P< 0.05
** P<0.01
***P<0.001

Prevention and Early Intervention Protective Factors Survey for Caregivers Items with Significant Increase from Pre to Post-Test by Agency[21]

Table 112: Protective Factors Survey for Caregivers Items with Significant Increase Greater Port Arthur Chamber of Commerce.

Item (#)	Pre-Test Score	Post-Test Score	Significance Level
In my family, we talk about problems (1)	4.77	6.00	p<.01
My family pulls together when things are stressful (4)	4.85	6.00	p<.05
In time of need, I know where to get help for my family with things like food or clothing (24)	5.42	6.58	p<.05
My family can talk about almost anything (25)	5.75	6.42	p<.01

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[21] Family Service Association did not have any items on this survey that had a statistically significant change from pre to post

Table 113: Protective Factors Survey for Caregivers Items with Significant Increase

Family Connections

Item (#)	Pre-Test Score	Post-Test Score	Significance Level
In my family, we talk about problems (1)	4.90	5.56	p<.001
When we argue, my family listens to "both sides of the story" (2)	4.96	5.39	p<.001
In my family, we take time to listen to each other (3)	5.10	5.68	p<.001
My family pulls together when things are stressful (4)	5.41	5.99	p<.001
My family is able to solve our problems (5)	5.33	5.70	p<.05
I have others who will listen when I need to talk about my problems (6)	4.90	5.56	p<.001
When I am lonely, there are several people I can talk to (7)	4.70	5.39	p<.001
If there is a crisis, I have other I can talk to (10)	4.94	5.60	p<.001
I know how to help my child learn (13)	5.04	5.48	p<.05
When I am worried about my children, I have someone to talk to (21)	5.35	5.84	p<.05
I have family, friends, or neighbors I could talk to if I am feeling down (22)	4.79	5.68	p<.001
In times of need, I know where to get help for my family with things like food or clothing (24)	4.22	5.01	p<.01

Table 114: Protective Factors Survey for Caregivers Items with Significant Increase

Children's Advocacy Center of Tom Green County

Item (#)	Pre-Test Score	Post-Test Score	Significance Level
In my family, we talk about problems (1)	5.42	5.89	p<.05
When we argue, my family listens to "both sides of the story" (2)	5.25	5.60	p<.05

Appendix D

Evaluation Element 4

Identify methods for transitioning state-funded child maltreatment prevention programs and services to an increased reliance on evidence-based practices.

The purpose of evaluation element 4 is to identify methods for transitioning state-funded child maltreatment prevention and early intervention programs and services to an increased reliance on evidence-based practices. Our approach to this analysis involved a step-by-step process involving (1) a review of the existing literature, (2) key informant interviews with experts in the field (3) ranking proposals submitted by agencies, (4) interviews with program directors and staff, and (5) content analysis of case records. Contained in this appendix is the full literature review that was submitted earlier to DFPS as a separate document; the detailed interviews with CEBC, SAMHSA NREPP, OJJDP, and FRIENDS; the full rating scales developed by these experts in the field; the program proposal rating scale used by OCP evaluators, and the interview guide employed with PEI grantees.

Review of the Literature

The purpose of this literature review is to inform the analysis and evaluation of the current use of evidence based practice (EBP) by state-funded child maltreatment prevention programs in Texas. In order to appreciate the consequences of the use, misuse, or absence of EBP in these programs it is important to understand what EBP is, the barriers to its effective implementation that have been suggested in the literature, and the way in which it can be used within the complex practice of child abuse prevention. This information will help to not only provide a stronger understanding of EBP to legislators, state level officials, and program staff, but will assist the Department of Family and Protective Services (DFPS) and the Interagency Coordinating Council (ICC) in establishing future policies in this area.

Evidence Based Practice emanates primarily from the medical field where attention was drawn to the gap that existed between practice and research resulting in wide variation in treatment not based on demographics, the continued use of ineffective

interventions, and the existence of unreliable outcomes (Chaffin & Friedrich, 2004; Gambrill, 2003; Steinberg & Luce, 2005; Walshe and Rundall, 2001). These observations led professional practitioners as well as academic researchers to question whether or not the practices that were being implemented in the field were based primarily on intuition and experience, termed authority-based practice (Gambrill, 2003), or professional judgments steeped in research based interventions which is the heart of EBP.

Evidence Based Practice can generally be defined as the use of the best empirically derived information in making practice decisions (Chaffin and Friedrich, 2004; Webb, 2001; Dawes et al., 1999; Sackett et al., 2000). The level of research evidence that is required to meet the EBP standard varies in the literature but is derived from traditional research methodologies including random control trials, case experimentation, and double-blind studies (Webb, 2001; Chaffin and Friedrich, 2004). Other evidential criteria include publication of the research in peer-reviewed journals and consistent reliability testing (Rosenthal, 2004). Less rigorous methods such as case studies can also be used, but do not hold the same weight as evidence garnered from the previously mentioned research methods (Witkin and Harrison, 2001).

The California Evidence-Based Clearinghouse for Child Welfare (CEBC) developed a scientific rating scale of six scores ranging from Well-Supported by Research Evidence to Concerning Practice. The following is taken directly from the CEBC web site (www.cachildwelfareclearinghouse.org/):

- Well-Supported by Research Evidence

  o There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
  o The practice has a book, manual, and/or other available writings that specify components of the service and describes how to administer it.
  o Multiple Site Replication: At least two rigorous randomized controlled trials (RCTs) in different usual care or practice settings have found the practice to be superior to an appropriate comparison practice. The RCTs have been reported in published, peer-reviewed literature.
  o In at least one RCT, the practice has shown to have a sustained effect at least one year beyond the end of treatment.
  o Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects.

- o If multiple outcome studies have been conducted, the overall weight of the evidence supports the benefit of the practice.

- Supported by Research Evidence

  - o There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
  - o The practice has a book, manual, and/or other available writings that specifies the components of the practice protocol and describes how to administer it.
  - o At least one rigorous randomized controlled trial (RCT) in usual care or a practice setting has found the practice to be superior to an appropriate comparison practice. The RCT has been reported in published, peer-reviewed literature.
  - o In at least one RCT, the practice has shown to have a sustained effect of at least six months beyond the end of treatment.
  - o Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects.
  - o If multiple outcome studies have been conducted, the overall weight of evidence supports the benefit of the practice.

- Promising Research Evidence

  - o There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
  - o The practice has a book, manual, and/or other available writings that specify the components of the practice protocol and describe how to administer it.
  - o At least one study utilizing some form of control (e.g., untreated group, placebo group, matched wait list) has established the practice's benefit over the placebo, or found it to be comparable to or better than an appropriate comparison practice. The study has been reported in published, peer-reviewed literature.
  - o If multiple outcome studies have been conducted, the overall weight of evidence supports the benefit of the practice.

- Evidence Fails to Demonstrate Effect

  - o Two or more randomized controlled trials (RCTs) have found the practice has not resulted in improved outcomes, when compared to usual care. The studies have been reported in published, peer-reviewed literature.
  - o If multiple outcome studies have been conducted, the overall weight of evidence does not support the benefit of the practice.

- Concerning Practice

  - If multiple outcome studies have been conducted, the overall weight of evidence suggests the intervention has a negative effect upon clients served;
    and/or
  - There is a reasonable theoretical, clinical, empirical, or legal basis suggesting that the practice constitutes a risk of harm to those receiving it, compared to its likely benefits.

CEBC also ranks the practice from 1 (high) to 3 (low) according to its relevance to child welfare. Practice scores are based on whether it is designed for children and/or families with strong or little/no similarity to child welfare populations.

The FRIENDS National Resource Center for Community Based Child Abuse Prevention adopted and slightly altered the CEBC model. They outline four levels of evidence based programs and practice:

- Emerging
- Promising
- Supported
- Well-supported

These four categories are based on the level of empirical research and evidence of efficacy associated with each program and/or practice. In determining what level of EBP is acceptable in a given setting it is necessary to consider the severity of the consequences to the target population if the intervention in question is not effective (Steinberg & Luce, 2005).

Differences between each level are based on programmatic and research and evaluation characteristics. Central to the former is the programs ability to articulate a theory of change that distinctly points to expected outcomes and the steps that must be taken to reach those outcomes. This can be delineated through a logic model or conceptual framework. This criterion moves a program or practice above Level two when it outlines not only the activities that are tied to the theory of change, but the specific inputs and outputs that will lead to short, mid-range, and long-term outcomes (CEBC, 2008). The final programmatic characteristic is that the program or practice is considered in general clinical practice as appropriate for use with the intended population.

Although there are slight differences between programmatic characteristics, the categorical differences for the research and evaluation characteristics are much more distinct. The base criterion for each level is that empirical evidence does not support a harmful outcome from the practice for the target population. Research design however becomes more of a critical area with Level One consisting of programs and practices that only use pre and post test designs without the benefit of a comparison group. The scale then moves up towards the existence of at least one study conducted by an independent group and the use of a control or comparison group in a quasi-experimental design that points to positive outcomes.

Categorization of a program or practice in Level 3 versus Level 4 depends for the former on the use of randomized control trials in controlled settings and/or matched comparison or regression discontinuity. The latter refers to the assignment of subjects based on a particular value (i.e. test score) as opposed to random assignment which is not always possible in social science settings.   Classification as Level 3 or Supported also requires that research on the program or practice has been published in peer reviewed literature indicating that the validity and reliability of the study has been evaluated. Level 4 on the other hand requires testing across multiple sites with evidence of positive long-term effects with no decay (CEBC, 2008). This ties in to the assertion that the level of evidence based practice relates not only to "identify[ing] all relevant studies and evaluat[ing] the quality of each individual study, but also assess[ing] the consistency of study results and the heterogeneity of key elements of study design to determine the comparability of studies" (Steinberg & Luce, 2005, 83).

Two other classification systems highlighted by the FRIENDS Network are the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP) and the Model Programs Guide (MPG) of the Office of Juvenile Justice and Delinquency Prevention (OJJDP). The NREPP uses six criteria to rate research on quality of research (0-4) and readiness for dissemination (0-4). The six criteria for quality of research are:

- Reliability
- Validity
- Intervention fidelity
- Missing data and attrition

- Potential confounding variables
- Appropriateness of analysis

Criteria for dissemination readiness are: completeness of implementation materials, availability of training and support, and provision of quality assurance protocols.

The lowest score for reliability results from evidence that various attempts to measure an intervention did not achieve the same results (Weiss, 1998) or there is a lack of evidence of the same. The score increases based on evidence to the contrary as well as if the research was conducted by independent evaluators. A high score is achieved for validity when outcome measures are evaluating what they are intended to measure. This is highly dependent on understanding the phenomenon under consideration and operationalizing it appropriately (Weiss, 1998). Whether the research is conducted by an internal or external evaluator, a strong theory of change can support this effort.

The third criteria used by NREPP in rating the strength of evidence supporting the outcomes of interventions (NREPP) is intervention fidelity that refers to the adherence of the study to the structure of the intervention being tested. In other words, the research must accurately model the social and/or psychological processes that are proposed. This again suggests the need for close ties between research and practice. The last three criteria of missing data and attrition, confounding variables, and appropriateness of analysis involve the implementation of research by a trained statistician. A low score on missing data and attrition involves not controlling for the absence of information or the exit of subjects from a study while poor results from confounding variables indicates that the researcher did not consider other factors that are contributing to the strength of weakness of causal inference. Finally, quality of research in NREPP ratings is judged according to the appropriateness of the analysis which refers to the overall model that was used for the study as well as sample size.

OJJDP's ratings system also considers these factors, but groups them into three overall categories: Exemplary, Effective, and Promising. The ratings are the result of summaries based on the:

- Conceptual framework of the program
- Program fidelity

- Evaluation design
- Empirical evidence of positive outcomes (OJJDP MPG)

In this classification system, programs are rated based on fidelity, evaluation design (i.e. experimental), and the theory of change.   Close attention is also paid to the population characteristics and environmental setting for which the practice is recommended (i.e. ethnicity, gender, target setting, problem behaviors etc.)

Finally, there are the Promising Practices Network (PPN) evidence levels of Proven, Promising, or Screened. For a program to be categorized as "Proven" it must meet all of the following criteria:

- Directly impacts one of the twelve Promising Practices Network indicators including, but not limited to, children living above the poverty level, regular involvement of father, no physical, psychological or emotional abuse
- Improves at least one of the twelve outcomes by 20% or more
- Results in a statistically significant effect at the 95% confidence level
- Research on the program uses a comparison group, randomized control trial or quasi experimental design
- Sample size of the research is equal to or greater than thirty
- Results are publicly available

Those programs that are found to be "Promising" must meet this second set of criteria:

- Indirectly impacts one of the twelve Promising Practices Network indicators
- Improves at least one of the twelve outcomes by more than 1%
- Results in a statistically significant effect at the 90% confidence level
- Research on the program may use a comparison group; however, there are concerns regarding statistical controls
- Sample size of the research is greater than 10 people
- Results are publicly available

Finally, those programs that are listed as screens have not been thoroughly evaluated by PPN, but have been screened by other reputable organizations.

Despite the importance of research design and outcomes to the classification systems mentioned above, there is general consensus in the literature that EBP is not based on rigorous testing alone, but on an appropriate understanding of the problem to be addressed (Wulczyn et al., 2005), a distinct connection between the evidence surrounding the proposed intervention and the target client or family, and consideration of the client's understanding of the evidence based treatment with which they will be

involved (Gambrill, 1999; Kessler et al., 2005; Sackett et al., 2000; Steinberg & Luce, 2005). It involves the use of "individual expertise to integrate the best external evidence, based on research findings, with information about the client's characterizations and circumstances, and the client's preferences and actions" (Gibbs & Gambrill, 2002, 453).

This characterization of EBP illustrates the fact that it does not represent a discrete moment, but rather a process connecting research that demonstrates effectiveness with context appropriate implementation. However, there is a division that often exists between these two worlds (Gambrill, 1999; Webb, 2001; Witkin & Harrison, 2001) with the former seen as out of touch with the practical day-to-day realities of direct service. Even those practitioners that occupy a so-called middle ground would be hard pressed to find time to collect information on the best available interventions in their field. There is also evidence that research findings either do not always result in effective practice outcomes (Walshe & Rundall, 2001) or are relatively scarce (Wulczyn et al., 2005). This leads some practitioners to conclude that their experience is a better determinate of what interventions work with their client population.

Due to this particular fact as well as the other arguments against EBP, Walshe and Rundall (2001) contend that for EBP to be used effectively requires a complete paradigm shift. This transition involves a transformation in research strategies, methods, outputs, and the dissemination of and understanding of research to and by direct service providers. Instead of seeing research and practice as mutually exclusive with the dominance of the former over the latter, it is important to understand that effective EBP involves an integration of the two. The steps of EBP outlined in the literature make this very clear. Typically the process begins by formulating research questions directly related to the problem at hand. This supports a guided search for information regarding evidence based practice and programs in the area of interest. It also is best viewed as a bottom-up approach (Rosenthal, 2004) rather than an inductive process. The professional judgment of the practitioner is especially important at this point. It is she/he who must critically examine the evidence that is available, decide if the application of the intervention would be appropriate given the client and context, and

track outcomes as well as participate in quality improvement (Gambrill, 2003; Gibbs & Gambrill, 2002; Rosenthal, 2004; Sackett et al., 2000).

One tool for ensuring success in implementing EBP is the development of a dissemination plan (Kauffman Best Practice Project, 2004). This document should begin with the program's logic model, which can act as a guide regarding the appropriate EBP to implement. This will then provide a structure through which the necessary infrastructure, training materials, supervision, and evaluation tools can be identified. This document can also be used as an important component in any proposals for future funding as it will provide a clear outline of the program's purpose, efficacy, and outcomes.

Before moving to this stage in the process; however, there is another step recommended by the FRIENDS network in their "Integrating Evidence-Based Practices into CBCAP Programs: A Tool for Critical Discussions (2008)." This step, and a requirement for CBCAP funding, is a community needs assessment. It is only by first defining the problem that practitioners can begin to collect information on the possible solutions. The selection of an evidence based alternative, as mentioned previously, can be challenging for several reasons and although practitioners are encouraged to evaluate programs and practices for themselves (FRIENDS, 2008), there are evaluations compiled from literature reviews. The FRIENDS network in particular has a CBCAP matrix that combines the four EBP, model program guides from the California Clearinghouse on EBP in Child Welfare, the SAMHSA NREPP, OJJDP, and the Promising Practices Network. One difficulty with relying solely on this compilation is that there is no final score based on the evaluations and there are slight differences between categories. For example, the Promising Practices Network does not include multiple replication or publication in a peer-reviewed journal as one of their criteria for even the highest category of "Proven." Although there may be legitimate arguments regarding why this criteria is unnecessary, it would be very difficult for a practitioner to judge the efficacy of an evidence-based practice on the summary of classifications across models.

However, as mentioned earlier given the nature of the time consuming work involved in direct service, especially child welfare, the ability of practitioners to find and

review research is often limited. It is therefore essential for this information to be disseminated in a variety of ways that are well in line with evidence regarding effective education techniques. Of course, a field such as child welfare struggles with not having consensus regarding definitions of prevention, reasons for involvement by child welfare systems, and a lack of availability of evidence of outcomes (Barth, 2007) for particular areas of practice (Kessler et al., 2005; Usher and Wildfire, 2003). This calls for the recognition of the limitations of evidence based practice and the need to make accommodations given particular practice settings. This is an acceptable adjustment as long as program/practice fidelity is maintained. It is also a necessary step to countering the claim that EBP ignores clinical expertise and to avoiding the implementation of expensive programs that do not fit certain practice settings.

It is also often difficult to find the resources that are required to implement programs recognized as EBP (Barth, 2007; Gibbs and Gambrill, 2002; Straus and McAlister, 2000; Whiting-Blome and Steib, 2004). These resources include purchasing curriculum, training staff in correct implementation, adjusting the practice to meet target populations, and ensuring continual monitoring of outcomes as well as fidelity to the original program (Barth, 2007).

Fidelity is adherence to the general principles of process and change outlined in the program or practice and can impact program effectiveness (Harding et al., 2007; Sweet & Appelbaum, 2004). It is highly dependent on the theory of change as well as the resources available in a particular organization. There are two positions in regards to fidelity. The first is strict adherence (Blakely et al., 1987), which leaves no room for contextual adaptation to the original model. The second supports modifications that do not damage the critical elements of the original model (Kessler et al., 2008).   This approach recognizes the specific context in which and populations for which the program is being implemented while ensuring that the factors that led to particular outcomes in the research are not jeopardized.

The skills and number of staff available to implement, sustain, and evaluate the program as well as the training and supervision that will be required to ensure fidelity are necessary considerations prior to the adoption of any evidence based program or practice. The FRIENDS National Resource Center for Community Based Child Abuse

Prevention also recommends considering financial as well as community capacity. The former is concerned with the overall cost of the EBP as well as those expenses associated with resources necessary to sustain the program and evaluate it. On the other hand, community capacity requires that the organization look to referral mechanisms as well as supportive community stakeholders that see the need for the program and will be necessary for it success. This focus on infrastructure goes a long way towards ensuring that the organization has the capacity to successfully achieve the original intentions that accompanied the adoption of EBP.

Several additional barriers that can hinder implementation include (Chaffin & Friedrich, 2004):

- lack of a long-term vision for the service system
- lack of agreement on desired outcomes
- lack of penalties for practices that are not evidence based
- short-term horizons for policy planning
- political mandates or competing public sector priorities

In the field of child welfare, there are also additional systemic barriers including (Kessler et al., 2005):

- Lack of marketing or support for EBP above more traditional practices
- Lack of funding from public and/or private sources for training and infrastructure development that is essential to adding and expanding EBP
- Connection of funding to outputs (i.e. number of families seen) versus client outcomes

Although focused on child welfare systems as opposed to child abuse prevention, the Kauffman Best Practices Project (2004) provides a number of suggested solutions to overcoming these challenges; all of which can be applied to the implementation of child abuse prevention programs and practices. Beginning with a general conception of the change that needs to take place in the system, there needs to be greater knowledge of what EBP exists in the field and movement towards the adoption of those practices applicable to the client population with which the organization is engaged. This is followed by acquisition of the skills appropriate for the implementation, sustainment, and evaluation of EBP. Training is essential in this regard

because it not only provides practitioners with the resources to perform their jobs successfully, but it helps to ensure their support for the program and its long-term successful implementation. Tasks that support this process include (Dansereau & Dees, 2002; Fixsen et al., 2005):

- Emphasizing practice versus rules and the use of feedback
- Connecting theory and practice through practice sessions
- Being open regarding the limitations of the practice
- Highlighting areas of practice that are open to professional judgment
- Encouraging support from management and fellow practitioners

To support the transition to EBP, there also must be funding structures that support the development of the training activities mentioned above in addition to other necessary resources such as appropriate evaluation tools and administrative support. This will involve buy-in from not only front-line workers, but management and public officials including legislators. Education in this regard must move beyond a mandate for EBP to a clear understanding of its challenges, specifically the movement from research to practice.

Despite the careful roads that must be navigated when implementing evidence based practice, the fact is that there is currently ample evidence that can be of use in policymaking in governments and agencies (Wulczyn et al., 2005). Ultimately, it is only through these efforts that child welfare practice and policy, especially in the area of prevention, will be able to more clearly identify appropriate program inputs that result in intended the outcomes.

Table 115 uses the four rating systems outlined in the literature review to provide an overview of the curriculum/programs used by DFPS child abuse prevention agencies (taken from proposals and interviews). Curricula rated by SAMHSA's NREPP are listed in Table 116 given the more detailed nature of the scoring system.

There are two important points to remember when viewing both tables. The first is that although a program is highly rated, it may not be appropriate for a particular organization and the populations with whom they work and/or environment in which this work takes place. In addition, a programs exclusion from the four rating systems listed in the tables below does not necessarily mean that it is not effective as none of these rating systems are completely exhaustive.

Table 115: EBP Rating of DFPS Child Abuse Prevention Agencies' Curricula

Curricula/Program	CEBC		Promising Practices	OJJDP	CBCAP (FRIENDS)
	Scientific	CW Relevance			
Nurse Family Partnership	Well-Supported	Medium	Proven	Exemplary	Well-Supported
Parents As Teachers	Promising	Medium	Promising	Promising	Supported
Homebuilders	Supported	High		Promising	
Brief Strategic Family Therapy			Screened	Effective	
Nurturing Parenting Inside/Out	Promising	High		Promising	Promising
Children in the Middle			Screened	Promising	
Healthy Families America	Evidence Fails to Demonstrate	Medium		Effective	Promising
BBBS Mentoring Program			Proven/ Promising	Exemplary	
Effective Black Parenting	Promising	High			
Family Connections	Promising	High			
STEP	Promising	Medium			Supported
1-2-3 Magic	Supported	Medium			Emerging/ Evidence Informed
AVANCE	Promising	Medium			
Love and Logic					
Family Forward					
Parent's Anonymous					
Healthy Start-Grow Smart					
Practical Parent Ed					
Family Focused Service (child communication classes)					
CALMS					
Parenting Counts					
Common Sense Parenting					
Active Parenting					
Nurturing Parenting Skills in African American Families					
Dads Make A Difference					
Middle Way					

Table 116: SAMHSA NREPP Detailed Ratings (0-4)

Curricula	Average Rating	Components	Component Score
Brief Strategic Family Therapy	3.3	Engagement in Therapy	3.4
		Substance Use	3.0
		Conduct Problems	3.4
		Family Functioning	3.2
		Socialized Aggression	3.4
Children in the Middle	2.3	Parental Conflict	2.2
		Communication Skills	2.3
		Child Reported Stress	2.0
		Awareness of Effects of Divorce on Children	2.1
		Rate of Re-litigation	2.4
Nurse Family Partnership	3.7	Maternal Prenatal Health	3.5
		Maternal Self-Sufficiency	3.2
		School Readiness	3.4
		Childhood Injuries & Maltreatment	3.5
		# of Subsequent Pregnancies & Birth Intervals	3.3

Key Informant Interviews

SAMHSA Science to Service Coordinator Kevin Hennessy

The Substance Abuse and Mental Health Administration created the Science and Service Awards in 2007. It is a national program to recognize community-based organizations and coalitions for exemplary implementation of evidence-based services. Mr. Hennessy described EBP as a part of the more general debate regarding how to improve service delivery to clients. It is practice that has some level of scientific assessment/evaluation behind it and exists along a continuum. He indicated that many people believe EBP is "black and white" and that you "either have it or you don't."

He reported that this attitude has resulted in inflexible mandates from administrators and legislators regarding the use of a particular level of EBP and has stifled innovation for the next generation of EBP. Mr. Hennessey argued that flexibility is the key and illustrated his point with the example of Oregon that has structured their state funding so that 85% of practice had to be EB. He said that there is also a movement towards comparative effectiveness research where a protocol is applied to what is known about a particular research area and then the effectiveness of one

approach is compared to others. It is an expensive alternative, but one that provides another way of discerning what is the best approach in a given area. He said that there is also some credibility to the idea of "practice based evidence" that highlights how practice can inform research and vice versa. Regardless of the approach, it appears to him that more resources seem to have been devoted to identifying EBP rather than developing it in order to draw people in and change their beliefs about and implementation of EBP.

Mr. Hennessey emphasized that it is this implementation phase that poses the biggest challenge for practitioners and it is here where mistakes are often made. Throughout this part of the process, practitioners need to not only look at outcomes they want to achieve, but at how the curriculum they are selecting fits into the culture of their organization and how it applies to the population they serve.

FRIENDS Training and Technical Assistance Coordinator Cassandra Firman

Figure 13: FRIENDS Continuum of Evidence Based Practice
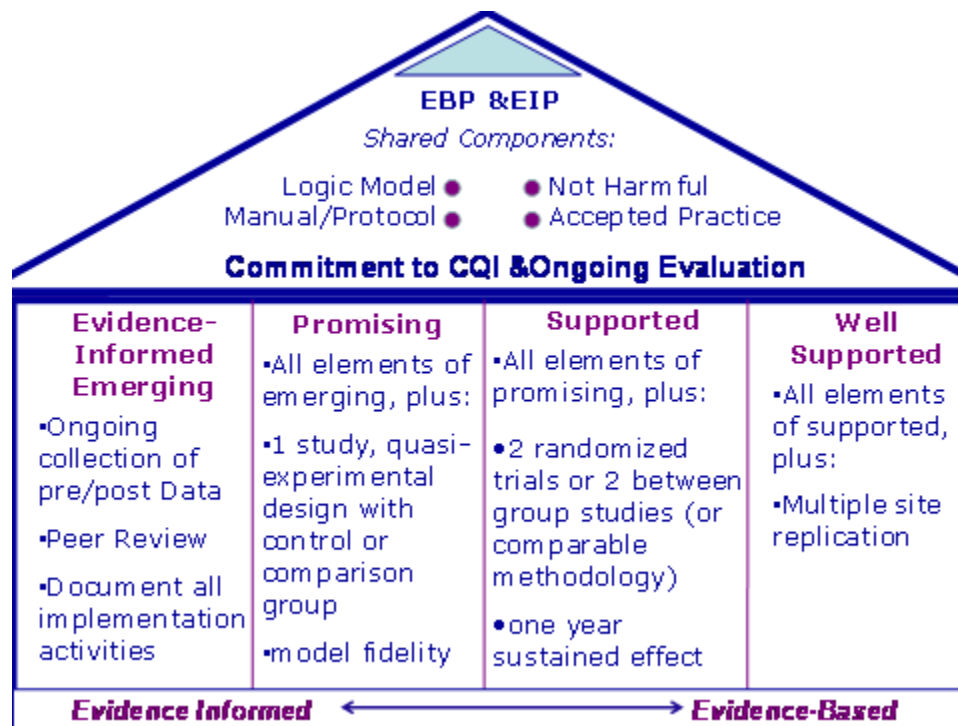
Ms. Firman emphasized that EBP should actually be conceptualized as a continuum that ranges from evidence informed to evidence based. She indicated that

regardless of where a curriculum falls on this spectrum there must be a logic model that is based on the population the organization is serving as well as outcomes derived from empirical evidence. An illustration of this range is the "house" created by the FRIENDS network (Figure 13).

Ms. Firman reported that it is also very important to be specific in regards to why a particular service will lead to those outcomes. She also pointed to the importance of having a manual that details the specifics of implementation in addition to evaluations that serve to continually collect evidence of the work the organization does and the impact it has. This is important because although you may be maintaining fidelity to the model it may turn out to be the wrong match for your population and may not achieve the outcomes for which you hoped.

Ms. Firman mentioned another factor that impedes implementation and that is a lack of resources. She reported that organizations often pull an EB curriculum off the shelf and then don't have the resources necessary to implement it exactly so they restructure it. She emphasized that this can still result in good outcomes, but only if the program is in contact with developers to identify the essential elements and what can be altered. She indicated that another way for programs to avoid encountering this challenge is to closely examine their infrastructure before they commit to a particular curriculum and to construct a strong logic model that delineates what resources are necessary to bring about particular outcomes.

California Evidence Based Clearinghouse (CEBC) for Child Welfare Project Manager Laine Alexandra

Ms. Alexandra emphasized the need for a shared language around EBP that is then used to train all of the stakeholders involved. She indicated that while engaged in this effort it is important to focus on the components and process of EBP rather than just desirable outcomes. An essential element to make this a successful endeavor is leadership buy-in that in turn facilitates buy-in from front line workers.

Ms. Alexandra delineated several challenges to EBP including:

- Securing adequate funding for training, supervision, and evaluation
- Apathy from staff about EBP requirements due to time and energy constraints

- Culture and language barriers to new curricula/programs
- Fidelity issues that come from improper implementation

She reported that one strategy to address fidelity challenges is flexible curricula that can be adapted to agency and client needs. In terms of securing funding for to support the growth of EBP, Ms. Alexandra indicated that research is slowly catching up to interest; however, until programs secure more resources, evaluation financing will probably need to come from the federal government.

Research Instruments

Table 117: EBP Initial Checklist

Level 1: Emerging Practice and Programs	YES	NO
Program Characteristics		
The program can articulate a *theory of change*, which specifies clearly identified *outcomes* and describes the activities that are related to those *outcomes*. This may be represented through a program *logic model* or *conceptual framework* that depicts the assumptions for the activities that will lead to the desired *outcomes*.		
The program may have a book, manual, other available writings, and training materials, OR may be working on documents that specify the components of the practice protocol and describe how to administer it.		
The practice is generally accepted in clinical practice as appropriate for use with children and their parents/caregivers receiving child abuse prevention or family support services.		
There is no clinical or *empirical* evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.		
Programs and practices may have been evaluated using less rigorous *evaluation* designs with no *comparison group*, including *"pre-post"* designs that examine change in individuals from before the program or practice was implemented to afterward, without comparing to an *"untreated" group* – or an *evaluation* may be in process with the results not yet available.		
The program is committed to and is actively working on building stronger evidence through ongoing *evaluation* and continuous quality improvement activities.		
Level 2: Promising Practice and Programs		
Program Characteristics		
The program can articulate a *theory of change,* which specifies clearly		

identified *outcomes* and describes the activities that are related to those *outcomes*. This is represented through presence of a program *logic model* or *conceptual framework* that depicts the assumptions for the activities that will lead to the desired *outcomes*.		
The program may have a book, manual, other available writings, and training materials that specify the components of the practice protocol and describe how to administer it. The program is able to provide formal or informal support and guidance regarding program model.		
The practice is generally accepted in clinical practice as appropriate for use with children and their parents/caregivers receiving child abuse prevention or family support services.		
Research and Evaluation Characteristics		
There is no clinical or *empirical* evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.		
At least one study utilizing some form of *control or comparison group* (e.g., *untreated group*, *placebo group*, *matched wait list*) has established the practice's *efficacy* over the *placebo*, or found it to be comparable to or better than an appropriate comparison practice, in reducing *risk* and increasing *protective factors* associated with the prevention of abuse or neglect. The *evaluation* utilized a *quasi-experimental* study design, involving the comparison of two or more groups that differ based on their receipt of the program or practice. A formal, independent report has been produced which documents the program's positive *outcomes*.		
The local program is committed to and is actively working on building stronger evidence through ongoing *evaluation* and continuous quality improvement activities. Programs continually examine long-term *outcomes* and participate in research that would help solidify the outcome findings.		
The local program can demonstrate adherence to model *fidelity* in program or practice implementation.		
Level III: Supported Practice and Programs		
Program Characteristics		
The program articulates a *theory of change*, which specifies clearly identified *outcomes* and describes the activities that are related to those *outcomes*. This is represented through the presence of a detailed *logic model* or *conceptual framework* that depicts the assumptions for the *inputs* and *outputs* that lead to the *short, intermediate and long-term outcomes*.		
The practice has a book, manual, training, or other available writings that specify the components of the practice protocol and describe how to administer it.		

The practice is generally accepted in clinical practice as appropriate for use with children and their parents/caregivers receiving child abuse prevention or family support services.		
Research and Evaluation Characteristics		
There is no clinical or *empirical* evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.		
The research supporting the *efficacy* of the program or practice in producing positive *outcomes* associated with reducing *risk* and increasing *protective factors* associated with the prevention of abuse or neglect meets at least one or more of the following criterion:		
At least two rigorous *randomized controlled trials* (RCTs) in highly *controlled settings* (e.g., university laboratory) have found the practice to be superior to an appropriate comparison practice. The RCTs have been reported in published, *peer-reviewed* literature. OR At least two between-group design studies using either a *matched comparison* or *regression discontinuity* have found the practice to be equivalent to another practice that would qualify as supported or well-supported; or superior to an appropriate comparison practice. The practice has been shown to have a sustained effect at least one year beyond the end of treatment, with no evidence that the effect is lost after this time. Outcome measures must be *reliable* and *valid*, and administered consistently and accurately across all subjects. If multiple outcome studies have been conducted, the overall weight of evidence supports the *efficacy* of the practice. The program is committed and is actively working on building stronger evidence through ongoing *evaluation* and continuous quality improvement activities.		
The local program can demonstrate adherence to model *fidelity* in program implementation.		
Level IV: Well-supported Programs		
Program Characteristics		
The program articulates a *theory of change,* which specifies clearly identified *outcomes* and describes the activities that are related to those		

outcomes. This is represented through the presence of a detailed *logic model* or *conceptual framework* that depicts the assumptions for the *inputs* and *outputs* that lead to the *short, intermediate and long-term outcomes*.		
The practice has a book, manual, training or other available writings that specify components of the service and describe how to administer it.		
The practice is generally accepted in clinical practice as appropriate for use with children and their parents/caregivers receiving child abuse prevention or family support services.		
Research and Evaluation Characteristics		
Multiple Site Replication in Usual Practice Settings: At least two rigorous *randomized controlled trials* (RCT's) or comparable *methodology* in different usual care or practice settings have found the practice to be superior to an appropriate comparison practice. The RCTs have been reported in published, *peer-reviewed* literature.		
There is no clinical or <u>empirical</u> evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.		
The practice has been shown to have a sustained effect at least one year beyond the end of treatment, with no evidence that the effect is lost after this time		
Outcome measures must be *reliable* and *valid*, and administered consistently and accurately across all subjects.		
If multiple outcome studies have been conducted, the overall weight of the evidence supports the *effectiveness* of the practice.		
The program is committed and is actively working on building stronger evidence through ongoing *evaluation* and continuous quality improvement activities.		
The local program can demonstrate adherence to model *fidelity* in program implementation.		

Executive Director (or designee) Interview Guide

1. What was the process involved in deciding to use the _____ program model?

2. How did you determine this was a good match for your population?

3. Were there other programs you considered?   Yes   No
    If Yes:

What about these discouraged you from choosing them?

3. How long have you used _____ program?

4. What is the theory of change behind the EB programs that you are using? In other words, what specifically is it about the programs you use that indicates they will produce the desired results?

5. Do you have a logic model or other written documentation?

6. Were there costs associated with implementing _____ (i.e. for training, materials etc.)? Did your funder cover these costs?

7. Who trained staff to implement the program? How long was the training? Was it sufficient? If no, what changes need to be made for it to be effective?

8. What criteria do you use to select staff who will use this curriculum? (i.e. education, skill set, etc.)

9. Could describe the type, nature, and duration of the supervision of your staff who use this curriculum?

10. What is the caseload per worker

11. What is the length of service provision?

12. Is there a manual?   Does the manual clearly specify steps, strategies, and program content?

13. When you have had questions about the program is there some one you can contact for assistance? How has that worked?

14. Have you had to adapt the model to fit your client population or agency? In what way?

15. How did these changes affect the model's theory of change?

16. How did these changes affect fidelity to the original model?

17. Was the developer available to you when making these changes to ease the process?

18. How do you assess fidelity to the model?   Have you been aware of program drift? (Over time little changes that change the model?

19. Have you adopted the evaluation protocol associated with the _____ program? If yes, has it been useful in assessing the effectiveness of _____? Does it help you improve your program? If no, what were the barriers to adopting it and what have you put in its place?

20. What challenges have you faced with implementing evidence based practice?

21. What have been some of the benefits from/ using _____ model?

22. How have staff members reacted to using this model? Are they able to follow the model? What has helped them?

23. What would assist your organization in implementing it more effectively (i.e. money, technical support, more education on EBP)?

Program Staff Interview Guide

1. How is the program supposed to work? What kind of change is the program supposed to bring about and how is that suppose to happen?

2. What is your average caseload?

3. How do you ensure that you are following the model?

4. How well does the program work with your clients?

5. What happens if you observe or have feedback from clients that there needs to be an addition to the program or something should be changed? What process do you follow to implement those changes? Do you have to test it, check with executive or person who developed it etc?

6. Are there additional resources that you need to implement the program the way it is outlined in the curricula?

7. What challenges have you faced implementing EBP?

8. What have been the benefits to using an EBP?

9. What training have you participated in? How often? ….

10. Could you describe the type, nature, and duration of the supervision you receive?

Appendix E

EVALUATION ELEMENT 5
Evaluate existing methods for the ongoing identification of additional opportunities for comprehensive improvements to the delivery of services for the prevention of and early intervention in child abuse and neglect

Glossary

Outcomes
❖ The observable, measurable **results** of an intervention or program.
  o *Example: At-risk children of parents who completed the "Families in Education" program were 95% more likely to complete high school with their age cohort, than were a matched set of at-risk children who did not complete the program.*

Outputs
❖ The **products** of an intervention, i.e. the observable, measurable units of service, number of clients served, responses on demographics or similar surveys.
  o *Example: Families in Education served 120 families identified as having at least one child at-risk of dropping out of school before the age of 16.*

Performance improvement
❖ The process of implementing into practice the findings of process monitoring and outcome evaluation through a review of findings, planning, piloting and revision.
  o *Example: Based on the findings of the year 1 evaluation report, staff made the following revisions to the Families in Education program: (a) 12 rather than 15 week sessions; (b) the addition of 10 teachers as parent mentors; and (c) monthly family nights held at the school.*

Process monitoring
❖ A standardized process of accounting the outputs of an intervention.
  o *Example: A database was developed into which case workers enter the number and demographic features of clients, the types of services used and the number of contacts.*

Program evaluation
❖ A process of collecting, analyzing and reporting quantitative and qualitative data that shows the impact of an intervention on the population for whom it was developed and ideally includes an understanding of what components produced which results for whom.

Quality assurance
- ❖ The commitment of an organization to enact policies that require ongoing monitoring, thereby ensuring that their operations are consistent with their mission and related standards of care.

History

Continuous program improvement within child welfare agencies is most evident as a part of the Child and Family Services Review (CFSR). CFSRs were mandated by the federal government as part of the 1994 Amendments to the Social Security Act. They are an instrument of the Children's Bureau used to ensure that the practices of state child welfare agencies conform to Title IV-B and IV-E child welfare requirements. They also assist the federal government with tracking outcomes for children and families served by state child welfare services.

States utilize CFSRs to determine what practices best help children and families achieve positive outcomes. The CFSRs highlight the strengths and weaknesses of each state's child welfare services. They are then used by the states to develop a program improvement plan (PIP). The states are given two years to meet the targeted goals of their PIP, and if they fail to meet their goals, they are subjected to financial penalties.

The CFSR only addresses quality assurance in the areas of foster care and child/family service plans. States do have the opportunity to report on some of their prevention efforts such as the scope of available services and their resource development progress; however, prevention is not part of the quality assurance or continuous program improvement efforts that are of concern to the federal government.

States may utilize the exploratory issues attached to the CFSRs assessment of quality assurance systems to construct and maintain CPI/QA processes for prevention services. Additionally, the Children's Bureau provides examples of logic models and other tools to guide CPI/QA practices through the FRIENDS Community Based Child Abuse Prevention Resource Network. A standardized reporting requirement for prevention services, however, does not exist.

Table 118 provides an overview of what tools states are currently utilizing as well as the CPI/QA activities they employ, the way in which stakeholders are engaged and the challenges that the states face.

Table 118:   Overview of States' CPI/QA Activities

State	Key Indicators	CPI Activities	Participation	Challenges
California	CFSR FRIENDS logic model	CFSR results review State-level program improvement plan County-based program reviews and prevention plan Training & technical assistance	Identify key measures Develop corrective action plan Participation in trainings & meetings	Expense of Quality Assurance Difficult to communicate within a large state Lack of common CPI/QA language
Colorado	Legislated minimum standards	Annual reports Training & technical assistance	Identify key measures Participation in trainings & meetings	Expense of QA process Qualified staff Buy-in from legislature Agency culture regarding change

Table 118: Overview of States' CPI/QA Activities (continued)

State	Key Indicators	CPI Activities	Participation	Challenges
Florida	Kansas University Protective Factors Survey Individual program goals and objectives	Qualitative interviews between workers and supervisors Agency reviews based on stratified sample Case review Rating system Quarterly & annual Reports Training & technical assistance	Identify key measures Develop corrective action plan Participation in trainings & meetings Plan implementation Interpret findings	Did not identify any barriers to CPI/QA process
Kentucky	Individual program goals and objectives	Case reviews Site visits Regular reporting	Identify key measures Participation in trainings & meetings Plan implementation Interpret findings	Expense of CPI staff Legislative buy-in

Table 118:   Overview of States' CPI/QA Activities (continued)

State	Key Indicators	CPI Activities	Participation	Challenges
Michigan (CTF)	FRIENDS logic model	Quarterly reports Training & technical assistance	Identify key measures Develop corrective action plan Participation in trainings & meetings Local council as feedback mechanism	Lack of research regarding effectiveness of primary prevention Funding for QA Field buy-in to switch from traditional practice
Michigan (0-3)	Legislatively mandated indicators AAPI Individual program goals and objectives	Annual renewal evaluation Annual site visits Record review Corrective action plans Training & technical assistance	Identify key measures Develop corrective action plan Participation in trainings & meetings	Did not identify any barriers to CPI/QA process
Missouri	Strengthening Families Protective Factors survey Individual program goals & objectives	Quarterly & Monthly reporting Site visits Record review Shadowing Corrective action plan Training & technical assistance	Identify key measures Develop corrective action plan Participation in trainings & meetings	Did not identify any barriers to CPI/QA process

Table 118:   Overview of States' CPI/QA Activities (continued)

State	Key Indicators	CPI Activities	Participation	Challenges
Nevada	Kansas University Protective Factors Survey Internally developed client satisfaction survey Individual program goals and objectives	Quarterly reports Site visits Weekly intra-agency meetings Training & technical assistance	Participation in trainings & meetings Development of prevention plan Web-based feedback	Requirement of evidence based practice
Oklahoma	Nurse-Family Partnership logic model Healthy Families logic model Internally developed logic model	Yearly site visit Record review Shadowing Database review Narrative Rating system Corrective action plan Training & technical help	Participation in trainings & meetings Written rebuttal	Agreement on how to measure prevention Increasing cost
Tennessee	FRIENDS logic model Individual program goals & objectives	Bi-annual reports Contract end audit reviews Corrective action plan On-line feedback Training & technical assistance	Identify key measures Participation in trainings & meetings	Funding Lack of staff to conduct CPI/QA

Table 118:   Overview of States' CPI/QA Activities (continued)

State	Key Indicators	CPI Activities	Participation	Challenges
Texas	Kansas University Protective Factors Survey Parent satisfaction survey Individual program goals & objectives	On-going monitoring Site visits Corrective action plan Annual reports	Identify key measures Participation in trainings & meetings Develop corrective action plan	Reliance on individual Lack of communication between different funding levels Funding
Washington	Individual program goals & objectives University of Kansas Protective Factors Survey	Site visits Quarterly & annual reports Training & technical assistance	Identifying key measures Developing corrective plan Participation in trainings & meetings	Lack of political buy-in for funding

Process/Model

As Table 118 indicates, almost every state interviewed had a formal continuous program improvement and quality assurance model in place. The most frequently cited indicators/tools utilized in this process were the protective factors survey as well as logic models whose sources ranged from the FRIENDS National Resource Center for Community Based Child Abuse Prevention to the Nurse Family Partnership and Healthy Families programs. Most states used a variety of methods to collect the necessary information - including internal client program satisfaction surveys, site visits, formal case reviews and shadowing or accompanying a worker while they perform their job duties.

Three of the states that were interviewed (Florida, Washington and California) used a CPI/QA process that was primarily bottom-up. In other words, although there were guidelines provided by the state for the local communities to utilize (in the form of evidence based practice and logic models), each local entity was responsible for reviewing and reporting outcomes. States then track the outcomes and resulting

improvement plans – in California, for example, the Child and Family Service Review results are utilized to develop program improvement plans tracked by a Children's Operations Branch. In the case of Florida, they recently moved QA from the state to the regional offices. In Washington, community based organizations utilize community level indicators that are based on the protective factors survey. The case of Colorado is particularly interesting because they are working towards standardizing the CPI/QA process across all state prevention departments. They recently piloted a tool that can be used for self assessment as well as monitoring. Although derived from a variety of national sources, the tool is based on the uniform minimum standards designated by the same legislation that created the interagency collaboration in Colorado.

Addressing Areas for Improvement

When the practice of CPI/QA indicates a needed improvement, a formal process is triggered in most states. A corrective action plan is implemented, resources are provided to help programs improve and a follow-up review is conducted to ensure identified problems have been addressed. In most cases, grantees submitted reports regularly. Most states then developed annual reports including information from all of the CPI/QA efforts over the course of a year.

All states indicated that their current CPI/QA efforts were helping to identify not only needed changes but also areas of future growth. In the case of Florida, they found that although issues were being identified, little corrective action was taken. They, therefore, implemented a formal action plan and additional contract oversight to supplement quarterly quality assurance measures. States are also identifying ways to streamline operations. These changes include establishing consistent formats for data collection and reporting and the maintenance of data at the state level through coordinated information systems. Nevada, in particular, said that these changes helped advance their CPI/QA system because they were able to identify the need to establish and restructure client goal setting among their grantees.

Role of Stakeholders

Those states that were interviewed reported that stakeholders were involved at varying levels although this term seemed to primarily refer to program executives and

staff. Parents were a part of the CPI/QA process when parent satisfaction surveys were utilized or interagency collaborations included parent representation. In a few cases, local councils or workgroups facilitated information and feedback among providers as well as between providers and the state. Colorado, for example, hosts regular stakeholder meetings throughout the state in order to obtain input on planning implementation, identifying key measures and determining local needs.

Some states meet frequently with their providers regarding quality assurance and program improvement issues while other states are available to stakeholders but do not appear to have a formal structure in place for regular interaction. Consistent among those states that did, however, was confidence regarding the efficacy of their efforts as well as a clear direction for the future of their CPI/QA process.

Future Efforts

A common theme among a number of states was the desire to simplify future efforts by making reporting and data collection more consistent and therefore more practical for comprehensive feedback to stakeholders. This included the use of common measurements across programs as well as integrated reporting requirements and data management. Two states specifically mentioned a desire to know more about how outputs were directly related to preventing child abuse because they did not find consistent results in the field. Oklahoma, in particular, indicated that their legislature had a desire to move towards more "hard and fast" outcome data.

A Model for Quality Assurance

As suggested by the glossary, quality assurance in social services is the commitment of an organization to enact policies that require ongoing monitoring, thereby ensuring that their operations are consistent with their mission and related standards of care. Performance improvement is the set of strategies in place in an organization that enable staff to revise operations to meet their mission and standards. In other words, quality assurance is the context, performance improvement is the implementation.

While both have become more prominent in the operations of child welfare programs, as was shown in the preceding review of the literature and case studies, the two terms are regularly conflated so that either is used as a designation for both. In this document, the terms will be used as defined above.

A particularly detailed and useful handbook for developing and conducting quality assurance and performance improvement programs emerged from the National Child Welfare Resource Center for Organizational Improvement of the Edmund Muskie School of Public Services (NCWRC). Numerous sources were consulted in the creation of the Handbook (O'Brien & Watson, 2002):

- "state child welfare agencies
- existing Federal legislation and regulations
- child welfare research and management studies
- national standards developed in other areas of endeavor"

The Handbook incorporates best practices in both quality assurance and performance improvement, and most importantly, it does so specifically for child welfare agencies. Though not focused on prevention programs, as will be shown, the processes with some revision are quite applicable.

The provisions of the Handbook assist agencies in moving away from just monitoring operations for compliance—the more traditional approach—to being able to actively collect, analyze and use monitoring and evaluation data to inform and enhance their policies and practices and to advocate (within the regulatory confines) for the legislation that regulates service provision.

Outcomes upon which the Handbook creates its framework are derived from the Child and Family Services Review (CFSR), which are divided into three topics and seven outcomes as follows (O'Brien & Watson, 2002):

❖ Safety
   ○ Children are, first and foremost, protected from abuse and neglect
   ○ Children are safely maintained in their homes whenever possible and appropriate

❖ Permanency
   ○ Children have permanency and stability in their living situations

- o The community of family relationships and connections is preserved for children

- ❖ Child and Family Well-being
  - o Families have enhanced capacity to provide for their children's needs
  - o Children receive appropriate services to meet their educational needs
  - o Children receive adequate services to meet their physical and mental health needs

Drawing from numerous quality management and organizational development sources, NCWRC devised a framework for quality assurance and within it for performance improvement that is composed of five steps:

1. Adopt outcomes and standards
2. Incorporate Quality Assurance throughout the agency
3. Gather data and information
4. Analyze data and information
5. Use analyses and information to make improvements

Within ICC, as within the Texas child welfare system at large, many of these steps are already in practice, most notable Steps 1, 3, 4, and to a lesser extent Steps 2 and 5.

1. Adopt outcomes and standards

Extensive effort has been undertaken nationally by social service agencies to better define and adopt outcomes and standards. Texas has been no exception, and the ICC has well-established methods in place. However, CFSR has defined seven "systemic factors" that are associated with the most effectual processes for reviewing and refining outcomes even among child welfare programs that are currently outcomes-driven. According to NCWRC, these seven factors are "related to the state agency's capacity to deliver services leading to improved outcomes for children and families…They provide a good starting point for states to assess their current focus and determine whether they need to modify goals and outcomes underlying their child welfare systems (O'Brien and Watson, 2002)." They are offered as a "checklist" for periodic review and discussion within agencies. The factors are:

- Statewide information system
- Case review system
- Quality assurance system
- Staff training
- Service array
- Agency responsiveness in the community
- Foster and adoptive parent licensing, recruitment and retention

2. Incorporate Quality Assurance throughout the agency

Judging from the experiences of other child welfare organizations as well as those from other disciplines, this step is among the most difficult to implement because it is often misperceived in intent by management and staff. Further, it is rarely included in program or personnel evaluations, so the degree of implementation and its effect are not adequately assessed. As shown in the review of states' programs, QA programs have been implemented with a range of success. NCWRC suggests that QA programs are best served when there is an infrastructure within the agency to support it. As would be expected, it is critical that all levels of management, especially directors, regularly demonstrate support of a culture of quality assurance. However, it is also important that quality assurance practices be part of all job descriptions and staff evaluation. Further, quality assurance staff positions should be created, with the number of employees and scope of their work dependent on the size of the program.

Effective QA programs also include extensive communication both throughout the organization and with external stakeholders. That communication is twofold: a) reporting the commitment to and findings of QA activities; b) reinforcing the QA practices throughout the agency's culture and staff. NCWRC suggests the following communication practices (O'Brien & Watson, 2002):

- Incorporate expectations into training for new workers and existing staff
- Update policy and procedure manuals to reflect quality expectations
- Include quality expectations in personnel performance evaluation
- Include quality expectations in budgets
- Use existing case reviews for analysis of quality issues
- Include quality standards in licensing procedures
- Include quality expectations and standards in provider contracts

3. Gather data and information

       Most often methods of qualitative information collection are surveys with open-ended questions, focus groups and interviews. It is useful also to tap staff, clients, external stakeholders and even the public-at-large as sources of both types of information. External data analysis assistance, if needed, is readily available, from consultants and from universities.

4. Analyze data and information

       Most agencies have at this point well-established procedures for gathering and analyzing data at least for purposes of compliance with funding agencies. When part of a quality assurance and performance improvement program, a determination of what can be analyzed from the quality perspective in addition to a review of current data sources, collection methods and variables often proves beneficial. Most programs can be enhanced by assuring that the agency collects and analyzes both quantitative (numerical) and qualitative (narrative or textual) information. Narrative data forms a rich context for numerical data and often provides suggestions for programming that would not be apparent from strictly numerical data.

       Even at this stage, allowing input from all stakeholder segments can be most productive for validation of the range of data and for informing the application of the analyses.

5. Use analyses and information to make improvements

       It is at this stage that QA merges into the performance improvement process. It is the point where the data about the procedures and results of service are interpreted and compared with what was intended to be the process and outcome of services. The discussion below presents a framework for conducting ongoing performance improvement.

A Model for Continuous Program Improvement

NCWRC issued a follow up report in 2005 as a result of a conference for which they assembled 28 national experts in continuous performance improvement from child welfare agencies (National Child Welfare Resource Center for Organizational Improvement, 2005). The proceedings of the conference reinforced the relevance and importance of performance improvement programs for the agencies, especially in the current regulatory and funding environments that require more oversight, documentation of efficacy, the deployment of evidence-based practices and increasing competition for funding.

As they had in earlier works they listed key principles that are shown to enhance performance improvement programs. In summary, those principles reiterated the necessity of gathering multiple forms of information (as discussed above) and stressed that data is not an end in itself, but is only of benefit to the extent that is interpreted and applied.

Drawing from other resources and industries, the report encouraged agencies to adopt a "learning organization" structure, which in essence, is one that is consistently self-reflective and focuses on quality assurance and performance improvement as on-going ventures. Finally, the report again emphasizes that performance improvement must be the work of all employees who are best served when they are consistently and frequently engaged in processes of performance improvement and are specifically encouraged to generate information and communicate their findings broadly. It further suggests that employees be evaluated and rewarded on their participation and the degree to which the results of their performance improvement efforts yield documented improvements in the service delivery capacity of the agency and in the goals set in collaboration with their clients to improve their lives and those of their children. These recommendations were used as a foundation for the opportunities for the ICC & DFPS to strengthen CPI/QA of child abuse prevention and early intervention services and programming that are listed in the report.

APPENDIX F

Evaluation Element 6

Cost Analysis of Child Maltreatment and Analysis of Funding for Child Abuse Prevention

Out of State Interviews and Budget Review

The purpose of this part of Element 6 was to inform the ICC of the funding sources and budgets of other state child abuse prevention and early intervention efforts and to compare this information with funding for child abuse and neglect prevention in Texas. This information was used in order to look at states that have higher funding per capita than Texas and to examine child abuse trends and other risk factors for child maltreatment over a five year period. Finally, this information was integrated with that collected from the qualitative interviews and document review from the out-of-state interviews that were part of Element 1.

Funding Sources

Four federal funding streams are reported to be the major sources for supporting child abuse prevention efforts in the states (Children's Bureau, 2006). These include: the Child Abuse Prevention and Treatment Act (CAPTA) Title I, CAPTA Title II or the Community Based Child Abuse Prevention Grants (CBCAP), Title IV-B Part 2 Promoting Safe and Stable Families (PSSF), and Title XX or the Social Services Block Grants (SSBG). Other federal sources that can be used for child abuse prevention include Title IV-E, Temporary Assistance to Needy Families (TANF), Medicaid, and Title V (Maternal and Child Health Block Grants).

- *Child Abuse Prevention and Treatment Act Title I (CAPTA):*

    o CAPTA Title I money is dedicated for the purpose of improving child welfare services including, but not limited to child abuse prevention activities. Funding is based on the state population under the age of 18.

- *Child Abuse Prevention and Treatment Act Title II (CBCAP):*

  o   CBCAP is the only formula grant federal source of funding that has as its sole purpose child abuse prevention. Seventy percent of CBCAP is allocated based on the state's child population and 30% is based on leveraged funds. The latter represents a strategic area for states in that they have a large degree of control over what they choose to bring to the table. The allocation formula is based on total dollars leveraged divided by the total amount leveraged by all state, which is then multiplied by 30% of the total funding set aside for CBCAP leveraged funding. States are allowed to utilize any non-federal funding source to leverage funds; however, it cannot be in-kind, nor can it be funding that is being leverage for another federal grant. In addition, it must be money that comes through the budget of the agency designated as the lead organization. In addition, it must be money that is spent or designated within the previous fiscal year. Several sources can be used for leveraged funds including tobacco settlements, statutory dedications, individual donations, and contractual services (FRIENDS, 2007). Table 119 provides an indication of how for fiscal year 2007, states leveraged very little of the total amount available to them.

- *Title IV-B, Part II - Promoting Safe and Stable Families (PSSF):*

  o   Promoting Safe and Stable Families is directed at secondary prevention services to families that have been identified as struggling with risk factors known to increase the probability of child maltreatment. It is also used to fund services to families currently involved with children's protective services. This funding source is a capped entitlement whose formula is based on food stamp usage among a state's population.

- *Title XX – Social Services Block Grant (SSBG):*

  o   Social Service Block Grants are capped entitlements that are very flexible in terms of their use. One of its stated goals is to prevent child maltreatment. Allocation is proportional to a state's population and carries the requirement for states to transfer 10% of their TANF funds to the SSBG. This portion is only to be used for those families that fall under 200% of the poverty level.

- *Temporary Aid to Needy Families (TANF):*

  o   Funding for TANF is flexible within its parameters as a block grant. States are required to transfer 10% of TANF funds to the SSBG and have the ability to use TANF funds for child abuse prevention services.

- *Title IV-E:*

  o   Title IV-E is designated funding for foster care and adoption services for children who qualify for Aid to Families with Dependent Children criteria (TANF) and is

applicable to many populations and specialized projects. These include children who are aging out of care, training for child welfare workers and foster parents, and the development and support of automated child welfare systems. Child welfare demonstration projects were authorized beginning in the mid-1990s and many continue to this day. Some states have used this funding for child abuse prevention demonstration projects.

- *Title V:*

  o The Maternal and Child Health Services Block Grant is intended to prevent injury and serious health problems in children and mothers. It is used for prenatal services as well as to build community capacity to provide home visitation and other support services.

- *Medicaid:*

  o Although children not in the child welfare system meet Medicaid eligibility requirements, this funding source is available for child abuse prevention activities such as Nurse-Family Partnership programs.

Some of these federal funding streams are funneled through one state agency such as the child welfare department or health and human services. This is mandated in the case of CBCAP. However, in most cases the funding is divided with departments of education and health receiving some funding while trust funds are responsible for other allocations of both federal and state funds.

Table 119: CBCAP Leveraged Amount Compared to Leveraged Amount Available

2007 State	Leveraged	Allowable	Percent Attained
Oregon	6219	76162	8.17%
New York	42198	612375	6.89%
Florida	42107	647622	6.50%
Texas	91529	1598201	5.73%
Virginia	27474	487409	5.64%
Arkansas	13126	248160	5.29%
Alabama	25520	500000	5.10%
Washington	41873	844171	4.96%
Pennsylvania	96167	1985000	4.84%
Louisiana	41417	860000	4.82%
Illinois	127175	2662838	4.78%
North Carolina	94520	2000000	4.73%
California	571922	12356000	4.63%
Massachusettes	90452	1960118	4.61%
Michigan	165105	3588578	4.60%
Ohio	226033	4967299	4.55%
Missouri	122849	2709206	4.53%
Wisconsin	119613	2641438	4.53%
Georgia	342264	7663430	4.47%
Utah	125470	2818970	4.45%
Maryland	241990	5439171	4.45%
Tennessee	416647	9445000	4.41%
Arizona	474426	10755024	4.41%
Colorado	366176	8304111	4.41%
Nevada	249958	5682963	4.40%
Connecticut	447101	10186692	4.39%
Iowa	379976	8660380	4.39%
Indiana	1089202	24850000	4.38%
Kansas	500264	11418290	4.38%
Minnesota	1083618	24751128	4.38%
Oklahoma	782103	17866827	4.38%
Kentucky	2292200	52483226	4.37%
North Dakota	4762	109183	4.36%
Montana	1699	38955	4.36%
Maine	16123	369691	4.36%
Delaware	6815	156265	4.36%
South Dakota	11638	266855	4.36%
Rhode Island	54829	1257210	4.36%
Wyoming	7506	172111	4.36%
Hawaii	626263	14360117	4.36%
New Mexico	379182	8694598	4.36%
Vermont	76846	1762074	4.36%
Alaska	34751	796842	4.36%
Nebraska	37304	855385	4.36%
New Hampshire	5629	129074	4.36%
Idaho	2978	68291	2.31%
Mississippi	2551	0	
New Jersey	7367	0	
South Carolina	3500	0	

Calculated from data obtained through Administration for Children and Families, Program Instructions, 2007.

Of the states that were interviewed (N=17), funding sources vary to a certain extent with some states relying heavily on state general revenue sources and others being created with the intent that they would not be supported by state funds. Funding options for state child abuse prevention efforts also include fees from marriage certificates, birth and death certificates, license plate fees, private grants, donations, interest from trust funds, and tax check offs. Table 120 provides specific amounts and sources for these funding streams.

The most consistent funding for child abuse prevention activities across the states that were interviewed was from the Child Abuse Prevention and Treatment grant, money that is allocated as community based child abuse prevention grants (CBCAP) on the basis of population (70%) and non-federal leveraged funds (30%). This was followed by the use of state general revenue, which was the largest source of leveraged money. However, as one state indicated, it was very difficult to build up enough non-federal money to draw down significant federal dollars. Two states, Michigan and Florida, specifically mentioned that the funding structures of their collaborations were established with the specific intent not to receive state general funds. Michigan's first state collaborative effort in the form of the Children's Trust Fund was established with the expressed purpose of not using state general revenue to perform its functions. However, the Michigan Zero to Three initiative receives state general revenue through two different state agencies. Prevention efforts in Florida are also largely funded without state dollars. The only state revenue comes from various fees. This, in addition to the lack of a state income tax, has led them to rely heavily on federal funding. Delaware also relies heavily on a variety of federal funding sources to support prevention activities. In fact, 75% of their prevention funding comes from federal sources such as CBCAP, US Department of Education, and the Substance Abuse and Mental Health Services Administration (SAMHSA).

A few states also obtained child abuse prevention funding from birth certificates, license plates, other fees, and local money from community based organizations. Local match is required of grantees in Michigan and Washington and fundraising is done by grantees in California and Florida although these funds are not required to be reported to the state. Six states reported the use of Title IV-B funds for prevention efforts.

Florida was the only state that had a statewide IV-E waiver that is utilized for child abuse prevention efforts. Both Florida and Delaware indicated the use of TANF funds for child abuse prevention efforts. Medicaid dollars were used by Oklahoma to fund their Nurse Home Visiting program and Oregon for Healthy Start.

Table 120: Funding Sources of Interviewed States

| State	CBCAP Population	CBCAP Leverage	IV-B, Part 2	State General Revenue	IV-E	Birth, Death/ Marriage Certificates & License Plates	Tax Check Off	TANF	CTF	Local Funds	Other
Alaska	200,000	34,751	44,718						462,221		160,000 Rural social services grant
California	3.5 million	571,922	34 million	12 million		4 million Birth certificates	Part of 4 million			Local fundraising	From mental health dept. Tobacco money
Colorado	422,129	366,176	3 million	8.8 million							300,000 Maternal & Child Health Grant 2.65 million Local private foundations 2.1 million SAMHSA 150,000 CDC
Delaware	200,000	6,815	860,000	500,000							1 million SAMHSA 310,000 Dept. of Ed
Florida	1.5 million	42,107	5 million	13.9 million	2.2 million			11 million TANF	Interest	Local donations & fundraising	
Iowa	232,246	379,976	2.5 million*	8.6 million		220,000 Birth certificates	75,000	981,000			
Kentucky	353,642	2.5 million	7.2 million*	Not Available							

Table 120: Funding Sources of Interviewed States (continued)

State	CBCAP Pop	CBCAP Leverage	IV-B, Part 2	State General Revenue	IV-E	Birth, Death/ Marriage Certificates & License Plates	Tax Check Off	TANF	CTF	Local Funds	Other
Michigan	902,622 CTF	165,105 CTF		2.6 million 0-3 (Dept of Comm. Health, and Dept. of Ed)		210,000 license plates	380,000 CTF	4 million 0-3 (Through Dept. of Health)	794,000 Interest	589,722 CTF (In-kind match) 2.1 million CTF (Cash match)	150,000 CTF (Donations) 100,000 CTF (Fundraising)
Minnesota	425,707	1,083,618				700,000					
Missouri	507,521	117,346				590,673 Birth certificates 16,790 License plates 981,447 Marriage license	136,516		166,297	252,763 Fundraising	
Nevada	222,120	249,958	345,710	2.6 million		708,760 Birth certificates					10,000 Title XX 371,736 Grants Tobacco
North Carolina	741,275	94,520	2 million	700,000		500,000 License plates					Grants
Ohio	1,026,758	205,794				4.2 million Birth, death, & divorce certificates			372,061		

Table 120: Funding Sources of Interviewed States (continued)

State	CBCAP Pop	CBCAP Leverage	IV-B, Part 2	State General Revenue	IV-E	Birth, Death/ Marriage Certificates & License Plates	Tax Check Off	TANF	CTF	Local Funds	Other
Oklahoma	330,000	782,103	5.9 million*	15 million		Birth certificates 10,000 License Plates					1 million Medicaid
Oregon	300,926	3,720	2.8 million	33.3 million						Fundraising	2 million Medicaid
Tennessee	497,219	416,647		300,000		100,000 License Plates					Marriage counseling fee 500,000 Grants
Texas	2.1 million	91,259	16.7 million	3.4 million				14.3 million	3.2 million	1.4 million	29,183 Conference Revenue
Washington	530,775	41,873		2.5 million		4,925 Birth certificates 45,000 License plates	20,000			Local match	

Data Source: State interviews; *Data obtained from Administration for Children and Families, Program Instructions 2007.

In terms of states that were comparable in population to Texas (California, Florida, New York, Michigan, and Illinois) three were available for interview, providing a closer inspection of the sources of the majority of their child abuse prevention funding. Figures 14-17 illustrate the differences.
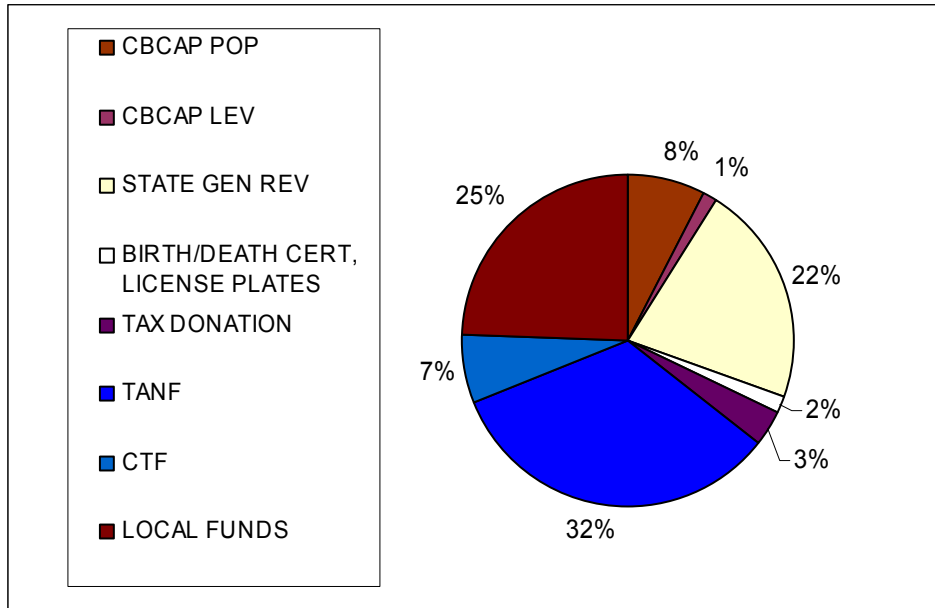
Figure 14: California Funding FY 2007
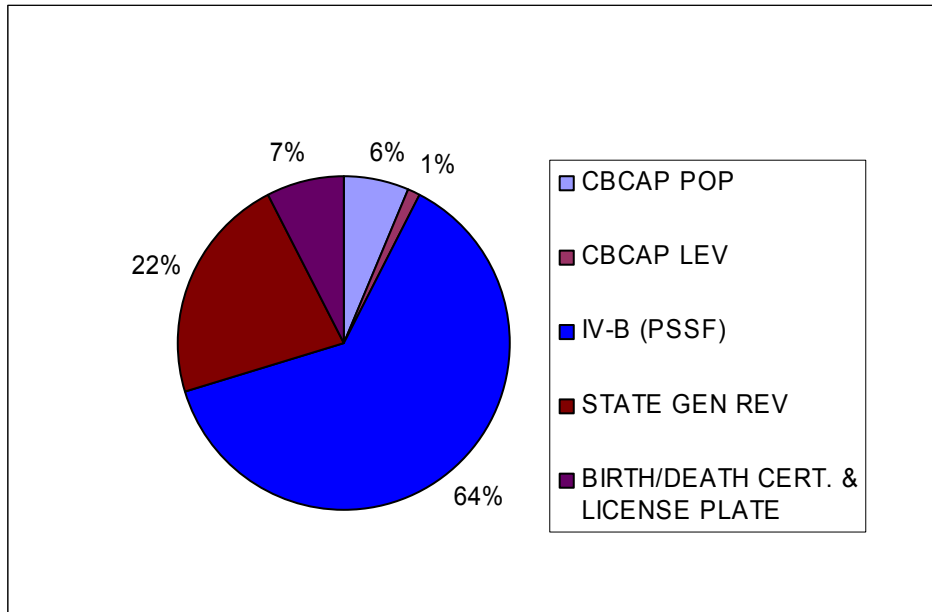
Data Source: State interviews

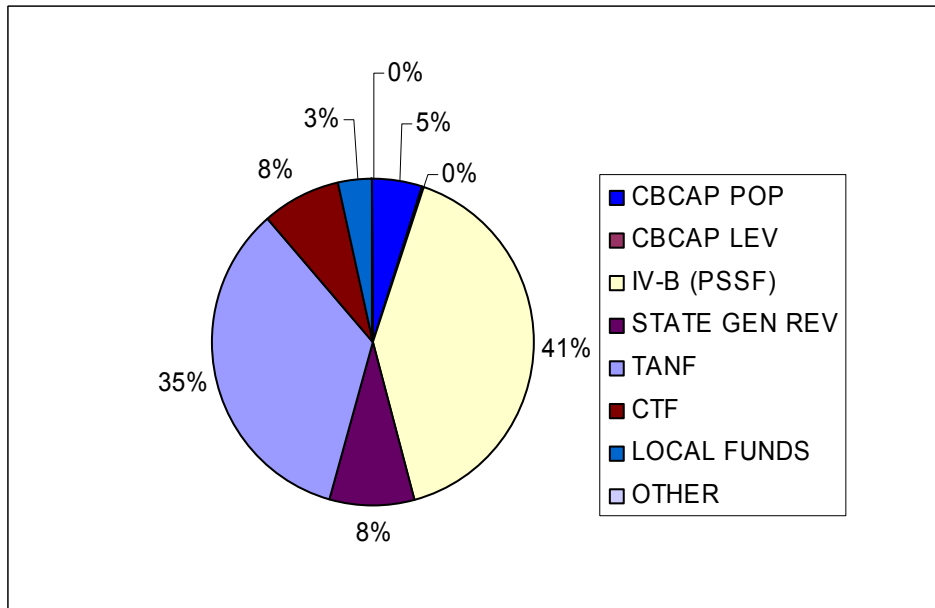*Figure 15: Florida Funding FY 2007*
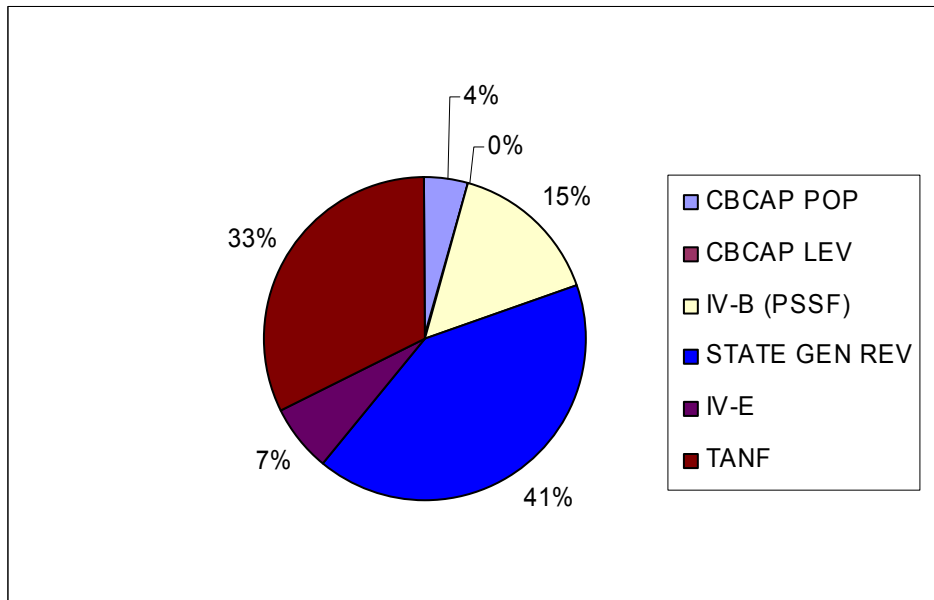
Data Source: State interviews

Figure 16: Michigan Funding FY 2007

Data Source: State interviews

Figure 17: Texas Funding FY 2007

Data Source: State interviews

Funding Strategies

All of the states that were interviewed utilized both braiding and blending of multiple funding sources in order to support child abuse prevention initiatives. However,

coordinated funding between different state agencies and organizations outside of the state structure tended to take place on an ad-hoc basis rather than as part of a regular effort. Under these arrangements, the policies and procedures regarding the coordination of funding varied. California indicated that the lead agency was determined either by who initiated the collaborative effort or who was named in the statute if the initiative was part of legislation. On the other hand, Oklahoma and Tennessee indicated that the fiscal agent on grant opportunities was the agency that took the lead on the grant. Michigan's Zero to Three effort was the only instance among the states that were interviewed where there was a consistent blending of funds between state agencies. In this case there is an interagency agreement that establishes the way in which the funding will operate. Although Colorado's legislation also indicates that there will be coordinated funding efforts, currently it is a "practice in progress" as each initiative brings forward different opportunities through which various departments put forward their own funds. An example includes one department transferring funds to another for a joint request for proposal.

North Carolina and Colorado both expressed a need to develop a common understanding or language in regards to funding and costs. Both states indicated that on the road to a full fledge collaborative funding effort there needed to be shared knowledge regarding:

- Program costs
- Fiscal and procurement rules of different state departments
- Restrictions on funding sources

Table 121 outlines the funding sources that fall into each funding category.

Table 121: Funding Sources According to Blended and Braided Funding

State	Blended/Pooled	Braided
Alaska	CTF Fund Raising	Dept. of Juvenile Justice
California	State General Revenue Birth Certificates Tax Check Off Local Fundraising	CBCAP Mental Health Department Health Department

Table 121: Funding Sources According to Blended and Braided Funding (continued)

State	Blended/Pooled	Braided
Colorado	State General Revenue Interest from Fund Departmental Transfers	CBCAP IV-B, Part 2
Delaware	State General Revenue	SAMHSA CBCAP Title IVB, Part 1&2 US Department of Education
Florida	Interest from Fund Multiple Fees	CAPTA CBCAP IV-B, Part 2 IV-E (statewide waiver) SSBG TANF
Iowa	State General Revenue Income Tax Check Off Birth Certificate	CBCAP TANF IVB, Part 2
Kentucky	State General Revenue	CBCAP IV-B
Michigan (CTF)	License Plates Interest from Fund Tax Check Off Local Match Fundraisers/Donations	CBCAP
Michigan (0-3)	Dept of Community Health Department of Education State General Revenue	TANF through Department of Human Services
Minnesota	Birth Certificates	CBCAP
Missouri (CTF)	License Plate Fees State Tax Check Off Marriage Certificates Birth/Death Certificates Interest from the CTF Donations Grants	CBCAP

Table 121: Funding Sources According to Blended and Braided Funding (continued)

State	Blended/Pooled	Braided
Missouri (Department of Social Services)	State General Revenue	Title IV-B, Part 2 CAPTA
Nevada	Children's Trust Fund State General Revenue Birth/Death Certificates	CBCAP IV-B, Part 2 Grants
North Carolina:	State General Revenue	CBCAP IV-B, Part 2
Ohio	Birth & Death Certificate Fees Divorce & Annulment Fees Interest from Trust Fund	CBCAP
Oklahoma	State General Revenue License Plate Fees Heirloom Birth Certificate	CBCAP Medicaid Department of Education
Oregon	State General Revenue Fundraising	CBCAP IV-B, Part 2 Medicaid
Tennessee	State General Revenue Marriage Counseling Fee	CBCAP Department of Corrections Victims Advocacy CDC
Texas	State General Revenue CTF	IV-B, Part 2 TANF CBCAP
Washington	State General Revenue Heirloom Birth Certificate License Plates Tax Donations Private Funders Local Match	CBCAP Dept. of Health Dept. of Early Learning Dept. of Social & Health

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