ELEMENTS OF BEST PRACTICE IN FAMILY CENTERED SERVICES

JUNE 14, 2000

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PART I

Introduction and Background

1 Introduction

In response to a request for a proposal to conduct a technical assistance and evaluation project for the Family Centered Services (FCS) Statewide Steering Committee, the Children and Family Research Center submitted a proposal for the FY2000–2001 Family Centered Services Project. This proposal outlined a workplan for accomplishing the tasks requested by the FCS Steering Committee through its Co-Chairs, Diane Scruggs and Ed Cotton:

1. Development of an index of elements that define "successful" FCS practice, based both on the literature on best practices and information collected from the *Evaluation of Family Centered Services in Illinois* (June, 1999)
2. Identification of at least ten successful or improved FCS programs based on these elements of successful practice
3. Discussion of the issues surrounding the replicability of these successful programs and finalize the common elements of best practice for FCS
4. Examination of the ways in which outcomes have been defined, both within individual FCS programs and in the research literature
5. Identification of existing tools to measure how well clients do in family services programs. Development of a set of outcome instruments or tools that would allow FCS programs of different types to measure their progress, based on specific community risk factors
6. Development of a process that can be used by FCS programs to identify and define specific program outcomes.
7. Provision of technical assistance to FCS programs in regional (or similarly arranged) meetings to develop their ability to define measurable goals, select and implement the outcome instruments
8. Limited program evaluations in selected FCS program sites

To date, two reports have been submitted for DCFS and FCS Committee review. These reports addressed the first two tasks above. The *First Project Report*, submitted February 1, 2000, included a preliminary project plan that outlined major tasks, start and end dates for each task, and personnel assigned to each task. The report also included an outline of the FY2000 annual report, a draft of the critical elements of successful FCS practice, and a draft discussion of programs identified as successful. The second report, *Outcomes Defined in FCS Programs*, was submitted February 7, 2000, and drew on findings from the Children and

Family Research Center's *Evaluation of Family Centered Services In Illinois* (June 1999) and *LAN Social Histories* (August 1999). Goals and outcomes reported by the 62 LANS were organized in a table format to indicate how reported outcomes could potentially be used to measure progress in achieving reported goals.

The present report builds on these previous reports to finalize tasks one and two above and present the findings for tasks three and four. In addition, preliminary findings for task five, tools for measuring outcomes, are included here. The goal of this report is to present the findings of this work in the form of a table of the elements of best practice in Family Centered Services and to provide an extensive review of outcome measures. Much of the work presented in this report will be adapted for the manual that will be used in providing technical assistance to the state and localities in the coming year.

After the introduction and a brief background discussion, the findings of the literature review are presented. The literature review is followed by a description of the ten "successful" FCS programs in Illinois that exemplify many of the elements of best practice. Issues involved in replicating these successful programs in other LANs are discussed in the next section. The final elements of best practice that resulted from a successive analysis of these queries, organized in a table format, are then outlined. Finally, an extensive review of outcome measures available for use in the field is presented.

2 Background

2.1 Legislative Mandate

The Omnibus Budget Reconciliation Act of 1993 (OBRA) created the Family Preservation and Family Support Initiative to aid states in establishing family support (preventative services) and family preservation (intensive or crisis-oriented services for families at risk of placement) programs. As a result of this legislation an emphasis has been placed on strengthening families and preventing family breakdown and out-of-home placement through the use of community-based service networks. This program was continued under the Adoption and Safe Families Act of 1997 and renamed "Promoting Safe and Stable Families" Program. Program requirements include annual state reports to the U.S. Department of Health and Human Services (USDHHS) and ongoing evaluation of program implementation.

The five-year plan submitted by Illinois for the Family Preservation and Support Initiative established a commitment to research and evaluation. However, several studies at the state and federal levels have revealed that statewide evaluations of locally designed programs yield little in the way of common data collection and reporting strategies. Difficulties in conducting meaningful evaluation and implementation studies are in large part based on the wide variety of local programs, individualized needs of these programs, and lack of resources (at the local level) to design and implement evaluation studies.

2.2 The Basis for the Current Project

A recent statewide evaluation of the Family Centered Services Initiative in Illinois (CFRC, 1999) revealed a similar state of affairs. Field research conducted during the course of the evaluation indicated that although a handful of FCS programs were collecting outcome data, most expressed a need for technical assistance, especially as it relates to conducting program evaluations, and identifying and measuring impacts (outcomes). Therefore, one of the recommendations of the statewide FCS evaluation was to develop ongoing evaluation capabilities in the LANs, which would serve to bolster statewide evaluations of FCS, in addition to allowing for use of the resulting data in local program development. With this aim in mind, the FCS Statewide Steering Committee asked the Children and Family Research Center to submit a proposal to provide assistance to the state

and local programs in the development of an ongoing evaluation system. This includes identification and operational definition of the elements that contribute to a "successful program," an organized set of prescribed outcome measures, and technical assistance in the development of program evaluation mechanisms.

2.3 Context of FCS in Illinois

In order to put the following discussion of best practice and outcome measurement in perspective, it is important to recall some of the major elements of FCS in Illinois. The following sections provide a description of a service typology developed based on reviewing services in all LANs and gives more specific information from LANs in which on-site visits were made. The LANs chosen for these on-site visits were selected based on size of child population, geographic representation, cohort of implementation (FCS was implemented in three phases) and diversity of needs and programs. The information below is adapted from the *Evaluation of Family Centered Services in Illinois* (CFRC, 1999).

2.3.1 Services Delivered

FCS services involved over 94,000 participants during FY98, including 64,386 children; 30,241 adults; and 25,050 family units. Children served ranged in age from infants through adolescents. The program served a diversity of children and families including European-American, African-American, Latino/a, Asian-American and others. Available data on income suggests that FCS also has succeeded in concentrating services for those most in need. Thirty-eight percent of participating families reported annual incomes under $10,000 and nearly 70% reported income under $20,000.

At the time of the first statewide evaluation, state guidelines for FCS funding allocated two-thirds of federal funding for family support services and one-third for family preservation services. Other than this requirement, guidelines for program development were relatively unstructured to allow for responsiveness to individualized community needs. To explore the types of programs funded in the LANs with FCS money, the most recently available Program Services Outline Report from 61 of the 62 LANs was reviewed, and each funded program was classified into one of six mutually-exclusive and exhaustive categories within four major program types.

1. Family preservation programs
   a. Intensive family preservation programs (program must possess all of the following characteristics):
      - ✍ target population includes families who are at imminent risk of having a child placed outside the home or have been the subject of an indicated maltreatment report
      - ✍ in-home service provision
      - ✍ crisis-oriented services — intensive services (at least four hours per week) of a brief duration (4 to 12 weeks)
   b. Other in-home services: services provided in the home setting (e.g., homemaker, counseling, case management) that involve a service goal, plan, and specified interventions. The clientele is open, although services may be targeted at DCFS clients.
   c. Targeted secondary prevention services: services provided to targeted, at-risk populations; services are an effort to prevent the need for DCFS involvement. The target population may include DCFS clients, but is not specifically limited to them.
2. Family support programs: preventive services provided to the community-at-large. Program services focus on building strengths, knowledge, and/or skills.
3. Mixed services: service programs that combine two or more of the above types of services (e.g., parent education and respite).

Results of the classification revealed the following distribution of program types:

One intensive family preservation program

13 in-home service programs

50 targeted secondary prevention services

189 family support programs

27 mixed programs

Of the total of 280 programs, approximately one-third offered some service that could be classified as “family preservation,” and approximately two-thirds focused on “family support.”

2.3.2 Specific Types of FCS Programs

FCS has provided an extensive array of services across the state with each LAN identifying their own service needs and modifying services as necessary over time. These services have included: home visiting, parenting classes, counseling, respite care, after school youth development, child care, mentoring, support groups, family activities, life skills and

personal safety, and community awareness. Home visiting, for example, was provided by 71% of the reporting LANs (N=60). It ranked as the first or second most frequently provided service in 23% of the LANs.

Based on a review of FCS Quarterly Progress Reports conducted prior to June 1999, Table 2.1 indicates the types of FCS services provided during FY98. The first column shows the percent of LANs serving any clients with each service type; the second column shows the percent of LANs in which each service type was a number one or number two service area as measured by the number of clients served.

Table 2.1 FCS Services Provided in FY98

Service	Percent reporting service to any clients (N = 60)	Percent reporting service as a top service area (N = 60)
Home visits	71%	23%
Parent education	79%	17%
Counseling	71%	22%
Respite care	34%	18%
After school programs	57%	28%
Child care	63%	22%
Mentoring	55%	30%
Support groups	56%	5%
Family events	73%	12%
Life skills education	69%	10%
Community service awareness	74%	8%

Children and Family Research Center, 1999

2.3.3 Background Summary

The breadth and diversity of services detailed above begin to give some indication of the challenges inherent in evaluating the FCS program as a whole, or even in focusing on a few programs to determine their effectiveness. By enabling the program providers to systematically gather data that can be used for evaluation, both the state and the local providers will be able to evaluate and report on program effectiveness in a way that no statewide evaluation could.

This report encompasses the diversity of effort, geography and community found in the 62 LANs and provides a comprehensive basis for understanding quality of service delivery and measurable outcomes required for any program evaluation effort.

3 Project Approach

The approach to completing project tasks has closely followed the outline presented in the letter written by statewide FCS Co-Chairs Ed Cotton and Diane Scruggs on October 12, 1999, and represented by the summary tasks in the Introduction.

3.1 Progress to Date

The development of the elements of best practice and the identification of the outcome measures has been an iterative process that has included:

- a review of the literature,
- analysis of the 1999 FCS Evaluation findings,
- discussions with FCS program staff in the field,
- reviews by the project staff, DCFS staff and the research sub-committee of the FCS statewide steering committee.

The literature review highlighted several of the critical elements of best practice, and a number of successful FCS programs were identified using this information. In addition, conversations with FCS program staff and review of the findings of the 1999 FCS Evaluation were also conducted in order to identify 10 successful FCS programs. Information from these 10 successful programs then helped further inform the development of the list of the critical elements of best practice. The replication study provided additional information and a final review of the literature was conducted in order to produce the elements of best practice presented in this report. The recommended outcome measures went through a similar iterative process with constant re-checking between the literature and practice, resulting in the tables provided here.

In addition, project findings regarding the ten successful programs, elements of best practice, and a review of how outcomes have been measured in FCS programs were submitted to DCFS and the FCS research subcommittee in February 2000. The additional information on replication of successful programs and measuring outcomes in FCS programs is presented for the first time in this document. The project work to date has been regularly represented at FCS Statewide Steering Committee and Executive Committee meetings by the DCFS Research Director's Office.

3.2 Next Steps

Phase III of the project began in April 2000 with the identification of the outcome measures used in the FCS programs and recommendations for outcome measures useful for FCS program evaluation (item 1, below). This report marks the completion of items (a) and (b) of step one in Phase III. The FCS research committee and DCFS staff will provide feedback to the project staff by June 30th on these measures. Steps 2 and 3 will be accomplished, complete with FCS/DCFS review and revisions, by September 20, 2000. The resulting Sourcebook will be a manual for use at the local and state levels in planning and conducting program evaluations. The technical assistance protocol will be developed and piloted by the end of November 2000. Technical assistance will be provided to the state and locally from February 2001 through June 2001.

PHASE III - Technical Assistance to State and LAN FCS Programs

1 Establish Common Outcome Measures for All FCS Programs--
   a. Identify measures and tools that already exist for evaluating FCS program client progress
   b. Develop a potential set of outcome measures that can be adapted locally
   c. DCFS/Exec committee review
   d. Revisions
2. Develop guidelines for identifying and selecting outcome measures
   a. Write instructions for developing goals, variables, definitions, and data elements at local level
   b. Write instructions for developing reports on process and outcome variables for local use
   c. Identify and develop references, resources, e.g., Tables in Best Practice report
   d. Develop sample data recording formats for evaluating clients, program functioning, commun. impact
   e. Draft formats
   f. DCFS/Exec committee review
   g. Revisions
3. Deliver Sourcebook and LAN TA protocols to DCFS
   a. Document Production
   b. Mailing

4. Develop protocol for providing TA - guidelines for person offering TA
    a. Draft, review and revise protocols in-house"
    b. DCFS/Exec Committee Review
    c. Complete protocols for LAN TA
5. Pilot LAN TA guidelines and materials with 3 LANs
    a. Make initial contacts and set up pilot procedures
    b. Prepare for and hold one group meeting
    c. Conduct follow-up TA by telephone/fax
    d. Prepare for and hold one follow-up group meeting
    e. Revise LAN TA guidelines for use in the field
    f. Revisions
    g. DCFS/Exec committee review
    h. Final revisions
    i. Document production
    j. Mail document
6. Provide technical assistance to state/local FCS people in using guidelines to specify goals/measures
    a. Provide TA to FCS in regional meetings organized by type of program
    b. Plan approach with DCFS, FCS executive committee, and LAN co-chairs
    c. Schedule meetings
    d. Conduct 8 meetings (Cook/non-Cook on 3-4 different types of programs)
    e. Conduct 8 follow-up meetings
    f. Provide limited telephone consultation
    g. Assemble and deliver report summarizing work and deliverables for LANs
7. Begin Draft Final Report
    a. Complete Draft Final Report
    b. DCFS/Exec committee review
    c. Revisions
    d. Document Production
    e. Mailing

In accordance with the agreement reached by the DCFS Research Director's Office and the FCS Statewide Steering Committee in February 2000, Phase IV evaluations will be conducted after the implementation of the Technical Assistance. This plan differs to some

degree from the original proposal and should be verified by the FCS Statewide Steering Committee and DCFS.

PART II

CRITICAL ELEMENTS OF BEST PRACTICE IN FCS

4 Literature on the Elements of Best Practice in FCS

The family preservation and family support literatures are largely independent of one another (for exceptions, see Ahsan, 1996 and McCroskey & Meezan, 1998). Yet these literatures, and more broadly social work practice in general, emphasize a number of similar critical elements of best practice. Specifically, they emphasize attending to family needs and strengths (McCroskey & Meezan, 1998), empowerment, culturally competent practice, flexibility in accordance with the client's/community's needs, responsiveness, and a firm community base (Dunst, 1995; Garbarino & Kostelny, 1994; Hodges, 1991; Jones et al., 1976; Kinney et al., 1990; McCroskey & Meezan, 1997; Pecora et al., 1992; Pecora et al., 1995; Wells & Tracy, 1996). The challenge to the practitioner is in the differential application of these concepts in accordance with the program's service goals. For example, family support is largely a preventive service while family preservation is concerned with preventing family breakdown when serious troubles occur.

The major difference in application of these principles grows out of the intensity and consequences of the intervention. In family support, there is no imperative to participate, nor is there a threat of harsh consequences due to non-participation or failure of the intervention. Basically functional families are sought out and recruited to engage in identifying essential services and supporting their development. In addition, they are free to refuse participation without penalty. In family preservation, failure to participate or follow the prescribed path of intervention could result in family dissolution, or at least, court intervention. In addition, there is more emphasis on the position that the society at large endorses even involuntary intervention to help the family to function at least at a minimal level. The goals of family support are often to optimize family functioning, while family preservation may focus on achieving a minimally acceptable level of performance.

The second major challenge to identifying critical elements of best practice in the literature is that some of the literature is largely philosophical or theoretical, while other practice guidelines are more concretely linked to empirical findings about practices that "work." This review includes analyses of the similarities and differences in best practice for family preservation and family support, and includes both theoretical and empirical literature. Empirical support for critical elements of best practice in family centered services is cited wherever it has been found.

4.1 Critical Elements of Best Practice

4.1.1 Practice is Family-Centered

The commitment to family-centered practice is based on the premise that any intervention supporting or strengthening the family helps all members of the family (Hartman & Laird, 1983; Jenson, Hawkins, & Catalano, 1986; Lightburn & Kemp, 1994). In family preservation, an immediate crisis is to be resolved by focusing services on, and including, the whole family (Berry, 1997; Fraser et al., 1997; Pecora et al., 1992). In family support, there is an additional emphasis on letting the family guide when and how services should be provided based on their own needs and priorities (Racino, 1998). Dunst (1995), in a review of the ten "best practices" that constitute the day-to-day actions and program activities of family support programs, calls this element "family directed practices," or practices which are based on family-identified needs. The fundamental touchstone is allowing families, rather than professionals, to identify needs. This approach recognizes the family's right to decide what is in the best interest of the family unit and its members (Hobbs et al., 1984).

4.1.2 Practice Focuses on Family Empowerment

In general, empowerment practices de-emphasize the family's responsibility for causing problems, focus on helping families acquire the skills necessary to solve problems, meet needs, and attain desired goals. They assume that families are competent or have the capacity to become competent. Emphasis is placed on enhancing and strengthening family functioning by fostering the acquisition of adaptive behaviors. Families are the essential agents of change. Workers provide families with support, encouragement, and opportunities for competency (Dunst, 1995). Empowerment practices emphasize family participation in decision-making (Lightburn & Kemp, 1994), family strengths (Weissbourd, 1990; Weissbourd & Kagan, 1989; Zigler & Black, 1989), and the enhancement of status, problem-solving skills, and self-efficacy (Gutierrez, 1990; Parsons, 1991; Ruger & Woten, 1982).

The implementation of empowerment practices in family preservation consists of asking clients to identify and prioritize their own treatment goals, and encouraging families to assume greater responsibility and self-determination over their own lives (Pecora et al., 1992; Pecora et al., 1995). Contracts between parents and workers are often used in family

preservation programs to specify the tasks both family members and workers agree to perform to achieve mutually agreed upon goals (Berry, 1997).

In the family preservation literature, family participation in setting goals, the type of goals set, and reducing the distance between professionals and families by allowing families to choose whether to participate in services, have all been found to be related to placement prevention (Fraser, Pecora, & Haapala, 1991; Nelson & Hunter, 1994; Nelson & Landsman, 1992; Reid, Kagan, & Schlosberg, 1988; Schwartz, AuClaire, & Harris, 1991). In their review of the literature, Fraser et al. (1997) identify empowerment practices (family members assist in or set service goals and are viewed as colleagues in defining a service plan) as one of the essential elements of family preservation programs with promising findings.

In the family support literature, the adoption of empowerment models has been associated with parents rating program staff as effective helpers (Dunst et al., 1994). In addition, a review of six successful family support programs found that an emphasis on empowerment was a common element (Comer & Fraser, 1998).

In both family support and family preservation there is an attempt to create "enabling experiences" that give families opportunities to use and expand on existing strengths, as well as opportunities to learn new skills in ways to support and strengthen family functioning. These interventions are also empirically supported. Enabling interventions which emphasize skill and self-esteem building, and actively assist families in identifying and accessing community services and support on their own, were more effective than simply providing concrete services or "doing for" families (Fraser & Haapala, 1988; Fraser, Pecora, & Haapala 1991).

4.1.3 Practice is Culturally Sensitive and Culturally Competent

Culturally sensitive or culturally competent practice is stressed in both the family preservation (Pecora et al., 1992, Fraser et al., 1997; Berry, 1997) and the family support literature (Dunst, 1995; FRCA, 1996; McCroskey & Meezan, 1998). Various authors emphasize a range of elements of what culturally competent services entails, including respect for the family and the family's culture (Pecora et al., 1992), reliance on volunteers or paraprofessionals from the community (Allen, Brown, & Finley, 1992; Weiss & Halpern, 1990; Weiss & Jacobs, 1988; Williams, 1987), bilingual staffing (Williams, 1987), affirming and strengthening families' cultural, racial, and linguistic identities and enhancing their ability

to function in a multicultural society (FRCA, 1996), and planning programs to assure their relevance and sensitivity to the culture and values of the families served (Fraser et al., 1997; Weissbourd, 1990). Other authors point out that such planning efforts present a challenge to program planners and practitioners, because the "existing research literature contains little information about appropriate methods of parent education and support for cultural and linguistic minority populations" (Powell, 1989; p. 17). Dunst (1995) does suggest some specific components that culturally sensitive family support programs should include: efforts to be sensitive and responsive to the beliefs, values, and traditions of people from diverse cultures; the inclusion of activities that affirm children's and families' roots, such as honoring and celebrating ethnic holidays and traditions, and acknowledging the contributions of cultural traditions to society in general; and efforts to strengthen the behaviors and beliefs in families that are valued in their communities. In addition to these suggestions, several recent publications contain more specific descriptions of culturally sensitive and relevant practices for working with families having specific cultural roots (e.g. Lynch & Hanson, 1992; Denby, 1996; Hodges, 1991).

4.1.4 Practice is Flexible and Responsive

Flexibility of services is described variously as either flexibility in terms of scheduling delivery of services to families, or flexibility in terms of being responsive to the particular needs of individual families. The family support literature tends to focus more on the provision of services that are flexible in the sense of being continually responsive to emerging family and community issues (Dunst, 1995; Schorr, 1989; Weissbourd, 1987). As an example of this type of flexibility and responsiveness, Lightburn & Kemp (1994) describe a program designed to adapt to a community where few families had responded to previous outreach efforts. This program used a nine-week summer day camp to attract mothers who had not responded to other outreach efforts. The parents helped design the camp program, creating culturally valued services. At the end of the summer, these parents were ready for and continued with the year-long intensive day program.

The family support literature also addresses the importance of flexibility in scheduling. Lightburn & Kemp (1994) stress the importance of a highly flexible staff and program structure, and Comer & Fraser (1998) stress the importance of services being provided at convenient times.

The family preservation literature tends to describe flexible services in terms of structural flexibility, that is, the ability of programs to schedule services so that family members can participate without conflicts with school, work or other commitments (Fraser et al., 1997). This flexibility is described primarily in terms of making appointments at the convenience of the family, and providing services to families in their homes (Pecora et al., 1992; Pecora et al., 1995), although it also includes tailoring services to the needs of family members through the development of individualized service plans (Fraser et al., 1997).

4.1.5 Practice Includes Mobilizing Resources

Both the family preservation (Fraser et al., 1997; Pecora et al., 1992) and the family support (Dunst, 1995; FRCA, 1996) literatures stress the importance of mobilizing resources in the service of families. They stress the need to mobilize informal resources as well as traditional formal resources, including family members, friends, neighbors, day-care centers, neighborhood and community organizations, churches and synagogues, recreation centers and YMCAs, hospitals and community health centers, public health and social services departments, and early intervention and human services programs (Dunst, 1995; FRCA, 1996). Fraser et al. (1997), in his review of family preservation programs, describes making referrals to and coordinating community resources as one of the essential elements of family preservation programs. He describes a process of building partnerships with collateral services; for example, for children with behavior problems, negative school and peer influences are addressed both by developing family plans regarding school and friends and by actively engaging resources in the school and community.

4.1.6 Practice is Community-based

An essential element of family support services is that they are community-based (Ahsan, 1996). Some authors describe the involvement of family support programs more strongly, viewing family support programs as not only community-based, but "embedded in the community and contributors to the community-building process" (FRCA, 1996). Thus, family support programs are not only based in the community they serve, but they emphasize the importance of creating strong connections to the neighborhood and community (Lightburn & Kemp, 1994) through program development activities that result in family support programs being viewed as vital resources (Weissbourd, 1990). More

recently, Weissbourd (1994) has emphasized the "intent (of family support programs) to extend well beyond the initial goal of establishing linkages and to work instead to build a comprehensive community of support for parents" (p. 40).

While descriptions of family preservation services suggest that services are provided in the community (e. g. Berry, 1997) and discuss the importance of linking families to community resources (McCroskey & Meezan, 1998; Pecora et al., 1992), there is less of a focus on the community in family preservation services. In its place there is a much greater focus on service provision in families' homes (Berry, 1997; Fraser et al., 1997; Grigsby, 1993). Fraser et al. (1997), however, combine both in-home services and community-based services in an element he calls an "in vivo focus." He describes this "in vivo focus" as service provision that is focused on the present and delivered in a home or community setting, and believes that in vivo focus is one of the seven essential elements of family preservation practice.

Some empirical evidence supports clinical impressions regarding the importance of in-home services. Berry (1994) found, in a study of outcomes in a family preservation program, that no children were removed from their families in cases where more than fifty percent of caseworkers' time had been spent in the home. This was in contrast to a twenty-eight percent placement rate when more than fifty percent of caseworkers' time had been spent in the agency.

4.1.7 Relationships are Important

Both the family preservation and the family support literatures emphasize the importance of the characteristics of the relationships between staff and families. Some sources discuss this in general terms. For example, the Family Resource Coalition of America (1996) describes an essential element of practice as "staff and families work together in relationships based on equality and respect." Other authors discuss the relationship essentials in more specific terms, describing them as being characterized by collaboration and shared decision-making (Kagan & Shelley, 1987; Weiss, 1990), which attempt to alter the traditional balance of power in worker-family relationships (Dunst et al., 1994). A recent study found that both parents and staff identified similar characteristics as essential to collaboration. These included trust, mutual respect, open communication,

honesty, active listening, flexibility, caring, information sharing, and support (Dunst et. al., 1992).

Several evaluations of family support programs have found that one of the important program features appears to be the quality of the relationship between families and staff (Powell, 1994; Yoshikawa, 1995; Olds & Kitzman, 1993; Gomby et. al., 1995). Comer & Fraser (1998), in a review of six successful family support programs, found that a common characteristic of the six successful programs was that family members were viewed as colleagues and were involved in planning and carrying out service-related activities.

In the family preservation literature, the importance of the relationship between families and caseworkers is also emphasized. Family preservation programs emphasize the idea that a supportive, empowering, and respectful relationship with families facilitates change (McCroskey & Meezan, 1998). Some empirical support exists for the importance of the relationship. Two separate studies found that the relationship between the worker and the family was more critical to the family's success than structural features of service provision such as the length or intensity of services, or the workers' caseloads (Jones et al., 1976; McCroskey & Meezan, 1997). It should also be noted, however, that for workers to establish positive relationships with families, they need manageable caseloads, adequate training and supervision, and a commitment to the philosophy and values of family-centered services.

4.2 Specific Services and the Structure of Services

While family preservation and family support programs share the above seven critical elements, they may structure their services differently, consonant with their different goals and targeted families. Because family support programs are intended for families who are coping with the normal stresses of parenting related to stressful life circumstances and inadequate support, these programs are generally open to anyone who chooses to participate, and enrollment is voluntary. Family preservation programs, on the other hand, are designed to help families who are facing serious problems, and possible out-of-home placements, and participation may be required.

While the structure of specific services varies considerably, both types of programs share a number of service types. Specifically, both family preservation and family support programs may offer educational or skill building services, supportive services, concrete

services, clinical services, and advocacy services. The specific focus and content of these services may vary between the two types of programs. In addition to the types of services they have in common, family support programs may also provide social and learning experiences for parents and children, as well as often focusing on specific concerns such as medical care. Also in addition to common services, family preservation services generally offer crisis intervention and 24-hour availability, since the families in these programs are generally at some crisis point in their lives.

Empirical support for services that lead to positive outcomes is limited, especially in regard to family support services. Few researchers have focused exclusively on service composition and characteristics and their relation to outcomes (Berry, 1997). In addition, in those outcome studies that have evaluated the relationship between service composition and characteristics and client family outcomes, many found the relationship between service characteristics and outcomes to be inconsistent (e.g., Barth et al, 1986; Berry, 1992; Bribitzer & Verdieck, 1988; Hess et al., 1992). Most of the empirical findings in the literature concern specific structural or service elements of family support or family preservation services. These findings will be reviewed below.

4.2.1 Structure

Family support services are generally open to all, however, they may have as a goal service to the community at large, or they may focus on specific concerns, such as pre-natal care or child developmental screening. Family preservation services, by contrast, are based on referrals of specific families in need of services, and generally progress through an initial assessment and treatment planning process that generally includes establishing a contract with the family. Family preservation services are generally short-term and intensive, with workers carrying small caseloads, although the intensity varies depending on the type of family preservation program (Berry, 1997; Fraser et. al, 1997; Kinney, Haapala, & Booth, 1990; Pecora, Whittaker, & Maluccio, 1992; Whittaker & Tracy, 1990).

Reviews of evaluations of family support programs have shown that the design of the family support program appears to significantly influence outcomes; important program features appear to be the frequency, intensity, and comprehensiveness of the program services (Powell, 1994; Yoshikawa, 1995; Olds & Kitzman, 1993; Gomby et al., 1995). However, in the family preservation literature, findings regarding service intensity have been

conflicting; some studies have found a relationship between service intensity and outcome, while others have found no relationship (Barth et al., 1986; Frankel, 1988).

4.2.2 Services

The literature reviews two types of family support programs. The first focuses on global family outcomes (strengthening families or helping families realize greater potential). These programs are more likely to employ community-organization initiatives and an ecological or multi-systems approach (e.g. creation of a family resource center where participants might go to meet and discuss neighborhood issues). The second type focuses on more specific concerns such as prenatal and infant health, children's school readiness, family literacy, prevention of child abuse, or teen parenting (Comer & Fraser, 1998; Kagan, 1996).

Evaluations of successful family support programs reveal a set of interventions common to most, which are often organized along educational, medical, and social dimensions (Comer & Fraser, 1998; Kagan & Shelley, 1987; Weiss & Jacobs, 1988). These interventions, which appear to form the core elements of family-support programs, include: home visiting (to provide support & concrete assistance), child development screening (medical, social, & health), parent training (in child development, discipline, nutrition), and social, emotional, and educational support for parents. In addition, other services common to many programs include: child care, educational programs for children, referral and advocacy information, organized activities or sporting events, prenatal or neonatal care, adult education (including GED prep and ESL), and opportunities for family members to interact with other families in support groups and organized activities.

The family preservation literature discusses two types of family preservation programs, rehabilitative family preservation and intensive family preservation. The services provided in these two types of programs are similar, but families receive rehabilitative services when abuse or neglect may lead to removal at some point, versus intensive services, which are provided when the family's problems make removal imminent or when reunification efforts are underway (McCroskey & Meezan, 1998)

A wide range of services is often part of family preservation services, usually including a mixture of services such as case management, advocacy, home-based counseling, behavior modeling, parent education, anger management, techniques for coping with

behavior problems, communication skills, assertiveness training, linkages to community resources, respite care, intensive in-home assistance by parent aides, crisis intervention, and concrete services such as transportation, clothing, emergency funds, and help with housing (Ahsan, 1996; Fraser et al., 1997; Nelson, Landsman, & Deutelbaum, 1990; Pecora et al., 1992; Pecora et al., 1995).

There is empirical support for a number of family preservation services. Fraser et al. (1997), after reviewing successful family preservation programs, found that four types of services were common to the successful programs. These services included crisis intervention, skills building, marital and family intervention, and concrete services. Pecora et al. (1992) surveyed workers regarding what interventions they felt were most effective. Workers cited concrete and goal oriented services as being most effective. Specific examples they gave included role-playing and modeling, teaching and demonstrating appropriate parenting behaviors, keeping behavioral records, using psycho-educational materials, and fostering the use of appropriate communication techniques.

Several studies have examined the correlation of hard (concrete) and soft (clinical) services with case outcomes. Lewis (1991) found that one concrete service, "giving financial assistance," was associated with "establishing trust between therapists and families." Fraser, Pecora, & Lewis (1991) reported that the overall amount of time spent providing concrete services was significantly associated with reduced risk of placement, but no clinical services were related to outcome. McCroskey & Meezan (1997) found that family reports of help received in a specific area were correlated with improvement in that area according to both parents and caseworkers. However, when the family needed help in concrete areas, such as finances and living conditions, receipt of such help was a prerequisite for improvement in interpersonal areas of family functioning.

Berry (1994) found that concrete and enabling services were associated with better outcomes for families in general. Specifically, families were most likely to remain intact when services had included modeling effective parenting skills, teaching family care (like cooking and health care), and securing food and medical help. Families who received these services made the greatest gains in skills and were the most likely to remain intact after leaving the program. More “clinical” services, such as counseling and assessment, were not associated with better outcomes even though they were provided in greater (though not significantly so) amounts to families who subsequently had a child placed.

Attention to the repair of family relationships has been found to be important in many different types of programs (Meezan & McCroskey, 1996; Nelson & Landsman, 1992; Nelson & Hunter, 1994). This attention generally includes either de-escalating parent-child or marital conflict or repairing relationships with the extended family. Two studies provide evidence for the effectiveness of support services. Brunk, Henggeler, & Whelan (1987) found that without attention to support for caregivers, parent education by itself showed little ability to improve parenting. Bribitzer & Verdieck (1988) found only the number of support services used by a family to be significantly related to outcome.

The most encouraging results have been found in programs that combine interventions at several levels. For example, multi-systemic family therapy which addresses family conflict and dysfunction, provides individual therapy, and works with parents to improve relationships with the school and promote prosocial peer activities for their children has been found in carefully controlled studies to significantly reduce placement and recidivism among youthful offenders (Henggeler, et al., 1993); these services have also been effective with substance abusing and sexually offending teenagers (Borduin, Henggeler, Blaske, & Stein, 1990; Henggeler et al., 1991)

There is also a literature on "enhanced" services for families that have not traditionally been successful in programs, generally families in poverty, and families with neglect allegations. Fraser et al (1997) notes the lower levels of success in family preservation efforts with families referred for child neglect. He notes that brief models of family preservation services may be of insufficient duration to affect the complex parental and environmental factors that place children at risk of neglect. He cites findings that demonstrate effectiveness with this population, using services of longer duration (Guterman, 1997; Kolko, 1996 in Fraser, et al., 1997). In support of this issue of duration, are findings from secondary prevention programs. Daro & McCurdy (1994) found that providing services to parents for longer than six months was critical to successful intervention with parents at high risk of maltreating their young children. Wells & Tracy (1996) also suggest the necessity of long-term family preservation services for public child welfare practice.

Dore (1993) also discusses ways of enhancing family preservation programs. She notes findings that demonstrate that family preservation is less effective with maltreating families characterized by extreme poverty, single-parent status, low educational attainment, and mental health problems. She suggests that work with these families must include a

supportive relationship built over time with a skilled therapist, assistance in obtaining concrete resources, screening for depression, attention to the treatment needs of women (e.g. domestic violence, history of childhood sexual abuse), and attention to poverty. She also suggests the need to assist families in building alternative coping behaviors (problem solving, tension reduction, use of social skills, self-disclosure-catharsis, assertive responses) by empowering clients through a series of small successes. Lightburn & Kemp (1994) suggest a strategy similar to this last point, for family support services. They suggest that family support services should be structured as a set of interconnecting and achievable steps that allows families to build on their successes.

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5 Ten Successful FCS Programs

Identification of successful FCS programs is important to the current project in a number of ways. Information gleaned from a review of successful FCS programs can highlight important considerations in the implementation and maintenance of programs, suggest methods of overcoming obstacles, and provide examples of innovative program designs, useful outcomes, and methods of data collection. In addition, identification of successful programs allows for discussion of the critical elements of success, or "best practices," in a concrete manner. Finally, the identification and discussion of successful FCS programs can suggest ways in which crucial aspects of these successful programs can be replicated in other programs or LANs. The programs identified here were chosen to aid in informing this process but are certainly not the only successful FCS programs.

5.1 Method

To select successful FCS programs, researchers began by identifying LANs that seemed to be successful according to a variety of criteria. The first step in identifying successful FCS programs was an examination of the number of successes reported by each LAN and the degree to which these successes matched stated program goals. During the course of the FCS 97–99 Evaluation, 34 of the 62 LANs were visited for in-depth field research and information on goals, obstacles, and successes was collected. This information was compiled in a database, called the LAN Archival and Field Research Database (LAFR). Based on information in the LAFR database, it was calculated that the 34 LANs visited reported an average of five successes, ranging from increased collaboration to increased positive youth behaviors. The selection of successful programs followed a two-pronged approach. In the first, the social histories of all 62 LANs were reviewed and potential programs identified. At the same time the LAFR database was reviewed and programs from the 34 site visits were also identified. The process for identifying programs from the LAFR database is described below.

All LANs reporting six or more successes as recorded by project researchers in the LAFR database were compiled into a list. The types of successes that were reported by the LANs were then examined. It is important to note that, in general, reported successes were based on the impressions of the people working in each LAN, not on empirical data. The successes reported by the LANs were grouped into three categories: those relating to

process, those relating to outcomes, and those relating to capacity building. The average number of successes was calculated for each of the categories, and LANs reporting a greater than average number of successes were noted. Those LANs reporting a greater than average number of successes in all three areas were compiled into a list, as were those LANs who reported greater than average successes in two of the three areas.

Finally, the goals and successes reported by each LAN were compared, using information from both the LAFR database and the LAN Social Histories. This particular step was important, as the literature suggests that one aspect of a successful program is the ability to produce results that are in accordance with community needs and the goals set for that initiative. The LANs identified as having high congruence between reported goals and reported successes were compiled into a list.

These three methods resulted in different sets of LANs identified as potentially successful. When these three sets of LANs were compared, there were 11 LANs that reported a greater than average number of successes, reported a greater than average number of successes in at least two of the three specific domains (process, outcomes, and capacity building), and that reported relatively high congruence between reported goals and reported successes.

Once successful LANs were identified, the next step was to identify specific successful programs within these LANs. Unfortunately, program information contained in the social histories of the eleven LANs identified as successful was, in many cases, too brief to allow for identification of particular successful programs. Thus, it became necessary to return to the social histories of all 62 LANs, in order to select 10 programs that most clearly exemplified those elements critical to success. Program descriptions that included information on program goals, organization, and successes, and that supported their reported successes with outcome information were selected for further review. Based on these criteria, a preliminary set of successful programs was developed.

Once the preliminary list of successful programs was developed, feedback from DCFS and the FCS Research Committee was solicited. Those who had worked extensively with the LANs during the 1997-99 FCS Evaluation, indicated that some revisions were necessary. The revised successful program list reflects a wider range of regions and program types; this greater variability will greatly increase the utility and scope of any discussion of replicating those programs. The current list of ten successful programs follows, and includes

a program description, program successes, and elements of success exemplified by the program.

These programs are classified into the typology developed during the 1997-99 Evaluation of Family Centered Services in Illinois:

1. Intensive Family Preservation—Target population includes families who are at imminent risk of having a child placed outside of the home, or have been the subject of an indicated maltreatment report; in home services are provided; crisis oriented services (intensive and time-limited) are provided
2. Other in-home services—Services provided in-home, that involve a service goal, plan, and specified interventions.
3. Targeted secondary prevention services—Services provided to at-risk populations, services are designed to prevent the need for DCFS involvement.
4. Family Support Programs—Preventative services provided to the community-at-large. Services focus on building strengths, knowledge, and/or skills.

Categorization of the successful programs into this typology allows for a more in-depth discussion of elements of success exemplified by each type of program.

5.2 Critical Elements of Best Practice

The critical elements of best practice in FCS were then reviewed in light of the information gathered about these ten most successful programs as well as from a review of information on all 62 LAN social histories and the LAFR database. Additional elements were added to the critical elements of best practice and some were expanded or emphasized based on the experiences reported from these programs. Finally, the critical elements of best practice were consolidated based on the findings of the replicability study reported below.

5.3	Ten Successful Progams: Program Descriptions	
LAN	Program Name	Program Description
2	Home Visits for Mothers	Provided by Egyptian Mental Health Center. This intensive home visitation program targeted at-risk first time parents, teen parents, and mothers needing additional parenting and child development skills. LAN 2 reported that the home visiting program worked "extremely well" due to staff following through with referrals, and to an assessment phase during which staff were able to enroll all members of referred families in activities and educational components of the program. The Egyptian Mental Health Center and the Anna Bixby Women's Center were able to work together to provide a complete array of services, including home visits, peer support groups, recreational activities for families, and volunteer mentors for young parents and parents-to-be. Outcomes/Successes: In FY98, the Egyptian Mental Health Center served 36 adults and 36 children. Participants were successfully maintained with their children with no DCFS intervention. The program also experienced an increase in volunteer mentors. Critical Elements: Pre-enrollment assessment allows for services to be tailored to specific family needs; services are comprehensive – educational services are bolstered by mentoring, peer support can serve the educational, social, and emotional needs of at-risk parents, and parents-to-be; cooperation between agencies allows for more complete array of services to be provided.

5.3	Ten Successful Progams: Program Descriptions	
LAN	Program Name	Program Description
5	Family Support Program and associated mentoring services	Provided by Catholic Social Services and Lutheran Child and Family Services. The Family Support Program services targeted first-time parents, teen parents, and parents who have children with special needs. The program was developed to assist families with crisis situations and to link them with resources to maintain stability in the home. Intensive in-home parent skill-training was provided. The home-based specialist worked with the family on appropriate parenting skills, behavior management, budgeting, nutrition, meal planning, home management, safety, and communication skills. At-risk parents with a child aged 0–5 who completed the Family Support Program were linked with a mentor who monitored them for one year. The Mentor reinforced the concepts and skills taught in the Family Support Program, making contact with the family at least once per month. During FY97, families participating in the mentoring program were assessed using the Family Risk Scale at the beginning of services, at the end of the Family Support Program, and at the end of mentoring. During FY98, services were extended to families in the local housing project with children under the age of five. To increase services, the program was marketed to school groups, civic groups, churches, medical groups, and other social service organizations. Outcomes/Successes: In FY97, assessments using the Family Risk Scale, which identifies situations predictive of child placement due to neglect or abuse, indicated that each of the families involved in the Family Support Program showed a decrease level of risk (at the end of mentoring). In FY98, Lutheran Child and Family Services provided mentoring/monitoring to 25 parents at high risk for entrance into the child welfare system due to child abuse or neglect. Critical Elements: Program was marketed to organizations in order to increase family services; service was comprehensive – addressing all aspects of parenting and home management, including training in parenting skills, budgeting, meal planning, nutrition, etc; new skills and concepts were reinforced during a one year follow-up period through consistent contact with a mentor; participants' progress and program effectiveness were monitored through use of the Family Risk Scale as an outcome measure.

5.3	Ten Successful Progams: Program Descriptions	
LAN	Program Name	Program Description
7	24 Hour Help Line	A centralized referral process was established through a Family Centered Services Parent and Youth Help Line, via Call for Help, Inc. The Help Line was available 24 hours a day. Community liaisons were engaged to provide local support. Calls included requests for help with child care and respite, youth and teen problems, child abuse, sexual abuse, pregnancy and family planning, parenting skills, transportation, legal assistance, psychiatric problems, and temporary shelter. The greatest emergency need was for financial assistance to pay utility bills, rent and mortgage. Assistance was provided through the client assistance funds. Follow-up contacts were made to assure that families' needs were being met, and to determine if further assistance was necessary. In FY97 and FY98, brochures were mailed to 336 organizations within the area, and the FCS community liaisons began efforts to contact the parents and families in their communities. A needs assessment survey was distributed to schools and community locations frequented by families. Outcomes/Successes: In FY97, a total of 258 contacts were received, and linkage to community support systems were provided to 118 families through referrals to appropriate agencies. Tangible assistance was provided to 11 families. Critical Elements: Referrals were available 24 hours a day; families' service and emergency financial needs were met; follow-up contacts were made to ensure families' needs were met; community input was elicited through a needs assessment survey; advertising and contact with community organizations, parents, and families in the community allowed for an increase in services tailored to the community's' needs.

5.3	Ten Successful Progams: Program Descriptions	
LAN	Program Name	Program Description
25	Project Success	Project Success prioritizes families at-risk for involvement with DCFS. The program uses schools as a primary source of referrals. The program provides in-home and in-school one-on-one parent training and parent-child relationship enhancement, and links to conflict resolution, mentoring, and referrals. Program involvement typically runs for about three months; meetings are daily to weekly in the beginning, decreasing to monthly toward the end. Parent mentors keep logs of intakes. Outcomes/Successes: Development of effective relationships with schools; schools generate knowledge of families and help in identifying families for referral. In addition, the program is flexible in tailoring responses to particular problems, and parent mentoring has gotten 75 parents to training, which is a major achievement in this rural area. Critical Elements: The program is designed to address a wide range of needs, providing both skills training and linkages to conflict resolution, mentoring, and other referrals. Services are provided in natural settings (in-home or in-school), and meetings are frequent and one-on-one. Intakes are monitored through the use of logs. While a case monitoring and reporting system that was in construction had to be abandoned, due to repeated changes in requirements externally imposed on the program, the attempt to develop an organized case monitoring and reporting system is laudable, and shows a focus on outcomes for clients.
27	Parent Education Classes	Provided by Catholic Social Services, “State of the Heart Parenting” serves children ages 4-13 and their parents/guardians. Three times a year, it offers a four-session parenting series which stresses conflict management and communication skills. There are separate workshops for parents and children, followed by a family activity. The program also includes special events during transition seasons (beginning and end of the school year, holidays), and special programs (e.g., for mothers and their pre-adolescent daughters, grandparents as parents, divorced parents and children, children with special needs and their parents). Participants are referred by DCFS and the schools, but also through word-of-mouth recruiting. Outcomes/Successes: Parent surveys given at beginning and end of programs indicate great success in meeting client needs. Despite lack of mandate to attend, a large portion of participants complete the program. Critical Elements: Use of multiple strategies to recruit participants, including a newsletter, informal endorsements by parents, and an emphasis on parent education and support as needed by all parents. Transportation issues are addressed by having meeting in different locations throughout the community and “borrowing” a van from another program. Interagency collaboration occurs on every event. Staff are highly trained and provided with continued, specialized in-service training. Program self-evaluation occurs on a regular basis.

5.3	Ten Successful Progams: Program Descriptions	
LAN	Program Name	Program Description
27	Front End Intervention Project	The project was designed to deflect families from the child welfare system while minimizing risk to the children within those families. Referrals came from DCFS supervisors within the local field offices in Ottawa and Princeton. Referrals were of substantiated, low risk cases, investigated and unfounded cases needing services, and Child Welfare Service cases. The Child Endangerment Risk Assessment Protocol was conducted and child and family service teams were developed. Other activities included family assessments of needs and strengths, linkages to local service providers, short-term case management services, and emergency financial assistance. Seven of the fifteen families assessed were appropriate for the wraparound type services to be provided. Outcomes/Successes: In FY97, fifteen families were screened for services. Seven families were assigned child and family teams. The other eight families were linked with local service providers. In FY98, the program served 56 adults and 70 children. Outcomes for the service indicate that 95% of the families were deflected from the DCFS system. Critical Elements: Assessment of families' needs and strengths to tailor services; services are comprehensive – service, case management, and emergency financial needs are met; child safety is maintained through assessment with CERAP – if child safety could not be maintained through this project, families were sent back to DCFS; use of a client satisfaction survey was planned.
32	Parent/Infant In-home Project	Program is provided by the Janet Wattles Center, and targets caregivers of children 0-4 years with behaviors that indicate risk of significant dysfunction (feeding and sleeping problems; attachment difficulties; aggressiveness). Guardians request services, sometimes with encouragement from their pediatrician, child welfare worker, LAN, or DCFS adoption unit. The program provides counseling during home visits and in office, referrals, case management, individual and family mental health assessments, and psychiatric medication assessment and monitoring. In general, visits take place weekly. The program also attempts to collects outcome information, such as noting observations (for example, of increased parental awareness) in the case record, using the Parent-Child Behavior Checklist (however, they report difficulties in getting both pre-intervention and post-intervention assessments done), and the Child Global Assessment Progress Scale (however, scale is not considered not very appropriate for young children). Outcomes/Successes: There have been no substantiated instances of child abuse for clients involved in the program, and no children have been placed outside the home of the caregiver. The program also reports increased parental awareness. Critical Elements: Program addresses a wide range of needs in a variety of ways. Referrals come from a range of sources. Meetings are frequent, and are provided in more than one setting. Outcome data is collected, including the use of subjective methods and standardized measures.

5.3		Ten Successful Progams: Program Descriptions
LAN	Program Name	Program Description
63	Parents Plus	The program is provided by Metropolitan Family Services of Chicago, and serves parents with children 0-5 years old. Services focus on families living in the four communities located within 3 miles of the office; most families involved are low-income. Participants can come to the drop-in center on their own, but are generally invited or solicited by the program via radio, word of mouth, veteran participants, schools, or brochures. Services provided include informal interaction ande information-exchange among parents; presentations on child development and child-rearing (with subject decided by parents); structured activities for the children; referral information; developmental screening once a year for vision and hearing; and a family camp. The program is offered two days a week in Polish, and one day a week in English/Spanish. There is no time limit on participation except that children need to be below school age. Outcome data is collected through parent feedback surveys, workers' records of parent participation, questionnaires on community resources completed by parents, and standardized measures such as the Index of Parental Stress and Index of Parental Attitudes. Outcomes/Successes: Participants have grown to trust the program and recruit others. The program reports reduced parental stress, improved parental attitudes, and use of community resources. During discussion, parents demonstrate verbal appreciation of strengths and weaknesses of parenting strategies. Critical elements: Program shows a consideration of cultural sensitivity in its provision of services in languages other than English. A mix of structured and unstructured activities provided variety for participants, and services cover health, developmental, skill building and recreation needs of families. Community resources such as schools and radio stations are used to disseminate program information. A trusting relationship has developed between the program and participants, and there are no time restrictions on involvement. Outcome data is collected in a variety of ways.

5.3	Ten Successful Progams: Program Descriptions	
LAN	Program Name	Program Description
65	Parent Training Program	Program is provided by the Community Counseling Center of Chicago, and seeks to aid white, African-American, and Latino parents with little or no income who need extensive services. Many clients are very poor, in need of jobs, single parents, or abandoned families. Thirty-percent of clients are under DCFS mandate; the client calls to register and DCFS later checks in on them. Most other clients come from community agencies, e.g., libraries, shelters, and the 250 agencies receiving the monthly newsletter. Services are provided in-home, in-neighborhood, and in-school. Services include six weeks of parent education classes (two hours each), 3 home visits by the parent educator, and referrals. Outcome data is collected through the use of a pre- and post-intervention instrument developed by the program that consists of eight questions regarding cognitive gains. Parent feedback surveys and home visitor's logs are also used, yielding participant satisfaction data and observed behavior data, respectively. Outcomes/Successes: Close to 700 parents have "graduated" in four years, and participation now averages over 200 parents a year. Last year, 111 parents received home visits. The program has reached English-speaking and Spanish-speaking populations, as well as parents of Ethiopian, Cambodian, Laotian, Chinese, and Vietnamese heritage. Critical elements: The program makes use of an extensive information dispersal and referral network (250 agencies receive the monthly newsletter). Services are provided in a variety of settings. Outcome data is collected, and makes use of both observer and participant reports.
87	Mentor Moms	Targeted teen moms between the ages of 13 and 18 who were participating in prenatal care or who had recently given birth. Mentor Moms, mothers from LAN 87 who were identified as role models and had overcame difficulties with raising their children, gave assistance and support. Mentors were given training on how to communicate the elements of appropriate parenting, how to provide realistic and effective support, and how to recognize the signs of family crisis. The program holds club meetings twice a week, during which participants received training from the Mentor Moms. A LAN resource directory was updated and translated into Spanish to improve access to pre-existing services and programs. The problem of recruiting participants was solved by having Mentor Moms identify young mothers for participation. In FY 97, a teen father's group was also formed, involving job training, support and parenting training. Father's and mothers received counseling together for relationship, parenting skills, child development, and counseling. Five teenage dads were required to establish legal paternity for their children, and received on-site job skill training that led to permanent employment. Outcomes/Successes: No program participant became pregnant for a second time, nor were any instances of child abuse observed or reported. Teen participants were clear about the goals of the program and internalized them. All infants were developing appropriately and immunizations were kept current. Critical Elements: Well-defined population; well-defined goals; comprehensive services; culturally sensitive services (mentors are from similar situation and live in community, resource directory was made available in English and Spanish); participants are made aware of additional services; providers respond well to obstacles (e.g. lack of referrals).

6 Replicability of the Ten Successful Programs

This analysis focuses on the experiences of ten programs sampled from the range of more than 300 program operating throughout the state's 62 Child & Adolescent Local Area Networks (LANs). Available information directed attention to these particular programs as among those that appear to offer documentation of best practices in community-based family support and preservation and of success as measured in participant outcomes. This study addresses the following questions:

- ✍ What do featured FCS programs do that constitutes best practices?
- ✍ How can other LANs implement such programs?
- ✍ What do these programs seek to achieve as favorable outcomes?
- ✍ How do they measure, or document, outcomes?

6.1 Method

Drawing primarily on information contained in the LAN FCS social histories (CFRC, September 1999), the evaluation team's February 1st draft report (*First Project Report*) identified ten programs for this inquiry. Based on feedback from DCFS staff and on further review of program files and field research from the original (1997-1999) FCS evaluation, the list underwent deletion of four programs and inclusion of their replacements. The final list appears below.

After informing program representatives by letter and interview guide and requesting their participation in the study, the researcher conducted the interviews by telephone. The ten primary interviews took from 55 minutes to 95 minutes, with most requiring about 60 minutes. In addition, some interviewees sent in supplemental information.

6.2 Ten Featured Programs

Basic descriptors -- LAN, program name, sponsoring agency, ecological location (urban/rural), and program type -- for the ten featured programs appear below.

Table 6.1 Ten Successful Programs by LAN, Progam Type and Host Agency

LAN	Urban/ Rural	Program	Program Type	Agency
2	Rural	Family Connections	In-home services Targeted secondary prevention	Egyptian Health Department
5	Rural	Family Support Program (and mentoring services)	In-home services Targeted secondary prevention	Catholic Social Services and Lutheran Child and Family Services
7	Rural	24-Hour Parent and Youth Help Line	Family support	Call for Help, Inc.
25	Rural	Parent Services Coordinator	In-home services Targeted secondary prevention services	Project success of Vermilion County
27	Rural	State of the Heart Parenting	Family support	Catholic Social Services
27	Rural	Front-End Intervention	Targeted secondary prevention services	Youth Service Bureau of Illinois Valley
32	Urban & Rural	Parent-Infant In-Home Program	In-home services Targeted secondary prevention services	Janet Wattles Center
63	Urban	Parents Plus	Family support	Metropolitan Family Services of Chicago
65	Urban	Parent Education Program	In-home services Targeted secondary prevention services	Community Counseling Center of Chicago
87	Urban	Mentors of Mothers (MoMs)	Targeted secondary prevention services	Metropolitan Family Services of Chicago

These ten programs extend across the range of FCS programs, including areas primarily rural and primarily urban, small and large agency sponsorship, and types of programs (from in-home services through targeted secondary prevention services to family support). Their FCS contracts range from about $21,000 to $96,000 annually, and this funding constitutes from 19% to 100% of total program budget (with 7 of the programs relying on FCS for 80-100% of their funding). FCS funding was used to create all but one of these programs. Thus, this small sample nevertheless provides significant representation of the variety of FCS programming.

6.3 Lessons for Replication: Elements of Best Practice

The findings of the interviews with key representatives of these ten featured programs reveal some key patterns and characteristics. These dot points stand out as important lessons learned from the experiences recounted of these ten programs.

6.3.1 Management and Staffing

- ✍ offer substantial entry-level training and focused, opportunistic ongoing training
- ✍ benefit from local FCS planning/collaboration/monitoring process
- ✍ have detailed knowledge of local problems, resources, culture, and community context
- ✍ have in place and build on good working relationships and service record in community
- ✍ have developed a serious, ongoing planning process, beginning with early identification of likely obstacles, e.g., transportation, extended family opposition, gang turf issues, and devising anticipatory responses to them

6.3.2 Cultural Sensitivity/Competence

- ✍ cultural sensitivity (e.g., location of services, knowledge of community culture, relationship building) is essential for program effectiveness

6.3.3 Resource Usage/Collaboration

- ✍ provide quick response capability to address family needs – cutting through usual bureaucratic and turf obstacles to service delivery
- ✍ further build trust of program participants by responding quickly and effectively to immediate needs for assistance
- ✍ coordinate and manage existing services where relatively abundant, while concentrating on filling in gaps in communities lacking necessary services
- ✍ an ethos of making do – excellently -- has emerged, as confident programs skillfully and pragmatically stretch scarce dollars to address huge needs

6.3.4 Family and Community Outreach/Empowerment

- ✍ emphasize clients/participants/community residents solving own problems (with facilitation from program), including increasing their knowledge of available

resources and developing their capacity to use them and to train peers accordingly

✍ emphasize and nurture word-of-mouth recruiting

✍ situate program in physical settings, such as schools, where participants feel comfortable and safe, not stigmatized, and which offer opportunities for mutual aid social relationships, e.g., with other parents

6.3.5 Identifying and Documenting Favorable Outcomes

With regard to the need to document program outcomes, the interviews revealed the following.

✍ a continuing general pattern of local perceptions of effectiveness, but without accessible and reliable documentation

✍ great variation, even within this select group of programs, in efforts to provide such documentation

✍ efforts extending to systematic use of pre- and post-instruments, even to planned hiring of full-time outcomes analyst, but much remains in narrative or anecdotal form

✍ the possibility of a reverse halo effect in pre-tests (before participants trust the program) suppressing evidence of program effectiveness

✍ concerns expressed about Quarterly Progress Reports, and associated record of changes and questions about utility

✍ the need to avoid evaluation overkill, relative to small amount of funding provided but great scrutiny devoted

6.3.6 Service Specific Issues

✍ generally, emphasize application of basic principles of family support

✍ in particular, take a strengths-based focus

These programs exhibit a maturity such that now, after several years of development, each displays a substantial history, institutional memory, and experience in crafting a program theory or logic model that makes sense in terms of local realities and that works in addressing local needs.

6.4 Replication Lessons by Program Type

The FCS Program Evaluation Technical Assistance Project emphasizes the importance of tailoring outcomes measurement approaches to the realities of individual program focus, activities, and context. Thus, this study also studied potential for replication by program type. This analysis uses the classification scheme developed in our earlier evaluation (CFRC, 1999a: 71-72), with special attention to the following three components:

> *In-home services (treatment/intervention services)* are those services provided in the home setting (e.g., homemaker, counseling, case management) that involve a service goal, plan, and specified interventions. The clientele is open, although services may be targeted at DCFS clients. While not necessarily synonymous, in-home services are often also referred to as family preservation services.
>
> *Targeted secondary prevention services* are provided to targeted, at-risk populations; services are an effort to prevent the need for DCFS involvement. The target population may include DCFS clients, but is not specifically limited to them.
>
> *Family support services* encompass preventive services provided to the community-at-large. Program services focus on building strengths, knowledge, or skills.

Concise, detailed descriptions of each of these ten programs appear in the prior section of this report (Section 5.3).

6.4.1 In-home Services Combined with Targeted Secondary Prevention Services

These five programs -- LAN 2's Family Connections, LAN 5's Family Support Program, LAN 25's Parent Services Coordinator, LAN 32's Parent-Infant In-Home Program, and LAN 65's Parent Education Program -- represent the more intensive end of the FCS continuum of services. In addition to offering in-home services as a key program component, they include various out-of-home services as a critical program complement.

Thus, issues for replication include the general requirements for effective in-home service delivery and attentiveness to community context realities. These realities vary across the ecological range of Illinois -- from rural areas in the southern and central-eastern parts of the state to a mixed urban-rural LAN in the far north to a large sections of Chicago's north side. Yet all these programs share various challenges in offering services most needed by those families most deprived of economic resources. These challenges include designing attractive and appropriate services, reducing stigma sometimes associated with them,

ensuring interagency cooperation, and relying on informal sources of information and mutual aid to spread program reach and impact.

In general, the interviews indicated that other areas could replicate all of these programs, assuming that they face comparable contextual issues and plan carefully. Hence, rural areas facing access difficulties associated with transportation shortages can build corrective costs into the budget (e.g., Family Connections), arrange sessions opportunistically in the community on a mentoring outreach basis (e.g, Family Support Program), or rely additional telephone contact (e.g., Parent-Infant In-Home Program). Successful replication also would depend on appropriate, sufficient, and ongoing training, and complementary supervising arrangements.

Reliance on other community agencies to provide referrals and other types of cooperation, e.g., Parent Services Coordinator Program's work with schools in particular, depends on a history of trust relationships and ongoing nurturing of them. Likewise, here as elsewhere, no cookie-cutter or one-size-fits-all approach will suffice. Thus, program operators must develop a fine ear for variations across schools and even within schools as to what relationship building requires in a particular setting.

Another key theme emerges with reference to complementarity of program components, a fundamental consideration for prospective programs seeking to combine in-home with in-office or in-community services. For example, the Parent Education Program finds that providing free services and amenities serves as a draw, but does not determine program success. Instead, the presence of excellent parent educators, together with in-home visiting and language fluency and cultural sensitivity, encourage participants to bond.

Perhaps the most difficult challenge for replication concerns the availability of appropriately qualified staff willing to work within what programs with limited funding can provide. As with the Parent-Infant In-Home Program, this often will require only part-time assignments or the necessity of transforming clinicians into clinician-administrators.

What considerations for replication do in-home services in particular pose? In general, as indicated in the research literature (e.g, Olds) and implied in the interviews, in-home services promise an especially appropriate and intensive response to the needs of families dealing with multiple and severe stresses. As such, they especially require adequate resources such as training in skills needed to motivate and encourage parents dealing with

extreme deprivations. They also can exhaust providers, for example, part-time mentors covering large geographic areas and lacking frequent workgroup contact.

At the same time, the perceived behavioral impact of in-home services needs documentation in logs maintained by home visitors. In turn, agencies will need to devise ways to extract and summarize such case histories to document program outcomes in general.

When other services follow in-home services, the program needs to make the transition as smooth as possible. Thus, toward the end of the 4-6 week in-home intensive training phase, the Family Support Program brings in the mentor who then works with the family for a year. Also, for a non-mandated population (with a majority referred from schools), the program emphasizes from the beginning that the home visitors are guests who can be asked to leave at any time. It thus attempts to foster a more congenial approach yet must inform families that these guests also are mandated reporters.

Home visiting also presents major needs for on-going supervision, especially of mentors. Similarly, such programs must provide for ongoing supervisory contact, both in-person and supplemented by phone, as geographic dispersion requires. In addition to supervision of service delivery and case consultation, this contact addresses the personal safety needs that can attend this work. This consideration also can require initial supervisory screening visits prior to dispatching a home-visiting mentor.

6.4.2 Targeted secondary prevention services

These two programs -- LAN 27's Front End Intervention Project and LAN 87's Mentors of Mothers (MoMs) Program -- emphasize secondary prevention. The meaning of secondary prevention, differs between the programs, with the first program emphasizing deflection from DCFS and the second working toward no subsequent unwanted pregnancies. In addition, they share the common goal of preventing child abuse and neglect.

The most salient point in looking at these programs is what they can tell us by virtue of the contrast presented by their ecological locations. What considerations for replication do they share? How do replication needs differ for the rural program representative in contrast to the urban program representative?

Both programs offer strong prospects for replication, according to interviewees. The Front End Intervention Project has already been replicated in a couple of other LANs. Its

CERAP assessment and wraparound linkage approach, responding to immediate crisis on a short-term (two weeks) basis, is straightforward and amenable to community-specific replication. The MoMs program also has attracted interest from elsewhere and has counterparts. One special feature, the program apartment used as a focal point for group sessions, would need to be provided for in any faithful replication.

One clear contrast derives from differences in program intake arrangements. The Front End Intervention Project receives its referrals from DCFS while MoMs must generate referrals from schools and other local agencies. While the former program initially had to seek and advocate for referrals, it now has an abundance of cases. In contrast, the latter program continues to need to aggressively seek out referrals and recruit young mothers at risk.

In different ways, these two programs have experienced rather smooth staffing arrangements that auger well for any areas considering replication in similar contexts. Thus, the MoMs Program has had no problems in recruiting mentors, usually women from the community. Also, they tend to stay with the program, such longevity contributing to program stability. The Front End Intervention Project has a markedly different staffing situation, assigning cases on a rotating and as-needed basis to staff who typically have other responsibilities. For some, the FCS assessment and linkage work constitutes a change of pace from their usual routine. For others, it amounts to more of the same kind of work, but without the same bureaucratic requirements with which to contend. Hence, in either situation, this work provides some intrinsic interest or relief for staff doing the assessments. Thus, both programs enjoy relatively high staff morale along with some passion for the work.

Finally, the realities of poverty link this rural and this urban program, albeit again taking slightly different forms. FCS interagency collaboration enables the Front End Intervention Project to arrange for greatly reduced charges from categorical service agencies for clients with no insurance coverage. Paradoxically, the MoMs Program must sometimes temper the eagerness that the teen mothers sometimes show for paid employment by noting that the minimum wage jobs available to them actually would put them further behind economically after taking into account child care and transportation costs.

6.4.3 Family support services

These three programs -- LAN 7's 24-Hour Parent and Youth Help Line, LAN 27's State of the Heart Parenting, and LAN 63's Parents Plus -- represent a majority of original FCS programs and the two-thirds of funding designated for family support services. As described more fully in Section 5.3, these three family support programs offer rigor, focus, and structure, albeit in different ways. Thus, the 24-Hour Parent and Youth Help Line program provides telephone hot-line services modeled on the agency's longstanding suicide prevention service. Similarly, State of the Heart Parenting delivers a series of parenting workshops that first deal separately with parents and children and then bring each family together to work on a shared activity. Finally, Parents Plus offers parenting education in three languages (Polish, Spanish, English) as a drop-in center activity.

As with the two previous program types, the family support services programs also offer strong promise for replication -- contingent on local circumstances and care taken in planning and flexibility in implementation. The 24-Hour Parent and Youth Help Line might be the most difficult to replicate since it built on a long-established program and its relationships and infrastructure. Thus, the program representative interviewed stresses that an area could hardly simply begin such a program in a church basement somewhere, and that it would require sufficient funding.

State of the Heart Parenting also depends on certain requisites, but having more to do with program leadership and philosophy than with resources. Hence, the program representative interviewed emphasizes that any replication would need to: embrace the idea that family-building is a challenge for all members of a community; offer a program where everyone works together; recognize that needs must be addressed by the community -- including those served, not just the agencies; and offer the program free of charge. Nevertheless, with the transportation gaps and dispersed geography of this rural LAN, it could not be any more difficult to try to launch a similar program elsewhere.

Parents Plus already has demonstrated the potential for replication in that the sponsoring agency operates the program in three other locations in Chicago. This experience demonstrates that the framework can be transferred and work elsewhere, just needing adjustment to local parenting needs. The program representative interviewed highlights the need for intense focus on whom to outreach to and how and for reasonable expectations tailored to best serving the community, for example, program scheduling

around other responsibilities participants must accommodate. For this program, this meant focusing on older mothers (over 20 years of age) after learning not to mix teen and older mothers due to different issues faced and attendant frustrations that can arise.

As may be more generally characteristic of wider access family support programs, these three also have had to attend energetically and thoughtfully to participant recruitment and engagement. Strategies including broad circulation of information, via brochures and newsletters, together with relying on collaborative relationships with agencies and developing trust relationships with participants.

6.5 Potential for FCS Outcomes Measurement

As noted above, FCS experience offers much more extensive lessons for program replication than for replication of outcomes measurement. Nevertheless, some promising examples also emerge in this area from the interviews with these ten featured programs. All of the programs recount successes perceived, all impressive and all important relative to program goals. Those familiar with FCS history already recognize and value such statements.

All the programs recognize the desirability of more adequately documenting participant outcomes, yet deal with the twin demands of continuing to operate the programs effectively and realistically and reliably measuring outcomes in a practical way. Participant satisfaction surveys and case records remain popular, but generally are insufficient in one way or another, either in terms of substantive significance or logistical accessibility. Pre-intervention and post-intervention instruments are used by some programs and show promise, but pose challenges of attrition or artifact (for example, a reverse halo effect for pre-intervention measurements when client/participant suspicions have not yet been allayed and trust relationships established in the course of service interactions).

Yet, these FCS programs display a refreshing perseverance in continuing to seek to solve this puzzle too. The need for guidance and technical assistance surfaces especially clearly in this context. One program has even submitted a proposal for a foundation grant that would include funding for a full-time outcomes documentation specialist. (In the spirit of practical technical assistance, CFRC provided a job description in support of this effort.)

A thumbnail sketch for each of the ten programs follows. It highlights what each as attempted or plans with regard to outcomes measurement.

- ✍ LAN 2 Family Connections - gathering data on nine outcomes linked to goals, will create file on each and every report
- ✍ LAN 5 Family Support Program - Family Risk Scale and Adolescent Adult Parenting Inventory document generally favorable outcomes, including desired increases in parenting skills
- ✍ LAN 7 24-Hour Parent and Youth Help Line - while frequently never meeting clients, nevertheless receives calls from many families expressing appreciation for critically needed services
- ✍ LAN 25 Parent Services Coordinator - worked closely and intensively with local community college to design a Microsoft Access program to document outcomes, but had to abandon due to frequent changes in FCS reporting requirements
- ✍ LAN 27 State of the Heart Parenting - conduct parent evaluation survey at start and end of most programs
- ✍ LAN 27 Front End Intervention Project - deflect cases from DCFS so that it does not have to respond to reports
- ✍ LAN 32 Parent-Infant In-Home Program - no founded instances of child abuse; no children placed outside of home of caregiver; Parent Child Behavior Checklist administered pre- and post-intervention; use Child Global Assessment Progress Scale reluctantly (not actually appropriate for young children, but not much else available)
- ✍ LAN 63 Parents Plus - 80% of parents complete Index of Parental Stress and Index of Parental Attitudes, and show 10% reduction/improvement at end of 6 months
- ✍ LAN 65 Parent Education Program - collect cognitive gain data via pre- and post-intervention instrument adapted by program, participant perceptual data from feedback surveys, and behavioral data from home visitors log
- ✍ LAN 87 Mentors of Mothers (MoMs) - 5 of 6 current participants, graduating from high school, plan to go on to college; no second pregnancies among those who continue to participate (over 100; about 3-4 second pregnancies among those who have dropped out of program); no founded reports of abuse ore neglect; program evaluation report completed recently by Institute of Juvenile Research

Program managers interviewed, often with responsibilities for other programs, tend to report a special fondness for their FCS programs. This appears to reflect a belief that the approaches devised represent how communities and agencies should respond to family need and seek to improve the welfare of children. This appears to be more than a matter of the

pride of ownership, of having helped devise these programs -- although that is an important consideration not to be viewed cynically -- but a kind of measure of what such programs, now with significant history, accomplish. In addition, several favorable comments also emerged about the value of the LAN approach to supporting and monitoring FCS program development.

7 Elements of Best Practice Table

The table of critical elements of successful FCS practice was compiled through an iterative process of

- ✍✍ reviewing the findings of the Evaluation of Family Centered Services 1999;
- ✍✍ reviewing the best practice, family support, and family preservation literatures;
- ✍✍ interviewing the staff of the FCS programs identified as successful; and
- ✍✍ identification of salient factors essential for successful replication.

To enable readers to more easily understand how these elements of best practice relate to different aspects of successful programming, the table is divided into two main sections: elements that are considered best practices for all FCS programs and elements of best practice that relate specifically to different program types.

The general elements of successful FCS practice are grouped under seven categories: Management and Staffing; Establishing Needs and Goals; Cultural Sensitivity; Collaboration/Resource Usage; Context/Substance of Programs; Family and Community Outreach/Empowerment; and Evaluation/Outcome Measurement. Management and Staffing includes elements related to providing strong, efficient leadership, and to selecting and training capable, effective staff, both at the LAN level and program level. Establishing Needs and Goals covers those elements related to development of relevant goals for individual programs. Cultural Sensitivity includes elements related to ensuring that services and staff members reflect a dedication to providing culturally relevant services that show respect for the beliefs and strengths of family and community members. Collaboration/Resource Usage lists elements that are important to strengthening collaboration efforts, and developing and expanding resource networks. Context/Substance of Programs includes elements concerning program goals and aspects of program structure. Family and Community Outreach/Empowerment lists elements related to involving family community members in all aspects of programming, as a means of strengthening family/community ties and enhancing service provision. Finally, Evaluation/Outcome Measurement deals with those elements that provide for efficient data collection, and the selection and reporting of appropriate, descriptive outcomes.

Program specific elements vary greatly across programs and cannot be generalized across all program types. It is important to note also that program specific elements do not replace the general elements of best practice, but are supplemental.

For clarity, the elements of successful practice for specific program types are organized into two groups. DCFS requires each LAN to complete FCS Quarterly Progress Reports, in which they broadly classify individual services/programs as either Prevention/Support Services, or Intervention/Treatment Services. Support/Prevention Services are community based, open to the community at-large, and may or may not have a targeted population. Intervention/Treatment Services are generally directed at families who are at imminent risk of having a child placed outside of the home, who have been the subject of an indicated maltreatment report, or who are preparing to reunite or adopt. These services are typically crisis-oriented and often provided in-home.

Prevention/Support Services include both Family Support Services and Targeted Secondary Prevention Services. Both types of services are designed to protect children and increase child and family well-being by addressing community, family, and personal issues that can lead to child abuse and neglect. While Family Support Services are typically offered to the community at-large, Targeted Secondary Prevention Services are directed at groups known to be at a higher risk of child abuse and neglect.

Intervention/Treatment Services include Family Preservation Services, In-home Services. Both types of services are directed at families who have either been brought to the attention of DCFS and are at imminent risk for child abuse/neglect or out-of-home placement, or families that are scheduled to reunify or adopt. Family Preservation Services in this context, are crisis-oriented, often include an in-home component, are intensive in nature (e.g., the caseworker meets with clients at least once a week), and time-limited. In-home Services are provided in the client's home setting, and involve a service goal, plan, and specified interventions. These services are most often a part of family preservation efforts, but not always.

Elements included in the tables are drawn from a wide variety of sources, the majority of which are discussed in the earlier, in-depth discussion of elements of best practice. In some cases, elements have been reworded, combined, or broken down to improve clarity. It is important to point out that the table is not exhaustive, and there may be elements that do not appear due to lack of consensus or other reasons. As much as possible,

all elements that commonly appeared in the literature, that have been borne out through empirical study, and that have been suggested through interviews conducted with FCS program staff were included. In general, there was considerable consensus between these sources.

Table 7.1 Elements of Best Practice and Outcome Reporting

Elements of Best Practice
I. Generic Elements of FCS Service Provision
A. Management and Staffing
Oversight/Planning/Steering Committees
1. Application of and adherence to basic principles of family support
2. Governing body includes parents and community representatives, such as schools, churches, grass roots organizations, banks, legislators, etc.
3. Input from parents, staff members and community resources is included in assessment of community needs
4. Input from parents, staff members and community resources is included in planning of services
5. Governing body requires/elicits frequent communication from local service providers (for example, briefings, monthly reports, monthly meetings, monthly site visits, etc.)
6. Parents, community members, local providers, and other interested parties are made aware of all scheduled meeting times, and have access to minutes from each meeting
7. Local providers and staff members are made aware of all decisions made by the governing body
Local Providers/Agencies
1. Program directors/managers are experienced and committed to the goals and principles established for the program
2. Program directors and staff members are knowledgeable about the resources available in the community
3. All staff have an explicit awareness of what the program's goals are
4. Staff and volunteers are provided with a vehicle for voicing concerns or complaints (for example, comment boxes or weekly staff meetings)
5. Program managers elicit frequent communication from staff and clients/consumers on programmatic issues and satisfaction with services (for example, weekly staff meetings, or anonymous client satisfaction surveys)
6. All staff and volunteers receive appropriate and sufficient training upon entry. Staff's training næds are periodically surveyed to ensure that staff and volunteers feel adequately prepared for their duties, and that additional training is provided when necessary.
7. A staff support group or similar arrangement is organized so that staff have an opportunity to receive emotional support
8. Responses to issues raised by staff and clients are timely, and staff/clients are made aware of changes and reasoning behind those changes

Elements of Best Practice
I. Generic Elements of Service Provision (continued)
B. Establishing needs and goals
1. Parent, community and local providers are involved in needs assessment and goal development
2. Both long-term and short-term (e.g. yearly) goals are identified; services and target populations are also well-defined and in line with these goals
3. Needs, goals and services are continuously monitored to ensure that goals remain consistent over time, and also to ensure that services are relevant to existing needs and identified goals
4. Staff and clients are made aware of what FCS and individual program goals are
5. Program goals remain consistent over time, yet are also responsive to changes in community needs
C. Cultural sensitivity
1. Involvement of parents and community representatives in needs assessment, planning, and monitoring encourages services that are culturally relevant and sensitive
2. Services are readily accessible to clients (in-home/neighborhood), and in settings which are comfortable to the participants
3. Clients have active role in development of service plans
4. Services/interventions are individualized, addressing specific needs/goals of client/family
6. Services and service planning focus on client/family strengths, in addition to addressing weaknesses
7. Training of staff and volunteers includes discussion of cultural sensitivity, how to recognize ones own biases, and how to address bias
8. Services and materials are provided in easily understood language, including bilingual materials or services where needed
9. Mentors are selected from the surrounding community whenever possible
D. Resource Usage/Collaboration
1. Programs identify existing resources in the community, including potential sources of financial support
2. Existing resources are mapped to community needs, in order to identify areas that are lacking.
3. Programs/agencies collaborate with parents, parent organizations, existing agencies, existing programs, grassroots organizations and others to provide services, forming a resource network to draw on in future endeavors
4. Programs/agencies collaborate with other community providers/agencies to share resources, support or expand upon existing programs and services, and organize a comprehensive set of resources and linkages for clients to make use of
5. Programs/agencies identify outside sources of leveraging; community businesses and organizations, school districts, private organizations, and local, state, and federal government programs or grants are all good sources
6. Programs/Agencies establish public-private partnerships

Elements of Best Practice
I. Generic Elements of Service Provision (continued)
E. Context/Substance of Programs
1. Skill Building—Programs/services do not just address clients' current crises or needs, but provide them with the skills needed to be self-sufficient and address future needs or difficulties
2. Programs/services are collateral/holistic/exhaustive, addressing needs and difficulties from several angles (e.g. teen moms may need development of skills related to parenting, stress management, child development, job training, securing health care, and money management in order to avoid situations leading to abuse or neglect, not just skills related to parenting)
3. Programs/services have mechanisms in place for responding to crisis situations that may arise
4. Programs/services are flexible, offering a variety of ways for families to access services (home visits, group meetings, peer mentoring, etc.)
5. Programs/services work toward increasing each family's linkages with community resources and other community members
6. Supports to allow parents to participate in programs are provided (childcare, respite care, transportation, etc.)
7. Staff monitor clients' progress, current needs, and satisfaction with services throughout the course of the program
8. Staff follow-up with clients after completion of services, monitoring progress and providing assistance when needed
9. Clients are allowed to participate in programs/services until their needs have been fully addressed, not just until a particular program has been completed.
10. Service providers/workers are willing and able to respond quickly to family needs, avoiding many of the bureaucratic tangles that often make accessing services difficult for the general population
F. Family and Community Outreach/Empowerment
1. Programs/agencies act to empower parents/communities through their involvement in goal development and service planning
2. Programs/agencies make an effort to increase visibility and community awareness of programs (through radio spots, newspaper adds, and linkages with other social welfare agencies, parent organizations, local DCFS offices, the local health department, schools, churches, etc.)
3. Agency representatives/staff attend community functions and develop rapport with community members, aldermen, local mayors, etc.
4. Agencies solicit community feedback through forums, open discussions, surveys, radio call in shows, chat rooms, message boards, etc.
5. Parents/clients have a means of making suggestions/complaints that is confidential and comfortable, such as a 1-800-number, one-on-one meetings with staff, easily accessible anonymous suggestion/complaint forms, or provision of program director's phone or e-mail
6. Open-houses, fairs, or other events are staged to allow community members to visit facilities and access many programs/agencies in one place
7. Programs/agencies/organizations collaborate to develop a resource tool with program/agency descriptions and contacts, which staff then keep on hand to distribute to clients. Separate tools could also be developed for specific needs/issues, e.g. respite care
8. Program participants are strongly encouraged to inform others in the community about programs

Elements of Best Practice
I. Generic Elements of Service Provision (continued)
G. Evaluation/outcome measurement
1. Periodic needs, goals, and program assessments involve agency/program representatives, parents, and community representatives
2. Periodic meetings are held to identify and address obstacles encountered by communities, agencies, and organizations
3. Needs are periodically re-assessed to be determine whether those needs still exist, and also to determine if new needs have surfaced
4. Both long-term and short-term community goals are periodically (e.g. yearly) re-evaluated for relevance and progress toward meeting those goals
5. Individual programs goals are periodically re-evaluated to ensure that they fit with current community needs and goals (long- and short-term), and continue to fulfill federal/state requirements
6. A portion of the budget is allocated specifically for ongoing evaluation activities
7. Indicators and outcome measures for each goal (short-term and long-term) are identified
8. An organized process for responding to and incorporating qualitative parent/community feedback is established
9. Methods of data collection are established, including client satisfaction instruments. Data collection is not obtrusive, but is incorporated into the normal record keeping activities of staff members
10. An evaluator is identified (internal or external), and included in the development/selection of outcomes and measures
11. Staff are trained in data collection techniques from the beginning
12. Evaluation methods are documented and made accessible
13. Outcomes/findings are reported; shared with parents, community members, providers, and staff in a way that is clear and easily understood
14. Feedback on outcomes and suggestions for improvement are solicited from parents, clients, staff, and community representatives
15. Allocation and use of funds and staff are assessed yearly, including total funds expended, costs expended per participant and per service hour, number of full-time-equivalent staff, percentage of staff hours spent with clients, etc

Elements of Best Practice
II. Elements Unique to Program Types
Support/Prevention Programs
A. Family Support Programs
1. Family support principles are used to guide development of services
2. Program managers and staff understand and believe in family support principles
3. Service planning is culturally sensitive, taking into account cultural differences; including specific cultural beliefs and needs
4. Services are culturally sensitive, taking into account non-traditional strengths of communities (e.g. close community ties in African-American communities)
5. Services are family and community-focused; assistance takes place with the awareness that the family is not separate from the community
6. Families are encouraged to develop rapport and linkages with program members and the surrounding community
7. Clients/families have direct input into service planning and decision-making
8. Services are designed to improve family functioning and self-sufficiency; particular needs are addressed, but families are also given the skills needed to function successfully once the program has ended
9. Home-visiting services are provided
10. Mentors are drawn from the community and are trained along with staff
11. Services provide access to a wide range of supports; emotional, educational, and financial
12. Participants are provided with/made aware of a wide range of services, and are provided with a simple means of accessing these services (e.g. a resource guide)
13. Youth directed activities are frequent and consistent, incorporate both education and recreation, and involve parents.

Elements of Best Practice
II. Elements Unique to Program Types (continued)
Support/Prevention Programs
B. Targeted Secondary Prevention Programs
1. Target population and goals are well defined
2. Risks particular to targeted groups are identified; service plans focus considerable attention of providing skills needed to avoid those risks
3. Participants are made aware of risks to that group and program goals to avoid those risks
4. Individual needs are also identified and incorporated into service plans
5. System for monitoring progress (outcomes) is pre-established
6. Trained mentors are provided; mentors are from similar backgrounds, circumstances, and/or community
7. Services are culturally sensitive (e.g. providing bilingual materials in predominantly Latino areas
8. Services are accessible (in-home, or within the neighborhood)
9. Services are flexible, providing alternative ways for clients to access services (in home, group meetings, facility visits, peer mentoring, etc)
10. Services are designed to allow participants to function independently at close of the program; this ability is assessed periodically throughout and at the end of the program.
11. After program completion, clients are regularly assessed for progress and additional needs
12. Program completion is determined by client progress rather than by a set time length

Elements of Best Practice
II. Elements Unique to Program Types (continued)
Intervention/Treatment Programs
A. Family Preservation Programs
1. Services are family-based and culturally sensitive
2. Family is involved in all aspects of service development; they assist in developing service goals, are made aware of potential issues/difficulties, are allowed to review and add to needs/strengths assessments, assist in planning of services to be provided, planning of crisis services, and planning of aftercare services
3. Periodic evaluations/needs assessments are used to continuously monitor family progress/change
4. Service plan is modified as family's needs/goals change, in response to progress reports
5. Service plan includes skill building, so that the family has the skills necessary to function independently
6. Service plan includes quick response crisis intervention, including marital and/or family intervention when necessary to de-escalate conflict
7. Community resources are utilized; workers provider referrals to and coordinate with community resources to provide a complete array of services
8. Concrete services are provided (e.g. assistance in meeting food, housing, or health care needs)
9. Workers develop a supportive, trusting relationship with clients
10. Workers are continuously assess and are aware of child safety indicators over the course of services
11. Family monitoring includes frequent (e.g. bi-monthly) home visits by worker and service providers
12. Family instability at start of services is addressed with structure and control imposed by the worker*
13. When a case if transferred from one worker to another, the first worker carries full responsibility for services until the hand-off visit occurs*
14. During the first 90 days of services, workers are especially aware of safety indicators and the effectiveness of the safety plan*
15. Until a trusting relationship develops between workers and clients, the safety plan includes a high level of external oversight *

* Drawn from "Intact Family Services: A Guide to Best Practices" by the Best Practice Workgroup for Intact Families, Illinois DCFS.

Elements of Best Practice
II. Elements Unique to Program Types (continued)
Intervention/Treatment Programs
A. Family Preservation Programs, continued
16. Safety plans must be effective, and require: services that target the behaviors/conditions that immediately threaten the child, services that are available immediately, services that are available in the correct frequencies/amounts, families that are stable enough to participate and make providers feel welcome and safe in their homes, and frequent monitoring by the caseworker and possibly other family members to be assured of the occurrence and effectiveness of services[*]
17. As the family progresses, more objective safety factors assessments should take place, such as supervisory reviews, conferences or crisis planning[*]
18. Workers maintain close contact with service providers, including regular progress reports and immediate contacts if safety concerns or crisis situations arise[*]
19. Families must be evaluated for progress prior to termination of services, including child safety and permanency, family functioning, achievement of service goals, and a joint discussion with the worker, family, and service providers to determine appropriateness of the action[*]
B. In-home Services
1. A pre-enrollment home assessment should be conducted
2. Services address a wise range of skills; parenting, financial management, food preparation, life skills, accessing formal and informal services, knowledge of child development, etc.
3. Services include alternative care service (such as respite/sitter services or personal care assistants) to avoid distraction during home visits and allow parents to focus. Children not directly involved in the program should be watched by another worker or family member
4. Families are encouraged and assisted in connecting to families in similar situations, their neighborhood, and their community at-large
5. Workers are aware of the importance of cultural sensitivity, including: respect for the family's beliefs and practices, worker's ability to speak in the family's native language, awareness of issues that may be of special importance due to culture or ethnicity (e.g. an immigrant family will likely need assistance in connecting to local service structures)
6. Workers must have the ability to establish a rapport with parents, address problems quickly and reliably, and to respond to crises while remaining true to program schedules, and must have in-depth knowledge of supports and services available in the community[??]
7. Workers should have a high skill level, be well trained, and have a degree higher than a high school diploma. Worker should be closely supervised to help them maintain adherence to program protocols, maintain objectivity, deal with emotional stresses, and reflect.[??]

[??] Adapted from "Home Visiting: Recent Program Evaluations-Analysis and Recommendations", The Future of Children, v. 9 n.1, Spring/Summer 1999

Elements of Best Practice
II. Elements Unique to Program Types (continued)
Intervention/Treatment Programs
B. In-home Services, continued
8. Parents must be involved in development of program goals, and must believe that these goals are important, obtainable, and worth the time invested in the program[??]
9. Workers collaborate with families to develop a visitation schedule that is convenient and consistent, and to develop a schedule for visits (including content, milestones, and evaluations)
10. Contact is maintained between visits (e.g. regular scheduled group sessions, outings, or phone calls)
11. Home-visits must be relatively frequent (i.e. weekly or bi-monthly) in order to be beneficial
12. Missed visits should be rescheduled if possible, or replaced with interim out-of-home contacts
13. Content and time length of each visit should be logged by workers, in order to keep track of what the content of each meeting was, keep track of whether the intended curricula was addressed, and to ensure that clients are receiving the intended intensity of visits
14. Progress is monitored/evaluated consistently and regularly, using the same instrument(s). Evaluations should include parental and/or child self-reports, and observer reported measures
15. Parental attendance at group functions is monitored; low participation is addressed if it becomes an issue (e.g. finding out what the obstacles to attendance are, speaking to parents about the negatives of poor attendance and the benefits of high attendance, providing transportation, asking a different family to host each group session, etc)
16. Home-visiting programs designed to improve child characteristics (behavior, cognition, development) in addition to parental characteristics, through the use of structured parent-child interactions, should schedule those sessions to take place outside of the home, where completion and structure of the activities can be monitored
17. Overall program evaluations should monitor enrollment, engagement, and attrition of families, as well as training and support for staff, and delivery of program content[??]

[??] Adapted from "Home Visiting: Recent Program Evaluations-Analysis and Recommendations", The Future of Children, v. 9 n.1, Spring/Summer 1999

PART III

OUTCOMES FOR FCS

8 Outcomes in FCS

One of the most important elements of best practice is a dedication to measuring program outcomes for children and families. The 1997-99 FCS Evaluation found that program staff and LAN members think that FCS programs have been beneficial and have had a positive effect on participants and communities. However, program staff, DCFS staff, and the Federal government have all expressed frustration that there has not been a way to provide concrete evidence of the positive effects of FCS programs. Part of the goal of the current project is to provide LANs and programs with the tools needed to produce concrete, objective proof that programs are working and are providing a service to the communities and LANs.

8.1 Existing Goals and Outcomes for FCS Programs

As a part of the construction of Illinois' original Five-Year Plan for FCS, a set of statewide goals for FCS and all 62 LANs were developed. Later, as a part of the application process for FCS, each of the LANs devised a separate set of goals, based in part on needs assessments conducted within the involved communities. Using information from Illinois' Five Year Plan, the FCS 1997-99 Evaluation, and the LAN Social Histories, a table was created that organized the goals and outcomes reported by the 62 LANs. This table [Table 8.1] reflects a necessary step toward addressing a major issue in conducting statewide program evaluations: the difficulty in selecting a set of outcome measures that can be used by all types of programs. The table is organized by type of goal, specifically, whether the goals address child functioning, parent functioning, permanency/reunification, or general service issues. Child functioning and parent functioning goals are further classified by whether they address mental/physical health or social issues. This table provides a synopsis of where needs exist, both in terms of defining clear-cut outcomes and in identifying measures for monitoring success in those outcomes.

In preparing the table, it was noted that while many LANs reported outcomes relating specifically to their goals, many also reported successes or outcomes that were not directly related to their reported goals. As reported goals and successes for each LAN did not always map to each other, the list of goals and the list of outcomes were prepared separately. However, it seemed necessary to link particular goals with particular outcomes or successes in order to provide clear examples of what types of successful outcomes LANs having a particular goal should look for.

In addition to the problem of mapping goals to outcome measures, many LANs reported "non-standardized" outcomes such as attendance at particular events, parents reporting more

confidence after parenting classes, or a high degree of trust between workers and participants. While collecting these types of information allows the LAN to monitor usage of certain services to some degree and get an idea of client satisfaction, this type of information does not tell the whole story. For example, a program may have few participants, but provide a great deal of service to those clients; collecting attendance information would therefore be less descriptive of the program than number of service hours provided. Conversely, a program may have hundreds of participants, yet not have a measurable impact on the quality of these participants' lives; using attendance as the only outcome could make a program look more successful than it actually is.

There is also the issue of bias when using these types of "outcomes," because program coordinators may remember the most vivid commentary (positive or negative) more than other, less dramatic statements. It is also reasonable to expect that programs/LANs may be more likely to report what they see as successes (as opposed to setbacks), even if those successes are not representative of the overall impact of the program or service. Yet, even programs that did not have the desired impact provide important information for everyone in determining future program directions.

For this reason, pre-determined outcomes, including standardized instruments, are especially important. A pre-determined, goal-specific outcome or set of outcomes can give a clear sense of whether a particular goal has been met, to what degree that goal has been met, and perhaps where service/program deficits lie. It was relatively rare for LANs to use standardized instruments or their own pre-developed instruments to measure program impact. However, if a LAN or program made use of a standardized instrument to provide information on a particular outcome, the instrument is listed in Table 8.1.

8.2 Recommended Outcomes and Measures for FCS Programs

The information from Table 8.1 was reviewed during the preparation of a "reference table" of outcomes and outcome measures. Table 8.2 lists recommended outcomes, outcomes in use by various LANs/programs, and outcomes currently in use in the child welfare field. To create this table, researchers surveyed public/community health, child welfare, family support, and family preservation literature. Child welfare outcomes and measures were also available through some internet-based resources, including state child welfare agencies, research organizations, and social service professionals, or agencies such as the National Child Abuse and Neglect Clearinghouse. The

tables provide information on outcomes and measures related both to the provision of services (*process measures*), and the effects of services on clients (*outcome measures*).

The tables of outcome measures include domains thought to be important to the safety and well-being of children, their families, and surrounding communities. Each outcome (*marker of success*) is linked to both indicators (*specific ways of monitoring the outcome*) and measures (*methods of collecting actual data on an indicator*). Outcomes and associated indicators and measures are grouped according to whether they relate to children, parents, families, or communities. Within these four broad categories, there are more specific categories relating to particular domains of child, parent, family, or community well-being (e.g. physical health, mental health, etc.).

The Child Welfare Outcomes Table [Table 8.3] lists outcomes that are specifically applicable to children that are in the care of the department, such as degree of preparation for independent living. These outcomes should be considered to be supplemental to those listed in the General Outcomes Table [Table 8.2], and are thought to provide important information on those domains of child development (physical, emotional, and educational) that are of particular importance in assessing the well-being of children involved with the child welfare system. The Process Measures Table [Table 8.4] lists outcomes relating specifically to agency/program organization, community outreach, and other issues involved in assessing the effectiveness of service provision.

The last table provided in this section [Table 8.6] is a table that lists sources of data on potential outcome measures that are available on the Web. Information is provided about the type of data available, the unit of measurement and the level(s) at which data is aggregated (e.g., local, statewide, national). The information provided at these Web sites can begin to help program developers put their own communities in context, both within the state and nationally.

Taken as a whole, the tables presented in this chapter provide a reference guide for program staff interested in measuring outcomes. For instance, Tables 8.1, 8.2, and 8.3 can be used to identify program goals and match them with the potential corresponding outcomes. Tables 8.2 and 8.3 provide a wide range of indicators of goal achievement, outcome measures, and the sources from which the outcome was derived. These tables are provided as resource materials rather than absolute requirements, however. Section 8.3 elaborates more on the potential uses of these tables and their inclusion in the technical assistance work-book for local program coordinators.

8.3 The Outcomes and Process Tables as Resources for Program Development

All of the resource materials in this report will become part of a larger, more "user-friendly," work-book that will be given to program directors/coordinators/developers as part of the technical assistance project. They are provided here in order to give the FCS statewide steering committee a preview of the work to date and an opportunity to comment during the work-book development phase. There will be another opportunity to comment on a draft work-book that will also be circulated. Reviewers may have recommendations on both format and content. The team is asking for comments on any material in this report by June 30, 2000.

There are several issues that should keep in mind when reviewing these tables.

1. There are six tables:

    a. FCS Goals and Outcome Measures

    b. Potential FCS Outcome Indicators and Measures

    c. Child Welfare Outcomes

    d. FCS Process Measures

    e. Child Welfare Process Measures

    f. Data Sources for Outcome Measures

2. The tables are not in their final format but are presented in compact format here for review. Comments on format are welcome.

3. The final work-book will include information on benchmarking and goal-setting for outcomes, including information on data available on certain outcome measures. Table 8.6 provides information on Web sites containing selected available data.

4. Wherever possible, process measures, e.g., number of people participating in a program, were separated from outcome measures, e.g., changes observed in the behavior of program participants

5. It is not necessary to choose any specific number of outcomes for a particular program. For example, some types of parent training programs may require only one or two outcome measures. These tables are an attempt to provide the universe of potentially useful outcome measures. Even so, they may not apply to each specific program and may need to be tailored to fit individual needs.

6. The potential outcome measures in these tables reflect the most commonly used or those identified by project staff with the most potential for being useful in the field. Some outcome measures will be very simple and will not require complex data analysis systems.

Others are more advanced and may require access to computer databases or spreadsheets for tabulation and interpretation.

7. Some outcome measures may require a trained psychologist for administration and interpretation. Clearly, these indicators/measures will not be appropriate for many programs but will be appropriate for others.

8. In some cases, the measures named here are copyrighted and cost money to administer. This information will be provided in the final work-book.

9. The clinical measures of outcomes for children and families have been reviewed for usefulness in child welfare services. The asterisk (*) in the outcomes tables indicates that the measure meets all four criteria, established by the project team, for usefulness in the field: 1) under 20 minutes to administer; 2) relevance to child welfare outcomes; 3) ability to show change over time; 4) relative ease of administration, e.g., doesn't require a psychologist to administer.

Table 8.1 FCS Goals and Outcome Measures as Identified in the 1997-99 FCS Program Evaluation

Goals and Outcomes Identified in FCS 1997-1999 Study	
Goals Identified by One or More LANs	**Potential Matching Outcome Measures as Derived from FCS 1997-99 Study and LAN Social Histories**
Child Functioning Goals	
Physical and Mental Health Functioning	
Reduce child abuse and neglect	Families remain free of DCFS involvement No indicated reports for families involved in services
Violence prevention	Reduction/prevention of violence *operational definition not available*
Increase supervision to at-risk, school aged children	Increase by 100% the number of youth 5-12 who are supervised in before and after school care
Increase the number of students who refrain from drug and alcohol use	Reduction/prevention of substance abuse *operational definition not available*
Social Functioning	
Increase positive youth behaviors/decrease negative youth behaviors, especially for at-risk children	Revised Behavior Problem Checklist (RBPC; Simpson, 1989) Family Adaptability and Cohesion Evaluation Scales (FACES III; Olson, Portner, & Lavee, 1982) Vandalism and juvenile crime in community decreases
Increase the number of students who delay parenting until high school graduation	*--Information not available--*
Improve school performance	Steady improvements in conduct, attitudes toward education, and completion of classroom assignments
Provide youth with mentors/appropriate role models	*--Information not available--*
Improve outcomes of at-risk children	*--Information not available--*

NOTE: LANs may not have corresponding outcome goals and measures. They are matched in this table to illustrate both the goals established by the LANs and potential indicators/measures used in the field for measuring achievement of these goals. The information in this table is limited to that given to the researchers during the 1997-1999 FCS Evaluation.

Goals and Outcomes Identified in FCS 1997-1999 Study	
Goals Identified by One or More LANs	**Potential Matching Outcome Measures as Derived from FCS 1997-99 Study and LAN Social Histories**
Parent Functioning Goals	
Reduce domestic violence	Recidivism rate among program participants is less than 1%
Promote/increase positive parenting skills/abilities	Less parental stress/anxiety (Index of Clinical Stress) Amount of satisfaction felt about their relationship with children (Index of Parental Attitudes) Increased parent-child attachment Increased caregiver understanding of child development Improved behavior management techniques. Decreased risk of child placement due to abuse or neglect (Family Risk Scale) 75% of parents receiving skill training demonstrate increased knowledge of age-appropriate child behaviors and increase skills in disciplinary techniques Pre- and post-test show improved understanding of family issues
Increase parents life skills	*--Information not a vailable--*
Improve parents knowledge of available support systems	Increased attendance in parent-focused programs High demand or waiting lists for existing programs
Family Functioning Goals	
Improve family functioning/coping skills	Pre- and post-test show improved understanding of family issues
Reduce family stress/conflict	Reduced family stress, and increased self-esteem.
Reduce family isolation	Members of hard to reach populations participate in programs/social activities *operational definition not available*
Decrease negative effects of living with a substance abuser	*--Information not available--*

Goals and Outcomes Identified in FCS 1997-1999 Study	
Goals Identified by One or More LANs	**Potential Matching Outcome Measures as Derived from FCS 1997-99 Study and LAN Social Histories**
Permanency/Family Reunification Goals	
Reduce out-of-home placements	Reduction in out-of-home placements *operational definition not available*
Family reunification	Increased family reunification Children returned home from residential facilities Children returned home, and remain safely for more than 60days
Adoption/legal guardianship	Increased child adoption or legal guardianship *operational definition not available*
Service/Program Goals	
Provide networks to empower families	Parent input (surveys, verbal feedback) leads to institution of programs/services
Provide respite care	*--Information not available--*
Provide child care	*--Information not available--*
Provide appropriate time structuring activities for youth and families	*--Information not available--*
Provide parents with mentors/appropriate role models	Mentoring provided to a particular number of participants
Increase support to at-risk families	A 100% increase in the number of successful voluntary programs, such as Parents Anonymous, support groups, and parent mentors 98% of targeted population served
Increase the number of parents who access the community support system	An 10% increase in the number of parents/family members who access community services
Increase access to intervention services	*--Information not available--*

Goals and Outcomes Identified in FCS 1997-1999 Study	
Goals Identified by One or More LANS	**Potential Matching Outcome Measures as Derived from FCS 1997-99 Study and LAN Social Histories**
Service/Program Goals, cont.	
Increase linkages between families and the community	97% of families served are linked to community services
Increase level of parent/community resident involvement	High level of parent/community resident involvement *operational definition not available*
Increase community awareness of services available in LAN	Participants increased knowledge of services-- *operational definition not available* Media coverage of activities/services Number of referrals given double from one year to the next.
Improve community conditions which increase violence	--*Information not available*--
Reduce reliance on services outside community	--*Information not available*--
Build community-based networks	High level of interagency collaboration No agency competition Non-FCS funded agencies/ organizations involved with FCS High level of parent/community resident involvement Grassroots organizations involved Programs sponsored by private agencies, school districts, city governments, the federal government, etc. Increase in trust between organizations
Improve parent/school relationships	--*Information not available*--
Program/service expansion	More services available in rural areas Individual programs link and collaborate with various providers and community agencies

Goals and Outcomes Identified in FCS 1997-1999 Study	
Goals Identified by One or More LANS	**Potential Matching Outcome Measures as Derived from FCS 1997-99 Study and LAN Social Histories**
Service/Program Goals, cont.	
Move programs/services toward self sufficiency	FCS provide substantial services with little money Centralized social service system as a result of FCS External funding secured Economic self-sufficiency
Reduce financial and transportation barriers to services	*--Information not available--*
Ensure that youth have access to activities that promote pro-social behaviors, and decrease negative behaviors.	*--Information not available--*
Provide ongoing monitoring and evaluation of activities	*--Information not available--*
Improve service coordination	*--Information not available--*
Improve access to services	*--Information not available--*

Table 8.2 Potential FCS Outcome Indicators and Measures

✍ **Outcome measures focus on the well-being of the child, family and community**

Outcome	Indicator	Outcome Measure	Source of Indicator
Community Outcomes			
Health Factors			
Health care availability	Proportion of children 0-17 who have health care coverage	Current Population Survey, school supplement (CPS)-annual, national data	Oklahoma Family Services Initiative (1998) Hauser, Brown, & Prosser (1997) **[M]**
	Percentage of mothers receiving early prenatal care	Vital Statistics (women beginning prenatal care months 1-3/total pregnant women)	Brown & Botsko (1996)
	Percentage of mothers receiving late or no prenatal care	Vital Statistics (women beginning prenatal care after month 3/total pregnant women)	Brown & Botsko (1996)
Reduce preventable disease	Rate of occurrence of vaccine-preventable diseases, e.g. diphtheria	Illinois Project for Local Assessment of Needs Database (IPLAN)-state, county and community level data	Oklahoma Family Services Initiative (1998)
	Rate of occurrence of Hepatitis A in community	CDC	Oklahoma Family Services Initiative (1998)
	Prevalence of HIV/AIDS infection in community	CDC	Oklahoma Family Services Initiative (1998) Hauser, Brown, & Prosser (1997) **[M]**
	Incidence of primary and secondary syphilis in community	IPLAN	Oklahoma Family Services Initiative (1998)
Economic Factors			
Reduce poverty levels	Child poverty rate	--US Census (children in poor families/children in families), county level data --CPS-school supp. -- Survey of Income and Program Participation (SIPP)-annual, nat'l data	Oklahoma Family Services Initiative (1998) Hauser, Brown, & Prosser (1997) **[M]**
	Family poverty rate	US Census (poor families/total families)	Hauser, Brown, & Prosser (1997) **[M]**
	Child public assistance rate	County Entitlement Services (Public Assistance recipients < 18/pop. < 18)	Hauser, Brown, & Prosser (1997) **[I, M]**
	Proportion of single-parent families below poverty line		Oklahoma Family Services Initiative (1998)
	All families w/children living in poverty as a % of total households in poverty		Oklahoma Family Services Initiative (1998)

Key: Unless otherwise noted, the Source refers to the Indicator in the table. **[M]** denotes that the Source refers only to the Measure in the table. **[I, M]** indicates that the Source refers to both the Indicator and the Measure.

Outcome	Indicator	Outcome Measure	Source of Indicator
Family Outcomes			
Parent Functioning			
Reduce unplanned and unhealthy pregnancies	Birthrate among teenage girls	Vital Statistics (births to females 12-17/females 12-17)	Oklahoma Family Services Initiative (1998) Hauser, Brown, & Prosser (1997) **[M]**
	Percentage of births to unmarried teen mothers	Vital Statistics (births to unmarried mothers, age 19 and younger)	Brown & Botsko (1996)
	Percentage of births to teens that are second births	Vital Statistics	Brown & Botsko (1996)
	Percentage of women who experience mistimed and unwanted pregnancies	Pregnancy and Risk Assessment Monitoring Systems (PRAMS)-IL C.H.S	Oklahoma Family Services Initiative (1998)
	Percentage of pregnant women who receive risk-appropriate prenatal care in the first trimester of pregnancy	Pregnancy and Risk Assessment Monitoring Systems (PRAMS)-IL C.H.S	Oklahoma Family Services Initiative (1998)
	Prevalence of cigarette smoking, alcohol or drug use among pregnant women.	Vital Statistics	Oklahoma Family Services Initiative (1998) Hauser, Brown, & Prosser (1997) **[M]**
	Percentage of low-income/at-risk pregnant women who receive WIC services in the first trimester	Pregnancy and Risk Assessment Monitoring Systems (PRAMS)-IL C.H.S	Oklahoma Family Services Initiative (1998)
Improve physical, emotional, and social functioning of parents	Parental Disposition	Magura & Moses Child Well-Being Scales	Christner (1998)
	Amount of stress (related to finances, health, living conditions, relationship, etc.) experienced by parents	Index of Clinical Stress	Abell (1991)
	Parenting stress	Parenting Stress Index (PSI)	Daro (1994)
	Parental depression	Beck Depression Inventory	Beck, Ward, Mendelson, Mock, & Erbaugh (1961)
	Perceptions of burden	Burden of Care Questionnaire (BCQ)	Cross, McDonald, & Lyons (1997)
	Substance abuse/acute drinking by parent	BRFSS-IL C.H.S.	
	Number of arrests or convictions of parent(s)	Police records	
	Parent has obtained high school diploma/GED	BRFSS-IL C.H.S.	
	Job status; ability to obtain work	BRFSS-IL C.H.S.	

Outcome	Indicator	Outcome Measure	Source of Indicator
Family Outcomes			
Parent Functioning, continued			
	Parents' budgeting and home management skills	Observation/interview/self-report	
	Parents' nutritional and meal planning skills (Fruit and vegetable consumption)	BRFSS-IL C.H.S.	
Increase positive parenting skills	Parents' perceived parenting competence and efficacy	Parenting Sense of Competence Scale (PSOC-17 items)	Benedict & Zuravin (1996) **[I, M]**
	Percentage of parents who demonstrate increased knowledge of age appropriate behaviors	Knowledge of Infant Development Inventory (KIDI)	MacPhee (1981)
	Caregiver understanding of child development	Adult-Adolescent Parenting Inventory (AAPI)	Bavolek (1989)
	Parents' grasp of behavior management/disciplinary techniques	Observation/interview/self-report	
	Assessment of the emotional/cognitive care provided to the child	Childhood Level of Living Scale (CLL) Part B: Emotional/Cognitive Care Scale	Cabral & Strang (1983)
Family Functioning			
Reduce domestic violence	Rate of incidence of psychologically and physically abusive behaviors among parents	Conflict Tactics Scale (CTS)	Straus (1979)
Improve family functioning	Living conditions of family	--Family Assessment Form (FAF) -- ACLSA	Mullen & Magnabosco (1997) Christner (1998) **[M]**
	Financial condition of family	-- FAF -- ACLSA	Mullen & Magnabosco (1997) Christner (1998) **[M]**
	Assessment of family resources	Family Resource Scale (FRS)**	Cross, McDonald, & Lyons (1997)
	Access to transportation	ACLSA	Christner (1998) **[M]**
	Level of inter-familial stress	Self-report Family Inventory (SFI)	Green (1987)
	Assessment of family stress and support	Family Index of Regenerativity and Adaptation-General (FIRA-G)	Cross, McDonald, & Lyons (1997)
	Assessment of family social support	-- Family Support Scale (FSS)** -- FAF	Daro (1994) Mullen & Magnabosco (1997)
	Assessment of family adaptability and cohesiveness	Family Adaptability and Cohesion Evaluation Scales (FACES III)	Olson, Portner, & Lavee (1982)

NOTE: The clinical measures of outcomes for children and families have been reviewed for usefulness in child welfare services. The asterisk (*) indicates that the measure meets all four criteria for usefulness in the field: 1) under 20 minutes to administer; 2) relevance to child welfare outcomes; 3) ability to show change over time; 4) relative ease of administration, e.g., doesn't require a psychologist to administer.

Outcome	Indicator	Outcome Measure	Source of Indicator
Family Outcomes			
Family Functioning, continued			
	Communication and cooperation between caregivers	FAF	Mullen & Magnabosco (1997)
	Developmental stimulation of children	FAF	Mullen & Magnabosco (1997)
	Quality of interactions between caregivers and children	FAF	Mullen & Magnabosco (1997)
	Satisfaction felt by parent concerning relationship with children	Index of Parental Attitudes	Hudson (1992)
	Quality of relationship between child and parents/parent-child attachment	Parent-Child Relationship Inventory (PCRI)**	Heinze, & Grisso (1996)
	Assessment of family identity, process, change, information processing and role structure	Family Dynamics Measure (FDM)	Sawin, & Harrigan (1995)

Outcome	Indicator	Outcome Measure	Source of Indicator
Child Outcomes			
Safety			
Increase child safety	Percentage of at-risk children age 5-12 who are supervised in before and after school care	Interview/self-report	
	Percentage of children under age 13 in a latch-key situation (no supervision)	Survey of Income and Program Participation (SIPP), child-care module, annual, national	Hauser, Brown, & Prosser (1997) **[I, M]**
	Child homicide rate Note: Not recommended by project team. Occurrence of phenomenon is low, and number of occurrences fluctuate and do not necessary reflect on the quality of services provided	--Crime statistics (murders of young children by relative) -- Indicated reports/administrative data (deaths of children due to abuse) --County Coroner (child homicides/pop. < 18)	Administration for Children and Families (1998) Hauser, Brown, & Prosser (1997) **[M]**
	Child trauma rate	Hospital Emergency Room records (children's injuries/pop. < 18)	Hauser, Brown, & Prosser (1997) **[I, M]**
	Number of children reported missing	Police statistics	
Reduce child abuse and neglect	Risk of harm to children	Child Abuse Inventory (CAP)**	Heinze, & Grisso (1996)
	DCFS involvement with families	DCFS Investigated Reports/Administrative Data	
	Indicated report rate	DCFS Indicated Reports/Administrative Data	Hauser, Brown, & Prosser (1997) **[M]**

Outcome	Indicator	Outcome Measure	Source of Indicator
Child Outcomes			
Physical Health and Development			
Physical Health	Incidence of low birth weight or very low birthrate	Vital Statistics (births <2500 grams/live births)	Oklahoma Family Services Initiative (1998) Hauser, Brown, & Prosser (1997) **[M]**
	Proportion of births with congenital anomalies	Vital Statistics	Hauser, Brown, & Prosser (1997) **[I, M]**
	Global Assessment of Child Health	National Health Interview Survey (NHIS)-annual, national	Hauser, Brown, & Prosser (1997) **[I, M]**
	General Health Care	Enumeration of child visits for preventative health care and non-emergency health care	Gomby (1999)
	Assessment of child physical care	Childhood Level of Living Scale (CLL) Part A: Physical Care Scale	Cabral & Strang (1983)
	General physical health and self care of child	Ansell-Casey Life Skills Assessment (ACLSA)	Christner (1998) **[I, M]**
	Percentage of children receiving basic immunizations: infants, children age 2, children age 5	NHIS	Oklahoma Family Services Initiative (1998) Mullen & Magnabosco (1997) **[M]** Hauser, Brown, & Prosser (1997) **[I, M]**
	Child has reached age-appropriate physical milestones	Medical records	
	Child receives treatment for any chronic physical conditions	Medical Records	
	Percentage of children 4-12 who received dental care in the last year	Dental records	Oklahoma Family Services Initiative (1998)

Outcome	Indicator	Outcome Measure	Source of Indicator
Child Outcomes			
Physical Health and Development (continued)			
Increase attainment of age-appropriate cognitive and behavioral milestones	Mental development of infants; including infant verbalizations and motor control	Cattell Infant Intelligence Scale	Cattell (1946)
	Infant mental and motor development	Bayley Scales of Infant Development – Second Edition	Bayley (1969)
	Cognitive ability for youths ages 2.5-12.4 years of age	Kaufman Assessment Battery for Children (K-ABC)	Kaufman, & Kaufman (1983)
	Assessment of social, language, and motor skill development	Denver Developmental Screening Test (DDST)	Daro (1994)
	Assessment of communication, daily living skills, socialization, and motor skills	Vineland Adaptive Behavior Scales: Survey Form (VABS)	Sparrow, Balla, & Cicchetti (1984)
Social/Behavioral Health			
Decrease Maladaptive Cognitions and Behaviors	Caseworker assessment of child's functioning	Child and Adolescent Functional Assessment Scale (CAFAS)**	Hodges, & Wong (1996)
	Parent assessment of child's internalizing and externalizing behaviors (2 versions: ages 2-3 and ages 4-16)	Child Behavior Checklist (CBCL)**	Achenbach (1991)
	Depressive cognitions and behaviors	Children's Depressive Inventory (CDI)**	Kovacs (1980/81)
	Teacher report of interpersonal problems, depressive symptoms, fears and inappropriate behavior	Devereux Behavior Rating Scale: School Form (DBRS: School Form)**	Cross, McDonald, & Lyons (1997)

Outcome	Indicator	Outcome Measure	Source of Indicator
Child Outcomes			
Education			
Educational needs (including special education) are identified and met	Percentage of students having patterns of regular school attendance	Child's report card indicates regular attendance	South Carolina Department of Social Services (1998)
	Percentage of kindergartners who are "unready for kindergarten"	National Household for Education Survey (NHES)-occasional, national	Hauser, Brown, & Prosser (1997) **[I, M]**
	Percentage of children who are school ready	--Cooperative Preschool Inventory (CPI) -- Metropolitan Readiness Test	Nurss, & McGauuran (1976)
	Percentage of children below age 16 who are two or more years below grade level for age	CPS-School Enrollment Supplement	South Carolina Department of Social Services (1998) Brown & Botsko (1996)
	Percentage of children with identified special education needs who have IEP's	Case record review/interview/self-report	
Improve school performance	Conduct, attitudes toward education, and completion of classroom assignments	Teacher/parent/child interview	
	Academic Achievement	--Child Classroom Adaptation Index (CCAI) -- Metropolitan Achievement Test -- Stanford Early School Achievement Test	Halpern, Baker, & Piotrkowski (1993) Barlow, Farr, Hogan, & Prescott (1978) Madden, Gardner, & Collinis (1982)
	Percentage of students with positive attitudes toward math and science; 4th grade, 8th grade, 12th grade	National Assessment of Educational Progress (NAEP), semi-annual, national, selected states	Hauser, Brown, & Prosser (1997) **[I, M]**
	Percentage of students engaging in extra-curricular activities	Parent/child interview/self-report	
	Performance in math and reading	Board of Education (mean performance score)	Hauser, Brown, & Prosser (1997) **[I, M]**

Outcome	Indicator	Outcome Measure	Source of Indicator
Teen/Youth Outcomes			
Health Outcomes			
General Physical Health	Percentage of teens in grades 9 to 12 with a healthy diet	Youth Risk Behavior Surveillance System (YRBSS)-semi-annual, national, selected states	Hauser, Brown, & Prosser (1997) **[I, M]**
	Percentage of teens in grades 9 to 12 who attended PE class daily	YRBSS	Brown & Botsko (1996)
	Percentage of females 15-20 who have received gynecological examinations (including PAP test) within the past 1-3 years; percentage who have received examinations (including PAP test) ever	Medical records; interviews	
Sexually Transmitted Diseases	Percentage of teens diagnosed with STD's; by gender, by race	CDC	
	Percentage of teens diagnosed with incurable viral STD's, such as Hepatitis B, Herpes Simplex, or HIV/AIDS	CDC	Hauser, Brown, & Prosser (1997) **[M]**
	Percentage of teens diagnosed with incurable viral STD's, who are receiving treatment	Medical records; interview	
Social/Behavioral Health Outcomes			
Decrease sexual risk behaviors	Percentage of teens in grades 9-12 who report ever having had sexual intercourse	YRBSS	Brown & Botsko (1996)
	Percentage of teens in grades 9-12 who report being sexually active during the past three months	YRBSS	Brown & Botsko (1996)
	Percentage of teens in grades 9-12 who report a total of four or more partners	YRBSS	Brown & Botsko (1996)
	Percentage of sexually active teens in grades 9-12 who used birth control during last intercourse	YRBSS	Brown & Botsko (1996)

Outcome	Indicator	Outcome Measure	Source of Indicator
Teen/Youth Outcomes			
Social/Behavioral Health Outcomes (continued)			
Decrease suicide risks/behaviors	Rate of incidence of teen suicides, suicide attempts, or self-mutilation incidents; by gender, by race.	--DCFS and provider incidence reports --County Coroner (child suicides/pop. < 18)	Tennessee Department of Children's Services (1998) Hauser, Brown, & Prosser (1997) **[M]**
	Percentage of teens in grades 9-12 who have seriously considered suicide in the previous twelve months	YRBSS	Brown & Botsko (1996)
	Percentage of teens in grades 9-12 who have attempted suicide in the previous twelve months	YRBSS	Brown & Botsko (1996)
Decrease Substance Use	Percentage of teens in grades 9-12 who report using smokeless tobacco in the past 30 days	YRBSS	Oklahoma Family Services Initiative (1998) Brown & Botsko (1996)
	Percentage of teens in grades 9-12 who have ever smoked cigarettes	YRBSS	Brown & Botsko (1996)
	Percentage of teens in grades 9-12 who report smoking cigarettes daily in the past 30 days	YRBSS	Oklahoma Family Services Initiative (1998) Brown & Botsko (1996)
	Drug and alcohol use by youth	Diagnostic interview schedule, from DSM IV (drug and alcohol sections)	Oklahoma Family Services Initiative (1998) Benedict & Zuravin (1996) **[M]**
	Percentage of teens grades 9-12 who report ever having had a drink of alcohol	YRBSS	Brown & Botsko (1996)
	Percentage of teens grades 9-12 who report having had one or more drinks in the past 30 days	YRBSS	Brown & Botsko (1996)
	Percentage of teens who drink alcohol (daily, in the previous month)	YRBSS	Hauser, Brown, & Prosser (1997) **[I, M]**
	Percentage of teens grades 9-12 who report having had five or more drinks on a single occasion in the past 30 days	YRBSS	Brown & Botsko (1996)
	Percentage of teens grades 9-12 who report having ever used marijuana	YRBSS	Brown & Botsko (1996)

Outcome	Indicator	Outcome Measure	Source of Indicator
Teen/Youth Outcomes			
Social/Behavioral Health Outcomes (continued)			
	Percentage of teens grades 9-12 who report having ever used cocaine	YRBSS	Brown & Botsko (1996)
	Percentage of teens grades 9-12 who report having ever used crack or freebase cocaine	YRBSS	Brown & Botsko (1996)
	Percentage of teens grades 9-12 who report having ever used steroids	YRBSS	Brown & Botsko (1996)
	Percentage of teens grades 9-12 who report having ever used intravenous drugs	YRBSS	Brown & Botsko (1996)
	Teen drug violation arrest rate	Municipal police depts. (drug related arrests of teens/pop. 12-17)	Hauser, Brown, & Prosser (1997) **[I, M]**
Decrease risk behaviors associated with substance use	Percentage of teens (grades 9-12) who have ridden with a drunk driver	YRBSS	Hauser, Brown, & Prosser (1997) **[I, M]**
	Rate of occurrence of teens driving while under the influence	Police records; adolescent interview	
Decrease Antisocial Behaviors	Delinquency rate	County juvenile court (delinquent filings/pop. 10-17)	Hauser, Brown, & Prosser (1997) **[I, M]**
	Percentage of teens in grades 9-12 who have carried a gun in the last 30 days	YRBSS	Brown & Botsko (1996)
	Percentage of teens in grades 9-12 who have been in a fight in the last 30 days	YRBSS	Brown & Botsko (1996)
	Percentage of youth population arrested; distribution by race, gender	Crime and Justice Electronic Data-CDC	Oklahoma Family Services Initiative (1998)
	Teen homicide rate among youths 15-19	Crime and Justice Electronic Data-CDC	Oklahoma Family Services Initiative (1998)

Outcome	Indicator	Outcome Measure	Source of Indicator
Teen/Youth Outcomes			
Social/Behavioral Health Outcomes (continued)			
Decrease Maladaptive Cognitions and Behaviors	Caseworker assessment of child's functioning	Child and Adolescent Functional Assessment Scale (CAFAS)**	Hodges, & Wong (1996)
	Adolescent Report of Depressive symptoms	Reynolds Adolescent Depression Scale (RADS)**	Reynolds, & Johnston (1994)
	Teacher report of interpersonal problems, depressive symptoms, fears and inappropriate behavior	Devereux Behavior Rating Scale: School Form (DBRS: School Form)**	Cross, McDonald, & Lyons (1997)
	Observer assessment of psychpathology	Devereux Scales of Mental Disorders**	Cross, McDonald, & Lyons (1997)
	Teacher report of psychopathology and academic performance	Teacher's Report Form (TRF)**	McConaughy (1993)
	Assessment of negative and positive behaviors	Vermont System for Tracking Client Progress (VSTCP)	Cross, McDonald, & Lyons (1997)
	Assessment of psychopathology	Revised Behavioral Problem Checklist (RBPC)	Simpson (1989) Quay & Peterson (1987)
Increase positive youth cognitions and behaviors	Percentage of youth 16-24 who are productively engaged in school or work	Teacher/parent/adolescent interview	Oklahoma Family Services Initiative (1998)
	Social development (communication, social relationships, etc.)	ACLSA	Christner (1998) **[I, M]**
	Moral development (values, rights, responsibilities, etc.)	ACLSA	Christner (1998) **[I, M]**

Outcome	Indicator	Outcome Measure	Source of Indicator
Teen/Youth Outcomes			
Social/Behavioral Health Outcomes, continued			
Increase general social well-being of teens	Percentage of high school seniors who see friends, read, do sports, work around the house, play music, do art, or write on a daily basis)	Monitoring the Future Survey (MTFS)-annual, national	Hauser, Brown, & Prosser (1997) **[I, M]**
	Percentage of teen age 16-19 who are idle (not working and not attending school)	CPS-12 month Earning File	Brown & Botsko (1996)
	Percentage of teens in grades 9-12 who report missing one or more days of school in the past 30 days, because they felt unsafe at school or unsafe traveling to/from school	YRBSS	Brown & Botsko (1996)
	Assessment of youth functioning in relationships, cultural identification, competence, educational development, self sufficiency and legal history	Casey Youth Outcome Survey (CYOS)	Pecora, Adams, LeProhn, Paddock, & Wolf (1998)
	Self-Esteem	Self-Esteem Questionnaire (SEQ-3)**	Daro (1994)
	Domain Specific Self-Worth for Adolescents	Self-Perception Profile for Adolescents (SPPA)	Cross, McDonald, & Lyons (1997)
	Domain Specific Self-Worth for Children	Self-Perception Profile for Children (SPPC)	Cross, McDonald, & Lyons (1997)
	Assessment of Self-Evaluation	Wahler Self-Description Inventory (WSDI) **	Western Psychological Services

Outcome	Indicator	Outcome Measure	Source of Indicator
Teen/Youth Outcomes			
Social/Behavioral Health Outcomes, continued			
Prepare youth to live independently	Percentage of youth who have received sexual education (use of contraceptives, STD information, etc.)	Case record review; interview	
	Percentage of youth who have received or are scheduled to receive a high school diploma or GED	Case record review; interview	
	Percentage of youth who have plans to continue in higher education or vocational planning	Case record review; interview	
	Educational and vocational development (decision-making, study and work skills, employment, etc.)	ACLSA	Christner (1998) **[I, M]**
	Percentage of youth who have received job skills training	Case record review; interview	
	Youth employment rate	US Census (employed persons 16-25/persons 16-25)	Hauser, Brown, & Prosser (1997) **[I, M]**
	Percentage of youth who have financial planning or budgeting skills	Interview; self-report	
	Percentage of youth who have nutritional meal planning skills	Interview; self-report	
	Percentage of youth who have awareness of how to obtain and access health care	Interview; self-report	
	Percentage of youth with a savings or checking account	Interview; self-report	
	Percentage of youth who have available social supports	Provision of Social Relations Scale (PSR-15 items self-report measure)	Benedict & Zuravin (1996) **[M]**

Outcome	Indicator	Outcome Measure	Source of Indicator
Teen/Youth Outcomes			
Education			
Educational needs (including special education) are identified and met	Percentage of students having patterns of regular school attendance	Attendance records	Casey Outcomes and Decision-Making Project (1998)
	Percentage of children with identified special education needs who have IEP's		
Improve school performance	Academic Achievement	Child Classroom Adaptation Index (CCAI)	Halpern, Baker, & Piotrkowski (1993)
		Metropolitan Achievement Test	Barlow, Farr, Hogan, & Prescott (1978)
		Stanford Early School Achievement Test	Madden, Gardner, & Collinis (1982)
	Percentage of students with positive attitudes toward math and science	National Assessment of Educational Progress (NAEP), semi-annual, national, selected states	Hauser, Brown, & Prosser (1997) **[I, M]**
	Performance in math and reading	Board of Education (mean performance score)	Hauser, Brown, & Prosser (1997) **[I, M]**
	Percentage of students in grades 7-12 with plans for attaining educational/vocational goals		Casey Outcomes and Decision-Making Project (1998)
	Percentage of high school seniors who plan to go to college	MTFS	
	Percentage of youth who graduate from high school or obtain a GED		Casey Outcomes and Decision-Making Project (1998)
	Percentage of teens age 16-19 who are high school dropouts; by gender, by race		Casey Outcomes and Decision-Making Project (1998)
	Percentage of 18-24 year-olds who are high school drop-outs	CPS	Hauser, Brown, & Prosser (1997) **[I, M]**

Table 8.3 Child Welfare Outcomes

Outcome	Indicator	Outcome Measure	Source of Indicator
Child Welfare Outcomes			
Ensure the safety of children at home	Number of CA/N allegations received	DCFS/Administrative Data	
	Percentage of children placed in out-of-home care	DCFS/Administrative Data	South Carolina Department of Social Services (1998)
Increase the effectiveness of family preservation/support efforts	Percentage of children receiving *family preservation services* who enter care	DCFS/Administrative Data (children entering care while receiving services/total children receiving services during time period)	Zeller (1991)
	Percentage of children who enter care after termination of *family preservation services*; within 6 months; 12 months; 18 months	DCFS/Administrative Data (children entering care after services/total cohort of children completing services within a particular time period)	Zeller (1991)
	Percent of *family preservation cases* returning for services within 12 months after termination	DCFS/Administrative Data (cases returning/total cases terminated within last 12 months)	Zeller (1991)
	Percentage of families receiving *family support services* with verified CA/N findings	DCFS/Administrative Data (Indicated reports)	Tennessee Department. of Children's Services (1998)
	Percentage of families receiving *family support services* with verified CA/N findings within six months after services are completed	DCFS/Administrative Data (Indicated reports within timeframe for participants/all participants)	Tennessee Department of Children's Services (1998)
Increase permanency of child placements	Rate of occurrence of runaway attempts by children in care	DCFS/Administrative Data (incidence reports)	Christner (1998)
	Percentage of placements, by type, disrupted within 6 months; 12 months; 18 months	DCFS/Administrative Data (Disrupted placements/total placements; within timeframes; by type)	
	Degree of child satisfaction with placement		
	Degree of foster/adoptive family satisfaction with placement		

Outcome	Indicator	Outcome Measure	Source of Indicator
Child Welfare Outcomes, continued			
Increase reunification of children with families	Rate of reunification for children/families receiving services; by type of care and time in care (group home, foster care, guardianship)	Program Data/DCFS Administrative Data (for time in care and type of care: children returned home/children entering with goal of return home)	Zeller (1991)
	Percentage of children (by type of care) for whom their permanent plan of return home is achieved within 12 months of entry into care; within 18 months; within 24 months	DCFS Administrative Data (for each type of care: children returned home >12 months/children returned home)	South Carolina Department of Social Services (1998)
	Percentage of all children returned home, who remain safely for >60 days; by race; gender; type of placement	DCFS Administrative Data	
Prepare youth to live independently	Percentage of youth who receive or are scheduled to receive a high school diploma or GED prior to emancipation	DCFS/Administrative data	
	Percentage of youth who have plans to continue in vocational/higher education	DCFS/Administrative data	
	Employment rate of emancipated youth	DCFS/Administrative data	
	Percentage of youth in care with a savings or checking account	DCFS/Administrative data	
	Percentage of youth in care who have available social supports	DCFS/Administrative data	Benedict & Zuravin (1996)

Table 8.4 FCS Process Measures

✍ Process measures indicate the degree, amount, type and quality of services delivered

Goal/Objective	Indicator	Process Measure	Source of Indicator
Process Measures			
Community			
Increase community awareness of services available	Provision of referral services (resource guides, telephone referral services)	--Number of referrals provided --Number of participants served	
	Visibility in community		
	Incorporation of schools or other community organizations into information dispersal network.	Administrative Records** (agencies/organizations involved, method of information dispersal used by each)	
	Public announcements/Information Dissemination efforts	Administrative Records --Number of flyers distributed --Number of pamphlets distributed --Number of community organizations contacted	
Improve general community health and well-being	Identification of major community problems to address	Administrative Records (List of identified problems; preliminary plan for addressing each problem)	
	Number of community directed programs/efforts (block parties, beautification efforts)	--Units of service provided --Number of participants served --Percentage of target population served	
Build community-based networks	Non-FCS funded community agencies or organizations involved in FCS activities (schools, churches, etc.)	Administrative Records (identification of all additional agencies or organizations involved; mapping out of the role each plays within the network)	1997-1999 FCS Evaluation
	Level of parent/community resident involvement		1997-1999 FCS Evaluation
	Involvement of grassroots organizations	Administrative Records (identification of grassroots organizations involved in FCS activities)	1997-1999 FCS Evaluation
	Trust between community organizations		1997-1999 FCS Evaluation

** Administrative Records indicate any records maintained by the organization/agency. The existence and availability of these records would need to be determined on a program by program basis during program development.

Goal/Objective	Indicator	Process Measure	Source of Indicator
Process Measures			
Service Provision			
Optimize use of FCS monies and personnel	Total funds expended on services	Administrative Records (Sum all costs, subtract monies from sources other than FCS)	Zeller (1991)
	Average cost of services per participant	Administrative Records (Total funds/total participants)	
	Average cost of services per service hour	Administrative Records (Total funds/total staff hours)	
	Average hours of training for program staff	Administrative Records (hours of training for each worker, summed/total staff)	Zeller (1991)
	Number of full-time equivalent staff providing services	Administrative Records ([total staff*total work hours]/[annual work days*daily work hours])	Zeller (1991)
Move programs/services toward self sufficiency	Expansion in service networks: Increase in linkages between individual programs and various providers and community agencies	Administrative Records ([total programs/providers *currently* involved in service network-total programs/providers *previously* involved in service network]/ total programs/providers *previously* involved in service network	
	Sponsorship or funding from sources other than FCS are secured (e.g. school districts, churches, city government, federal government, etc.)	Administrative Records (identification of all additional sources of funds and amount of funding provided by each)	1997-1999 FCS Evaluation
	Reliance on services outside community	Administrative Records	1997-1999 FCS Evaluation
	Interagency collaboration	Administrative Records	1997-1999 FCS Evaluation
Provide ongoing monitoring and evaluation of activities	Portion of budget is allocated specifically for ongoing evaluation activities	Administrative Records	
	Source of evaluation is identified (internal or external)	Administrative Records	
	Short and long-tem program goals are established	Administrative Records	

Goal/Objective	Indicator	Process Measure	Source of Indicator
Process Measures			
Service Provision (continued)			
	Indicators and outcome measures are identified	Administrative Records	
	Methods of data collection are established	Administrative Records (Identification of data collection instrument(s) containing data elements required to measure process and outcomes desired)	
	Staff are trained in data collection techniques	Administrative Records --Number of training hours per person --Number of training sessions provided	

Goal/Objective	Indicator	Process Measure	Source of Indicator
Process Measures			
Service Provision (continued)			
	Surveys of client satisfaction are conducted and integrated into program planning and evaluations	Client satisfaction surveys should include general service and program specific items, including the following: **General Service** Global ratings of satisfaction Surroundings/facility (location, safety, etc.) Overall satisfaction with specific services Overall satisfaction with specific workers Availability of services Availability of client advocacy and support groups Waiting lists/delays Cultural sensitivity (e.g. language spoken) Sensitivity to religious preferences Program Specific Would client recommend program? Would client return to services? Degree to which services met needs Length of program Amount of services provided by program Satisfaction with outcome Confidentiality Sensitivity to religious preferences Worker skills/abilities Worker empathy Worker availability Worker honesty in communication Workers' respect for clients Workers' level of trust Workers' cultural sensitivity Provision of information on existing rights Involvement in planning/decision-making	New York City Task Force (1998)
Family Directed			
Promote positive parenting skills and health/well-being of parents	Provision of child care to mothers of at- risk children and infants	--Units of service provided --Number of participants served --Percentage of target population served	1997-1999 FCS Evaluation

Goal/Objective	Indicator	Process Measure	Source of Indicator
Process Measures			
Family Directed			
	Provision of respite care to mothers of at-risk children and infants	--Units of service provided --Number of participants served --Percentage of target population served	1997-1999 FCS Evaluation
	Provision of role models/mentoring services to at-risk parents	--Units of service provided --Number of participants served --Percentage of target population served	1997-1999 FCS Evaluation
	Provision of parenting classes to at-risk families	--Units of service provided --Number of participants served --Percentage of target population served	1997-1999 FCS Evaluation
	Provision of life skills training to teen and/or at-risk parents (budgeting, meal planning, home management)	--Units of service provided --Number of participants served --Percentage of target population served	
	Provision of support groups for substance abusing parents and spouses/family of substance abusers	--Units of service provided --Number of participants served --Percentage of target population served	1997-1999 FCS Evaluation
	Provision of services which match individual family needs	--Service plan identifies family needs and strengths	Administration for Children and Families (1998)
	Provisions of assistance to parents in establishing and making use of available social supports (family, churches, etc.)	--Units of service provided --Number of participants served --Percentage of target population served	1997-1999 FCS Evaluation
Provide networks to empower families	Solicitation of child and parent input (surveys, focus groups)	Number of surveys/focus groups/other conducted	
	Incorporation of client/participant input/feedback into service planning and program development		1997-1999 FCS Evaluation
	Increased family/child participation in case planning		Administration for Children and Families (1998)
Increase targeted populations' access to services	Provision of services within *rural areas*	--Units of service provided --Number of participants served --Percentage of target population served	1997-1999 FCS Evaluation
	Provision of services within *targeted communities*	--Units of service provided --Number of participants served --Percentage of target population served	

Goal/Objective	Indicator	Process Measure	Source of Indicator
Process Measures			
Family Directed			
	Provision of transportation services	--Units of service provided --Number of participants served --Percentage of target population served	1997-1999 FCS Evaluation
	Increased program participation by members of hard to reach populations	--Units of service provided --Number of participants served --Percentage of target population served	1997-1999 FCS Evaluation
	Reduction in financial and transportation barriers to services	--Units of service provided --Number of participants served --Percentage of target population served	1997-1999 FCS Evaluation
	At-risk families' access to intervention services	--Units of service provided --Number of participants served --Percentage of target population served	1997-1999 FCS Evaluation
Increase families' awareness of and access to community services and supports	Provision of referral services (resource guides, telephone referral services)	--Number of referrals provided --Number of participants served	
	Incorporation of schools or other community organizations into information dispersal network.	Administrative Records (agencies/organizations involved, method of information dispersal used by each)	
	Public announcements/Information Dissemination effo rts	Administrative Records --Number of flyers distributed --Number of pamphlets distributed --Number of community organizations contacted	
	Increase in the number of targeted at-risk families who are provided with needed services	--Units (by type) of service provided --Number of participants served --Percentage of target population served	

Goal/Objective	Indicator	Process Measure	Source of Indicator
Process Measures			
Child Directed			
Promote general health and well-being of children and youth	Children under age two are provided with basic immunizations	--Units of service provided --Number of participants served --Percentage of target population served	Oklahoma Family Services Initiative (1998) Mullen & Magnabasco (1997)
	Percentage of children 5-12 who are supervised in before and after school care	--Units of service provided --Number of participants served --Percentage of target population served	1997-1999 FCS Evaluation
	Grade school children are provided with at least two balanced meals per day	--Units of service provided --Number of participants served --Percentage of target population served	
Promote pro-social behaviors and development of healthy lifestyles in teens and youth	Provision of cultural enrichment activities to children and teens	--Units of service provided --Number of participants served --Percentage of target population served	
	Provision of teen mentoring services	--Units of service provided --Number of participants served --Percentage of target population served	
	Provision of sexual education/counseling services to teens	--Units of service provided --Number of participants served --Percentage of target population served	
	Provision of alcohol or drug abuse counseling to teens	--Units of service provided --Number of participants served --Percentage of target population served	
	Provision of recreational activities for children and teens	--Units of service provided --Number of participants served --Percentage of target population served	1997-1999 FCS Evaluation

Goal/Objective	Indicator	Process Measure	Source of Indicator
Process Measures			
Child Directed (continued)			
Enhance educational/academic experience	Provision of school-based peer mediation	--Units of service provided --Number of participants served --Percentage of target population served	1997-1999 FCS Evaluation
	School-age children have an educational plan appropriate to their abilities		South Carolina Department of Social Services (1998)
	Provision of academic support services to children and teens (tutoring, homework help, etc.)	--Units of service provided --Number of participants served --Percentage of target population served	
	Provision of preparatory assistance to youth with plans to continue in vocational or higher education (assistance in procuring applications, SAT/ACT preparation, help in writing entrance essays, etc.)	--Units of service provided --Number of participants served --Percentage of target population served	
	Provision of job skills training services	--Units of service provided --Number of participants served --Percentage of target population served	

Table 8.5 Child Welfare Process Measures

Goal/Objective	Indicator	Process Measure	Source of Indicator
Child Welfare Process Measures			
Increase the effectiveness of family preservation/support efforts	Number of families receiving *support services*	Administrative Data (families receiving services)	Zeller (1991)
	Number of children/teens receiving supportive services, by age and ethnicity	Administrative (children receiving services, age, race)	Zeller (1991)
	Number of families receiving *preservation services*	Administrative Data (families receiving services)	Zeller (1991)
	Average length of time families receive *preservation services*	Administrative Data (date services end-date services begin, summed for all clients; divide by total number of clients receiving preservation services)	Zeller (1991)
	Percentage of families referred for *support services* who receive services	Administrative Data (families receiving services after referral/families referred)	Zeller (1991)
	Percentage of families referred for *preservation services* who receive services	Administrative Data (families receiving services after referral/families referred)	Zeller (1991)
	Average time from referral/request for *family support services* to initiation of services	Administrative Data (date requested-date initiated, summed for all clients; divide by total number of clients who receive support services)	Zeller (1991)
	Average time from referral for *family preservation services* to initiation of services	Administrative Data (date requested-date initiated, summed for all clients; divide by total number of clients who receive preservation services)	Zeller (1991)
	Percentage of families served that were referred for child abuse/neglect or risk of harm to child	Administrative Data (families referred for abuse, neglect or risk of harm/families referred for services)	Zeller (1991)
	Percentage of families served that were referred for *parental characteristics* (drug use, alcohol abuse, mental illness)	Administrative Data (families referred for parental characteristics/families referred for services)	Zeller (1991)
	Percentage of families served that were referred for *child characteristics* (Alcohol/drug use, mental illness)	Administrative Data (families referred for child characteristics/families referred for services)	Zeller (1991)

Goal/Objective	Indicator	Process Measure	Source of Indicator
Child Welfare Process Measures			
Facilitate contact between children in care and their families	Percentage of children placed with siblings	DCFS/Administrative data (children placed with siblings/all children with siblings in care)	Poole, S.
	Percentage of children placed in the same county as their siblings	DCFS/Administrative data (children placed in same county as siblings/all children with siblings in care)	
	Percentage of children placed in the same county as their parents	DCFS/Administrative data (children placed in same county as parents/all children in care)	South Carolina Department of Social Services (1998)
	Frequency of contact between children in care and their families	DCFS/Administrative data (visits per month with parent/guardian; siblings)	South Carolina Department of Social Services (1998)
Increase effectiveness and permanency of child placements	Percentage of children placed within 180 days	DCFS/Administrative data	Poole, S.
	Percentage of children with fewer than three moves while in placement	DCFS/Administrative data	Poole, S.
	Percentage of children in care who are returned to foster care after reunification or adoption	DCFS/Administrative Data	South Carolina Department of Social Services (1998)
	Percentage of children who achieve permanency goals; within one year of entry into care; within 18 months; within 24 months	DCFS/Administrative Data (discharges to goal destination within each timeframe/total discharges)	South Carolina Department of Social Services (1998)

Goal/Objective	Indicator	Process Measure	Source of Indicator
Child Welfare Process Measures			
Prepare youth to live independently	Percentage of youth who receive sexual education (use of contraceptives, STD information, etc.) prior to emancipation	DCFS/Administrative data	
	Educational and vocational development services (decision-making, study and work skills, employment, etc) provided prior to emancipation	DCFS/Administrative data	
	Percentage of youth who have received job skills training prior to emancipation	DCFS/Administrative data	
	Percentage of youth who receive training in financial planning or budgeting prior to emancipation	DCFS/Administrative data	
	Percentage of youth who receive training in nutritional meal planning prior to emancipation	DCFS/Administrative data	
	Percentage of youth who receive training in how to obtain and access health care prior to emancipation	DCFS/Administrative data	
	Percentage of youth who receive training in accessing needed services prior to emancipation	DCFS/Administrative data	

Table 8.6 Data Sources for Outcome Measures and Indicators

✍ The sources/websites listed below contain actual data giving baseline information on many of the measures that would aid in program planning, development and evaluation.

Federal Databases and Indicators			
Measure/Database	Source	Website	Information
	Bureau of Labor Statistics	http://stats.bls.gov	What: Labor force statistics Who: Employed and unemployed population is U.S. When: Monthly, quarterly and annually Where: National How: Current Population Survey (CPS) What: State and metropolitan area civilian labor force and unemployment statistics Who: Employed and unemployed populations in IL When: Annually (state) and monthly (metropolitan) Where: Federal and state cooperative endeavor How: Local Area Unemployment Statistics (LAUS) program and the national Current Employment Statistics (CES) program.
		Http://stats.bls.gov/cps_htgm.htm	Website describes how and why the government measures unemployment.
		Http://www.bls.census.gov/cps/cpsmain.htm	Information about, and copy of, the Current Population Survey (CPS) that was used by the Bureau of Labor Statistics to obtain labor statistics.

Federal Databases and Indicators			
Measure/Database	Source	Website	Information
CDC Wonder	Centers for Disease Control and Prevention	CDC Wonder Home Page: http://wonder.cdc.gov/ (Logon as "Anonymous User")	What: Center for Disease Control's Public Health Data Set Who: Target population varies depending upon the nature of the data request (e.g. injury victims vs. AIDS patients) When: Frequency of data collection varies depending upon the data source (e.g. IL injury mortality data collected annually, IL AIDS cases collected semi-annually, etc.) Where: Source of information varies depending upon the requested data set. Possible sources of information include state and local health departments, the Public Health Service and the academic public health community. Comprehensive documentation for any given data set is available in the on-line help under each data sets request screen
		Data Sets: http://wonder.cdc.gov/DataSets.shtml	Summary of CDC Wonder datasets available.

Federal Databases and Indicators			
Measure/Database	Source	Website	Information
	Centers for Disease Control and Prevention: AIDS Reports	http://wonder.cdc.gov/aids00.shtml (Logon as "Anonymous User")	What: Counts of AIDS cases by demographics (including case-definition, quarter-year of diagnosis, report, and death if applicable), associated diseases, and HIV exposure group Who: The US population from 1981-present. Statistics available only for areas with a population of 500, 000 or more according to the U.S. Bureau of Census estimates. In Illinois this includes Chicago and Lake County. When: Data updated annually, with the most available data being from 1996 Where: State and local health departments How: The CDC maintains national surveillance through the receipt of AIDS case reports from state and local health departments. Health departments may report cases directly or electronically through the CDC's HIV/AIDS Reporting System (HARS).
		http://www.cdc.gov/nchstp/hiv_aids/software/apids/apidsman.htm	To request a copy of the AIDS public information data set call the CDC National AIDS Clearinghouse at (800) 458-5231and ask for inventory number D206.

Federal Databases and Indicators			
Measure/Database	Source	Website	Information
	Centers for Disease Control and Prevention: Injury and Mortality reports	http://wonder.cdc.gov/injury.shtml http://www.cdc.gov/ncipc/osp/aboutmrt.htm	What: CDC's State Injury Mortality Data from The National Center for Health Statistics (NCHS) Injury Mortality Reports. Data set contains frequency and rates of death by type of injury, sex, and age. Who: Victims of firearm-related, firearm-homicide, firearm-suicide, homicide, motor vehicle, suffocation, suicide, drowning, fall, fire/flame and poisoning injuries and deaths When: National data on injury mortality are available from '79 through '97. State figures summarize national and state data for '89 through '97 for selected causes of injury mortality. Data is collected annually and is available approximately 18 months after the year ends (e.g. 1997 data will be available by the 3rd quarter of 1999). The most current data available is from 1997. Where: National and state-level data available Website provides a description of the Injury Mortality Reports from NCHS.
MMWR	Centers for Disease Control and Prevention: Morbidity and Mortality Weekly Report (MMWR)	http://www.cdc.gov/nip/coverage/data.htm	What: The CDC's Morbidity and Mortality Weekly Report (MMWR) vaccination coverage levels by type of vaccine, race/ethnicity and poverty level Who: Children in the U.S. aged 19-35 months When: 1994-1997 Where: National data collected from all 50 states and 28 selected urban areas, including Chicago How: National Immunization Survey (NIS)

Federal Databases and Indicators			
Measure/Database	Source	Website	Information
	Centers for Disease Control and Prevention: Mortality	http://wonder.cdc.gov/mortJ.shtml http://wonder.cdc.gov/wonder/help/mort.html	What: Compressed Mortality File (CMF) contains mortality and population counts for all U.S. counties based on age (17 groups), race (white, black, and other), gender, year, and underlying cause of death Who: Mortality data derived from U.S. records of deaths that occurred in '79-'97. Population data obtained from U.S. Bureau of the Census estimates of national, state, and county resident populations When: Data available on CDC Wonder for the years of '79-'97. Data exists for the years of '68-'78 but is not available on CDC Wonder. Where: County-level national data base This website explains how statistics used in the Compressed Mortality database were obtained (e.g. US Bureau of the Census), how certain variables were defined/calculated (e.g. infant mortality rate) and provides database users with helpful search tips.
	Centers for Disease Control and Prevention: Natality	http://wonder.cdc.gov/nataJ.shtml (Logon as "Anonymous User")	What: Natality data base includes number of births occurring within the United States. Counts can be obtained by state, county, child's gender and weight, maternal race, age, and education, gestation period, prenatal care, and birth plurality Who: U. S. residents and non-residents who have given birth When: 1995-1997 Where: National, state and county level data available
	Centers for Disease Control and Prevention: Sexually Transmitted Disease Morbidity	http://wonder.cdc.gov/sexu00.shtml	What: The Sexually Transmitted Disease Morbidity data set is organized by state, year, gender of patient and type of STD. Who: United States population When: 1989-1996 (1991-1996 population comes from the postcensal population estimates) Where: National and state-level data available

Federal Databases and Indicators			
Measure/Database	Source	Website	Information
	Centers for Disease Control and Prevention: Sexually Transmitted Disease Report	http://www.cdc.gov/nchstp/dstd/Stats_Trends/1998Surveillance/98PDF/surv98.pdf	What: Health and Human Services (HHS's) 1998 Sexually Transmitted Disease Surveillance Report. Who: United States population When: Data reported annually, with the most recent data from 1998 Where: National, state, county and select city-level data available How: The STD surveillance systems operated by state and local STD control programs have provide the case report data and are the primary sources of information in the 1998 Sexually Transmitted Disease Surveillance Report
	Health Resources and Services Administration	http://www.hrsa.dhhs.gov/profiles	What: U.S. Department of Health and Human Services' (HHS) summary of selected access and health status indicators including, but not limited to, percentage of Americans and Illinoisans living below the poverty level, on medicaid, without medical insurance, degree of access to a primary health care provider, those living in health professional shortage areas (HPSA), etc. Who: Low-income, uninsured and medically underserved population nationwide and in Illinois When: 1996 Where: National and Illinois percentages available
	National Center for Health	http://www.cdc.gov/nchs/products/catalogs/subject/nhis/nhisstat.htm	What: The National Health Interview Survey (NHIS) is a personal interview household survey that collects data on household characteristics, personal characteristics, health conditions, doctor visits and hospital stays Who: U.S. civilian, non-institutionalized population When: Annual. National data available for purchase for years '69-'96, state data available for years '90-'94 Where: National and state-level. State-level data is available for analysis in raw form in SAS version 6.06 format for the cost of $60. File usage instructions and variable information are included.

Federal Databases and Indicators			
Measure/Database	Source	Website	Information
	U.S Census Bureau	http://www.census.gov/datamap/www/17.html	What: U.S. Census Bureau and Vital Statistics (NCHS) summary of the national and Illinois population, demographics, housing, income/poverty, business patterns, government finances and general profile data. Who: United States and Illinois residents When: Varies depending on the data. For example, population estimates (annual, state and county-level, most recent information from July of 1999), demographic and housing statistics (state and county-level, 1990 census), income/poverty statistics (state and county-level, 1995 model based estimates), business patterns (annual, state and county-level, 1997), government finances (state-level, 1996), business patterns (county-level, 1997) and general profile (every other year, county-level, most recent from 1998) Where: Illinois state and county-level data
SIPP CPS AHS CES PUMS	U.S Census Bureau	http://www.census.gov/des/l1	What: U.S. Bureau of the Census Data Extraction System. Users can request raw data, not simple counts or tabulations, via e-mail from the following sources: (SIPP) Survey of Income and Program Participation (CPS) Current Population Survey (AHS) American Housing Survey (CES) Consumer Expenditure Survey (Sponsor BLS) (PUMS) Decennial Census Public Use Microdata Samples Who: All U.S. residents included in public information data files, including surveys and census reco rds When: Depends upon type of data requested. For example, (SIPP) data available for '90-'93, (CPS) for '92-'95, (AHS) for '93 and '95, (CES) for '93 and (PUMS) for '90

Federal Databases and Indicators			
Measure/Database	Source	Website	Information
YRBS	Youth Risk Behavior Surveillance	http://www.cdc.gov/nccdphp/dash/MMWRFile/ss4703.htm	What: 1997 Youth Risk Behavior Surveillance System (YRBSS) monitors six categories of health-risk behaviors including unintentional and intentional injuries, tobacco use, alcohol and other drug use, sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases (STDs), unhealthy dietary behaviors and physical inactivity Who: Youth in grades 9-12 When: National and state surveys were conducted in '90, '91, '93, '95, and '97 (all 50 states did not participate). The current report summarizes the 1997 national school-based survey and trends from 1991 through 1997 for selected risk behaviors. Where: National percentages for risk behaviors, including information from the city of Chicago, but not for State of Illinois. Data cannot be manipulated to give county or community level information.
YRBS	Youth Risk Behavior Surveillance: 1999 Survey	http://www.cdc.gov/nccdphp/dash/yrbs/survey99.htm	1999 Youth Risk Behavior Survey

State of Illinois/Local Databases and Indicators			
Measure/Database	Source	Website	Information
	Illinois Department of Public Health (IDPH)	http://www.idph.state.il.us/health/statshome.htm	What: Illinois Department of Public Health (IDPH) statistics, including births, deaths, marriages, divorces and annulments, and abortions Who: All babies born to Illinois women and teenagers, all Illinois residents who married, divorced or received annulments, Illinois infants who died before their 1st birthdays, Illinois adults who died, and Illinois women who received abortions (by age and marital status). When: Annual data collection. Years of available statistics: birth '89-'98, infant death '93-'98, adult death '90-'98, marriage/divorce/annulment '93-'98, and abortion '73-'98 Where: State and county-level
	County Vital Statistics Tables (Available through IDPH website)	Links to 1995-1997 Vital Statistics tables are provided on the IDPH homepage, under the section entitled "County Vital Statistic Table" (see above for IDPH website address) or access website directly: http://www.idph.state.il.us/vital/pdf/1997.pdf http://www.idph.state.il.us/vital/pdf/appendices.pdf	What: County Vital Statistics, including live births (by sex), caesarean sections (primary and secondary), birth weight (0-1499 grams or 0-2499 grams), mortality (neonatal, post-neonatal, infant, fetal or perinatal) maternal education (no H.S. diploma), prenatal care by trimester (including no care), marital status, age of mother (20>, 20-34, 35<), multiple births, age distribution (1-4, 5-14, 15-24, 25-44, 65+), total deaths, and deaths by selected causes Who: Illinois residents When: Data collected annually. Statistics available from '95-'97. Where: State and county-level statistics Downloadable pdf file that details the data sources and analysis used to create Illinois' vital statistics, including definitions of terms, rates and ratios (e.g. the formula for determining neonatal death rate).

State of Illinois/Local Databases and Indicators, continued			
Measure/Database	Source	Website	Information
IPLAN	Illinois Project for Local Assessment of Needs (IPLAN) (Available through IDPH website)	http://163.191.194. 35/	What: IDPH's Illinois Project for Local Assessment of Needs (IPLAN) Data System. Indicators include demographic and socioeconomic characteristics (e.g. population by race, age, and gender, high school drop-outs, single parent households); general health and access to care (e.g. mortality rates, life expectancies, population uninsured); maternal and child health(e.g. live births, low birthweight, mother's prenatal care, teen births); chronic disease(mortality and hospitalization rates for various diseases); infectious diseases (e.g. prevalence of STD's, AIDS/HIV, and vaccine preventable diseases); environmental, occupational and injury control, sentinel events (e.g. child hospitalizations for dehydration, rheumatic fever, asthma) and summary reports. Who: Illinois residents. Where: Data available at the county-level and, for some indicators, the community-level Select "Indicator Descriptions" for details about indicators including the data source, data availability, and formula examples

State of Illinois/Local Databases and Indicators, continued			
Measure/Database	Source	Website	Information
	Center for Disease Control: Reproductive Health	http://www.cdc.gov/nccdphp/drh/srv_prams.htm	What: Pregnancy Risk Assessment Monitoring System (PRAMS) is a surveillance project of the CDC and participating state's health departments. PRAMS assesses maternal attitudes and experiences prior to, during, and immediately following pregnancy. Also, includes content and source of prenatal care, maternal alcohol and tobacco consumption, physical abuse before and during pregnancy, infant health care, maternal living conditions and knowledge of pregnancy-related issues Who: Illinois mothers who recently delivered a liveborn infant When: Data collected annually. 1998 statistics are not posted on the website, but can easily be obtained via mail by contacting Gayle Blair (217) 524-0794 Where: State-level. System allows for comparison among participating states. A sample of PRAMS questionnaire and methodology are also available on the w ebsite
	IL Dept. of Corrections	http://www.idoc.state.il.us/hsp2000/hsp2000_5.pdf http://www.idoc.state.il.us/news/1999_data.pdf	What: Illinois Department of Correction's Juvenile Institution statistics, including statistics about juveniles' age, gender, race and crime Who: Illinois youth ages 10-21 committed to the Juvenile Division (consisting of 7 IL youth centers and 3 field service districts) When: Annually, from '91-99 Where: State-level What: Illinois Department of Correction's Statistics, including sex, race, average age of juvenile and adult offenders, committing county (Cook, Collar, Other), type of crime, offense class and type, average felony sentence, and average length of stay Who: Illinois adult and juvenile inmates When: Annually, with most recent statistics from '99 Where: County-level (Cook, Collar, other)

State of Illinois/Local Databases and Indicators, continued			
Measure/Database	Source	Website	Information
	Illinois Criminal Justice Information Authority	http://www.icjia.org/public/index.cfm?metaSection=Data&metaPage=FrontPage	What: C J Datanet, an internet clearinghouse for Illinois criminal justice data. Dataset includes number of offenses, offense rates, and changes in offense rates from previous years for the following categories of crime: total index offenses in a selected county, violent and/or property index offenses in a selected county, murders, criminal sexual assaults, robberies, aggravated assaults, burglaries, thefts, motor vehicle thefts, and arson. Who: Illinois criminals When: Annually from '83-'98 Where: County-level. Data set allows for county-specific information, comparisons of a particular county with bordering counties, comparisons with counties having similar populations or with any other counties of choice.
	Illinois State Police	http://www.state.il.us/isp/docs/cii00098.pdf	What: 1998 Illinois State Police Crime Statistics, based on the reports of over 910 statewide agencies (e.g. police depts., sheriff depts., colleges/universities, hospitals, etc.) to the Uniform Crime Reporting Program. Includes crime index/crime rate comparisons, drug crime/arrest rate comparisons, percentages of domestic violence crimes, hate crimes, crimes against kids and crimes against school personnel. Who: Illinois residents arrested and/or convicted of a crime When: Annually, most recent statistics from '97-'98 Where: County-level

8.4 Outcome Tables Bibliography

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