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Supporting Innovative Child Protective Services

ADA County Family Violence Court

Comprehensive Evaluation Report

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INTRODUCTION

In July 2002, Ada County in the State of Idaho launched a pilot program to concentrate on the challenges the court faces in managing cases that involve domestic violence. The pilot program, called the Ada County Family Violence Court (FVC) Grant Project, focused on strengthening families that are confronting multiple issues.

The goals of the RMQIC are to financially support the FVC Grant Project, evaluate its effectiveness, provide technical assistance, assist in establishing a working relationship between child protection workers, and share findings of the project.

The program uses an approach of "one family, one judge" to support the coordination of civil domestic violence cases involving children with families' divorce, custody, and child support cases, as well as any misdemeanor cases for domestic assault and battery, violation of no contact orders, or injury to child, to protect children and other victims from violence. Research describes this approach:

> "This new practice of 'one family, one judge' is designed to facilitate access to, and sharing of, accurate information pertaining to families within the court system, increase consistency when there are multiple court orders, and allow the judge to apply expertise to meet the unique needs of each family, while assuring continued, close judicial oversight to safeguard the safety and well-being of children" (Bonney, Moe, & Morse, 2005, pp. 40-41).

The end goals for the court are to provide a safe environment for families and for the judge to create a coordinated response that factors in all the familial issues, removing the possibility of separate judges handing down different rulings that may be confusing and carry negative consequences to families.

At the beginning of 2003, the Family Violence Court (FVC) was awarded a three-and-one-half-year grant by the U.S. Department of Health and Human Services through the American Humane Association's Rocky Mountain Quality Improvement Center (RMQIC). This grant greatly expanded the support the court could provide by implementing a case coordinator position and community services for a sub-set of families seen by the court. Henceforth, the implementation and research initiative funded through RMQIC is referred to as the Family Violence Court (FVC) Grant Project.

The primary purpose of the RMQIC is to strengthen families facing issues with child maltreatment and substance abuse. Goals of the RMQIC are to financially support the FVC Grant Project, evaluate its effectiveness, provide technical assistance, assist in establishing a working relationship between child protection workers, and share the findings of the project (Castleton, Castleton, Bonney & Moe, 2005). The research-based FVC Grant Project sought to determine whether assessment, comprehensive services, and a streamlined delivery process assist in strengthening and supporting families that have substance abuse issues and are or

at risk of experiencing child maltreatment when they become involved in the judicial system due to family violence issues.

This report includes an extensive review of the literature in support of the project's purpose, a detailed design of the research approach, and a comprehensive examination of the project's outcomes. Further information in regard to the project's processes and procedures are detailed in a Replication Manual and a Case Coordinator Handbook [1].

Description of the program

The FVC Grant Project was designed to strengthen families that struggle with child maltreatment, substance abuse, and domestic violence through streamlining the response of the judicial system and using the authority of the court to achieve highly collaborative service delivery for families seen by the court. The concern was that families experiencing this combination of issues may not receive a coherent, comprehensive, and collaborative approach to service planning and coordination. This project field-tested a court-administered collaborative case management approach that also involved partnering with the Department of Health and Welfare, Family and Children's Services (DHW), probation, and community service organizations. Families were referred to the FVC Grant Project through the DHW, the court itself, and Family Court Services (FCS) when concerns of child safety, family violence, and substance abuse were believed to exist or existed. All adult members of the family were eligible to receive FVC Grant Project services. Parents did not need to be married or living in the same household to participate. In addition, stepparents and significant others living in the household with a parent also were deemed eligible to participate.

The FVC Grant Project had four major goals:

- Keep children and families safe while providing appropriate social service referrals and community support through the judicial process.
- Establish a multi-system approach to treat families involved with the court and social service agencies, replacing a fragmented, contradictory, or redundant approach with a cohesive treatment plan that focuses on the needs of children and families.
- Monitor substance abuse treatment, domestic violence treatment, and parent education and/or counseling through active case management and coordination.
- Strengthen child safety and improve family well-being through early identification of all issues contributing to these families' distress.

The FVC Grant Project funding supported the FVC Case Coordinator position (henceforth referred to as the Coordinator), as well as services and treatment to

[1] These materials are available at American Humane (www.americanhumane.org/RMQIC) and the Child Welfare Information Gateway (www.childwelfare.gov).

families in the project. Since the program was a research project, participation was voluntary. While participants could not be court-ordered to participate in the FVC Grant Project, they, as well as non-program participants, could be court-ordered to undergo evaluation and treatment as part of normal court proceedings. If they elected to participate in the FVC Grant Project, these services were coordinated and funding for services was provided.

Three entities within the court system, the Idaho Supreme Court (ISC), the FVC, and Ada County FCS, provided oversight for the FVC Grant Project.

- The ISC was responsible for administering funds for the project in accordance with the policies and budget of the project and in compliance with RMQIC requirements. The ISC also had access to and could use the evaluation information to identify best practices for replication of this program in other courts throughout the state.

- The senior judge who presided over the FVC provided oversight for the FVC Grant Project, which worked within a narrowly defined population within the larger FVC (i.e., those having child maltreatment concerns or risk and substance abuse issues). The judge presided over numerous co-occurring misdemeanor cases such as domestic assault and battery and violations of no contact orders. If participants in either civil or criminal domestic violence court had companion divorce or custody cases, the judge presided over those cases as well.

- The Ada County FCS Administrator (program manager) and the clinical supervisor oversaw evaluation activities, assisted in developing policies and procedures, and provided general project oversight. Additionally, FCS staff reviewed the FVC assessments, participated in the FVC Grant Project's MDT and treatment planning meetings, and provided assistance in project evaluation. The FCS also provided information related to FVC Grant Project cases through researching criminal histories and court files. The FCS clinical supervisor also conducted court assessments. Through the in-kind hours provided by the program manager and staff, Ada County provided a minimum 17% match and cost sharing for the FVC Grant Project.

Literature review (general background and current research)

The FVC Grant Project sought to provide intensive case coordination, funding for services, thorough intake assessment, and coordination of a treatment plan to strengthen and support families that have substance abuse issues and child maltreatment concerns and are experiencing family violence. In addition, the project sought to determine the effectiveness of building partnerships with community resources and systems. The literature gathered in general supports these goals.

Literature review

Connection between child maltreatment, family violence, and substance abuse and their impact on children

Research suggests that the risk of child maltreatment increases in families where domestic violence is present (Schechter & Edleson, 1994). The U.S. Department of Health and Human Services, Administration on Children, Youth and Families (USDHHS) reports "a review of relevant research suggesting that about one-third of all individuals who were maltreated will subject their children to maltreatment" (2003, p. 28). Research also indicates that children are abused in one-half of families in which the mother is a victim of domestic violence (Edleson, 1999). While it is common knowledge that children are harmed by direct abuse, researchers have recently recognized that children who witness domestic violence also may be harmed by that exposure. The estimated number of children who witness domestic violence may be as high as 10 million per year.

While it is common knowledge that children are harmed by direct abuse, researchers have recently recognized that children who witness domestic violence also may be harmed by that exposure. The estimated number of children who witness domestic violence may be as high as 10 million per year.

There is consensus in the literature that children who are present or nearby during incidents of domestic violence are at increased risk of emotional or developmental problems (Edleson, 1999; National Clearinghouse on Child Abuse and Neglect Information, 2004; Schechter & Edleson, 1994). Further, the literature cites multiple studies that demonstrate that men who abuse their partners are far more likely than other men to abuse children, physically, sexually, or psychologically (Bancroft, 2002, p. 245). Thus, in families in which domestic violence has occurred, children are at greater risk either as witnesses or as victims of violence.

During the past decade, substance abuse has been reported to be the single most common reason families receive intervention from the child welfare system. Links between substance abuse and child maltreatment are documented in numerous printed formats (Azzi-Lessing & Olsen, 1996; Sun, 2000), and at least one-third and as high as two-thirds of cases reported to child welfare systems involve parental substance abuse (USDHHS, 2003; USDHHS, 2006). Young, Gardner, and Dennis (1998) report that parental addiction is a significant factor in child abuse and neglect, affecting 40% to 80% of families in the child welfare system. Additionally, the USDHHS (December 2003) recognizes the magnitude of substance abuse in families, finding that 85% of states report substance abuse as one of the two major problems in homes in which child maltreatment is an issue (National Center on Child Abuse Prevention Research, 2001). The Arthur Liman Policy Institute (Rubenstein, 2003) confirms an estimated 11% of American children (8.3 million) live with at least one parent who abuses or is addicted to alcohol and/or drugs (U.S. Department of Health and Human Services, 1999).

One study indicated that nearly all children of substance abusers received some level of neglect, while one-third of these children suffered serious neglect (Semidei, Radel, & Nolan, 2001). A recent study conducted by the National

Committee to Prevent Child Abuse established that 80% of child abuse cases have an association with alcohol use or other drug use (Bonney, Moe, & Morse, 2005).

Research further indicates that children from families where there is substance abuse tend to be involved in the child welfare system at a younger age, are more likely to be placed in out-of-home care, and once in out-of-home care are more likely to remain there longer (Semidei et al., 2001). These children are more likely to have been severely and chronically neglected in comparison to other children in the child welfare system (Semidei et al., 2001). In Idaho, the governor's chief of state was quoted as stating, "In over 80% of the cases drug involvement is the reason kids are removed from their homes" (Gamache, 2006, para. 43). In addition, these children are more likely to exit the child welfare system through adoption, a process that typically takes longer than family reunification (Semidei et al., 2001).

Multiple studies over many years reinforce the commonly held understanding that alcohol use often is involved with incidents of domestic violence (Chartas & Culbreth, 2001). Two-thirds (66%) of domestic violence victims reported alcohol was a factor in an analysis conducted in 1996 (Chartas & Culbreth, 2001). Further, chronic alcohol abuse is associated with a greater level of severity of violence in the home (Chartas & Culbreth, 2001; National Center on Substance Abuse and Child Welfare [NCSACW], 2003). While research shows an overwhelming association between alcohol abuse and domestic violence, it is less clear on the causality or nature of the correlation (Chartas & Culbreth, 2001; Fazzone, Holton & Reed, 2002; Lee & Weinstein, 1997; Maiden, 1997). It is unclear whether abusive partners use alcohol as an excuse for violence, are incited to violence by the alcohol, or are less inhibited because of alcohol use (Chartas & Culbreth, 2001). Because of the lack of clear explanation, evidence, or consensus in the research, many researchers consider alcohol a contributing factor (Chartas & Culbreth, 2001; NCSACW, 2003) but not the cause of violent incidents.

Although the literature well documents the association of alcohol to domestic violence it does not so well document the association of other drugs to domestic violence. Other substances, such as amphetamines, PCP, barbiturates, and cocaine, have been examined to determine the extent of their relationship to violence, and some research shows that the increase or decrease in the likelihood of domestic violence may depend in part on the type of drug used (Irons & Schneider, 1997; Lee & Weinstein, 1997; Rittner & Dozier, 2000; Schafer & Fals-Stewart, 1997). However, studies have shown that the combination of alcohol and drug abuse is more likely to lead to domestic violence than the use of alcohol alone (Lee & Weinstein, 1997). The combination of alcohol and drugs also seems to lead to greater severity of injury in domestic violence incidents (Irons & Schneider, 1997).

Methamphetamine addiction, a particularly serious problem in Idaho, warrants concern due to the relationship between methamphetamine abuse and violence. Research on methamphetamine abusers consistently cites a tendency toward

violence, and according to some researchers, the possibility of violent incidents rises the longer the addiction continues (Miller, 1990; National Institute on Drug Abuse, 2002).

Alcohol and substance abuse are frequently factors in the lives of domestic violence victims as well. Some studies have revealed that women who drink excessively are at an increased risk for battering (Irons & Schneider, 1997; Miller, 1990). Conversely, women often respond to trauma by abusing substances. Domestic violence, substance abuse, and child maltreatment all are interwoven aspects of the complicated family systems in which courts and agencies may be called upon to intervene.

Overwhelming research has shown that substance abuse, domestic violence, and child maltreatment co-exist, and while substance abuse is not the cause of domestic violence and child maltreatment, each needs to be addressed to increase family safety.

Status of inter-agency cooperation – challenges and need to work together

The need for cooperation between courts, social services (e.g., child protection services, cash assistance), and treatment programs stems from the understanding that single intervention programs and the criminal justice system by themselves cannot address all the complexities of cases and the urgent goal of reducing recidivism (Healey & Smith, 1998). Overwhelming research has shown that substance abuse, domestic violence, and child maltreatment co-exist, and while substance abuse is not the cause of domestic violence and child maltreatment, each needs to be addressed to increase family safety (NCSACW, 2003; Collins, et al., 1997; Fazzone et al., 2002; Healey & Smith, 1998; Irons & Schneider, 1997; Mills, 1999).

An additional rationale for building a coordinated system of services lies in the fact that each system – courts, CPS, other social services, and substance treatment programs – serves an overlapping population. It is estimated that at least 50% of individuals in these systems are the same population (NCSACW, 2003).

However, agencies have underlying values that cause them to make assumptions or to misunderstand other agencies (NCSACW, 2003). Sharing data and information on individuals or families presents both technical difficulties and ethical problems for agency staff, in that such sharing may be viewed to violate the mandates of confidentiality. There is a lack of existing collaboration between child welfare agencies and domestic violence programs. For example, Carter and Schechter (1997) postulate that there is an inclination for child welfare professionals to look to abused mothers to protect children and, when this does not occur, to feel there is no choice but to force mothers to leave the abusers or to find mothers unable or unwilling to protect children. In addition, substance abuse treatment providers may be unaware of the timeframe requirements within which CPS must work, while CPS may have unrealistic expectations for substance abuse recovery and rehabilitation (Brittain & Hunt, 2004).

Providers of treatment and services in each of the three fields have different priorities based on their perspectives and foci. For example, substance abuse treatment programs may treat the disease first and consider the violence as a

symptom of the disease. Domestic violence intervention models may focus on the safety of victims, ensure batterers have taken full responsibility for the incidents, and work toward preventing the behavior from reoccurring. Further, domestic violence intervention programs may resist discussing or treating the alcohol addiction because of concerns that batterers are using alcohol as an excuse for the violence (Collins et al., 1997). CPS is committed to child safety with safety being paramount.

Organizational practices also present barriers to families as well as to staff who attempt to coordinate with other agencies. Differences may include hours of operation or eligibility criteria for accepting individuals or families. In addition, staffing changes can affect agencies' ability to cooperate over time. Judges may be forced to rotate and agency staff may experience high levels of turnover, making it difficult to build relationships and sustain integrated programs (NCSACW, 2003).

Agencies functioning in different but related spheres of service to families may have little or no knowledge of their counterparts. Domestic violence treatment providers may not screen or be knowledgeable about substance abuse issues, and chemical dependency program staff may not understand how to evaluate for domestic violence (NCSACW, 2003; Bennett & Lawson, 1994). Likewise, few communities have collaborative relationships among CPS and domestic violence programs (Carter & Schechter, 1997).

Cellini (2002) concludes that a coordinated response based on effective practices is more effective than a single treatment program designed to address substance abuse or domestic violence only. A report by the National Institute of Justice states that monitoring and case management seem to improve the success rate (NIJ, 2003). Healey and Smith (1998) list the types of effective responses: expedite cases, use specialized prosecution and probation court systems, utilize culturally specific interventions, and coordinate interventions. Another study backs up this finding, stating that a streamlined system results in higher completion rates and lower re-assault rates (Gondolf, 2004).

This research further suggests that men who are court-ordered to participate in domestic violence treatment appear to have a significantly lower likelihood of re-offence if they complete three months or more of domestic violence treatment compared to men who drop out of treatment within three months of intake (Gondolf, 2004). In addition, effective interventions in domestic violence courts are identified, including better information gathering, an emphasis on victim safety, enhanced accountability, and improved access to justice and judicial leadership to promote interagency collaboration (Conference of State Court Administrators, 2004).

Coordinated intervention models are critical for an effective response to the widespread problems of domestic violence and substance abuse (Fazzone, Holton, & Reed, 2002). While linkages among programs happen informally as staff

struggle to meet the needs of their clients, Collins, Kroutil, Roland & Moore-Gurrera (1997) found that relationships between substance abuse and domestic violence treatment programs are infrequent and weak. They observed, "Our systems of care tend to be narrowly focused on a specific problem, and the systems operate independently" (page 394). This breakdown routinely leads to a fragmented response that cannot combat systemic family issues. On the other hand, pilot programs that have sought to integrate substance abuse treatment with the child welfare system have had promising results, promoting interagency cooperation and improving the likelihood that parents who need alcohol and drug treatment decrease their substance abuse and retain custody of their children, with reduced complaints of abuse or neglect (Rubenstein, 2003).

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It is within this context that family courts, unique within the judicial system, are expected to understand a wide range of legal, social, and psychological issues, such as child development, the effect of domestic violence, and family relationships (Badeau, 2003). Further, family courts often are strained by enormous caseloads and complex cases involving many hearings; just as the child welfare system was strained by the increased number of families in need and in need of reform, so is the court system in need of improvement (Badeau, 2003; Schneider & Crow, 2005).

Researchers also propose that the complexity and scale of problems encountered by their clients may themselves be barriers. Families that have faced child protection, domestic violence, and substance abuse issues often need a comprehensive set of services: medical care, mental health services, housing, subsistence, safety, substance abuse treatment, intervention, and parental education. The logistics of linking these services together would be difficult for agencies and treatment providers, let alone families.

EVALUATION DESIGN AND APPROACH

Formulation of specific research questions

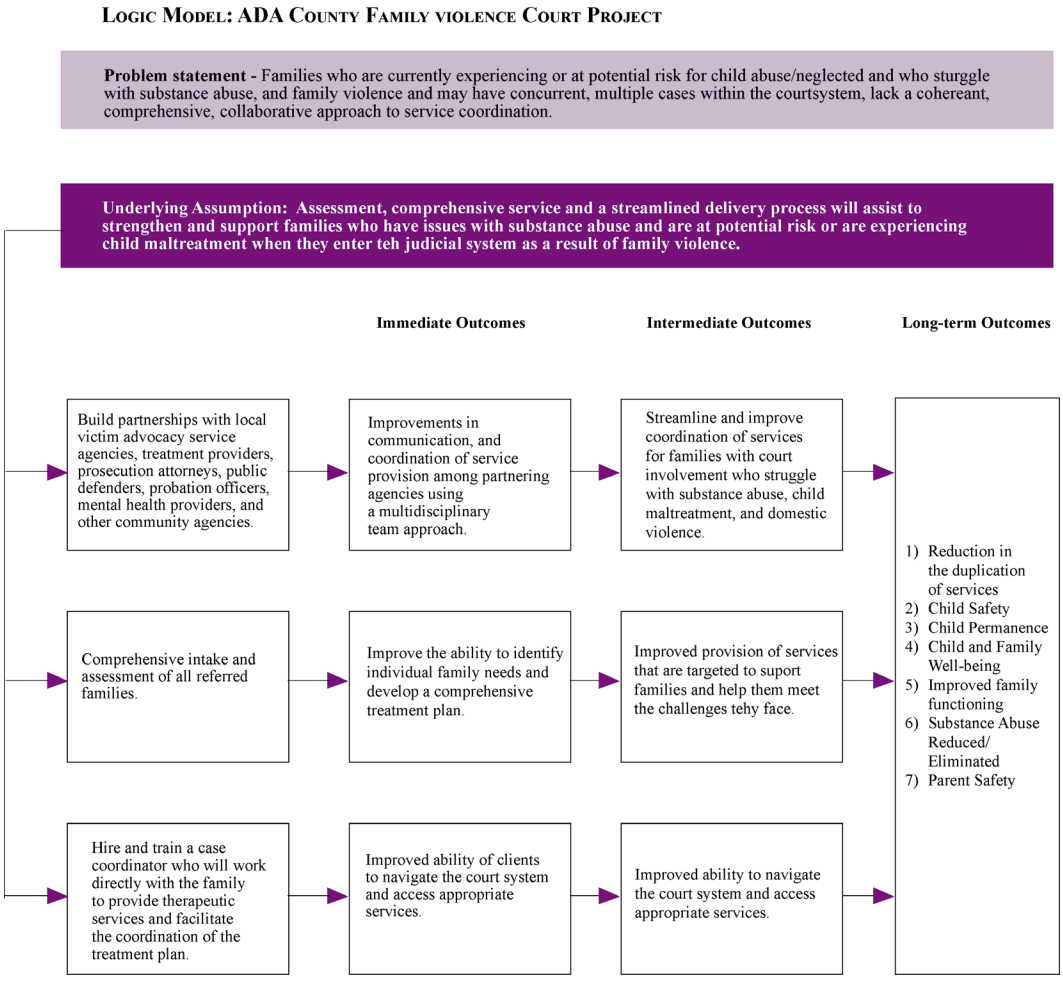
The FVC Grant Project responded to three primary research questions to determine which approaches would result in positive outcomes for children and families that had multiple cases in the court and child welfare, substance abuse, and family violence issues.

- Does a comprehensive and collaborative approach serve to strengthen families?
- Does a thorough assessment of family functioning, which includes substance abuse, domestic violence, and child maltreatment and which identifies and provides early interventions for these characteristics, strengthen families?

- Does having a trained case coordinator, who provides therapeutic support and facilitates a coordinated treatment plan, lead to increased access to necessary resources and improved family functioning?

Project Logic Model

The research tracked process and participant outcomes, indicators, and measures using the logic model design. The logic model also was used to guide and monitor program direction, implementation, and progress. Developed through a participatory process among FCS staff, the RMQIC, and the Coordinator, the logic model began by stating the overall problem to be addressed by the project and the underlying assumption. In addition, three implementation objectives, activities, and interventions were identified and supported by clearly defined intermediate and long-term outcomes for each of the implementation objectives, activities, and interventions. Participant outcomes included child safety, child permanency, child and family well-being, improved family functioning, parent safety, and the reduction or elimination of substance abuse as well as a system change outcome (i.e., reduction in duplication of services). The logic model is presented here.



In support of the logic model and to further guide program activities and research, for each implementation objective, activity, and intervention, outcomes, indicators, and measurement methods were specified. Appendix A includes copies of these detailed tables.

Evaluation approach

To address the research questions and the extent to which this project strengthened families with multiple problems, the evaluators and project staff collected both quantitative and qualitative data. The Boise State University Institutional Review Board (IRB) approved the FVC Grant Project research approach in February 2005. The gathering of participant outcome information occurred through standardized pre- and post-instruments, participant intake and assessment documentation, and secondary administrative data from the court, probation, and DHW systems. FVC Grant Project participants who agreed to take part in the project signed release of information and consent forms. (Information gathering and release of information occurred prior to final IRB approval; however, the IRB approval supported access to data collected earlier.)

In addition, throughout the project, process data were collected through a series of interviews with professionals from public agencies including referral sources, treatment and service providers, and participants upon program exit and during follow-up activities.

The project also utilized a comparison group approach. The type of information gathered on individuals and families selected for the comparison group included administrative data from DHW, FCS, and Ada County Misdemeanor Probation. This information was de-identified and the IRB did not require individuals' consent. State and national data also were used for comparison purposes.

A Microsoft Access database was designed to support the evaluation. The database consisted of family unit data, individual participant data, and project activity/function data. Within the family and participant sections of the database were several different points of data entry. Some variables remained the same (e.g., birth date) while some tracked progress/change with participant data collected at the beginning and end of the project. The DHW, FCS, and probation data for each participant were tied together with an assigned number. Only the program manager, clinical supervisor, and Coordinator had access to the electronic and paper copies of the data, which were stored in a secure office. The information then was placed in an SSPS database for statistical analysis.

Description of evaluation processes and data collection tools

Evaluation data were collected from program partners, service providers, service provider administrators, members of MDTs, and project team members, as well as from participants. While professionals contributed to information related to

system and process findings (i.e., immediate and intermediate outcomes and program strengths and challenges), participants provided information on the efficacies of the program and its services. To supplement this information, secondary administrative data collected when families exited the project; comparison group data regarding substantiated child maltreatment reports; and criminal charges and other court involvement, reported domestic violence incidents or charges, and/or court appearances were collected.

In addition, the court and program intake and initial assessment processes yielded demographic data on participants, specifically regarding criminal history, children's involvement in the child welfare and juvenile systems, divorce and custody issues, and adult mental health concerns. Awareness of these issues is important since, for example, divorce and custody issues can complicate families' situations, and early knowledge of children's special needs and adults' mental health concerns enables the identification of treatment needs. Other data gathered through these processes included more detailed history of substance abuse, type and number of prior child maltreatment reports, and history of domestic violence reports.

Awareness of these issues is important since, for example, divorce and custody issues can complicate families' situations, and early knowledge of children's special needs and adults' mental health concerns enables the identification of treatment needs.

To effectively serve participants and support evaluation, the Coordinator documented participants' engagement and completion of substance abuse treatment, domestic violence counseling and treatment, and parent education. The Coordinator also recorded information regarding participants' drug testing results, probation and DHW compliance, criminal involvement, court involvement, and child maltreatment and placement.

In addition, four standardized instruments were used pre- and post-program. Each participant completed the self-report ICPS-Family Functioning Scale, which examines intimacy, conflict, and parenting styles, pre- and post-program. The Coordinator also completed three clinical pre- and post-tests, one assessing family functioning and child well-being, another assessing risk of future violence, and the third assessing parental conflict. A brief description of these instruments is provided here.

- ICPS-Family Functioning Scale is a client self-assessment tool given to each participant regarding family functioning (Noller, 1992). ICPS-Family Functioning Scale uses a six-point scale in three subscales: intimacy, conflict, and parenting styles. This test was given to participants by the Coordinator during the intake process and at the exit interview.

- North Carolina Family Assessment Scale (NCFAS) completed by the Coordinator examines family functioning and child well-being. (Kirk & Reed-Ashcraft, 1998). The instrument focuses on five assessment "domains" or factors: environment, social support, family/caregiver characteristics, family interactions, and child well-being. Each of the five domains and associated sub-scales utilizes a six-point rating scale, ranging from -3 (serious problem) to +2 (clear strength), through a "0" point

labeled Baseline/Adequate. The assessment was completed once at intake and once at closure.

- Spousal Assault Risk Assessment (SARA) is a clinical checklist of risk factors for spousal assault (Kropp, et. Al, 1995) that also was completed by the Coordinator. Its purpose is to assess risk for future violence. Each participant was rated on a three-point scale (0-1-2) regarding criminal history, psychological adjustment, spousal assault history, alleged (current) offenses, and other considerations. The summary rated imminent risk of violence toward partner and toward others as follows: low, low to moderate, moderate, moderate to high, and high. This assessment was completed at program intake and exit.

- Garrity and Baris Parental Conflict Scale, from *Caught in the Middle: Protecting the Children of High-Conflict Divorce* by Garrity and Baris (1994), assessed the level of parental conflict ranging from minimal, mild, moderate, moderately severe, to severe. In the FVC Grant Project, the Coordinator completed the scale for participants at intake and exit.

Insights from stakeholders (i.e., participants, service provider administrators, frontline workers) regarding their thoughts and experiences with the FVC Grant Project were gathered through standardized written surveys and interviews developed for the evaluation. While the number of respondents was small and the data should be interpreted cautiously, the insights did shed light on the effect of collaboration.

Participants' experiences were gathered through two approaches and at two points in time: when they exited the program and during a follow-up interview. After families completed, withdrew, or dropped out of the project, the Coordinator conducted an exit interview with participants. The exit interview identified any remaining family-level concerns so the Coordinator and family members could collaborate to construct a plan to address them. Data also were collected at this point for evaluation purposes. Post-tests were completed, and the evaluation process and follow-up procedures were again explained to participants. The Coordinator distributed a satisfaction survey to all participants during the exit process and provided them with a pre-addressed, stamped envelope addressed directly to the research evaluators. For participating in the exit process, participants received a $50 gift certificate to the local mall.

The second approach involved the evaluation team, which scheduled individual meetings with parents willing to meet with them one-on-one. The initial group of participants was interviewed in a private room at the public library in April 2005 with follow-up telephone calls occurring throughout 2005 and 2006. The project used the same approach of conducting face-to-face meetings then follow-up telephone calls with another group of parents in 2006. These interviews occurred only after parents exited the program. Parents were given a $30 gift certificate to a

grocery store upon completion of the interviews. (See Appendix B – parent interview protocol.)

Table 1 summarizes the topical areas of interest and the corresponding data group responding to that area of examination.

TABLE 1: SUMMARY OF TOPICAL AREAS EXAMINED BY RESPONDENT GROUP

Topic Area	Service Provider (Admin)	Parent	Service Provider (Direct)
1. Knowledge of FVC Grant Project			
Strengths of the project	✓		✓
Personal knowledge of project	✓		✓
Improvements for the project	✓	✓	✓
Challenges in serving participants	✓		✓
Availability of services		✓	
Stigma related to mental health services		✓	
Stigma related to substance abuse services		✓	
2. Project Personnel			
Satisfaction with the program	✓		✓
Parent involvement		✓	
3. Project Services			
Multidisciplinary Team		✓	✓
Overall satisfaction with project services	✓	✓	✓
Case coordination	✓	✓	✓
Relationship with the project	✓	✓	✓
Utilization of services	✓	✓	✓
Importance of project	✓		✓
4. Project Services			
Nature of the relationship between services and families (coordination)	✓		✓
Extent of family inclusion		✓	
Strength of relationships between service providers	✓		
Type of information shared between service providers and project	✓		
Referrals between service providers and project			✓

Exit and follow-up activities and tracking of participants

Throughout the project families were asked to provide information to help locate them so that their whereabouts would not became unknown and in order to support follow-up evaluation. Participants were asked to provide the names, addresses, and telephone numbers of two people they would likely stay in contact with and permission to contact these people. These contact individuals were not considered program participants and were not entitled to any information regarding participants' involvement, status, or outcomes.

As noted participants were offered an incentive to complete the exit process. In total, 48 individuals elected to participate in this exit process. The incentive did encourage some families that dropped out of the program or completed the program earlier to come forward. However, some participants did not complete the exit phase because they could not be contacted, refused to participate, or were incarcerated. Unfortunately, two participants died during the project due to recurring, previous medical issues.

It was anticipated that after completing the FVC Grant Project, project staff would contact participants monthly for the first three months to follow up, offer support, and determine whether families needed additional resources. Participants also would be contacted at six months and at 12 months after exiting the project to gather data. The intent was for this information to support ongoing program quality improvement and evaluation; however, since over 75% of participants remained in the program for more than the anticipated six- to 12-month timeframe, they exited the project during the last six months of the three-year implementation phase. Therefore, the six-and 12-month data are not available for most participants since sufficient time had not pass from program exit to the drafting of the evaluation report. The plan to gather pre-tests and post-tests, however, was still in tack. In addition, secondary administrative data were assembled by the court, probation, and DHW systems and follow-up interviews were conducted with families by the evaluation team.

Project staff were able to identify 30 potential respondents as potential follow-up resources for the evaluation team, of which 15 participated. Nine of the interviewed parents were mothers and six were fathers. Five parents from each of the following age categories participated: 15-25 years of age, 26-35 years of age, and 36-45 years of age. The ages of their children were widespread, ranging from three to 18 years.

It is possible that parents who were willing to participate in follow-up might have been different from those parents who did not. For example, they may have been more successful than other participants or may have believed they benefited more from the project than other parents. However, there was no indication that participants who engaged in the follow-up process were more successful than participants who chose not to engage. Although limited numbers of parents participated, the interviews provided considerable information about which

services parents received, their perceptions about those services, and the FVC Grant Project.

Comparison groups

There were two sets of comparison groups, both consisting of parents who were identical to the program participants in all the qualifying criteria, yet were ineligible for participation in the FVC Grant Project due to technicalities (e.g., timing of DHW referral in relationship to their court involvement). Comparison families were identified and designated throughout the project. These parents were not expected to participate in the assessment, intake, or FVC Grant Project. They did not receive case coordination support nor did they have their services funded through the grant. However, they did receive the services that were already available through the courts and community prior to the FVC Grant Project.

The presence of two comparison groups in the FVC Grant Project stemmed from the program eligibility expansion. The first comparison group's profile matched all the qualifying criteria met by the initial program group. This group was required to have an open case with the DHW, current substance abuse concerns, and a court case involving domestic violence. Due to systemic timing issues, not all families were identified when their cases were initially opened to both systems and therefore could not be offered the chance to participate in the program. For example, the FVC Grant Project may not have received a referral from the DHW until after court activity had reached completion. Sometimes the court process can be as short as one day; other times it can be two weeks or even several months. Thus, these families became part of the comparison group if, within the same 30-day timeframe, there was an open DHW case, current substance abuse concerns, and a court case involving domestic violence.

The criteria for the second comparison group also was consistent with the criteria for families in the program group at that time. These were families with active court involvement in Ada County with domestic violence concerns, substance abuse issues, and child protection concerns (but not necessarily open DHW cases). The expansion of eligibility criteria supported enrollment of children who were regarded by the court to be at high risk of harm, referred to as Enhanced Child Protection Concern cases. Enhanced Child Protection Concerns were defined as a Criminal Injury to Child/Child Endangerment charge, children present during domestic violence, and/or past DHW referrals or involvement. These families may not have been involved in criminal court or had domestic violence concerns that brought criminal charges, but they were identified in a court assessment related to a civil process. Again, families that met these expanded criteria were placed in the comparison group if the court case closed quickly.

The project discontinued accepting referrals up through the first week of June 2005 because, based on experience, families generally needed at least six months

to participate in the project. It was decided that it would not be appropriate to enroll new families that could not be served for at least that length of time. However, referrals received between June 7 through the end of July 2005 were added to the comparison group.

Each of the comparison groups were identified in the database so that if there were different outcomes between the two program groups (i.e., those from the original and expanded program groups), data could be segregated and evaluated separately. It turned out that there were no differences (per *t* test analysis), so for analysis purposes the comparison groups were combined.

PROGRAM AND PROCESS EVALUATION

This section reports details on the program startup, implementation, referral process, intake, and service delivery. Second, this section reports on the "immediate" and "intermediate" outcomes listed in the logic model.

Program startup

By nature, program startups—taking a concept outlined in a grant and bringing it to full implementation—presents many demands and challenges. Additional challenges were experienced in the FVC Grant Project because there were early and sudden changes of staffing at FCS. A new FCS Director, who also was not familiar with the grant, had to complete a number of key activities that promoted a successful startup:

- Establishment of a protocol for supervision and administration of the project
- Development of the project outline, measures, data for evaluation, feedback, and approval process regarding tools, in consultation with the RMQIC for suggestions, feedback, and approval
- Development of an outcomes flow sheet that was later converted into the Program Logic Model
- Development and revising of documents for project operation (e.g., intake, assessment process, consent, releases)
- Meeting with all service evaluators, providers, educators, and other professionals who supported the grant project and provided services. (The meeting was to inform providers of the project and needed services, establish a system of collaboration, and discuss the procedures for billing and reporting).
- Meeting with the Ada County Misdemeanor Probation Director regarding collaboration and monthly reporting procedures
- Discussions with the FVC Senior Judge pertaining to referrals with DHW and potentially eligible cases

Program implementation

One of the first steps in the implementation phase was hiring the Coordinator. In formulating the job description, it was determined that the Coordinator would be responsible for performing participant intake and assessment; administering pre- and post-tests; performing case management and coordination; monitoring treatment progress and completion; maintaining direct contact with families; coordinating and facilitating MDT meetings with treatment providers and other community members; and assisting in developing treatment plans.[2] The Coordinator's job also included assisting in developing and maintaining policies and procedures for the program operation, developing data forms and information-sharing agreements, performing and supporting research functions and evaluation tools, completing quarterly reports to RMQIC, and following up on evaluation activities with families.

The Coordinator was hired in March 2003, and fortunately, had a Master's Degree in counseling and was a Licensed Professional Counselor with a background in intensive case management with families and children. In addition, the Coordinator had worked in the Ada County court system in the past. Had this not been the case, training/program orientation would have required a longer learning curve.

Seminal project events are enumerated below:

- Grant start date was January 1, 2003.
- A service provider meeting to establish referral, billing, and monitoring procedures with substance abuse assessment/treatment, mental health counseling, and domestic violence assessment/treatment providers in the community interested in providing services to participants was held in April 2003.
- First referral from DHW Family and Children Services occurred on May 27, 2003.
- First MDT meeting was held on May 29, 2003.
- First family assessment occurred in June 2003.
- First treatment planning meeting was held on June 26, 2003.
- A meeting between FVC and the DHW regional program manager to agree to expand criteria for referral to the project was held in Fall 2003.
- First exit interview occurred on December 20, 2004.
- Program ended December 31, 2005.

[2] The Coordinator activities are described in detail in the *Case Coordinator Handbook.*

Referral process and number of participants referred and enrolled

Program referrals came from two sources. Prior to criteria expansion, all referrals were from DHW. When program eligibility also included Enhanced Child Protection Concern cases, referrals directly from FCS were accepted. In total, DHW referred 81 families, averaging 16 referrals every six months, and FCS referred 34 families. A total of 115 families were referred to the FVC Grant Project from these two sources.

Of the 115 families referred, 58 were found to be eligible for participation. Of these, 53 consented to participate in the program for a total of 93 adults (48 fathers, 44 mothers, and a stepmother) and 135 children.

The low participant eligibility rate stemmed from a variety of reasons: there was no court involvement at the time of referral, their court case had already closed, or their court case was being presided over by a judge who was not involved in the FVC (Table 2).

TABLE 2: REASONS FAMILIES ARE IN THE COMPARISON GROUP

Reasons	Number
FVC case closed prior to agency referral	11
Another judge presiding	7
Referrals after June 7, 2005	6
Lack of DHW referral (referral prior to expanded criteria)	3
Total	27

Table 3 presents patterns of referrals and participation decisions.

TABLE 3: REFERRAL AND PARTICIPATION DECISIONS

Event	Total
Number of DHW Referrals	81
Number of FCS Referrals	34
Number of families enrolled	53
Adult Individuals	93
Number of comparison families	27

Intake and service delivery

The intake and service delivery processes were designed at program start, but as with many programs, they were refined and streamlined over the course of the project. Following is the process used for most of the project.

Following a referral the FVC Grant Project parents were recommended or court-ordered to meet with the Coordinator or the FCS assessor for an initial court intake and assessment. (Prior to the FVC Grant Project, families would have followed the same process, but would have had the option to meet only with the FCS assessor since the Coordinator position did not exist.) Parents who had pending criminal charges sometimes elected not to participate in the assessment process until their criminal cases were resolved, depending on what they and their lawyers decided. Prior to this initial court intake and assessment, families were asked to sign a one-page consent form—a different form from what they would later sign if they elected to participate in the FVC Grant Project. The form explained the initial court assessment process and the limits of confidentiality, and that their case could be eligible for the FVC Grant Project if they elected.

The purpose of the initial court intake and assessment process was to collect information for a written summary for the court that included clinical recommendations. The Coordinator or FCS assessor interviewed parents separately to obtain information related to families and decrease potential conflict that might result between parents. The assessment was not designed to decide the results of the case nor to "take sides" with participants.

During this phase, the Coordinator and FCS assessor also conducted screenings to determine whether mediation or other resolutions were appropriate and to assess whether families might be eligible for the FVC Grant Project. If they were

eligible, the Coordinator explained the FVC Grant Project and provided a copy of the informed consent form, which included a description of the project and the research process. It also included details about the services participants would be eligible to receive at no cost, the pre- and post-assessment tools they would be asked to complete, the voluntary nature of the project and their ability to withdraw at any time without penalty, and the risks associated with participation.

As noted, after the initial court intake and assessment, regardless of any interest in program participation, a written report was submitted to the court. It summarized parents' history, issues, and concerns; identified child concerns; and offered recommendations for the court's and participants' consideration. The report also proposed service and treatment recommendations to enhance family functioning, provide alternatives for resolving issues, and improve parent and child safety.

Upon reading the written summary report, the judge might have ordered other evaluations (e.g., substance abuse, domestic violence, mental health, child at risk). If family members agreed to participate in the FVC Grant Project, funding was available to pay for these evaluations and for the Coordinator to coordinate these and other referrals.

If families enrolled in the FVC Grant Project, the Coordinator worked with families and other members of the Treatment Planning Team to develop families' comprehensive treatment plans based on the assessment and clinical evaluation. Treatment plans also incorporated recommendations from the Child Protective Investigation Report from the DHW or the DHW case plan, probation requirements, and input from others on the Treatment Planning Team. For example, participants may have been required, ordered, or recommended to participate in domestic violence or substance abuse treatment and other community services (e.g., parent education programs). The Treatment Planning Team could consist of the FCS staff, DHW staff, Ada County Probation, advocates (e.g., court advocates, individual counselors) involved in families' cases, and families themselves.

There was a pre-approved list of treatment and service providers who already had a contract agreement with the project to whom individuals and families generally were referred. However, program participants were not limited to these providers. If participants requested providers not on the pre-approved list, project staff would ensure these providers agreed to the billing procedure and would review the quality of their services.

As part of the treatment plan, the victim of domestic violence may have been required to attend a Family Safety Planning Meeting. The purpose of this meeting was to address safety concerns regarding domestic violence and child safety and to develop an Individualized Family Safety Plan. Participants were instructed to contact the Women's and Children's Alliance (WCA) to register for this free service. After completion of the Family Safety Planning Meeting a copy of the safety plan and documentation of attendance was submitted to the Coordinator. If

participants could not attend the WCA meeting or had already attended the WCA meeting before entering the project, or the Coordinator determined families needed additional support and information, participants would take part in an individual safety planning session with the Coordinator to develop, refine, or review the family safety plan.

In addition, most high-conflict divorce or custody cases in Ada County are ordered to attend an Alternative Dispute Resolution (ADR) Screening. It became possible for an ADR Screener to refer families to the FVC Grant Project if families came into the court initially through a divorce or custody case but presented with issues of domestic violence, substance abuse, and child maltreatment concerns.

Further, parents who participated in the FVC Grant Project and were not living in the same household—but had a co-parenting relationship—may have been required to participate in an Effective Co-Parenting Education program taught by the Coordinator at no cost. Parents were responsible for setting up their separate initial sessions with the Coordinator and attended additional sessions with the other parents if the Coordinator deemed it appropriate based on safety and court order concerns.

Effective Co-Parenting Education included pre- and post-tests, psychosocial education, handouts individualized to ages of children and level of parental conflict, and supported discussions related to the development of individualized case plans. After parents completed Effective Co-Parenting Education, a status report was placed in the FVC Grant Project file and, if court-ordered, a copy was sent to the judge to document participation.

The Coordinator worked directly with families to provide resources, offer support, and facilitate services as outlined in the treatment plan. The Coordinator had contact with individual participants as often as needed and until participants were discharged from the program. Frequently this contact took place on a weekly basis by telephone, during participants' court appearances, or in individual one-on-one meetings. The Coordinator supported families through the court process and served as families' contact person and liaison with providers, community services, and DHW. The Coordinator had frequent contact with providers to monitor participants' progress in substance abuse treatment, domestic violence treatment/counseling, and parent education. As part of the project, each family's case was staffed at least once a month during an MDT; with the FVC Grant Project staffing cases twice a month.

After completion of the FVC Grant Project, the Coordinator conducted an exit interview with participants. Additionally, the Coordinator and/or evaluation staff contacted families and conducted follow-up meetings. Appendix C contains the flow chart summarizing this process. A case example illustrating a treatment planning treatment plan is included in Appendix D.

Findings: Program elements and considerations

The startup phase of the project was to be concluded within three months of grant award. This time line was very short given the number of items needing to be addressed for a new program. For example, prior to accepting participants, the FVC Grant Project had to hire and train the Coordinator, equip the office, establish acceptable measurement tools, create partnerships, build relationships, clarify referral processes, create service provider forms, and collect provider agreements. The program started to serve families during its fifth month of funding.

The number of referrals was fewer than anticipated and were initially slow. In addition, the initial eligibility guidelines resulted in several of those families that were referred to be ineligible. There were two main causes—the first issue of fewer referrals was related to the time needed to educate and build trust for a new program among DHW workers (who initially were the only referral gatekeepers). The second issue was that eligibility guidelines flowed from different definitions and mandates between the court and the DHW regarding what constitutes child safety.

Initially, the project operated under the belief that when a Child Protection Investigation Report was requested, DHW was actively involved in constructing the report, and—if there was sufficient evidence—a case was "opened." However, at the time of the project, in many situations DHW only "opened" cases when law enforcement removed children from the home. Since the initial grant application stated that eligible participants had to have children remain in the home, this technicality made nearly all open DHW cases ineligible for participation in the project.

Meanwhile, the FVC perception is that if there is substance abuse and domestic violence in a home, exposure to this chaotic environment, especially the violence, constitutes harm to children in the home. This barrier partly was overcome by using the community referral option (alternative response) for the DHW. This means that although the case was not an open child protection case, DHW would refer and/or recommend that families seek community services. However, educating DHW workers and building a practice of using this approach took some time. In addition, RMQIC supported the expansion of eligibility and adjusted it to include families that recently had a child removed from the home (not more than two months) with the permanency goal to return home.

Immediate and intermediate program outcomes

This section describes results, based on interviews and surveys/questionnaires, of the project as they pertain to the "immediate" and "intermediate" outcomes as enumerated in the logic model. These represent the areas/goals identified for each of the three activities and interventions of the program. For example, in the logic model, Activity 1 was "Build partnerships with local victim advocacy service agencies, treatment providers, prosecuting attorneys, public defenders, probation

officers, mental health providers, and other community agencies." The Immediate outcome for this activity was to make "Improvements in communication and collaboration among partnering agencies using a multidisciplinary team approach." The Intermediate outcome was to "Improve coordination of services for families using a multidisciplinary team approach." (Appendix A has more detail regarding this activity and other program activities.) The overall research effort was to determine the extent to which achieving these "program/process outcomes" would result in achieving participant outcomes such as child safety. Thus, this section discusses the findings related to the program's immediate and intermediate outcomes: coordination and team-building among service and court professionals, improved assessment and case planning, and the relationships between participants and the Coordinator.

Communication, collaboration, and coordination of service planning

Frontline staff, administrators, and community service providers were the primary sources of information for communication, collaboration, and coordination via interviews, questionnaires, and MDT records.

Project staff identified 14 service partners. A survey was e-mailed to the designated leader of each service provider. Eight administrators completed the administrative questionnaire and three elected to answer as frontline service providers, resulting in a 78.5% response rate. Their years of work experience ranged from one to 30 with a mean of 10.4 years.

The frontline service provider questionnaire was similar to the administrator form and was adapted from the Substance Abuse and Mental Health Services Administration's Systems of Care initiatives. Twelve of 14 direct service providers completed the survey. Respondents represented diverse work settings, including child protection, substance abuse treatment, probation, community-based counseling, and social services. Six described their jobs as management, two were social workers, two were counselors, one was a treatment specialist, and one was a psychologist. The average years of work experience among these respondents was 13 years, ranging from six months to more than 40 years.

Table 4 shows the response rate for both surveys combined by service provider type; some service providers offered more than one service type. Data were entered into an SPSS database.

TABLE 4: RESPONDENT BY SERVICE TYPE

Service Provider	Number of Respondents by Provider Group
Substance Abuse	8
Domestic Violence	5
Parent Education	2
Child Protection (DHW)	2
Probation	1

In addition to the survey, administrators from each of the two agencies whose staff referred families were interviewed. These two individuals provided comprehensive insights into the working of the FVC Grant Project since they had contact with the program at all levels, including referral, treatment delivery, and court appearances. They provided insights regarding the FVC Grant Project functioning, type and level of collaboration, and the process and participant outcomes.

The two administrators interviewed rated their relationships with the FVC Grant Project and the criminal justice system as strong. However, their relationship with others such as the women's and children's shelters, substance abuse treatment providers, juvenile court, and law enforcement was not as strong due to less communication and interaction. The data indicated even weaker relationships among service providers and schools, health services, mental health services, community health programs, juvenile detention, child protection, and domestic violence treatment providers.

The judge cited several telling signs of increased coordination. He noted that the actions of the DHW program manager were key in getting the FVC Grant Project off the ground. The DHW program manager negotiated many obstacles and kept progress on schedule. The judge also praised the DHW for its support of the project. He mentioned that he too met with the program manager to establish the relationship and foster collaboration. One sign of increased communication and collaboration was the DHW's willingness to provide the Coordinator with office space and supporting the Coordinator's participation at the DHW staff meetings. The action fostered increased referrals, communication, collaboration, and coordination of services.

A key activity among agencies is sharing family information. The questionnaire asked administrators the type of information given by their agency to the FVC Grant Project. Most frequently, agencies shared diagnosis information and suggestions about treatment needs. In a few cases, agencies also shared data on participant progress, psychological evaluations, test profiles, and demographics.

The 12 frontline staff who responded to their analogous questionnaire expressed overall great satisfaction with the program. Two of the 12 frontline staff said the referrals seemed slow or inconsistent (i.e., the Coordinator getting back to them). One staff person commented on the need for brief updated reports on participant progress. Another requested more frequent MDT meetings and more agencies participating in those meetings.

As for participants, in the exit interview, 90% reported that the coordination of services by the project helped their families. In addition, parents appreciated the FVC Grant Project service documentation. The Coordinator followed up with service providers and documented their participation and completion rates. This allowed parents to efficiently present to the court evidence of their timely completion of court-ordered activities.

Improved assessment and service planning

Personnel from RMQIC conducted focus groups and interviews with DHW staff during the project to assess fidelity to the model, and to independently determine the project's impact on processes. The DHW workers consistently and overwhelmingly reported that the project's assessment process and treatment team meetings were outstanding[3], and that the project's work contributed very positively to improved child safety, permanency, and increased parenting skills. The RMQIC survey results revealed a mean of 3.63 for "improved child safety," 3.58 for "supported permanency," and 3.61 for "increased parenting skills," on a scale of 1 to 4, with 1 being "strongly disagree" and 4 being "strongly agree."

The administrators provided the following statements regarding assessment and service planning: "Initial assessment and problem identification are major strengths of this project," and "The project's willingness to work with providers to assure the best services for clients is impressive."

Improved supportive relations between participants and the Coordinator

Completed exit surveys received from 39 program participants revealed that overall they were highly satisfied with their FVC Grant Project experience. Parents overwhelmingly found project staff to be knowledgeable, respectful, willing to answer questions, understanding, and supportive. The strongest endorsement came in the area "treat you with respect" (100%). The weakest came in the areas "conduct enough meetings" and "give you a voice," although these too received high ratings (74% and 82% respectively). In another question, participants were asked about their level of contact with staff. Ninety-two percent reported it was "just right" with the remaining 8% reporting "too little." Table 5 presents respondents' ratings for those who "strongly agreed" or "agreed" since they represented nearly all respondents.

[3] In a survey taken by the RMQIC staff, all 11 respondents rated assessments "very helpful" (the highest category).

TABLE 5: STAFF

Did the Staff...	Strongly Agree	Agree
Treat you with respect	84.6%	15.4%
Offer support	74.4%	23.1%
Show understanding	76.9%	20.5%
Answer your questions	66.7%	25.6%
Give you a voice	53.8%	28.2%
Conduct/coordinate enough meetings	46.2%	28.2%

In exit interviews, narrative feedback from participants included statements such as "The project staff developed trust with me. I wouldn't have gone to the classes and other services if that trust wasn't there," and "The project was non-judgmental and supportive; not blaming and authoritarian. People cared about our success and progress." Other participants reported to the evaluators that "The relationship with the project and [the Coordinator] greatly helped my motivation to get better; the project was the best thing that happened to us. The understanding, encouraging, and down-to-earth approach was effective," and "I'm happy it was available. We probably would not be clean and have our kids if not for this program."

Parents were asked if they had suggestions for improving the FVC Grant Project. The most common recommendation was to expand the program and hire more program staff. Universally, they commended the Coordinator for consistent support and guidance. Parents believed that participation in the project helped them navigate the complexities of the court processes, ensured they had access to needed services, and showed them that someone cared for and respected them. One parent said, "We would not have known what to do and couldn't have paid for it." Another said, "It is intimidating—it helps to have a smiling face."

Greater access to services

Primary activities for the FVC Grant Project, through the Coordinator, were to identify family service needs, support access to services, and coordinate the various service plans among the agencies. Thus, a good starting point is to identify the types of services families were seeking.

All but one of the 15 parents participating in the exit interviews indicated that substance abuse was one of the main reasons for seeking help. Most of the parents reported domestic violence as the initial reason for seeking help. Other reasons (in

order of frequency) included safety (4), family functioning (4), parenting and co-parenting issues (2), and financial problems (1).

Participants reported they were able to access a wide range of services once they became involved in the project. Some parents stated that prior to participation they were unaware of the breath of services available and how to access them. Thus, they were appreciative of their increased awareness of the services that, in turn, helped them improve their lives. In fact, two parents suggested that the project create a brochure that lists all available services in the community. They explained they would have used these services prior if they had known about them.

Additionally, parents underscored the importance of having services paid for by the FVC Grant Project. In fact 97% of them either "strongly agree" or "agree" that making funding available was important and the same percent praised the project for providing resources. They found these two program elements to be critically important and expressed appreciation for the financial support they received. They stated that having the services paid for resulted in higher rates of participation and more timely participation than if they had to pay for services themselves.

When asked which of the specific services coordinated through the FVC Grant Project were most useful to them as individuals and to their families, the following services were noted: substance abuse treatment, individual counseling, parent education, drug testing, and case coordination. Other useful services included domestic violence services, support by the probation officer, and family counseling.

When asked why they found these services helpful, parents reported that the services provided them with beneficial skills and tools they would draw upon and use in the future. One parent explained that all the services were necessary; she said, "It was *all* helpful. It's like a package—it all went together. We needed all of it."

SERVICE OUTPUTS

Frequency and duration of participant contacts

There were 2,786 participant contacts made between the 53 families involved in the project and the Coordinator. Of these contacts, 415 occurred face-to-face and 2,371 occurred through a variety of forms (e.g., telephone, e-mail, letters). Families ranged from three to 143 contacts per person with an average of 53 contacts with the Coordinator. The length of contacts, for all types, ranged from 10 minutes to 2 hours. The most likely type of participant contact occurred by telephone and was the primary form of contact once the relationship was established. Having access to the Coordinator on an as-needed basis was

extremely important to several participants. Ninety-two percent of participants reported the amount of contact was "just right."

Service outputs

Of the 93 individuals enrolled in the project, 71% (69) completed at least one of the recommended services with 49% (46) completing all court-ordered or recommended services. In addition, over one-half formally completed the program, engaging in the exit process.

The project conducted analysis to determine which service participants were more likely to attend and complete. From a practice perspective, in many cases, counseling and support groups cannot be measured in terms of completion or termination. Such groups, as well as ongoing recovery support programs, differ from treatment in that they usually do not have a measurable ending or completion date. From this perspective, if an individual received counseling or attended support meetings, it was documented, but "true" completion was not/could not be determined. As indicated in Table 6, rates varied widely across services. Data are presented in descending order of program completion rate, participants likely to complete substance abuse assessment (95%), followed by families likely to involve their children in counseling (93%). Meanwhile, completion of domestic violence treatment (38% completed and 53% attended) and the Co-parenting Education Program (30% completed) were the least likely services for people to complete. It also is important to note that figures for those who were still in treatment or attending are included in these figures and were placed in the completed column. There also appears to be a strong pattern in that individuals who start treatment are likely to complete it.

Specifically, with substance abuse services, the FVC Grant Project participants' attending and completing treatment rates were very promising. Sixty-seven percent attended treatment with 52% completing it. An Illinois Title IV-E Demonstration Waiver Project, in which "recovery coaches" delivered intensive services, reported 59% of individuals in the demonstration group had either engaged in or completed treatment; Delaware's Demonstration Project using substance abuse counselors co-located within CPS reported 24% of individuals had engaged in or completed treatment.

TABLE 6: BREAKDOWN BY ATTENDANCE AND COMPLETION OF REFERRED SERVICES

Topic Area	Number Referred	Number Attended	Percent Attended of those referred	Number completed and percent of those who attend	Percent Completed of those referred
Substance Abuse Evaluation	75	71	95%	71 (100%)	95%
Families involved children in counseling	29	27	93%	*	93%
Mental Health Assessment	22	20	91%	20 (100%)	91%
Domestic Violence Evaluation	48	43	90%	43 (100%)	90%
Individual Counseling Domestic Violence	29	24	83%	*	83%
Other Evaluations (e.g., Child at Risk)	22	17	77%	17 (100%)	77%
Alcoholics Anonymous (AA) / Narcotics Anonymous (NA)	20	14	70%	*	70%
Mental Health Counseling	26	18	69%	*	69%
Relapse Prevention (substance abuse)	28	17	61%	17 (100%)	61%
Parenting Education	67	40	60%	40 (100%)	60%
Anger Management	7	4	57%	4 (100%)	57%
Substance Abuse Treatment	48	32	67%	25 (78%)	52%
Individual Counseling (general)	22	11	50%	*	50%
Domestic Violence Treatment	32	17	53%	12 (71%)	38%
Effective Co-Parenting Education	46	15	33%	14 (93%)	30%

***Referred may be court ordered or project recommended treatment/services.**

While Table 6 reports numbers and percents of participants who both attended and completed treatment, Table 7 presents an analysis on attendance based only on whether attendance was court-ordered. The reason for this analysis was to determine if court-ordered services and activities were attended at higher rates than project-recommended services and activities. Findings revealed that for all service types, court-ordered services/treatments were attended at a higher rate than project-recommended treatments. However, caution with this "finding" is warranted due to small sample size. When asked what barriers impacted completion, participants provided a range of answers including continued drug or alcohol abuse, health concerns, transportation problems, and child care issues. Table 7 details the percentages of participants who were court-ordered or project-recommended to undergo treatment or services by type of service or treatment and who attended.

TABLE 7: COMPARISON OF COURT-ORDERED VS. PROJECT–RECOMMENDED TREATMENT

Type of Service	Court-Ordered Attended	Project Recommended Attended
Relapse Prevention (substance)	100%	58%
Anger Management	75%	33%
Substance Abuse Treatment	74%	62%
Effective Co-Parenting	73%	13%
Domestic Violence Treatment	65%	22%
Parenting Education	63%	59%

Data suggest that court ordering effectively facilitates participants to those services that the system believes to be in their best interest. Of course, it does not necessarily mean they were "successful" completions in terms of changes in behavior for participants. (Although later in this report, it appears that major position changes in these areas were made based on self-report and the Coordinator assessments.) In addition, it may not always be the case that individuals dealing with numerous difficult issues have to complete all services to be "cured." Is it possible that "getting" the most needed service eliminates the underlining problem; therefore, the need to "complete" all services is unnecessary. The answer to these questions at least for this study may be in determining to what degree compliance correlates with child safety, child permanency, child and family well-being, parent safety, and parental substance abuse.

PARTICIPANT OUTCOMES

Program and comparison groups' demographic and characteristics information

It is important to reiterate that there were two distinct research populations, a participant group and a comparison group. General demographic information was gathered for both groups (more limited data were available for the comparison group) as well as information regarding participant outcomes (e.g., child safety, decreased family violence, increased family functioning, reduced or eliminated substance abuse).

General demographic information

- **Program Group:** Fifty-three families were in the program group with 135 children (average of 2.55 children per family). Of the 93 program participants, nearly one-half were fathers and one-half were mothers. Racial/ethnicity adult breakdown was as follows: 90.3% Caucasian, 7.5% Hispanic, and the remaining 2% other ethnicities. Thirty percent of participants graduated from high school, 11.8% earned a GED, and 15% did not complete high school; 32.3% had some college, 4.3% had earned a bachelor's degree, and the remainder attended trade school or graduate school.

- At time of intake 62% of participants were employed. Of all participants, not just those employed, 41.9% reported having an annual income of less than $10,060; 23.7% reported an annual income of $10,061 to $20,560; and 12.9% reported an annual income of $20,561 to $24,060. The remaining 21.5% of participants had annual incomes above $24,060. Participants reported their annual household income. Most family members served through the project were not living together; therefore, they reported their incomes separately.

- **Comparison Group:** Fifty-three individuals were selected for the comparison group. There were 27 total families in the comparison group, with 51 children (average 1.89 children per family). The comparison group included 27 fathers and 26 mothers. Due to limited demographic data in the secondary data sources details regarding information such as marital status, household configurations, and income were not available.

Participant characteristics related to participant outcomes

Child safety

- **Program Group**: Approximately 63% had past involvement with CPS either in the form of substantiated or non-substantiated reports. Thirteen families (25%) were referred to the FVC Grant Project due to a current substantiated report of child maltreatment. The other 40 families were referred to the program due to concerns that children were at risk of child maltreatment due to children witnessing domestic violence, parental substance abuse, or other issues, which independently or collectively did not meet the statutory threshold to substantiate child maltreatment.

- Thirty-five percent of participants (parents) reported mental health problems and 33% reported a history of childhood abuse.

- **Comparison Group**: Approximately 58% had past involvement with DHW either in the form of substantiated or non-substantiated reports. Eight families (30%) in the comparison group were referred to the program due to a current substantiated report of child maltreatment, and

19 families had risk concerns similar to those outlined for the program group.

Child permanency

- **Program Group**: Almost all the children at intake (96%) were in the home as opposed to in out-of-home care (e.g., foster care). At intake, four families had children placed in out-of-home care, which affected a total of six children. Of these families, three families (four children) were involved in "formal" non-relative foster care placement. One family had children placed in "informal" care with relatives while the parents focused on recovery and completion of their treatment plan.

- **Comparison Group**: At the time of referral, 88% of families had children at home, while six families (22%) in the comparison group had their children in out-of-home care.

Substance abuse

- **Program Group**: For a family to be enrolled in the program at least one adult family member had to have a substance abuse issue. Thus, not all adults in the program presented substance abuse as an issue. In fact, 78.5% of adult participants were identified as having a present issue. An assessment revealed 64.5% reported abusing alcohol in the past and 68.8% reporting abusing drugs in the past. Primary substances used by participants were alcohol only 30% (n=22), methamphetamines only 22% (n=16), marijuana only 1% (n=1), and multiple substances 47% (n=34). Forty-six percent reported substance abuse problems in their family history.

- **Comparison Group:** Sixty-six percent (35) of individuals in the comparison group were identified as having an issue with substances at the time of referral with 59% currently using alcohol and 34% currently using drugs. Primary substances used by the comparison group were reported as alcohol only (17), methamphetamines only (9), marijuana only (4), and multiple substances (5).

Parental legal involvement and safety

- **Program Group**: Approximately 80% had a criminal record and 90% reported domestic violence in their past. Thirty-four families indicated that children had been witnesses to domestic violence.

- **Comparison Group**: Seventy-five percent of the comparison group had a criminal record with 89% having past instances of domestic violence.

Demographically, the program and comparison groups had nearly identical gender proportions. The program group on average had more children. Although, the program groups were more likely to have some form of CPS engagement, the

comparison group was more likely by 15% to have children in out-of-home placement. The program group was slightly more likely to use alcohol; however, they were twice as likely to use drugs than the comparison group. Criminal record and domestic violence in their past was very similar. Therefore, the comparison group was deemed appropriate.

Program participants' instrument change scores

Among the 93 individuals who participated in the program, most (48 or 52%) completed both intake and exit instruments and questionnaires. Given that 52% of participants completed both the entry and exit processes, it was important to explore how this completion rate and pattern influenced participant outcome findings. In other words, it should be questioned whether there are differences between the group that completed both entry and exit processes and the group that chose to forego the exit process. To check for this potential bias, pre-test score characteristics of the 45 participants who chose not to complete the exit materials were investigated to see whether there were differences. Independent samples *t* tests on intake scale scores were conducted to test for these differences. Following are the results from these analyses.

- The ICPS-FFS has three subscales: intimacy, conflict, and parenting. Only the conflict subscale showed statistically significant differences between the completers and the non-completers with conflict being higher in the completer group (t=-2.48; df=91; p=.01).

- The NCFAS has five subscales: environment, parent capabilities, family interactions, family safety, and child well-being. Three of the five were significant. The parent capabilities subscale revealed a significant difference between the two groups (t=-2.81; df=91; p=.006) with non-completers having lower capabilities. Family interactions (t=-2.33; df=79.5 corrected for unequal variances; p=.02) and Family Safety (t=-2.97; df=75.6 corrected for unequal variances; p=.004) showed similar trends with non-completers having significantly lower interaction and safety scores.

- The Garrity & Baris parental conflict scale showed no significant differences between groups; however, non-completers had 20 (44.4%) severe ratings (meaning severe conflict between parents) whereas completers had 25 (52.1%) such ratings. Although this difference is not statistically significant, it is meaningful given the importance of a severe rating on the scale.

- The SARA revealed differences between the groups. Non-completers had significantly higher ratings (t=3.03; df=91; p=.003) showing higher spousal assault risk. They also had significantly higher critical scores (t=2.93; df=83.2 corrected for unequal variances; p=.004).

To summarize, the evidence reveals that the two sub-groups of participants (those who did and those who did not complete exit documents) differed significantly upon entry into the program. Non-completers of the exit tools had statistically significant "negative" scores on some of the subscales on three of the four tools (e.g., higher rating of spousal assault risk on the SARA; significantly lower parental interaction and child safety scores on the NCFAS; and higher conflict scores on ICPS-FFS). The non-completers were slightly more likely, but significantly, to be the substance abusers and domestic violence perpetrators, per *t* test analysis.

However, what this means is not straightforward; there were some completers of exit tools who were highly at-risk and whose scores did reveal "positive changes." As a result, it is difficult to determine the overall impact for participant level change there would be if all participants completed the exit process. However, it does point out that it is important for future programs to focus more resources on and identify other procedures for attaining higher completion rates on exit documents.

Child safety

Child safety was measured for children and families in terms of the number of substantiated reports or substantiated re-reports to DHW after project involvement. The following data are based on a review of National Child Abuse and Neglect Data System (NCANDS) information.

- No children in the program were involved in a substantiated re-report during the program or six months after program completion. By comparison, according to NCANDS, the average percentage of re-reports for Idaho was 6.1% in 2003, 6.5% in 2004, and 3.8 % in 2005[4]. National recurrence rates were 8.3% in 2003 and 8.1% in 2004 and 2005.
- Five children (within one of three families) had an initial substantiated report of maltreatment during the program (details of these families follow).
- Three families (5.6%) had an initial substantiated report or a substantiated re-report after they enrolled in the project (an initial substantiated report for one family and a substantiated re-report for two families—the re-report was on other children in the household).
- For the two families with substantiated "re-reports within the family," one of the re-reports occurred more than six months after the prior report, and the other report was fewer than six months after the prior report.
- In addition, 13 other families had one or more substantiated reports in their history but prior to program enrollment, and none of these families

[4] *Child Maltreatment 2004.* Analyses of state submission NCANDS updates have indicated slightly higher rates than in the published report. (Personal Communication, 2007). – *Ed.*

had a substantiated re-report during the program or at six-month follow-up.

Since these were families with domestic violence in their histories, and exposure to such violence places children at greater risk for maltreatment, the research measured change in parental interactions or conflict as an indicator of risk of harm. These questions explored aspects of parents' relationships and interactions during visitations such as communication, trust, feelings, and child safety and well-being. The other measure to gauge child safety was a self-report by parents about their ongoing conflict.

Table 8 shows frequency and percentage of change on various items pre- to post-program. To test for statistically significant differences between program intake and exit, a series of McNemar Tests of Correlated Proportions (Field, 2005) were run on the results. The test examines whether the proportion of individuals responding in a certain way changes statistically significantly from program intake and program exit. For example, the first item is "Are there problems with visitation?" Thirty-six of 48 individuals responded "yes" to this question at intake, creating a proportion of .75. Only 15 of 48 responded "yes" at exit, creating a proportion of .31. The change in the proportion from intake to exit was an average .44. The McNemar Test assesses whether this change is statistically significant.

Because of the large number of tests (i.e., 24 tests) the alpha level was corrected for inflated Type I error rates by applying a Bonferroni Correction procedure (.05/24=.002). The last column reports which items are significant at the corrected alpha level of .002 and which items are significant at the uncorrected alpha level of .05. Readers are urged to use the more conservative alpha level (i.e., .002) so that inaccurate generalizations of the sample data to the larger population are avoided. Table 8 shows the detail at the aggregate level, and Table 9 presents a summary of these findings in the form of percent changes by individual for a select number of issues.

TABLE 8: FREQUENCY FOR RESPONSE AT PROGRAM INTAKE AND EXIT

Question	Intake (N=48)	Exit (N=48)	Percent Change pre-to post-program in aggregate	Statistical Significance
Are there problems with visitation?	36 Yes	15 Yes	44%	p<.002
Is the visitation supervised?	12 Yes	7 Yes	10%	--
Is there fighting between this participant and the other parent of the target child during exchanges?	14 Yes	5 Yes	19%	p<.05
Is the other parent of the target child not supportive of this participant's relationship with the children?	17 Yes	11 Yes	12%	--
Are there problems with the scheduling or times of exchanges for visitation?	28 Yes	5 Yes	48%	p<.002
Are there difficulties communicating about visitations or the children?	32 Yes	9 Yes	48%	p<.002
Does the participant trust the other parent of the target child?	29 False	20 False	18%	p<.05
Is the other parent angry with this participant?	32 True	18 True	29%	p<.002
Is it important that our children are able to see each of us frequently?	27 True	29 True		--
Does this participant feel he/she can reason with the other parent?	11 True	11 True	0%	--
Does this participant feel angry with the other parent?	13 True	8 True	10%	--
Does this participant not approve of the other parent's lifestyle?	24 True	18 True	12%	--
Does this participant not agree about the custody arrangement or child support for the children?**	27 True	15 True	25%	p<.05
Does this participant have concerns about the other parent's parenting abilities?	43 True	38 True	11%	--
When the children are with the other parent, how often is this participant worried about the following:				
Drinking excessively?	19 Always	11 Always	17%	p<.05
Using drugs?	17 Always	11 Always	12%	--
Potentially physically abusing the children?	17 Always	9 Always	16%	p<.05
Failing to feed/clothe/protect the children?	13 Always	9 Always	8%	--
Ignoring the child?	17 Always	9 Always	16%	p<.05
Not driving safely with the children in the car?	17 Always	10 Always	14%	--
Does this participant have concerns about a significant other in the target child's home:				
Using alcohol?	4 Yes	9 Yes	11%	
Using drugs?	4 Yes	7 Yes	7%	
Being violent?	2 Yes	5 Yes	6%	
Abusing or neglecting the child?	5 Yes	6 Yes	3%	

TABLE 9: PERCENTAGE OF DECREASE IN CONFLICT BETWEEN PARENTS

Issue	Percentage of parents who reported a dcrease or increase
Problems with visitation	48% decrease
Fighting during exchanges	25% decrease
Difficulties communicating	50% decrease
Trust of the other parent	25% increase
Can reason with the other parent	25% increase

In addition to all changes being positive for program individuals as a whole, approximately 71% of participants reported a reduction in conflict related to at least one of the five areas presented in Table 9.

Although not all differences pre- to post-program were statistically significant, trends show that parents perceive less conflict in their relationship to each other. Additionally, frequencies also show that parents believe their children to be safer when they are with the other parent post-program than pre-program. The only exceptions to these positive trends are found in answers concerning the presence of significant others in the target children's home. In all cases, there is an increase in the number of these concerns from intake to exit. These increases could be because reporting parents feel safer as a consequence of the program and are thus willing to divulge more about the quality of the children's home environment. Another possible cause for this increased concern could be related to an increase in the number of parents who began dating or living with significant others whom reporting parents may not know or trust. These parents may be facing the realization that their relationship with their children's parent has terminated.

Child permanency

Permanency for children was indicated if children remained in the home or were returned to the home after removal by CPS. According to site data, most all the program children (96%) were in home at time of intake and, of those children, none were removed during the project. However, one child was moved to a relative due to the death of a parent and the fact that the father had ongoing criminal issues. Additionally, at intake, four families had children placed in out-of-home care, which affected six children. Children from three of these four families were reunited with their families by program completion. At the time of this report, the remaining family with children in out-of-home care appeared to be moving toward reunification since the mother had maintained sobriety for more than one year and continued to follow her case plan with CPS.

The reunification figures compare favorably with the nation as a whole, and are in line with reunifications rates for the state of Idaho. According to the AFCARS database, in the nation in 2003, 55% of children exiting foster care were reunited with families (30% of the total number of children in foster care). In 2004, 54% of those exiting foster care (29% of the total number of children in foster care) were reunited with families, and in 2005, 54% of those exiting foster care (30% of the total number of children in foster care) were reunited with families. The state of Idaho has reunification rates somewhat higher than the nationwide rates: In 2004, 74% of those exiting foster care (54% of the total number of children in foster care) were reunited with families, and in 2005, 76% of those exiting foster care (31% of the total number of children in foster care) were reunited with families.

Child and family well-being

There were two primary indicators for child and family well-being as defined by the project: increased parenting knowledge and their ability to deal with conflicts, and decreased parental conflict. The belief was that if parents were to acquire knowledge and skill to decrease conflict, all members of the family, including children, would have an increased sense of well-being. A variety of data was collected upon program entry and exit that provided insights into family functioning. Presented here are results of the analysis by standardized instrument.

Intimacy, conflict, and parenting scale

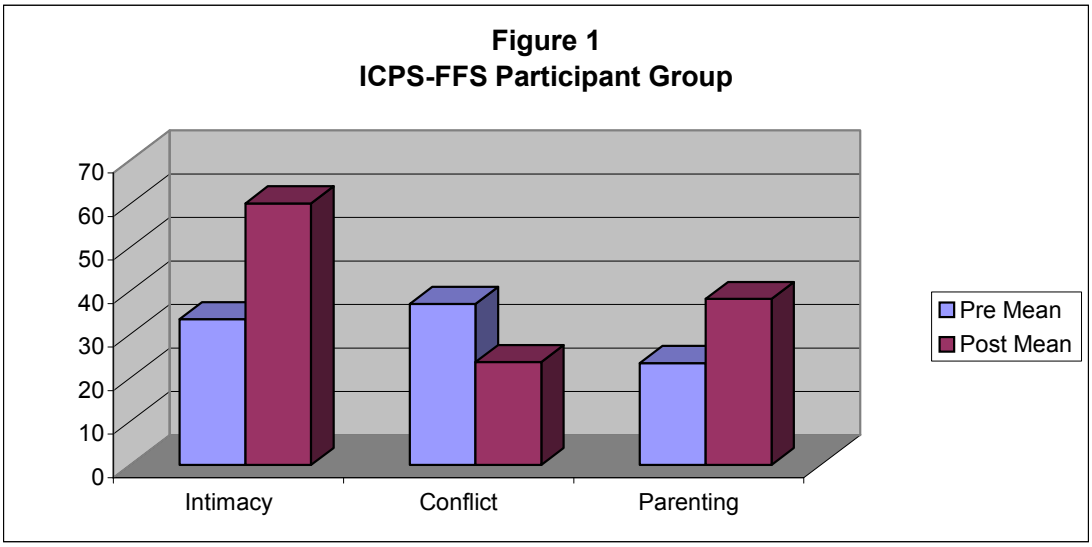
The Intimacy, Conflict, and Parenting Scale (ICPS)-Family Functioning Scale (adapted by P. Noller) is a 30-item participant self-report tool completed pre- and post-program with program families. Example items related to intimacy include "People in our family help and support each other"; example items related to conflict include "It is hard to get a rule changed in our family"; and items related to parenting styles include "We are flexible about who does what in our family."

Results indicate that participants (n=43) noticeably gained in all areas measured by the tool, and in gains in each of the three subscales were statistically significant even after correcting for inflated Type I error rates. The changes for intimacy were most powerful, with almost a 24-point average positive change, noting more honesty with family members, families feeling closer with each other, and families showing love for each other. Perceptions of conflict diminished an average of 15 points, indicating fewer misunderstandings, less anger between family members, and less difficulty making changes. Positive parenting style also increased an average of 13 points, indicating greater listening, talking about problems more, and family members having a greater say in important family decisions. Table 10 reports the results of testing at intake and exit and the results of *t* tests for dependent samples on the intake and exit means. Figure 1 illustrates results per the test format.

TABLE 10: INTIMACY, CONFLICT, AND PARENTING SCALE RESULTS, PRE- AND POST- PROGRAM

	Program Group Intake Mean (n=43)	Program Group Exit Mean (n=43)	Change	Program Group Intake Range	Program Group Exit Range	Program Group Intake Standard Deviation	Program Group Exit Standard Deviation
Intimacy	37.5	60.8	+23.8	17-71	22-72	13.9	11.1
Conflict	39.7	24.9	-14.8	19-55	10-42	10.1	7.6
Parenting	25.8	38.8	+13.1	7-44	10-48	10.8	7.1

*** Statistically significant differences: Intimacy (t=-8.53, df=42, p<.0001); Conflict (t=8.18, df=42, p<.0001); Parenting (t=-5.82, df=42, p<.0001)**



North Carolina Family Assessment Scale (NCFAS)

This scale measures family functioning and child well-being. This clinician tool is a practice-based, family assessment designed to measure many aspects of family functioning. The instrument focuses on five assessment "domains" or factors: environment (e.g., safety in the community, income/employment), parental capabilities (e.g., parent's mental health, parent's use of drugs/alcohol), family interactions (e.g., bonding with children, mutual support within the family), family safety (e.g., neglect, violence, abuse in the family), and child well-being (e.g., school performance, relationships with siblings and/or peers). Each of the five domains and associated sub-scales utilizes a six-point rating scale, ranging from -3 (serious problem) to +2 (clear strength), through a "0" point labeled Baseline/Adequate. There are two opportunities to rate each sub-scale and each domain: once at intake (labeled "I" on the form), and once at closure (labeled "C" on the form).

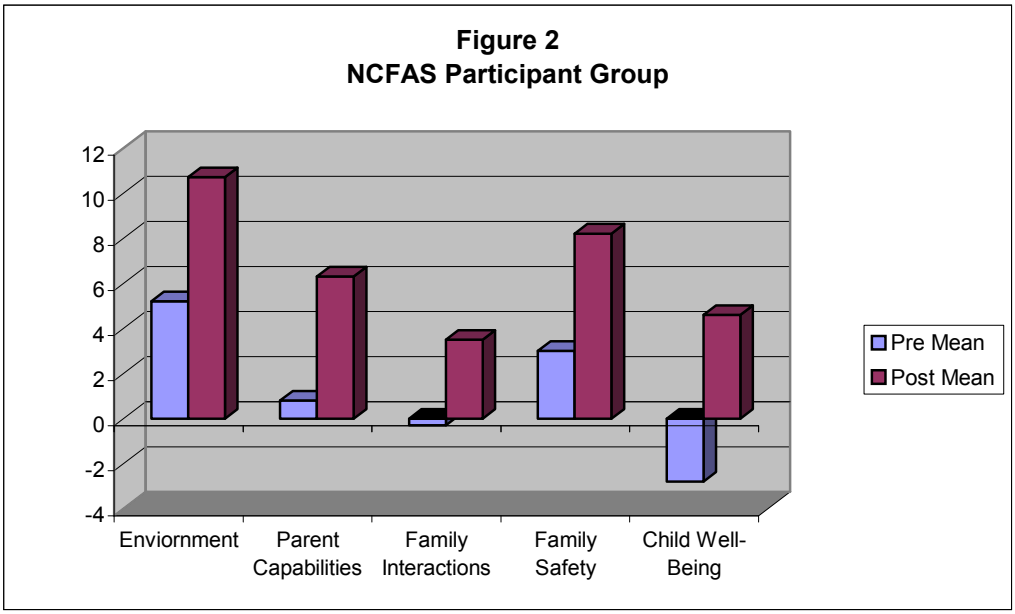
Results indicate that all areas as viewed by the clinician have improved to a statistically significant degree, even after employing a Bonferroni correction for inflated Type I error rates. In this situation with five subscales the original alpha level of .05 would be adjusted to .01. All p values fell below this value. Child well-being changed most significantly, indicating gains in areas such as school performance; relationships with parents, peers, and siblings; children's mental health; and cooperation and motivation to help the family. For participant families, parent capabilities also noticeably increased as did a supportive environment, family interactions, and family safety.

Table 11 reports results from entry and exit testing of 48 participants. The table includes descriptive statistics and the results from *t* tests for dependent samples, testing whether the changes in mean scores from entry to exit are statistically significant. Figure 2 illustrates results per the test format.

TABLE 11: NORTH CAROLINA FAMILY ASSESSMENT SCALE (NCFAS), PRE AND POST RESULT

	Program Group Pre Mean	Program Group Post Mean	Change	Program Group Pre Range	Program Group Post Range	Program Group Pre Standard Deviation	Program Group Post Standard Deviation
Environment	5.2	10.7	+5.5*	-20 to 18	-11 to 18	10.7	6.9
Parent Capabilities	.8	6.3	+5.5*	-14 to 12	-5 to 12	6.6	4.2
Family Interactions	-.30	3.5	+3.8*	-10 to 6	-7 to 8	3.8	2.9
Family Safety	3.0	8.2	+5.2*	-3 to 10	4 to 10	3.2	1.6
Child Well-Being	-2.8	4.6	+7.4*	-15 to 13	-15 to 13	8.5	6.1

* **Statistically significant differences: Environment (t=-5.32, df=47, p<.001); Parent Capabilities (t=-8.57, df=47, p<.001); Family Interactions (t=-10.34, df=47, p<.001); Family Safety (t=-11.09, df=47, p<.001); Child Well-being (t=-7.63, df=47, p<.001)**



The Garrity and Baris Parental Conflict Scale

The five-point scale focuses on parental conflict. It ranges from minimal conflict to severe conflict:

- 1 Minimal (e.g., "can affirm the competency of the other parent")
- 2 Mild (e.g., "occasional verbal quarreling in front of the child")
- 3 Moderate (e.g., "ongoing attempts to form a coalition with the child against the other parent around isolated issues")
- 4 Moderately severe (e.g., "threatens violence, slamming doors, throwing things")
- 5 Severe (e.g., "endangerment by physical or sexual abuse, severe psychological pathology")

Results indicate significant gains for the participant group in moving from severe or moderately severe parental conflict to moderate, minimal, and/or mild conflict.

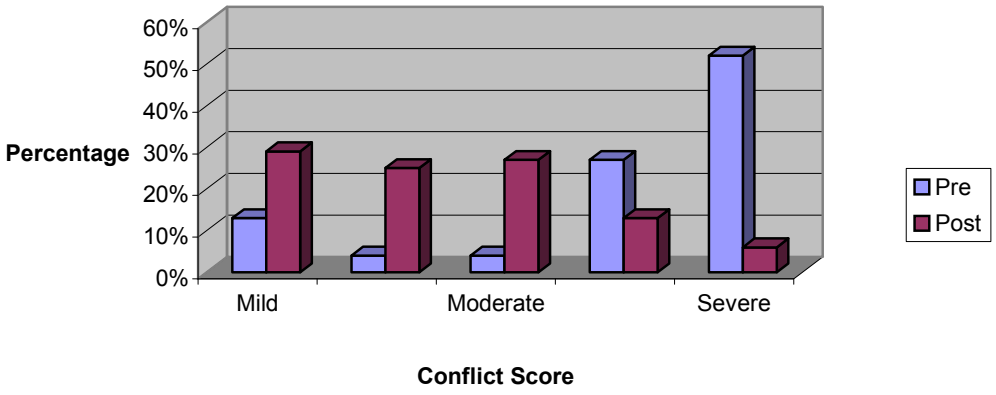
The results of pre- and post-testing are provided in Table 12 for the 48 participants who completed the tests. A series of McNemar Tests for Correlated Proportions were run to see if the changes from entry to exit were statistically significant. A Bonferroni correction for inflated Type I errors was employed to adjust the alpha level. In this case, the resulting alpha level was .01 (.05/5=.01: original alpha level/number of subscales being tested). Figure 3 illustrates results per the test format.

TABLE 12: GARRITY AND BARIS CONFLICT SCALE PARTICIPANT GROUP, PRE- AND POST–TEST RESULTS

	Participant Group Pre	Participant Group Post	Change
Mild conflict	13%	29%	+16%
Minimal conflict score	4%	25%	+21%
Moderate conflict score	4%	27%	+23%*
Moderately severe conflict score	27%	13%	-14%
Severe conflict score	52%	6%	-46%*
Total %	**100%**	**100%**	**N/A**

*** Statistically significant differences at Mild p<.01: Moderate Conflict: p=.007; Severe Conflict: p<.001**

Figure 3
Garrity and Baris Conflict Scale Participant Group



Participants reported the type of contact with the other parent, their living arrangements, and their marital status upon entering the program and upon exit. Table 13 shows participants' rates regarding their current contact with the other parent at time of program intake and again at program exit. A McNemar Test was run on the proportion of participants at intake and exit who said, "We cooperate well" to see if the change in response is statistically significant. Results showed that participants are twice as likely to report they cooperate well with the other parent.

TABLE 13: SELF-REPORT ON NATURE OF COOPERATION BETWEEN OTHER PARENT

How would you describe your current contact with the other parent of the target child? (n=48)							
We Cooperate Well*		**We Do Not Cooperate Well**		**Cooperation is Almost Impossible**		**No Contract**	
Intake	Exit	Intake	Exit	Intake	Exit	Intake	Exit
13	22	4	3	6	4	25	19

*** p< .01 (statistically significant)**

Financial situation

In addition to service completion as an indicator of positive family well-being, the program also conducted an analysis of change in participants' financial situations

pre- and post-program. There was a 31% increase in the number of families earning greater than $10,600, and a 39% increase in the number of participants who were employed at exit compared to at intake.

Self-report of increase family well-being
Improved family well-being also appeared in parents' qualitative self-reports gathered through the exit interviews and surveys. Parents reportedly appreciated the service and felt that it seemed to make a difference. One parent said, "We talk now." When asked what had changed as a result of the service, parents said the following: reduced/eliminated substance abuse; improved parenting skills; increased coordination and consistency in co-parenting; stayed together as a family and improved family functioning; and improved communication, respect, and tolerance.

Based on pre- and post-test scores and self-report, clearly the services made available through the FVC Grant Project made a difference in the lives of parents and families. One parent also said the services "helped get us [the other parent] on the same page, pulled us together." Another said the services "kept us focused, on the right track." In fact, all parents who accessed treatment for substance abuse and domestic violence and parent education through the Grant Project were "highly satisfied" except for one who was "dissatisfied" with parenting education.

Parent safety

In evaluating parent safety, the indicator was a decrease in the frequency and level of risk of domestic violence from program entry to exit, to six- and 12-month follow-up. The following characteristics were explored as measures: the completion of domestic violence treatment or counseling, participants' rating on the Spousal Assault Risk Assessment, the reported occurrence of another incident of domestic violence, a new violence-related criminal charge, or a shift in their demographic information, pertaining to living arrangement or employment status.

Completion of Domestic Violence Treatment
Of the 32 participants (perpetrators of domestic violence) who were referred to a state-approved domestic violence treatment program, 53% attended treatment. Of those who attended treatment, 53% completed, 18% were still in treatment when the project ended, and 29% completed some portion of their treatment. If completion rates consider individuals who are still involved with their treatment program at the exit of the project, and all of them were to continue, 71% completed treatment. It also is important to note that some participants were referred to other types of treatment to address anger and relationship issues (e.g., anger management classes) and 71% of participants referred to other types of treatment completed their treatment.

Eighty-three percent (83%) of participants who were victims of domestic violence and referred to domestic violence counseling participated in counseling. In

addition, of the families that were referred to counseling for their children, 93% involved their children in individual counseling.

Spousal Assault Risk Assessment (SARA)

As described in this report, the SARA is a clinical checklist of 10 risk factors related to spousal assault that is used to assess risk for future violence. The higher the rating the more likely the item is present (0=absent, 1= subthreshold, and 2 = present). Critical items are those that are sufficient on their own to conclude that an individual is an imminent risk. The assessor checks a critical items box if that item is present. Risk is determined not only by a total "score" but also by the number of risk factors present.

Analysis examined overall test scores and critical items checked pre- and post-program. Results indicate a statistically significant reduction in the presence of both participants' overall scores and critical item scores. Thus, findings show the potential for future violence is reduced. Table 14 presents the results of testing for 21 participants pre- and post-program. The table also includes results of *t* tests for dependent samples run on the entry and exit means to assess statistically significant changes.

Table 14: Spousal Assault Risk Assessment, Pre- and Post-Scores for Program Participants

TABLE 14: SPOUSAL ASSAULT RISK ASSESSMENT, PRE- AND POST-SCORES FOR PROGRAM PARTICIPANTS

	Pre-Test: Sum Mean Score	Post- Test: Sum Mean Score	Change in Mean Score*	Pre-Test: Score Range	Post-Test: Score Range	Pre-Test Standard Deviation	Post-Test: Standard Deviation
Total Score	13.2	5.9	7.3	3-25	2-17	6.5	3.9
Critical Score	2.9	.3	2.6	0-10	0-2	2.5	.7

* Statistically significant differences: (Total Score: t=7.26, df=20, p<.0001); (Critical Score: t=4.86, df=20, p<.0001)

Court Involvement: Changes Pre- and Post- Program

Another approach to examine increased parental safety, as well as the positive impact of the FVC Grant Project on the court, is to determine reduction in the number of violent criminal charges, violations of No Contact Orders or Protection Orders, and filings of new Protections Orders (Table 15). Examination of pre- and post-program data for both the program and comparison groups revealed in all areas that the program group was less likely to have new or continued charges or orders. In fact, all program participants at post-program had no new incidents or violations when compared to the comparison group that had some issues with all areas except violation of a Protection Order. No statistical analysis was conducted due to low post numbers.

TABLE 15: PRE- AND POST-TEST COMPARISON OF CHARGES AND ORDERS

	Program Group (n=53)		Comparison Group (n=53)	
Event	**Pre-Program**	**Post- Program**	**Pre-Program**	**Post- Program**
Violence-related charges *	67%	0%	73%	6%
Violated a No Contact Order	13%	0%	9%	2%
Violated a Protection Order	10%	0%	2%	0%
Filed for a Protection Order	42%	0%	32%	2%
Protection Order filed against them	39%	0%	34%	4%

*** Violence-related charges also include violations of No Contact Orders and Protection Orders (these charges may not have been violent incidents but were classified as violent charges.)**

Tables 16-18 outline additional detail regarding the various change events categorized into three areas: prior to/at intake, during the project, and after the project for the participant group. The goal was to determine the extent to which project involvement reduces criminal charges and other court involvement. At intake, those in the project group were more likely to have both criminal charges and other court involvement, with the exception of violence-related charges and felony charges. However, members of the project group were more likely to have a violence-related charge that led to police involvement and to have a no contact order filed against them or have violated a no contact order. The following tables present detailed activities for each of three time periods. Table 16 presents these data in rank order for program group.

Table 16: Criminal Charges and Other Court Involvement at Intake

Type of Charges and Court Involvement	Program Group at Intake (n=93)	Comparison Group at Intake (n=53)
Criminal Record	80%	76%
Misdemeanor (at least one)	76%	72%
Violence-Related Charges	67%	73%
Protection Order Filed*	42%	32%
No Contact Order in place***	40%	34%
Alcohol-Related Charges	39%	34%
Protection Order* (filed against them)	39%	34%
Domestic violence witnessed by children	39%	30%
Drug-Related Charges	23%	23%
Police Involvement due to domestic violence	23%	15%
Violated a No Contact Order****	13%	9%
Felony (at least one)	12%	22%
Protection Order Violation**	10%	2%

*** A Protection Order is filed by a victim of domestic violence in a civil court. If a Protection Order is granted, they are typically in effect for 90 days and restrict contact between the victim and perpetrator of domestic violence.**

**** A Protection Order Violation is a criminal charge, which is given when the restrictions in the Protection Order are violated by either party.**

***** A No Contact Order is issued as a result of a criminal charge that involves violence. No Contact Orders prohibit the perpetrator from being in the vicinity of the victim or from having any contact with the victim.**

****** A No Contact Order Violation is a criminal charge that arises if the order for no contact is violated by the perpetrator.**

Table 17 presents during and after program results for the same court events that were presented at intake. Data appear in the same type event order as presented in Table 16 to support comparisons. It is important to note that *during program data* for the comparison group were gathered one year from the date of referral to use for comparison purposes since most program participants were in the FVC Grant

Project for an average of one year. The *after program data* for the comparison group were gathered two years after the comparison referral date (or at the end of the FVC Grant Project's implementation period for those who were referred in the comparison group for less than two years).

During the program it appears that in the program group a number of participants did experience new alcohol and criminal charges, including misdemeanors, at a rate higher than the comparison group. However, they were less likely than the comparison group to be involved in new violence-related charges.

Although after the program, each group had high rates of new misdemeanor charges and equal levels of new criminal charges, the program group was less likely to have new violence-related charges, but the same level of charges involving either alcohol or drugs. However, as noted in Table 17, there were great reductions in a number of areas for all groups, with program participants showing the most reduction.

TABLE 17: DURING AND AFTER PROGRAM DATA

Type of New Events	Program Group During Program (n=93)	Program Group After Program (n=93)	Comparison Group At One Year (n=53)	Comparison Group After Two Years Period (n=53)
Criminal Charges	42%	17%	34%	17%
Misdemeanor Charges	38%	11%	32%	13%
Violence-Related Charges	10%	0%	17%	6%
Protection Order Filed	5%	0%	6%	2%
No Contact Order Violations	4%	0%	6%	2%
Alcohol-Related Charges	11%	2%	6%	2%
Protection Order Filed Against	3%	0%	6%	4%
Drug-Related Charges	3%	1%	4%	2%
Protection Order Violation	3%	0%	0%	0%
Felony (at least one)	4%	1%	6%	2%

In addition to the issue of percentage of participant and comparison groups with legal engagement at points and time (at intake, during program, and after program), the number of incidences for various types of legal and court events for each group also were examined. The complexity of this can be overwhelming but

careful analysis of the data reveals both similarities and differences in performance across the two groups. For example, an examination of "Violence-Related Misdemeanors" reveals that among the participant group, when they entered the program, the average incidence of violence-related misdemeanors per participant was 1.48 versus 1.03 for the comparison group. After the program, the average per participant was .0 versus .11 for the comparison group.

The "No Contact Orders" is an item showing interesting trends. The participant group entered the program with a higher rate (.81 per individual) than the comparison group (.54), yet by the end of the program the participant group rate was .0 and the comparison group was .09. Table 18 shows similar trends in the "Civil Appearances" and "Civil Cases." In both instances, the participant group dropped to lower numbers after the program. Finally, a scan of the "Participant Group After Program" column and the "Comparison Group After Program" column reveals the overall success of the program. The "Participant Group After Program" column has six zeros, meaning that after completing the program participants had no involvement with the courts in these areas. Although there are three zeroes in the "Comparison Group After Program" column, these scores are the same as at intake except for the pending crimes.

In summary, with only a few exceptions, the trends reveal that the program resulted in reduced involvement with the courts, translating into potential cost savings. This finding, however, requires additional study.

TABLE 18: COURT ACTION

Type of Court Action	Number (Per Individual Rate)					
	Program Group (n=93)			Comparison Group (n=53)		
	Intake	During	After	Intake	During	After
Misdemeanors	718 (8.39)	97 (1.04)	17 (.18)	355 (6.70)	355 (6.70)	355 (6.70)
Civil Appearances	320 (3.44)	268 (2.88)	13 (.14)	188 (3.55)	188 (3.55)	188 (3.55)
Civil Cases	294 (3.16)	57 (.61)	4 (.04)	111 (2.09)	111 (2.09)	111 (2.09)
Violence-Related Misdemeanors	138 (1.48)	15 (.16)	--	55 (1.03)	55 (1.03)	55 (1.03)
Alcohol-Related Charges	88 (.95)	11 (.12)	2 (.02)	32 (.60)	32 (.60)	32 (.60)
No Contact Orders	75 (.81)	4 (.04)	--	31 (.58)	31 (.58)	31 (.58)
Protection Orders Filed For	67 (.72)	9 (.10)	--	25 (.47)	25 (.47)	25 (.47)
Pending Crimes	65 (.70)	44 (.47)	20 (.22)	44 (.83)	44 (.83)	44 (.83)
Protection Orders Filed Against	64 (.69)	4 (.04)	--	23 (.43)	23 (.43)	23 (.43)
Drug-Related Charges	52 (.56)	4 (.04)	1 (.01)	46 (.87)	46 (.87)	46 (.87)
Felonies	22 (.24)	10 (.11)	1 (.01)	31 (.58)	31 (.58)	31 (.58)
No Contact Order Violated	17 (.18)	5 (.18)	--	9 (.17)	9 (.17)	9 (.17)
Protection Order Violations Against	15 (.16)	5 (.05)	--	1 (.02)	--	--
Family Violence Felonies	2 (.02)	10 (.11)	1 (.01)	--	--	--

Overall, participant and comparison groups were quite similar at program intake, during program, and after program percentages. This calls into question the efficacy of the FVC Grant Project in reducing court time and cases. Since participants received the coordinated services and financial support offered through the FVC Grant Project, the participant group percentages should show more positive trends than they did. In one case, however, this did occur. The percentage of participants with civil cases and civil case appearances after the program was less than for members of the comparison group (Table 19). Nineteen percent of the comparison group had new or reopened civil cases after the program period, whereas 4% of the participant group had new or reopened civil cases after the program. This shows potential cost savings for the court.

TABLE 19:

	Program Group (n=93)			Comparison Group (n=53)		
	Intake	During	After	Intake	During	After
Have a new/reopened Civil Case	88%	39%	4%	91%	26%	19%
Number of Appearances in Civil Court	320	268	13	188	78	24

Independent living arrangements

Participants also were asked about current living arrangements, which were tracked from entry to exit. Participants became more independent in their living arrangement as they progressed through the program. Thirty-two participants reported at intake living independently. The number increased to 41 at exit. This change is statistically significant. The increase in independent living arrangements came primarily as a result of fewer people living with families and friends. Table 20 indicates greater independence and resiliency from participants.

TABLE 20: LIVING ARRANGEMENT

WHAT IS YOUR CURRENT LIVING ARRANGEMENT? (N=48)													
Independent*		With Family		With Friend		Correction Jail		Shelter		Homeless		Other	
Intake	Exit	Intake	Exit	Intake	Exit	Intake	Exit	Intake	Exit	Intake	Exit	Intake	Exit
32	41	9	4	4	1	0	0	1	1	2	0	0	1

* p=.02

Parental substance abuse

Reduction in parental substance abuse was a key outcome for this project. Of special interest was the extent of decrease in substance abuse, considering its link with potential child maltreatment and its significant co-occurrence with domestic violence. Of the 93 participants, 20 reported no substance abuse issues (78% of participants indicated substance abuse at intake). Again, non-substance abusers could enroll if the other parent was the one with an issue). These 20 participants remained abstinent throughout the program.

Of the 73 individuals who were identified as having a present substance abuse issue, 48 were referred to substance abuse treatment, 28 were referred to relapse prevention, and 21 were referred to both substance abuse treatment and relapse prevention. Approximately 11 of 73 individuals either did not complete a substance abuse assessment to determine treatment needs or were not found to need treatment by a substance abuse evaluator and, therefore, were never referred to any type of substance abuse treatment. These individuals may have been

referred to other types of treatment and counseling as an alternative; however, they are not considered in the following analysis.

- Of those who were referred to substance abuse treatment, 67% attended treatment. Of those who attended treatment, 78% completed treatment and 22% completed a portion of their treatment.
- Of those who were referred to a relapse prevention program, 61% attended relapse prevention. Of those who attended, 76% completed and 24% were still in the program at exit.
- Of participants who were referred to substance abuse treatment as well as relapse prevention (21), 86% (18) began treatment. Of those who attended, 50% (9) completed both types of treatment, 16% (3) completed substance abuse treatment and were still involved in relapse prevention at the end of the project, 16% (3) completed substance abuse treatment and a portion of their relapse prevention program, and 16% (3) completed a portion of their substance abuse treatment and did not begin relapse prevention.
- Of all participants referred to Alcoholics Anonymous or Narcotics Anonymous during the grant project, approximately 70% attended meetings in addition to treatment services.

Information regarding abstinence was known for 51 of the 73 individuals with substance abuse issues. Data on 12 individuals are missing due to their dropping from the program. Ninety-four percent of the 51 (n=49) had periods of abstinence according to collateral conformation from sources such as DHW, probation, substance treatment providers, or biological testing.

Length of abstinence varied. Among the 49 participants with substance abuse issues, for whom the length of abstinence information was available, 86% had periods of abstinence lasting 60 days or longer based on collateral confirmation. Across the various substance of choice groups there was not any major difference in their ability to remain sober/clean for more than 60 days as visible in Table 21. Detailed data was available for 47 of the 49 participants. Thus, this indicates that all who are dependent are at equal risk for relapse based on this somewhat small sample size.

TABLE 21: DAYS OF ABSTINENCE BY SUBSTANCE OF CHOICE

Number of Days Abstained	Alcohol (n=18)	Methamphetamine (n=14)	Combinations of Substances (n=15)	Total (47)
Up to 14 Days	1	0	2	3
Up to 30 Days	2	1	1	4
Up to 60 Days	1	2	2	5
More than 60 Days	14	11	10	35

Summary of key process and outcome findings

- Of 53 families involved in the FVC Grant Project there were 2,786 participant contacts during the project with the Coordinator. Families averaged approximately 53 contacts with the Coordinator with 415 one-on-one contacts and 2,371 other contacts (e.g., via telephone, e-mail, letters). The length of contacts ranged from 10 minutes to two hours.
- Of those who were referred to substance abuse treatment, 67% attended treatment. Of those who attended treatment, 78% completed treatment and 22% completed a portion of their treatment.
- Of those who were referred to a relapse prevention program, 61% attended relapse prevention. Of those who attended relapse prevention, 76% completed and 24% were still in the program at exit.
- Of those who were referred to substance abuse treatment as well as relapse prevention, 86% began treatment.
- Of those referred to Alcoholics Anonymous or Narcotics Anonymous during the Grant Project, approximately 70% attended meetings in addition to treatment services.
- Of the 32 participants (perpetrators of domestic violence) referred to a state-approved domestic violence treatment program, 53% attended treatment. Of those who attended, 53% completed treatment, 18% were still in treatment when the project ended, and 29% completed some portion of their treatment.
- 83% of participants (victims of domestic violence) referred to domestic violence counseling participated in counseling.
- Of families that were referred to counseling services for their children, 93% involved their children in individual counseling.

Outcomes

- Child Safety:
  No children in the program were involved in a substantiated re-report during the program or six months after program completion
- Child Permanency:
  Of all the children who remained in home at intake, none were removed during the project due to safety concerns. At intake, four families had children placed in out-of-home care, which affected six children. Children from three of these four families were reunited by program completion.
- Child and Family Well-Being/Functioning:
  Standardized assessments administered at intake and exit from the program marked noticeable improvement indicated by fewer parental misunderstandings, more flexibility, and improved child school performance, cooperation, and conflict resolution. For example, the ICPS-Family Functioning Scale and the North Carolina Family Assessment Scale (NCFAS) both showed statistically significant improvements.
- Parent Safety:
  48 families (90%) had at least one instance of domestic violence (between parents) at intake of the project. Since program enrollment and one-year follow-up, only two families reported another instance of domestic violence.
- Parental Substance Abuse:
  Ninety-four percent of the 51 (n=49) participants, for whom there was detailed information, had periods of abstinence based on collateral confirmation from sources such as DHW, probation, substance treatment providers, or biological testing. Length of abstinence varied. Of the 49 participants with substance abuse issues, for whom the length of abstinence information was available, 86% had periods of abstinence lasting 60 days or longer based on collateral confirmation.
- Service Coordination and Collaboration:
  Through in-depth interviews with social service administrators, frontline social service providers, and parent participants, the project was consistently rated very highly for service coordination and collaboration. The Coordinator was given particular praise for effectively helping parents overcome challenges and change destructive attitudes and behavior.
    - Potential long-term changes in system coordination and collaboration are clear based on evaluation results and key informant comments.

Which elements proved most significant?

Six administrators and 11 frontline staff rated the extent to which the FVC Grant Project effected outcomes such as improved child safety and family function. Overall, administrators and frontline workers acknowledged that the FVC Grant Project contributed to improvements in families' health and function.

Administrators cited improvements in court involvement, compliance with treatment plans, access to services, parent safety, and case coordination, while frontline workers cited improved child safety, family function, and court system navigation. Moreover, all frontline staff reported that the FVC Grant Project contributed to increased family health. Unlike the administrators, however, frontline staff indicated slightly less confidence in the contribution of the project on two of the variables: reduced further court involvement and improved court system. (See appendix E for a copy of the frontline service provider survey and appendix F for a copy of the administrator survey.)

TABLE 22: ADMINISTRATORS' AND FRONTLINE STAFF RATINGS ON THE SIGNIFICANCE OF FVC GRANT PROJECT'S CONTRIBUTIONS

Family variables	Contributes Significantly		Contributes		Not Sure if Contributes	
	Admin	Frontline	Admin	Frontline	Admin	Frontline
Improved child safety and well-being	3	6	2	4	1	1
Improved family functioning	3	5	1	5	2	1
Parental substance abuse reduced/eliminated	3	5	2	6	1	--
Improved parent safety	4	4	2	6	--	--
Reduced future court involvement	2	2	3	5	1	4
Compliance with treatment plan and utilization of services	4	3	1	7	1	1
Improved court system navigation	4	5	2	3	--	3
Improved access to appropriate services	4	--	1	--	1	--
Improved case coordination of appropriate services	4	--	1	--	1	--

CONCLUSION

There are strong suggestions from the literature that the content of the treatment is less important than the structure. This idea is important in considering how to best design a set of coordinated treatments. It seems that the particular philosophy matters less than the components of the program, which include weekly monitoring, length of program, and appropriate coordinated treatments (Healey, 1998). Case management—along with coordinated treatment programs and the involvement of the criminal justice system—may be a key strategy to help families recover from domestic violence, substance abuse, and child maltreatment issues, as well as to regain their independence. As mentioned, the FVC Grant Project developed an infrastructure to specifically address salient issues discussed in this literature review. The FVC Grant Project's focus is to build a collaborative relationship between the court, CPS workers, and treatment providers in working with families experiencing domestic violence, substance abuse, and child

maltreatment issues. With the case coordination model suggested in the literature, this document thoroughly describes these successes.

Research suggests that male batterers are likely to avoid future battering of their partners if they own a home or have a job, regardless of their involvement in domestic violence treatment (NIJ, 2003). In addition, monitoring and case management is related to improved success rates (NIJ, 2003). At intake, 62% of project participants were employed, whereas at exit, this number increased to 77%. Based on the literature, it can be inferred that this increase in employed participants will in turn increase individuals' success in abstaining from battering behaviors. In addition, at intake, 67% of individuals had violence-related criminal charges, 39% had Protection Orders filed against them, 13% had No Contact Order violation charges, and 10% had Protection Order violations. At exit, these percentages in all areas significantly decreased to 0%. This indicates that the FVC Grant Project was successful in decreasing participants' rates of recidivism toward violence.

Carter and Schechter (1997) outline the problems that arise due to a lack of collaboration between child welfare professionals and domestic violence programs. The FVC Grant Project found an existing lack of understanding and collaboration between DHW and family court, which initially led to confusion and often conflicting court orders and family requirements. For example, a family may be under investigation by DHW due to concerns of child maltreatment in regards to the father. Then the mother of the family may acquire a Civil Protection Order, which orders that the father has visitation with the children. By following the Civil Protection Order, DHW workers may see the mother as not being protective of the children, while not following the Civil Protection Order could result in negative legal consequences for the mother. One of the primary activities of the Coordinator resulted in increased communication and collaboration among systems working with these families. One activity the Coordinator engaged in was attending weekly staff meetings at the Department of Health and Welfare, giving all members an opportunity to communicate about each family's progress and further needs. This activity reduced the amount of conflicting orders and requirements that were put in place.

Maiden found that combining treatments—for substance abuse and domestic violence—led to reduced rates of recidivism (Maiden, 1997). Data from the project may shed light on the relationship between combined treatments and participant outcomes. To explore this, the 48 participants who completed the exit process were broken into two groups. One group received both substance abuse treatment and domestic violence treatment as per Maiden's findings, and the other received just one or none of these particular treatments. A series of chi-square tests of independence were run using this grouping variable and the post-test nominal scores on the NCFAS and the Garrity and Baris measures. No statistically significant relationships were found. To further explore this relationship, a repeated measure ANOVA was run on the pre- and post-test total

scores on the SARA. The group that received both domestic violence and substance abuse treatments started out with a much higher SARA pre-test score, meaning greater risk, but dropped significantly more over time. This represents a statistically significant treatment by time interaction (F=10.1; df=1/45; p=.003; Partial Eta Squared=.18). Although the group that received both domestic violence and substance abuse treatment remained statistically significantly higher on the post-test than the other group, they dropped more over time. This relationship indirectly supports Maiden's findings. When participants receive both domestic violence and substance abuse treatment, risk factors for future spousal assault drop more over time than when participants receive only one or none of these treatments.

The U.S. Department of Health and Human Services (2006) promotes a national standard for effective interventions in addressing child maltreatment concerns. A state meets this standard if 6.1% or fewer children were involved in another substantiated report within six months. The FVC Grant Project had no families with a re-substantiated referral within six months of the original substantiated report. Although there were a few families with prior substantiated referrals, it can be inferred that the FVC Grant Project was effective in addressing and intervening to reduce re-reported child maltreatment concerns. As mentioned, 13 (25%) families were referred to the program due to a current substantiated report of child maltreatment.

The FVC Grant Project's design (a single-source case coordination of multiple treatments) supports Gondolf's (2004) and Cellini's (2002) assertions about how domestic violence care should be offered. The project's results further support the value of such an approach. Specifically, and as postulated by Gondolf and Cellini, use of outcome measures, reasonable time period in treatment (i.e., at least six months), accentuation of single-source case coordination, emphasis on inter-agency cooperation, and multi-model treatment programming (e.g., parent education, substance abuse treatment, domestic violence treatment) prove the efficacy of this project's efforts in the lives of participants. In line with these evaluation results, succinct recommendations of the project are indicated here.

Recommendations

- Continue ongoing collaboration with DHW.
- Employ an MDT approach, which is key to the successful collaboration. The ongoing dialogue enabled systemic flexibility as families' needs changed. It also kept all the key players on the same page and contributed to a continued holistic approach throughout the process.
- Consider using a broader criteria so more families can participate. While generally reporting a positive attitude toward the FVC Grant Project, administrators and frontline staff did provide suggestions for improving the project. Consistently, administrators expressed concern regarding the criteria

for inclusion in the project. Their comments indicated they wanted broader criteria so more families could participate.
- Expand the number of case coordinators so that more families in the region can be served.
- Increase accountability measures.
- Consider court ordering services to participants. While administrators acknowledged that participation in the program increased participant accountability to complete service plans, attendance at treatment sessions was inconsistent and may benefit from improved accountability measures.
- Choose wisely the case coordinator. For example it is important to have a professional with a flexible work style and the ability to work with diverse groups. The person should have Master's degree in a human service or counseling field.
- Work with families from a strengths-based perspective. Participants took ownership of their recovery and felt supported through the process.
- Streamline court coordination.
- Continue to address the domestic violence component with child custody and court authorities.
- Understand the judges' vision of how a family court should work. (In addition to adjudication, the judges' focus on helping individuals and families arrive at a positive resolution is critically important);
- Ensure funding and timely payment for an array of treatment services.

Legacy of the project

The court model of one-family one judge will continue in modified form beyond the grant within the state of Idaho. The judged for the FVC Grant Project changed his role to oversight going forward. While this judge coordinated the civil side regarding domestic violence, the new court's approach will be from the criminal side. Although family judges often do not see the benefit of combining civil domestic violence cases and custody cases in the criminal arena, the judges replacing the judge in the project will do this and alternate weeks with no criminal cases.

According to the court personnel involved in the successor model, the new court will function in the following ways. Within 15 days of the entry of a guilty plea with criminal charges, public defenders will work with the new court and participants. The judges' assistant will broker a treatment plan and court advocates will do the safety plan. If there is an overlap with the civil side, they may work with FCS. Participation in this program requires a guilty plea and it is voluntary. Ultimately, participants' charge can be dismissed upon successful completion of this program and in most cases participants will receive credit for any prior time served and no additional jail time imposed at the time of sentencing. The length of this program is generally 12 months to two years.

Open criminal cases need to be resolved instead of waiting for domestic violence civil cases. Prosecutors were not given a free hand to arraign and had to screen

cases to Judge Castleton. Now prosecutors screen these cases and a Public Defender has information immediately instead of in four months.

Throughout the probation period, the same probation officer involved with the Grant Project works closely with the judges to ensure compliance. Likewise, FCS staff, on a limited basis, meets to discuss child protection cases with judges and the DHW. This shift continues to use the alliances formed during the FVC Grant Project.

Another significant feature of this new court is that the three judges who hear child protection cases now also preside over the domestic relations divorce and custody cases when families are involved in both courts. This assures that permanent custody orders incorporate safeguards for children. Two of the judges in this new model also preside over the previously described domestic violence court. In many ways, this new model continues and expands on the enhanced judicial response to families at risk.

There are efforts on the part of many, especially the court, also to sustain a mental health care professional who will coordinate cases for this court and serve as an encouraging support for families.

This program would not have evolved without the commitment of the judge. Coordination of services and access to services is the key. Judges for the criminal court are designating special slots for domestic violence for the first time in Ada County court because of the work of Judge Castleton, the FVC, and the FVC Grant Project.

Project staff developed an array of forms and assessment tools during the project that will continue to be used in the court system. A comprehensive intake packet was adapted from the prior FCS intake packet to gather important information regarding court cases and parental issues. The FCS Alternative Dispute Resolution Screening process was revised for an interview and report format to be submitted to the FVC senior judge for families participating in the FVC Grant Project. An effective Co-Parenting Education Program curriculum also was developed to focus on domestic violence issues and substance abuse concerns. In addition, this *Evaluation Report*, a *Project Replication Manual*, and a *Case Coordinator Handbook* is available online for those interested in examining the results of the project or replicating it in full or in part.

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APPENDICES

Appendix A – Implementation Activities and Long-Term Goals

Table 1

TABLE 1

Implementation Activity #1: Build partnerships with local victim advocacy service agencies, treatment providers, prosecution attorneys, public defenders, probation officers, mental health providers, and other community agencies.		
Outcomes	**Indicators**	**Methods**
Immediate: Improvements in communication and collaboration among partnering agencies using a multidisciplinary team (MDT) approach	1. Program referrals from DHW 2. Understanding of and commitment to project goals and methods from all project partners (court, DHW, substance abuse provider) 3. Improved formal and informal communications, interagency agreements, and meetings	1. Track the number of referrals from DHW 2. Document efforts and materials to educate and communicate with DHW, substance abuse provider agencies, and other partners 3. Interview project partners (court, DHW, and substance abuse providers) 4. Review documents
Intermediate: Improve coordination of services for families using an MDT approach	1. MDTs held twice monthly, reviewing each family monthly. MDTs staffed by all key providers and comprehensive treatment plans developed 2. All identified participant needs addressed 3. Reduction in duplication of services	1. Observe MDT 2. Interview MDT staff 3. Provide MDT documentation (attendance, minutes) 4. Include participant self-report (exit surveys and interviews) 5. Compare treatment plans between program and comparison group families

Table 2

TABLE 2

Implementation Activity #2: Comprehensive intake and assessment of all referred families.		
Outcomes	**Indicators**	**Methods**
Immediate: Improve ability to identify individual family needs and develop a comprehensive treatment plan	1. Treatment plans developed by the family and the MDT are individualized and targeted to meet the needs of the family 2. Participants needs are identified	1. Review selected treatment plans 2. Have participants do self reports through exit interviews and selected interviews 3. Interview MDT staff
Immediate: Improve ability to identify individual family needs and develop a comprehensive treatment plan	1. Participants are more likely to access and complete services (increased compliance) 2. Participants feel that services are helping them achieve their treatment goals (increased satisfaction)	1. Perform analysis of correlation between FVC assessment, evaluations, and treatment plans 2. Compare treatment plans and entry and exit dates of referred treatment programs 3. Have participants do self reports through exit interviews and selected interviews

Table 3

TABLE 3

Implementation Activity #3: Hire and train a case coordinator to work directly with families to provide assessment and therapeutic services, and facilitate the coordination of the service plan.		
Outcomes	**Indicators**	**Methods**
Immediate: Provide participants with a case-coordinator who is available and accessible	Case coordinator will have frequent contact with family to provide resources and support, and facilitate service delivery	1. Review coordinator notes and contact sheets 2. Have participants do self-reports through exit surveys and selected interviews
Intermediate: Improve ability of participants to navigate the court system and access appropriate referred and/or court-ordered services	1. Participants are more likely to access and complete services (increased compliance) 2. Participants understand court processes and attend all court hearings	1. Compare treatment plans and entry and exit dates of referred treatment programs 2. Have participants do self-reports through exit surveys and selected interviews Review and compare court appearances between program and comparison families

Table 4

TABLE 4

Long-term Goals		
Outcomes	**Indicators**	**Methods**
Child Safety	No substantiated re-reports of child maltreatment from program entry to exit with a six- and 12-month follow-up	1. Review/compare DHW reports for program and comparison families at point-in-time intervals 2. Review/compare DHW safety and risk assessment ratings for program and comparison families
Permanency	1. Children remain in the home to exit with a six- and 12- month follow-up 2. Children in out-of-home placement returned in a timelier manner.	1. Review/compare DHW reports regarding living status within families and between group comparisons 2. Review/compare DHW reports for reunification between program and comparison families regarding length of time in out-of-home placement
Family well-being	1. Increased parenting knowledge and skills regarding the impact of conflict and family violence on children 2. Decreased parental conflict	1. Have participants self-report pre-and post-test regarding co-parenting 2. Have parents complete Effective Co-Parenting Program 3. Review parent education provider reports of progress and completion 3. Have participants self-report pre-and post-test regarding family functioning (ICPS-FFS) 4. Assess pre- and post-test regarding family functioning and child well-being (NCFAS) 5. Assess pre- and post-test regarding parental conflict (Garrity and Baris Parental Conflict Scale)
Parent safety	Decrease in the frequency and level of risk of domestic violence from program entry to exit to six- and 12-month follow-up	1. Review/compare court and criminal records 2. Have participants do self reports through exit interviews and selected interviews 3. Assess pre- and post-test regarding domestic violence (SARA) 4. Review domestic violence provider reports of progress and completion
Parent substance abuse reduced/ eliminated	Decrease in parents' substance abuse during and after program exit to six- and 12-month follow-up	1. Compare random biological screening measures at program entry, exit, and follow-up 2. Review substance abuse provider reports of progress and completion
		1. Review self-reports of usage from program entry, exit, and six- and 12-month follow-up

Appendix B – Interview Protocol for Parents/Participants

Interview Protocol for Parents/Participants
Ada County Family Violence Court Grant Project

THIS INTERVIEW INFORMATION IS CONFIDENTIAL. IT WILL NOT BE USED IN COURT FILES OR BY THE FVC GRANT PROJECT. NO ONE OTHER THAN THE INTERVIEWERS WILL HAVE ACCESS TO THIS INTERVIEW INFORMATION.

Hello…we are conducting interviews to develop an accurate picture of your perceptions of the FVC Grant Project. **PLEASE TELL US THE STORY OF YOUR involvement with the project.**

In relation to the child, are you a…
____Mother
____Father
____Grandmother
____Grandfather
____Guardian
____Foster Mother
____Foster Father
____Aunt
____Uncle
____Other
_____

About how old are you?
____15 – 25
____26 - 35
____36 - 45
____46 - 55
____56 – 65
____66 – 75
____75+

1. What happened that made you think you and the child/youth needed some extra help? (Check all that apply)
   ___ Substance abuse
   ___ Parenting ability
   ___ Family functioning
   ___ Safety concerns
   ___ Co-parenting concerns
   ___ Other, specify:_____

2. Whom did you FIRST turn to for help?

3. How/Why did you choose that person?

4. How did you come to be involved with the FVC Grant Project?

5. Please tell me about all the services you and your children accessed through the FVC Grant Project, and your opinions of the services. Feel free to name an agency more than once if it was accessed more than one time or for multiple reasons.

NAME OF ALL SERVICES OR AGENCIES USED	**HOW HELPFUL WAS THIS SERVICE** **Rate on a 1-to-5 scale with 1 being not at all helpful to 5 being very helpful (please circle one for each category –** **A. helpful to current family** **B. helpful to relationship with co-custody parent – if applicable)** **(not helpful) (helpful)**	**WHY WAS THE SERVICE HELPFUL OR NOT HELPFUL?**
Paid by the FVC Grant Project__	A. 1 2 3 4 5 B. 1 2 3 4 5	
Paid by the FVC Grant Project__	A. 1 2 3 4 5 B. 1 2 3 4 5	
Paid by the FVC Grant Project__	A. 1 2 3 4 5 B. 1 2 3 4 5	
Paid by the FVC Grant Project__	A. 1 2 3 4 5 B. 1 2 3 4 5	
Paid by the FVC Grant Project__	A. 1 2 3 4 5 B. 1 2 3 4 5	
Paid by the FVC Grant Project__	A. 1 2 3 4 5 B. 1 2 3 4 5	

5A. What services did you access that were not coordinated through the FVC Grant Project?

6. Overall, my satisfaction with the mental health-related services coordinated and/or referred through the FVC Grant Project is:
____High (very satisfied)
____Pretty Good (satisfied)
____Okay (somewhat satisfied)
____Not good (somewhat dissatisfied)
____Not at all (very dissatisfied)

7. Overall, my satisfaction with the substance abuse-related services coordinated and/or referred through the FVC Grant Project is:
____High (very satisfied)

____Pretty Good (satisfied)
____Okay (somewhat satisfied)
____Not good (somewhat dissatisfied)
____Not at all (very dissatisfied)

8. Overall, my satisfaction with the domestic violence services coordinated and/or referred through the FVC Grant Project is:
____High (very satisfied)
____Pretty Good (satisfied)
____Okay (somewhat satisfied)
____Not good (somewhat dissatisfied)
____Not at all (very dissatisfied)

9. Overall, my satisfaction with the parent education services coordinated and/or referred through the FVC Grant Project is:
____High (very satisfied)
____Pretty Good (satisfied)
____Okay (somewhat satisfied)
____Not good (somewhat dissatisfied)
____Not at all (very dissatisfied)

10. Please tell me about the services coordinated through the FVC Grant Project or activities that helped you and your family the most. (Check all that apply):
____family counseling
____group counseling
____individual counseling
____case coordination
____substance abuse treatment
____drug testing
____domestic violence counseling or treatment
____counseling for young children
____parent education
____probation services
____shelter services
____support groups
____recreational activities (such as basketball)
____educational support/tutoring
____crisis response
____prescription drugs
____school education (e.g., regarding gangs drugs)
____mentorship from extended family
____Other: _____

11. What services would you like that are not (or were not) available?

12. In your opinion, what are the best things the current family does that help functioning now (e.g., family gatherings, good communication)?

a. In your opinion, what are the best things that you and your co-parent do that help family functioning now (e.g, , family gatherings, good communication)?

13. What are the biggest challenges or concerns you face as a family today? How is it different from six months ago?

a. What are the biggest challenges or concerns you face as a co-parent today? How is that different from six months ago?

14. In your experience, which statement BEST describes the relationship between your current **family** and the FVC Grant Project? (Check the one that best describes your opinion.)

____ Parents are not included or not treated with respect.
____ Parents are somewhat included and are treated with respect.
____ Parents are included and FVC Grant Project treats parents with respect.

A. Describe your **co-parenting** relationship and the FVC Grant Project. (Check the one that best describes your opinion.)

____ Parents are not included or not treated with respect.
____ Parents are somewhat included and are treated with respect.
____ Parents are included and the FVC Grant Project treats parents with respect.

The following questions ask about services generally available in this community.

15. Do you think developing role models is important in this community?
___ yes ___ no
Ideas about how to do it?_____

16. Do you think there is a stigma to receiving Mental Health services in this community? ___ yes ___ no

17. Have you previously utilized Mental Health services in this community?
___ yes ___ no
If yes, have the services been useful? ___ yes ___ no
Did you terminate services because you were not happy with them?
___ yes ___ no

18. Was there adequate teaming w/ Mental Health services? Did your family have a voice? ___ yes ___ no

19. Are you confident in your ability to access Mental Health services, overall? ___ yes ___ no

20. Do the Mental Health services in this community seem adequate? ___ yes ___ no

21. Do you think there is a stigma to receiving Substance Abuse services in this community ? ___ yes ___ no

21. Have you previously utilized Substance Abuse services in this community? ___ yes ___ no
If yes, have the services been useful? ___ yes ___ no
Did you terminate services because you were not happy with them?
___ yes ___ no

22. Was there adequate teaming with Substance Abuse services? Did your family have a voice? ___ yes ___ no

23. Are you involved in community activities? ___ yes ___ no
If yes, please name a few_____
What barriers exist for you not being more involved?_____

24. Do you have other comments about working with the FVC Grant Project that you'd like to share?

Please rate the design of this interview protocol:
____ Excellent
____ Very good
____ Acceptable
____ Somewhat poor
____ Very poor

If you would like to be contacted in the future to participate in or receive information related to this project please provide the information below:

Name:_____

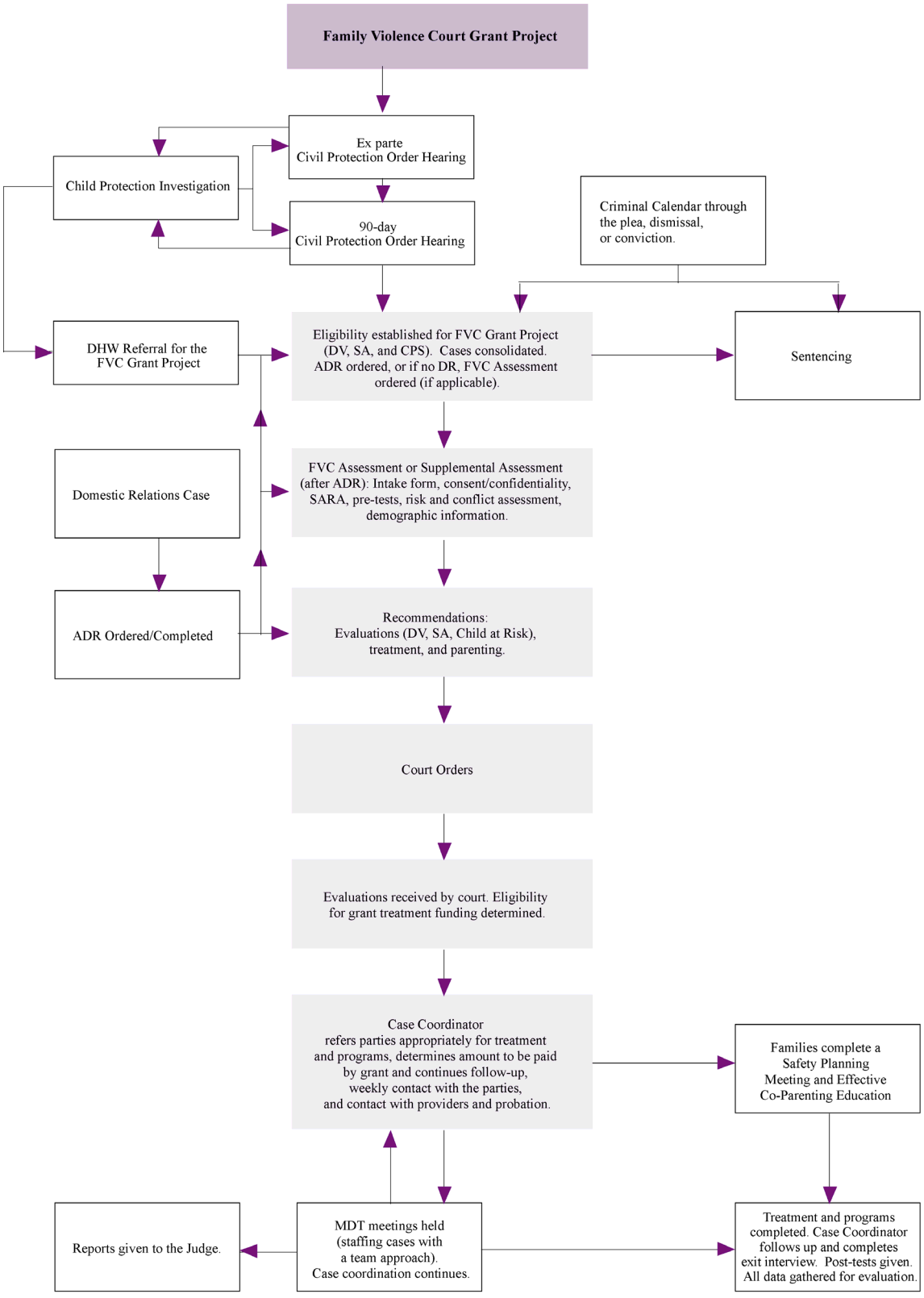
Address: _____

Phone:_____

Email:_____

Appendix C – FVC Grant Project Flowsheet

APPENDIX C



Appendix D – FVC Grant Project Comprehensive Treatment Plan

Family Violence Court Grant Project
Comprehensive Treatment Plan Father

Treatment Planning Date: July 6, 2004
Participant's Name: **Father**
Treatment Planning Team Members Present: Case Coordinator; Clinical Supervisor; Family Court Services Director; and Misdemeanor Probation Officer

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Strengths: Father stated that he has a good relationship with his extended family. He shared that he is staying out of situations that are unhealthy for him in his sobriety. He stated he loves his job and his time with his kids. The team indicated that Father is following through with his treatment and is encouraged by his sobriety.

Resources/Supports: Father shared that his family and treatment has been a support.

Identified Issues/Concerns: Father indicated that alcohol has been a problem in the past for him, but now things are going well. He shared that the No Contact Order between him and his ex-wife is complicated and he wants to have it lifted. Father stated he does not like probation and being involved in the court system.

Identified Barriers/Challenges: The team believes Father is focused on his contact with his ex-wife when he should be focused on his recovery and his children. Father is concerned about his visitation rights and the fear of losing more contact with his children.

Needed Resources: Father believes the financial support of the grant is helpful. He discussed attending AA and NA groups for additional support.

Court-Ordered Services:

- Domestic Violence treatment- 6 months
- Substance Abuse treatment- 6 months
- Parenting class
- Effective Co-Parenting Education

Completed:

- Substance Abuse Evaluation
- Domestic Violence and Child Risk Assessment
- Random drug testing

Recommendations from Evaluations:

- Substance Abuse treatment- 1 year intensive outpatient, including relapse prevention at court-approved facility

- Domestic Violence treatment- 12 month batterer treatment program with state-approved provider
- Parenting class addressing effects of domestic violence on children
- Supervised probation

Other Recommendations:
- Effective Co-Parenting Education
- Continued drug testing

Goal/Outcome: Participate in Substance Abuse Treatment to prevent relapse.

Treatment/Services Needed to meet Goal: Participate in drug and alcohol treatment. Participate in random drug testing requested by probation, substance abuse provider, or FVC Case Coordinator. Currently assigned to Color Code system.

Treatment Provider: Local substance abuse provider
Drug Testing Lab color is **teal**.
Timeline/Dates: Begin classes this week
Next Step: Continue substance abuse treatment on Monday evenings. Participate in random drug testing by calling drug testing lab daily and submitting to drug testing at least twice a week. Contact Case Coordinator regarding any treatment schedule changes or attendance information. Coordinator will contact providers frequently regarding attendance, progress, and drug testing results.

Goal/Outcome: Participate in court-ordered Domestic Violence treatment to reduce risk of re-offending and to build or enhance life skills and problem solving.

Treatment/Services Needed to meet Goal: Complete Domestic Violence treatment program through an approved provider.

Treatment Provider: Local approved provider
Timeline/Dates: To be determined by team and Father
Next Step: Contact provider and set up intake appointment when team determines it is appropriate. Need to complete alcohol and drug treatment for two months before beginning Domestic Violence treatment. Contact Case Coordinator to give provider information once registered for class. Coordinator will contact provider in regard to funding.

Goal/Outcome: Attend parenting class to increase awareness and understanding of child development and effects of domestic violence and substance abuse on children.

Treatment/Services Needed to meet Goal: Complete a parenting class recommended by FVC Case Coordinator.

Treatment Provider: To be determined

Timeline/Dates: To be determined by team
Next Step: Contact provider and set up intake appointment when team determines it is appropriate. Need to complete alcohol and drug treatment for a while before beginning parenting education. Contact Case Coordinator to give her provider information once registered for class. Case Coordinator will contact provider in regard to funding.

Goal/Outcome: Participate in Effective Co-Parenting Education to build a stronger, effective co-parenting relationship between Father and ex-wife.

Treatment/Services Needed to meet Goal: Effective Co-parenting Education Program

Treatment Provider: FVC Case Coordinator
Timeline/Dates: Set up 1st appointment with Case Coordinator after completion of substance abuse treatment.
Next Step: Set up appointment with FVC Case Coordinator (each separate sessions and then together).

Goal/Outcome: To provide support and resources to assist in building strong, healthy family relationships and compliance with probation and the Court (custody order).

Treatment/Services Needed to meet Goal: Have contact with FVC Case Coordinator frequently regarding progress & support.

Have monthly contact with probation and follow all probation requirements and supervision agreement.

Timeline/Dates: Frequently and/or required contact
Next Step: Continue all contacts with FVC Case Coordinator and probation contact and supervision.

Appendix E – FVC Grant Project Frontline Service Provider Survey

Ada County Family Violence Court Grant Project
Frontline Service Provider Survey
(Counselors, Social Workers, Mental Health Technicians, and Other Helpers)

The Ada County Family Violence Court Grant Project (FVC Grant Project) is conducting an evaluation of its program. The following survey is designed to help us gather information about the services provided to clients handled by your agency and the FVC Grant Project. This information will be used to identify current strengths and weaknesses of the project. As a direct service provider who personally interfaces with the FVC Grant Project, your viewpoint is particularly important to us. Please take a moment to answer the questions below.

Type of Agency/Program: _____

Job Title_____ Gender: _____ Years of Experience____

Number of clients served per week_____ Number of clients on your caseload ___

As a direct service provider interacting with the FVC Grant Project, your viewpoint about the strengths and challenges of the services provided by the project is very important to us.

How would you rate your knowledge of the FVC Grant Project?
High medium low

1. In thinking about the strengths of the services provided, in what areas would you say services are excellent (e.g., case coordination, resource referral, initial assessment, direct contact with clients)?

2. Why do you think the services listed above are excellent?

a. What services could be improved?

3. What is your average percent of time spent in FVC Grant Project-related work? ___%

4. How much time do you spend with each client per visit related to the project (on average)? _____ Is this time adequate? ____

5. What services do you believe are needed that are not currently or readily available from the project?

6. Please indicate two or three areas that are challenges in serving clients through the project.

1.

2.

3.

7. What is needed to overcome these challenges and better provide high-quality services? (Please list at least two ways.)

1.

2.

8. Using the following scale, please rate the statements below:

1 I believe the FVC Grant Project makes significant contributions to achieving this outcome
2 I believe the FVC Grant Project contributes to achieving this outcome
3 I am not sure of the FVC Grant Project contribution to achieving this outcome
4 I believe the FVC Grant Project does not contribute to achieving this outcome
5 I believe the FVC Grant Project detracts from achieving this outcome

a. ____Improved child safety and well-being
b. ____Improved family functioning
c. ____Parental substance abuse reduced/eliminated
d. ____Improved parent safety
e. ____Reduced future court involvement
f. ____Compliance with treatment plan and utilization of services
g. ____Improved court system navigation and access to appropriate services

9. In what areas (if any) would you like more information and/or training from the FVC Grant Project to be able to work better with the project (check all that apply)?

___ How referral works
___ How the court system works
___ How divorce cases work
___ How domestic violence court cases work
___ Other, specify _____

10. When you interact with project personnel, who do you talk to?

11. How helpful are they?

Very helpful Helpful Not sure Unhelpful Very unhelpful

12. How timely is coordination with the project?

Very timely Timely Not sure Untimely Very untimely

13. How efficient is coordination with the project?

Very efficient Efficient Not sure Inefficient Very inefficient

14 . When you work with a parent involved in the project, how well are they served?

Very well served Well served Not sure Poorly served Very poorly served

15. Have you ever attended an FVC Grant Project MDT meeting? ___yes ___no
If yes, How often have you attended? ____ (Estimated number of times)

How satisfied are you with project facilitation of MDT teams?

Very satisfied Satisfied Not sure Unsatisfied Very unsatisfied

a. Do you believe the MDT meetings are an efficient use of your time?
___yes ___no
b. Do you have suggestions for improving MDT meetings?

16. How satisfied are you with case coordination done by the project?

Very satisfied Satisfied Not sure Unsatisfied Very unsatisfied

17. How satisfied are you with how the project works with families?

Very satisfied Satisfied Not sure Unsatisfied Very unsatisfied

18. How would you rate the following items?

a. Relationship with the FVC Grant Project

Very positive Positive Neutral Negative Very negative

b. Satisfaction with the FVC Grant Project

Very satisfied Satisfied Neutral Unsatisfied Very unsatisfied

c. importance of the FVC Grant Project

Very important Important Neutral Unimportant Very unimportant

We are very interested in learning from you about any ideas you might have for "quick and easy" changes that could improve project services. We are particularly interested in ideas that do not require major policy changes or additional funding. Please use the back of this page to share any ideas about improvements that would be fairly easy to implement.

Thank you for you cooperation!

E-mail return address: kcoll@boisestate.edu
Fax return phone number: 208-426-2046
Return Mailing address:
Dr. K. Coll
Counselor Education (E 612)
Boise State University
1910 University Dr.
Boise, ID 83725

Appendix F – FVC Grant Project Description of Services Survey

Ada County Family Violence Court Grant Project
Description of Services Survey

The Ada County Family Violence Court Grant Project (FVC Grant Project) is conducting an evaluation of their program to coordinate services for domestic violence and substance abuse issues. The following survey is designed to help us gather information about the services provided to families handled by your agency and the FVC Grant Project. This information will be used to identify current strengths and weaknesses of the project. As a **service provider administrator** who interfaces with the FVC Grant Project your viewpoint is particularly important to us. Please take a moment to answer the questions below.

Your Agency/Program:_____

Your position/title:_____ Years of experience _____

Today's Date:_____

How would you rate your **Knowledge of the the FVC Grant Project**?

High Knowledge Some Neutral Little No Knowledge

Relationship with the FVC Grant Project

1. How would you rate the following items?

a. Relationship with the FVC Grant Project
Very positive Positive Neutral Negative Very negative

b. Satisfaction with the FVC Grant Project
Very satisfied Satisfied Neutral Unsatisfied Very unsatisfied

c. Importance of the FVC Grant Project
Very important Important Neutral Unimportant Very unimportant

2. What suggestions do you have to improve the FVC Grant Project?

3. What is the single most important function the FVC Grant Project does to serve your agency?

4. What are the top three positive things about the FVC Grant Project?

5. What are three areas that need immediate attention in the FVC Grant Project?

6. Using the following scale, please rate the statements

1 I believe the FVC Grant Project makes significant contributions to achieving this outcome
2 I believe the FVC Grant Project contributes to achieving this outcome
3 I am not sure of the FVC Grant Project's contribution to achieving this outcome
4 I believe the FVC Grant Project does not contribute to achieving this outcome
5 I believe the FVC Grant Project detracts from achieving this outcome

a. ____Improved child safety and well-being
b. ____Improved family functioning
c. ____Substance abuse reduced/eliminated
d. ____Improved parent safety
e. ____Reduced future court involvement
f. ____Compliance with treatment plan and utilization of services
g. ____Improved system navigation and access to appropriate services

Services Provided

14. Please describe the type of services your organization provides: (check all that apply)

___ individual counseling
___ self help/support groups
___ group counseling/therapy
    types of groups/topics offered (e.g., anger management, domestic violence)
    _____
    _____
___ family counseling
___ couples/marriage counseling
___ parent education
    list topics: _____
    _____
___ community or consumer education
    list topics: _____
    _____
___ individual living skills
___ education materials (e.g., books, tapes)
___ home visits
___ case management
___ traditional healing services (e.g., purification ceremony, healing ceremonies)
___ spiritual assistance
___ biofeedback and related services
___ nutritional/physical health counseling
___ inpatient/residential services
___ prescription drugs
___ crisis response
___ paraprofessional support (i.e., volunteer helpers)
___ alcohol/drug treatment ___inpatient ___ outpatient
___ alcohol/drug treatment ___inpatient ___ outpatient
___ other services offered: _____

15. When your agency has contact with the families you serve, what are the three most common reasons for the contact? Please mark the top three with 1 being the most common reason, 2 being the second most common reason, etc.

___ To inform the family of problems that have arisen
___ To inform the family of termination of services
___ To ask the family for specific information about family circumstances
___ To review progress
___ To solicit the cooperation of the family
___ To consult with the family about the direction or goals of the services provided

___ To obtain permission or consent
___ To integrate family into services
___ Other reasons: _____

16. How often does your agency provide the following services to families?
___ No routine services with families
___ Services for families at time child begins working with our agency
___ Services with families at the beginning and end of providing services to the child
___ Each time we see the child, the family receives a follow-up call or personal services
___ Services with families when they contact us with questions or problems
___ Other:_____

Referrals Out

17. Please rank the top three agencies to which you refer clients with 1 being the agency to which you refer the most people.
(check all that apply).
___Ada County FVC Grant Project
___Schools - Which school(s) did you receive the most referrals from?
Please list: _____
___Intensive Residential Treatment programs
___School-sponsored peer helper programs
___Substance Abuse Treatment programs
___Mental Health (Human Services)
___Health Services
___Juvenile Detention
___Child Protection Services (Department of Social Services)
___Other: Specify _____

17a. If the FVC Grant Project was not in your top three, please briefly explain why.

18. Please briefly describe your methods (policies) for referring out/in to the FVC Grant Project.

19. Do you have a waiting list? ____ Yes ____ No
If yes, how many people are currently waiting to be served?
____ # male _____# female

If yes, could some of these clients be served by the FVC Grant Project? Why or why not?

Relationships Between Service Providers

20. We are interested in learning more about your agencies' relationships with other groups. Please tell us about the relationship between the group you represent and other groups by placing a 1, 2, 3, or 4 in each of the blanks below.

1 = We have a very strong, cooperative relationship with this agency/group
2 = We have somewhat of a relationship with this group, but not very strong
3 = We have a poor relationship with this group because of past history and other issues
4 = We are basically unaware of the services provided by this group/agency

___Schools; Which school(s) did you refer out to, or contact, about helping support a child?_____
___Ada County FVC Grant Project;
Specify _____
___Health Services;
Specify _____
___Mental Health (Human Services);
Specify _____
___Community Health Representative programs;
Specify _____
___Juvenile Detention
___Child Protection Services (Department of Social Services)
___Women and Children's Shelters
___Families
___Influential persons in the community
___Adolescent Substance Abuse Centers;
Specify _____
___Juvenile Court
___Criminal Justice System
___Law enforcement/police officers
___Other; _____

21. What type of information do you, or your agency, typically share with the FVC Grant Project when making a **referral out:** (please check all that apply)

___Client demographic information
___Diagnosis
___Reason for referral
___Test profiles
___Psychological evaluations
___Information about the client's family
___Progress report

___Incidence reports from other agencies/schools
___Case notes
___Suggestions about the future direction of treatment
___Other:
_____

22. What treatment/intervention services do you believe are needed from the FVC Grant Project that are not currently or readily available?