THE PREVENTION REPORT

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Schools in Partnership with Families and Communities

by: Miriam Landsman, Executive Director

With education at the forefront of the national agenda, considerable attention is being focused on the state of the nation's public schools. Though much of the current debate is centered around academic performance standards and evaluating teacher competence, schools are facing a variety of much more critical issues that affect their ability to provide a safe and healthy learning environment. Among these issues are: ensuring school readiness and educational quality for all children, regardless of social class, race/ethnicity, nationality, or ability level; enhancing children's social and emotional, as well as intellectual development; providing supports such as access to health care, before and after school care, counseling and tutoring; maintaining environments which both support students' safety and the right to freedom of expression and freedom from harassment; and developing the capacity to serve the increasing culturally and linguistically diverse populations.

Human services programs have been experimenting with school-based or school-linked social services for decades, often with promising results. As a universal point of access for children, youth, and families, schools are increasingly being recognized as potential sites for innovation in attempts to tackle some of the vexing challenges facing youth, families, and communities today. While educational standards are important, successful school-based programs have long recognized that in order for students to learn, attention must be paid to the larger family and community systems of which they are a part.

Successful school based programs are characterized by many of the attributes of family centered services. They build on the strengths and capacities of students and their families; they are responsive to the cultural diversity and unique needs of the community; they are consumer driven, with strong involvement of students and parents; and they are oriented to achieving meaningful results. For schools to partner successfully with families and communities, school systems must be flexible and responsive in their approaches. School systems, themselves complex organizations, must participate actively in a process of learning and change.

This issue of Prevention Report features a number of articles on programs that are based in or linked to schools. The Success Program of the Des Moines Public School District is a large-scale effort in Des Moines to provide a continuum of services to children and families. The School of the 21st Century describes a set of core components and the principles that guide school readiness programming. An article on the Life Options Program summarizes a three-year evaluation of a comprehensive school-based approach to pregnancy prevention. Abstinence-Only versus Comprehensive Sex Education Programs in Iowa provides an informative comparison between these two initiatives, which are largely based in schools.

In other news from the National Resource Center for Family Centered Practice, we are continuing to expand the development

In this issue...

of user-friendly outcome-based systems. Over the last five years, the Center has been working with Community Action Programs to track outcomes throughout the state of Iowa using the Automated Assessment of Family Progress (AAFP). Building on the success of that federally-funded initiative, the Center began a statewide training and technical assistance program to work with community based Decategorization (Wrap-around), Juvenile Justice projects. Currently, the Center is conducting a statewide effort aimed at identifying, analyzing, and reporting outcome measures, and streamlining the reporting of outcomes by integrating these systems as much as possible into one reporting system across child welfare initiatives. During the first year of this initiative the Center has been working with 71 of Iowa's 99 counties.

In the Training Division, the National Resource Center is pleased to announce our upcoming Fourth National Training Institute, *"Powering Up" – Strengthening Families, Communities, and their Helpers.* The institute, to be held October 10-12, 2001 at Deerfield Beach, Florida, will feature one, two, and three-day sessions on a variety of specialized topics—including Advanced Family Development; School Based Services; Reunification, Placement and Adoption; Family Group Conferencing; Adolescent Identity Development; Family Centered Supervision; Stress-free Outcome Evaluation; and others. Further information about the institute is provided on page 22 or contact the NRC for a registration form at 319/335-4965. Registration will be limited, so please sign up early!

The Center is also happy to report on the successful launch of the Family Development Specialist Certification (FDS)on-line test. So far, hundreds of participants from the FDS courses nationwide have successfully completed this test on line. The exam tracks attendance, scores the performance on the exam, and produces summary reports which provide information on individual and group (class) performance levels. In addition, the online system provides summary statistics related to test question effectiveness and validity, and statistics on performance trends which will be analyzed according to variables such as: trainer, agency and job classifications and settings; performance in various training topic categories; and demographic characteristics (e.g., ethnicity, length on job, age, geographic regions, educational background, gender, etc.). This web-based option makes test administration and scoring logistically easier and consistent. It provides statistical assessment information and feedback about the training that can be collected in individual, aggregate, and longitudinal formats.

The NRC has also successfully piloted the Beta test of the Family Development Assessment Skills CD-Rom. The CD-ROM is being used as a supplemental learning tool to the Family Development Specialist certification training. The program draws from the 8-day FDS training and is to be used as an introductory teaching aid for many of the concepts presented in the training (i.e., systemic thinking, case planing, eco-mapping).

Internationally, the Center has increased its relationship with organizations in Mexico, Latin America and the Caribbean. Our recent efforts include the provision of training in cooperation with the CREFAL (The Latin American and Caribbean Regional Center for Adult Education/ Centro de Cooperación Regional para la Educación de Adultos en América Latina y el Caribe).

Please visit our website—www.uiowa.edu/~nrcfcp—for more details about the Center's upcoming training institute and to try out our new service, "Ask Doctor Outcomes." As always, we welcome your responses to the articles in Prevention Report and we are happy to accept article submission relevant to family centered practice and programs.

The Success Program

by: Kimberly Petersen, Success Program, Des Moines Public Schools

The SUCCESS Program is a school based youth services program offered through the Des Moines Public School District. The program began in 1990 in three schools, one elementary, one middle school, and one high school. The decision to place the program in these three original schools was based on high poverty levels, low academic achievement, and high mobility. Since then, the program has expanded to twenty-three buildings with forty-three staff. The SUCCESS Program provides a lifeline to children and their families through a continuum of services on a pre-natal through age twenty basis. The program is a vital link for children and families to connect with human services at the place most accessible to children—the neighborhood school. Case managers bridge the gap for children who come to school hungry, tired, mistreated or abused, or who may not make it to school at all, with the community resources that can help. Intensive case management services are provided by professional program staff in ratios not to exceed one staff person to 20 families. Their work includes assessment of need, identification of personal goals, coordination of services with a variety of human service agencies, and advocacy in accessing services and follow-up. The services are offered in homes and Family Resource Centers in school settings.

During the 1999-2000 school year, 2,145 children from pre-natal through age twenty and their parents received support from SUCCESS. Of these 2,145 individuals, 570 families received intensive case management services. Eighty-five percent of families receiving case management services made progress towards their goals. Making connections with other service providers is necessary in order for many participants to achieve their goals. Eighty-eight percent, or 2,048 of 2,337 referrals made by program staff resulted in a connection made by the client with a community resource. Forty-six percent of high school students receiving case manage-

ment services improved their GPA and forty-six percent of both elementary and secondary students receiving case management services improved their attendance. A case example would be a struggling 8th grade student involved in gang activities with a high number of truancies and suspensions. Through help from SUCCESS, her attendance improved 100 percent. She made the honor roll, had no office referrals, participated in numerous extra curricular activities, and gained a diverse group of friends.

Collaboration with human service providers is key to connecting families with resources. More than 20 community agencies have repositioned their staff to provide services at program schools. These professional staff offer services in many areas including health, employment, mental health, substance abuse, recreation, mentoring, and tutoring. The SUCCESS Program coordinates eleven collaborative grant-funded projects with community agencies. Partnerships with United Way of Central Iowa, the Human Services Planning Alliance, Iowa Departments of Education and Public Health, the Greater Des Moines Community Foundation and the Mid-Iowa Health Foundation have created a unique blend of planning and investment in programming.

There has been a great deal of growth within the last 10 years in the SUCCESS Program. In 1990, program staff consisted of three case managers and one program manager. Currently, the SUCCESS Program consists of 31.5 case managers, eight family development specialists, seven mental health clinicians, one early childhood specialist, one child psychologist (part-time), six full-time nurses at selected schools, one secretary, one program manager, two program specialists, and one student mentor. The SUCCESS Program is currently in seven elementary schools, ten middle schools, five comprehensive high schools, and one alternative high school.

One of the most successful collaborations in integrating community services into the school setting is the mental health component. Early in the program, the unmet mental health needs of children were identified as a priority to be addressed. Mental health clinicians employed by community agencies provide outpatient diagnostic and treatment services to children and families at school and in home settings. It is estimated by the Iowa Department of Education that about 85,000 children and youth in Iowa under the age of 18, or about 12 percent, are in need of some type of mental health services. Tragically, the majority of these children fail to receive appropriate mental health treatment because of barriers such as lack of resources to pay for services and lack of transportation. Children who would probably not access mental health services receive therapy in relation to traumas they confront such as sexual, physical, and emotional abuse; aggression; attachment problems; and post-traumatic stress syndrome. Young children surviving in these situations desperately need the service of mental health specialists.

Another effective collaboration is the prenatal through age six component. Early intervention with disadvantaged young children is the most humane and concurrently the most cost effective way to address high-risk issues. In 1993, United Way of Central Iowa helped to launch Way To Grow in conjunction with the SUCCESS Program to serve the most vulnerable young families and focus on those who are pregnant or have children under the age of six. Services are designed to strengthen families and help them nurture and care for their children. Further, these services will ensure that children are born healthy, receive the physical and emotional parenting and the intellectual stimulation necessary for successful development in a drug-free environment, and are prepared to begin school ready to benefit from teaching in a school setting. Select Way To Grow staff have received training in Parents As Teachers (PAT), a nationally acclaimed program which assists parents of young children birth to five years of age. Parent education, developmental screenings, and materials are incorporated into home visits and parent support groups. Way To Grow is also involved in the Family Support Network as part of the Empowerment and Healthy Start initiatives in Polk County.

The SUCCESS program has developed various other components for youth to assist them in becoming self-sufficient and successful. In its sixth year, the 2000 Learning Connections project served 25 eighth graders at risk for dropping out of school. The six-week program focused on career exploration and the skills needed to be successful in high school and in the work world. Due to the proven success of the Summer Learning Connections project, similar components were added for 25 fifth grade students to help them transition to middle school and for 30 high school students to help them prepare for post-secondary education and employment.

Learning Connections II, offered during the school year, completed its fourth year of programming with funding from the Iowa Department of Public Health. This collaborative effort with Children and Families of Iowa and Iowa State University offered several components to eighth and ninth grade students at risk of dropping out of school. The Challenge Teams Course presented during physical education classes helped students reconnect to Physical Education and raise their grades. Gender-specific groups for personal management skills were also offered.

Through funding from the Homeless Children and Youth grant, tutoring and related support services are provided to youth living in Youth Emergency Services and Shelter (YESS) and the Iowa Homeless Youth Center (IHYC) facilities in Des Moines. Through the collaboration of the Des Moines Public Schools, YESS, and IHYC, identified youth are linked to the SUCCESS program. In addition to the tutoring and supportive services available to youth living in the YESS facility, educational, supportive and advocacy services are provided to youth at IHYC through the Educational Liaison.

The Chrysalis Foundation has initiated funding for After-School Programs for Middle School Girls at two SUCCESS program middle schools. The "Star Choices" group at Harding Middle School is a collaboration with Iowa State University Extension and the SUCCESS program. "Star Choices" provides a safe place for

girls to enhance and strengthen resiliency through activities in team building, personal management skills, child care skills, homework and reading enhancement. The "Wise Girls" program at Hiatt Middle School helps girls find their voice and explore new ideas in relation to careers, sexuality, and interpersonal skills. In 2000-2001, the SUCCESS program will collaborate with programs in six additional middle schools. The SUCCESS staff at Longfellow elementary also began an after-school program that builds skills and resiliency of fifth grade girls. The group helps to prepare girls for the stressors that typify adolescence.

In 1999 the Des Moines School District was awarded a seven million dollar Safe Schools/Healthy Students grant to serve students in Polk County. It is a plan to coordinate, develop, and enhance youth-centered efforts in eight school districts throughout Polk County. This plan was based on the premise that innate strengths present in all communities are often depressed and unrealized due to negative risk factors. The Safe Schools/Healthy Students initiative provides support services and a variety of programming in such areas as the development/enhancement of a comprehensive drug and violence curriculum for Kindergarten through twelfth grade, violence prevention strategy training for parents of children Kindergarten through sixth grade, and programming for parent education.

The Safe School/Healthy Students grant allowed for the addition of 15 SUCCESS case managers. These case managers replicate the current SUCCESS intensive case management program which has been designated as an exemplary program by the State of Iowa, the federal government, and has been strongly supported by the corporate sector in Des Moines. The Safe Schools/Healthy Students initiative has also provided the opportunity for a collaborative effort between the Des Moines Public Schools SUCCESS Program and the National Resource Center for Family Centered Practice at the University of Iowa to provide Family Development Specialist training to anyone in Polk County. This training is designed to assist front-line workers from human service agencies in learning and implementing the Family Development model including family-based intervention strategies designed to support and empower families. This is an evidence-based training curriculum provided by the National Resource Center for Family Centered Practice of the University of Iowa, School of Social Work. The training has been very well received and to date, 136 individuals have received the eight-day training in Polk County.

For more information about the Success Program, contact Margaret Jensen Connet, Des Moines Public Schools, 1801 16th Street, Des Moines, IA 50314.

THE SCHOOL OF THE 21st CENTURY
Breaking Barriers to Serve Children and Families

by: Carole Weisberg, School of the 21st Century, Yale University

The School of the 21st Century (21C) was first announced in the fall of 1987 by Yale University Professor Edward Zigler, one of the principal architects of the federal Head Start program. Professor Zigler recognized that the changes in patterns of work and family life in recent decades require schools to assume an expanded role in the delivery of child care and family support programs to ensure that children arrive at school ready to learn and receive necessary support for academic success once they are in school.

With the School of the 21st Century concept, Dr. Zigler proposed a new kind of elementary school: a year-round, multi-service educational center providing high-quality, accessible services to children and families when they need it most - from early morning to early evening. Early skeptics told him it couldn't work. They doubted the ability of public schools, burdened by so many existing problems, to address a community's child care needs and provide support and education to new parents. Today, more than a dozen years later, the model is not only working in over 600 schools in 17 states, but it has helped to redefine the relationship between schools and families. In some communities, 21C schools are known as *Family Resource Centers* (FRC). Both Connecticut and Kentucky have launched statewide initiatives based on the 21C model.

The School of the 21st Century eliminates the distinction between child care and education, recognizing that learning begins at birth and occurs in all settings. Dr. Zigler points out that children will not succeed academically or socially unless their parents have the supports they need to be their first and best teachers. Young children need to be in caring and enriching settings long before kindergarten. Once in school, children need safe and enriching environments during non-school hours. In addition, children's basic needs, such as nutrition and health, must be met in order for children to develop properly and succeed academically. The ultimate goal of the School of the 21st Century is to ensure optimal development for all children and to benefit families, regardless of income.

21C CORE COMPONENTS

The 21C model is designed to meet the needs of a wide range of communities and has been successfully implemented in rural, urban and suburban settings. A particular strength of the School of the 21st Century model is that it is flexible enough to meet the needs of individual communities. This flexibility enables schools to tailor 21C to match their own needs and resources, add new services and/or strengthen and draw together existing efforts. In many communities, 21C serves as an umbrella for an expanded array of family support

services including adult education, youth development and social services beginning at a child's birth and continuing through the high school years. While each 21C school varies according to local needs and resources, the model includes the following six core components:

- Parent Outreach and Education: This component typically includes a home visiting program, playgroups, and parent education workshops designed to educate parents about child development and provide regular opportunities for parents to meet.
- Preschool-Age Programs: High-quality, developmentally-appropriate, full-day, year-round services for children ages 3-5 at the school or at a school-linked site, laying the groundwork for positive relations between schools and families, and children's later success in school.
- Before-, After-School and Vacation Programs for School-Age Children: Either at the school or at a linked site, school-age programs enable children to learn, grow and socialize in a safe environment during non-school hours.
- Health Education and Services: In collaboration with community-based health care providers, 21C schools can offer a range of services including: health, nutrition and fitness education, developmental assessments, and dental and mental health services.
- Networks and Training for Child Care Providers: To strengthen the quality of local child care, 21C schools offer workshops, training opportunities, support groups, and newsletters to support community child care providers.
- Information and Referral Services: 21C schools inform families about community options for child care, and provide information about health care and other community services pertaining to the well-being of children and families.

21C GUIDING PRINCIPLES

Although each School of the 21st Century is unique, 21C schools share a common foundation: the six guiding principles that serve as the basis for program quality and integrity.

- Strong Parental Support and Involvement: Parental involvement is essential for the optimal development of children and a critical factor in a child's educational success. Schools of the 21st Century recognize the importance of a strong partnership between the school and parents and work to provide opportunities, both at the school and at home, for parents to become more involved with their children's education.
- Universal Access to Programs: 21C programs and services are available to all families in a school's attendance area. The model is not intended only for "at-risk" children or those from a particular socioeconomic level because all families can benefit from support.
- Programmatic Focus on the Physical, Social, Emotional and Intellectual Development of Children: Schools of the 21st Century focus on the overall child by stressing all aspects of child development, including physical, social, emotional, and intellectual growth and well-being.
- High-Quality Services: 21C schools make a commitment to providing high-quality services and programs for children and their families.
- A Professional Framework for Child Care Providers: 21C schools help create supportive and professional environments for child care providers, which encourage them to stay in the field by offering them professional development and opportunities for advancement.
- Non-Compulsory Programming: While 21C services and programs are available for all families in the community, they are not required. Not all families need or want the services of the 21st Century School. Families who attend a 21C school make their own decisions about which, if any, of the services they use.

FOR MORE INFORMATION

To learn more about 21C, contact the School of the 21st Century office at Yale University at 203-432-9944 or visit their website at www.yale.edu/21c. The role of Yale University School of the 21st Century staff is to provide schools with consultation, training and technical assistance through all phases of implementation of the 21C model. Schools and organizations interested in the School of the 21st Century model are encouraged to become members of the 21C Network. Through the 21C Network, Yale keeps members informed about relevant research, new funding opportunities, evaluation findings and more. 21C Network members are also able to communicate with each other via email regarding implementation challenges and strategies through subscription to the 21C Listserv.

CATCHING THE WIND...Research & Outcome Tools Capture Family Strengths, Demonstrate Service Impact and Change Nursing Practice

by: Linda Wollesen, RN, MA, LMFT, and Patricia Orr, RN, MA, MPH

For a hundred years, Public Health Nurses have worked side by side with Social Workers in our communities to promote health and education, strengthen families, prevent child abuse and violence, and to support optimal child development. The impact of services has gone largely unmeasured. Occasionally, and usually through serendipity, one profession learns something from another. As a result of the introduction of strengths-based practice and the use of outcome measures instruments, the Public Health Nursing Program in Monterey County, California has been changed. Until now, this approach has been undertaken primarily by social workers, social scientists, and nursing researchers. Using a "scales and ladders" outcome assessment instrument called **The Life Skill Progression (LSP) (see pages 10-13)**, over the last two years, nurses have shifted from a problem-oriented medical model to a more effective strengths-based approach.

Research Impacts Practice—Discovering Strengths

Perhaps the single most influential development in Public Health Nursing practice over the last ten years has been the impact of the longitudinal studies carried out by **David Olds, Ph.D., and associates.** Olds has conducted formal research utilizing control groups in studies begun 20 years ago in Elmira, New York, and replicated in Memphis and Denver. This body of research has documented the long-term impact and cost-benefit of nurse home visitation with low-income first-time mothers. The outcomes demonstrated covered a broad range of health and psycho-social categories, but perhaps the most impressive is the **79% drop in child abuse & neglect**. Other outcomes included decreased tobacco (25%) and alcohol use (46%) during pregnancy, increased breast feeding rates (62%), reductions in subsequent pregnancies (43%), increased labor force participation (83%), increased income (20%), and a reduction in welfare dependence tracked over a 30-month period of time. Reductions in violence-related indicators was equally impressive for mothers and their now adult children. Mothers had 44% fewer behavior problems due to drug & alcohol abuse over 15 years, and 69% fewer arrests. Their children had 54% fewer arrests and 69% fewer convictions and probation violations. Clearly, the preventive impact of these nursing visits was remarkable, and raised questions about whether other nursing services were doing as well and how impact could be demonstrated short of doing a costly research control study.

While Olds et al. demonstrated the long-term benefits from 2½ years of nursing visits per family, the cost-effectiveness of these visits was also demonstrated with the costs being recovered by the time the child was 4 years old. Until this study, nurses everywhere were thought to be too expensive and their services were threatened with extinction because of shrinking local budgets, "costly" salaries and the emerging notion that paraprofessionals could do the job cheaper.

Through a grant by the Robert Wood Johnson foundation, Dr. Olds' "best practice" model is being replicated nationally with Monterey County Public Health Nursing, in collaboration with two other counties. The replication training totaled nearly a month and is comprised of a structured educational curriculum which teaches guidelines for each of the visits which begin in early pregnancy and continue until the infant's second birthday. Caseloads are limited to 25 families per nurse and the frequency of visits has been established at weekly or bi-monthly, and then monthly near case closure. Data is collected and transmitted to a central site in Denver, CO for analysis and compared with the clinical trial data.

The most valuable concept the curriculum has brought to Monterey County is the Strength & Relationship based theory applied to nursing practice. Nurses were taught to identify parent attitudes, skills, knowledge and supports that demonstrate strengths. Until now, nursing intervention was heavily influenced by the highly directive, problem-oriented medical model. A diagram in one of the classic public health nursing textbooks graphically illustrates that "good" nursing practice involves: Assessment, Planning, Intervention & Evaluation, and that each of these activities is carried out by the nurse with no mention of the role of the "client" in this process. Missing is any mention of a collaborative, strength-based element in the process.

From a supervisor's perspective, the contrast was remarkable between the old nursing model and the new ways of encouraging change by building on family strengths. Because the Olds curriculum is sanctioned for use only in replication projects with trained staff working with low income first time mothers, only primary source information for strength-based intervention, social ecology and motivational theory from the curriculum could be used to provide other nursing staff with a means to change their practice. But the success stories about families and optimism coming from the Olds-trained nurses has become the most powerful catalyst for our other nurses.

Interest In Outcomes—Proving It Works!

In Monterey County, Public Health Nursing uses a modified Kempe Risk Factors for Child Abuse Scale to triage the most at-risk referrals into the caseloads. This was done because the Olds research indicated that nurses had the greatest impact on the mothers with the lowest psychological resources, and because referrals significantly outnumbered staff available. While the preventive value of the long-term visits in the Olds model was obvious, it was ethically impossible to refuse service to troubled multi-child families & children already abused or neglected. The usual

nursing caseloads of 40 high-risk families per nurse had the potential for causing significant staff burnout unless strength-focused practice could be learned and used. The Olds-trained nurses were clearly energized by the successes they were seeing in their families. The Life Skill Progression was designed to provide perspective and to demonstrate positive family change across multiple skill areas.

While the LSP's initial design was intended as a structure for nurses to concretely identify a parent's strengths and needs and to see parent and child progress, the LSP soon became a way to shift from output measures to outcome measures in order to show results for funders. The third purpose was to provide a way of demonstrating the preventive value of local nursing services, since the Olds data could not be generalized to our other services. The LSP is expected to work well as a means to compare the target populations and service impact of various programs. The LSP data is analyzed locally and is not sent to Denver.

Outcome Theory and Other Models—Applying Concepts

In addition to the influence of the Olds study and outcome indicators, there were several other catalysts which contributed to the process. Two outcome instruments called the **Family Development Matrix** (developed by **Jerry Endres, M.S.W.** at the Institute for Collaborative Studies at California State University - Monterey Bay) and the Automated Assessment of Family Progress (developed by **Brad Richardson** at the **National Resource Center for Family Centered Practice**) contributed significantly to the concept of using concrete indicators to capture progress. The Automated Assessment of Family Progress (AAFP), described in The Prevention Report (1999 #2) tracks family progress for indicators across ten dimensions: Employment, Education, Community Involvement, Self-Sufficiency, Household Management, Food/Nutrition, Health, Housing, Emergency/Crisis and Household Linkages.

The Family Development Matrix (FDM), also described in the Prevention Report (2000, #1) tracks family progress across eleven categories: Shelter, Food/Clothing, Transportation/Mobility, Health/Safety, Social/Emotional Health, Finances, Family Relations, Community Relations, Adult Education/Employment, Children's Education/Development & Immigration/Resettlement. While these tools are both intended to focus on strengths and measure outcomes, they lacked the specificity we sought for parents and young children receiving nursing services, particularly in the area of infancy, health and development; however, building on the strengths of the design processes reported from the AAFP and the Family Development Matrix (FDM) contributed significantly to the structure of the Life Skill Progression (LSP).

Outcomes training by **Mark Friedman** of the Fiscal Policy Studies Institute in Baltimore, MD, was provided throughout California by the State Family & Children's Commission. The material contributed clarity by offering well-grounded definitions of Outputs, Outcomes, Indicators, & Performance Measures in understandable terms. The material used grids to show **Input/Quantity** (How much service was delivered?), **Input/Quality** (How well was service delivered?), **Output/Quantity** (How much Effect/Change was produced?) and **Output/Quality** (What Quality of Change was produced?). It became obvious that up to this point nursing and state programs had only been counting outputs, like the number of visits, and that we needed to define the outcomes desired in terms of the family or child. This paradigm shift resulted in Monterey County Public Health Nursing creating definitions of results for long-term nurse case management which were Outcomes-Based and focused on Client Competencies, Life Skills and Relationships with Clients. This is a significant departure from focusing solely on traditional clinical nursing goals such as immunization or breast feeding. Although the term "Case Management" is still locked into Federal funding terminology, a whole new vocabulary is needed to reflect the Strength-Relationship model. A statement of Monterey Nursing Program Goals for Mothers and Infants was developed to help see beyond the clinical health concepts being taught, to the skills and desired outcomes needed by the families. The clinical issues were only a part of the need. The goals evolved into the categories and competencies of Life Skills instrument when it became apparent that while the goals were important, something was needed to demonstrate where a family was in terms of progress toward the goals.

The concept and process of **"Utilization Focused Evaluation,"** a book written **by Michael Patton** presents very detailed and easily understandable explanations of the process that the National Centers for Disease Control and Prevention (CDC) is recommending as the best evaluation method currently available. Patton contributes the novel concept that outcomes data should be of some practical use to the staff generating the data and to the population served. This is a somewhat revolutionary concept to staff and management working in categorically funded bureaucratic agencies. So now, *all* that was needed was a tool to capture realistic outcomes data, the quality of outcomes across multiple categories, and one that staff would find helpful in their work with families. It also needed to hold up to Reliability and Validity studies, be something that funders would love and weigh less than twenty-five pounds!

Comparing Outcomes—The Learning Curve

In the **Packard Foundation's "The Future of Children"** ***Home Visiting: Recent Program Evaluations***, Vol.9, Number 1-Spring-Summer 1999, a comparison of the evaluations of six of the best and largest home visitation programs operating nationally, showed that results varied widely across program models, program sites, and individual families in the sites. Only two of the models described sought to impact maternal life course and only one produced significant results in rigorous studies (Olds). The variations in the number & frequency of contact ("Dose") with families and the attrition of both staff and families also effected outcomes. None of the models produced consistent results in child development or health. The summary concludes that benefits cannot be generalized from

one model to the next, that it is difficult to change human behavior, and that programs need to improve, particularly in the areas of "assessment of practice for enrollment, engagement, attrition, staff training and curricula." The report suggests that researchers and practitioners need to work on a collaborative basis.

Outcomes Tool Design—The Courage to Try

While the Packard Visitation Report was somewhat discouraging, Dr. Olds had demonstrated that it could be done and significant outcomes had been demonstrated. The need to design an outcomes tool for nurses became a compelling issue and the challenge to do it well was daunting.

The Monterey **Life Skill Progression (LSP)** was created as an intervention planning and outcomes assessment tool in 1999 and generalized for use by nursing and social work staff in August, 2000.

The purpose of the LSP is:

- To profile individual clients as well as aggregate client groups and subgroup characteristics at program entry, periodically over time and at exit to demonstrate the impact of services on groups and individuals.
- To identify individual client strengths, areas of need and goals for collaborative client/case manager intervention and referral.
- To compare populations enrolled in different programs or service delivery models.
- To demonstrate long-term outcomes, taking length of service and type of staff and program into account.
- To identify specific sub-scales and types of clients showing the most and least progress.
- To provide data & perspective for program improvement and funding purposes.

The LSP was not intended to be an interview tool or an assessment tool, but rather a summary of assessment and interview findings. It was not designed for direct client use, except in select cases where a positive relationship was established where the LSP could be used effectively for perspective on needs, strengths and progress. The information is gathered in six-month increments, and only applies to the previous six-month period in order to show current progress. There are a total of 37 sub-scales (33 Parent sub-scales and 5 Infant/Toddler scales), which are scored separately across a range of Inadequate to Competent on a scale of 0 to 5. There is no cumulative score and the sub-scale scores are specific to an individual parent or child. The descriptive words in each category that are pertinent are circled and scored, giving an instant visual and numerical view of needs and strengths. Descriptors in more than one column can be circled, and the score would be averaged between the columns indicated. The LSP also captures as variables, the months of service provided, the cumulative number of home visits, to give a dose ratio for comparison with the progress demonstrated. A male/female parent descriptor was added to be able to sort by sex of the parent described. Ethnicity and the generation of arrival was not included, because the family's goals drive the progress regardless of the ethnicity factors involved.

Concerns about validity and reliability also needed to be addressed. Following the methodology used for the AAFP and the California Family Development Matrix, case studies were scored by staff on the LSP at two points in time so that inter- and intra-rater reliability could be assessed. Based on an initial review of the results and recommendations by **Brad Richardson, Ph.D., at University of Iowa School of Social Work and Senior Researcher for the National Resource Center for Family Centered Practice**, revisions were made with the intent of bringing reliability up to 90 percent for each of the items. The LSP was subsequently included in two grant proposals as the outcome measurement tool including a federal Safe Schools violence prevention grant and for the expansion of the Olds and Parents as Teachers Home Visitation Programs. These grants also support the development of a centralized **collaborative interagency referral clearinghouse** for home visitation services.

In August, 2000, the LSP began to be used consistently for data purposes across all of the visitation programs in Monterey County, including Teen Pregnancy, Special Infant, Field Nursing, First Time Mothers (Olds replication), and Parents as Teachers (PAT). Other community agencies, including child care, are beginning to use the LSP as well. Validation studies are being planned for the coming year and will be conducted as funding becomes available. The LSP Data Management system is also being developed as an Access-based system that will be refined over the next year. Data analysis and design consultation, funded by the Safe Schools grant, will be provided by **Jim Wiley, Ph.D., and others from the Public Health Institute in Berkeley, California**. An added goal is to demonstrate that the children served, who later go on to kindergarten, arrive emotionally and developmentally sound.

Real Outcomes—The Rest of The Story

While hard data on valid outcomes are extremely valuable and present their own challenges, use of the LSP is already providing a wealth of anecdotal success stories from staff and clients. One clear indicator of the LSP's usefulness is the quickness with which staff can identify family strengths and skills, and the ease with which they are able to use this focus to cut through the chaos often encountered in the lives of low-income families. The LSP is one of the few forms we have encountered that staff actually want to use, and, at the end of the four hour LSP training, several staff spontaneously commented that it had been "fun." This is an unusual response to the introduction of a new form or data collection procedure. In order to provide staff with additional perspective on their caseload, a cumulative list of LSP scores are printed out on the monthly caseload lists under each parent and child. Staff also participate in design team meetings, and regularly contribute comments and questions which ultimately result in design changes. An example of one difficult area raised was how the LSP would be used with foster families. In some cases, an initial LSP might be used with the birth parent and child, then with a series of foster parents, and then either reunification or adoption would result in the use of the LSP with yet another family configuration. Another question raised was how to use the LSP if the custodial parent is the father? Should

number of visits be added to create a measure of service? Michael Patton has suggested that a valuable evaluation tool is one that continues to evolve in response to need.

For our nurses, the immediate rewards have come from the stories of changed lives. Some of the more powerful stories have come from substance abusing women who are able to see progress toward sobriety and the skills needed for parenting or reunification with their children. Mothers in recovery often ask for copies of the LSP for themselves and friends.

One nurse reported that one of the moms she was working with had recently dropped out of school when she became pregnant. She had given up hope for completing her education until she was encouraged by the nurse using the LSP in a strengths focused way. Within a short time, she had enrolled in adult school, completed her education, had her baby, graduated at the top of her class and was invited to give the graduation address. She is now employed with a good job and is currently enrolled in a community college with the goal of becoming a nurse. In LSP terms, this is a successful change from 1 to 5 on the education sub-scale.

Another case involves a 19-year-old mother in a violent relationship with her husband who was supported in recognizing the harm to her child as a witness to violence, as well as the harm to herself and her family. After the husband's arrest and following entry into treatment, the family has reunited. This family's progress is captured in the graph below which shows the degree of change in the Mother's LSP scores during the three months during which services were received.

It seems that catching the winds of family change with outcomes becomes it's own reward.

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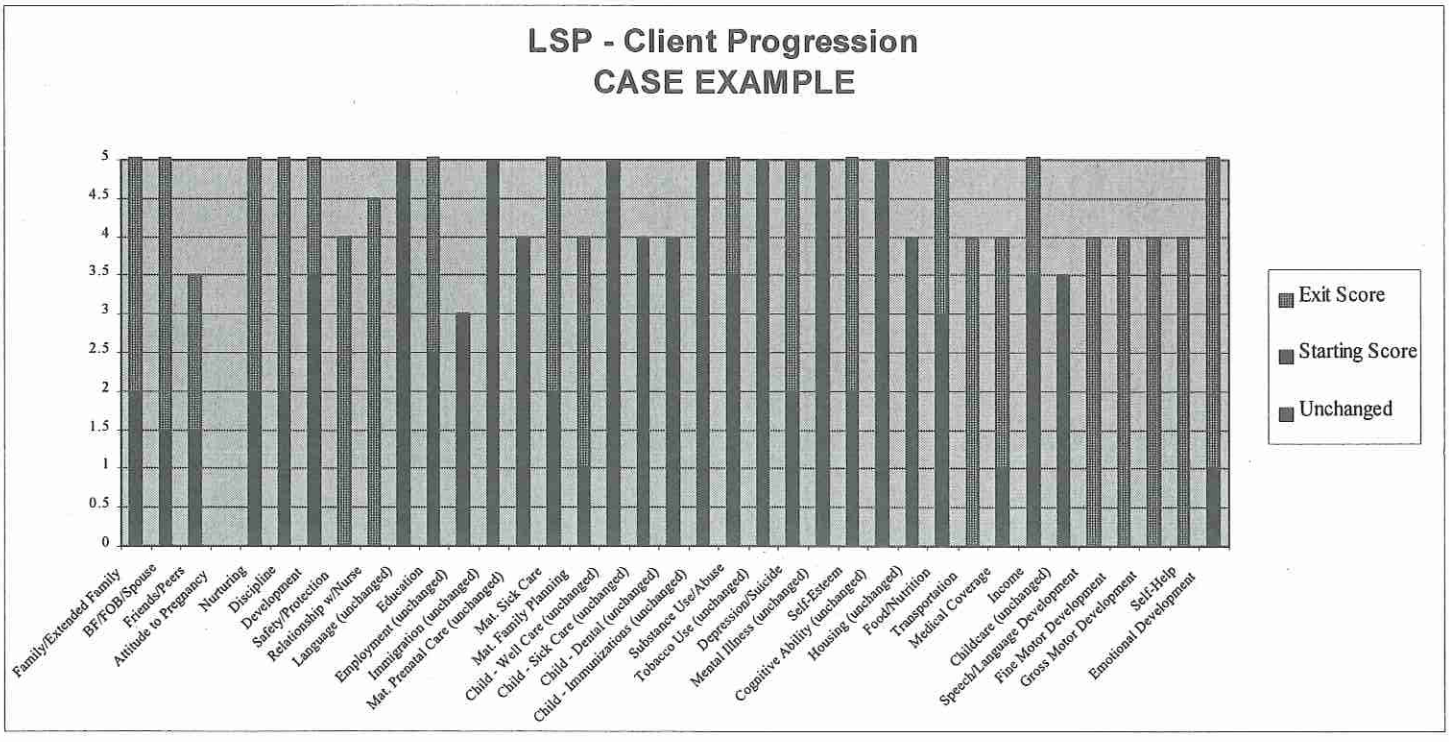


THE MONTEREY LIFE SKILL PROGRESSION - PARENT SCALE

Family Record ID #_____ Indiv #_____ ☐ Initial ☐ Ongoing # ____ ☐ Closing Months of Service ____ No. Visits ____

☐ Male
☐ Female

_____ Client Name (last, first)

_____ Date

_____ PHN/Case Manager ID# and Initials

_____ Agency/Program

Date next LSP Due _____

ITEM:	SCORE	AREAS OF LIFE SKILL DEVELOPMENT	INADEQUATE---1	1.5	2	2.5	3	3.5	4	4.5---COMPETENT
		RELATIONSHIPS WITH FAMILY/FRIENDS								
1		with Family &/or Extended Family	Hostile; Violent or physically abusive.	Separated; No Contact.	Conflicted, critical, Verbal Abuse		Unsupportive Emotionally Distant; Support only in crisis.			Supportive; Mutually nurturing.
2		with BF/FOB/Spouse (current)	Hostile Violent; Physically abusive or multiple partners.	Separated or No contact.	Verbal Aubse or arguments; Some support.		Stable, Some support; One partner.			Supportive; Loving/married or committed.
3		with Friends/Peers	Conflicted or Violent Relationships; Risky groups/gangs.	Few or no friends; Socially isolated.	Casual friends; Short relationships; Lonely.		A few close friends; Can count on them.			Close supportive friendships; Good network.
		RELATIONSHIPS WITH CHILD(REN)								
4		Attitudes to Pregnancy (current)	Unplanned; Unwanted; NX previous TAB.	Unplanned; Fearful or ambivalent.	Unplanned; Accepted		Planned but Unprepared.			Planned, prepared, welcomed.
5		Nurturing	Hostile-Unable to nurture/ bond/love; Limited holding.	Nurturing impaired by indifference, apathy or depression.	Lacks info/modeling of love--Afraid to "spoil" with attention; Marginal connected-ness.		Inconsistent; bonded & loves, but responds inconsistently; Some connectedness visible.			Loving, nurturing, praises, delights in and holds child; Reciprocal connectedness.
6		Discipline	Uses physical discipline; Abuse/neglect (current or suspected).	Frequent verbal abuse/ criticism.	Mixture angry, critical and appropriate discipline.		Inconsistent limits; fails to teach correct behavior; ineffective boundaries.			Uses age appropriate discipline; Teaches and corrects behavior well.
7		Development	Non-existent or unrealistic expectations; Lacks or refuses information.	Limited knowledge of development; Limits or fails to encourage develop-ment; Passive parental role.	Accepts developmental info; Uses some ideas; Provides a few toys for age; Open to parent resources.		Seeks info regarding develop-ment; Applies info. learned; Notices child's development, skills & interests.			Anticipates develop. with age appropriate toys; Enjoys playing with, reading to child.
8		Safety	Hospitalized for tx of unintentional injury; Has permanent damage.	Outpt./ER tx of unintention-al injury; No permanent damage.	No history of unintention-al injury; Home and car not safe--not child proofed.		No history of unnintentional injury; Home partially safe/ child proofed; Has/uses car seat; Accepts info.			Home and care safe--child proofed; Child protected; Teaches safety; Seeks/uses info as age changes.

RELATIONSHIPS

Instructions: Complete on primary parent with ISP and send to data entry at Intake, every six months and at closure. Circle applicable categories. Enter Score. File in chart after data entry.

THE MONTEREY LIFE SKILL PROGRESSION - PARENT SCALE

Family Record ID #_____ Indiv #_____

EDUCATION

HEALTH & MEDICAL CARE

ITEM:	SCORE	AREAS OF LIFE SKILL DEVELOPMENT	INADEQUATE---------- 1	1.5	2	2.5	3	3.5	4	4.5	----------COMPETENT 5
9		RELATIONSHIP WITH CASE MANAGER	Hostile, defensive, refuses services.		Guarded, distrust Frequent broken appts.		Passively accepts visits & info.		Seeks/uses info Calls for help.		Trusts; Open; Welcomes; Uses & enjoys visits.
		EDUCATION									
10		Language (non- Eng. Speaking only)	Non-English speaking; Low/no literacy any language.		Literate in Primary Language.		Takes classes; Verbal ESL established.		Takes classes/ Written ESL established.		Fully bilingual.
11		Education	< 12 grade.		GED or H.S. diploma.		Obtains job/Training skill.		Attends community college graduates.		Attends/graduates college &/or seeks adv. degree.
12		Employment	Unskilled, unemployed; No experience.		Occ. Entry level jobs or Seasonal employment.		Multiple &/or low income jobs.		Regular employment w/ adequate salary & benefits.		Career of choice with good salary/progresses up.
13		Immigration	Undocumented, migrant; Frequent return to country of origin and family.		Has work permit in US < 5 yrs; Migrant.		Has work permit. Children born in US; In US < 5 yrs; Migrant.		Has work permit or documented temp. visa; applied for citizen-ship; Plans to live in US.		US citizen; Values/retains culture of origin; Teaches children.
		HEALTH & MEDICAL CARE									
14		Maternal Prenatal Care	No P.N.C.		Starts care 2nd-3rd tri-mester; Keeps some appts.		Starts care 2nd-3rd tri-mester; Keeps most appts.		Starts care in 1st trimester; Keeps most appts.		Keeps P.P. appt.
15		Maternal Sick Care	Acute/chronic conditions go w/o Dx or Tx.		Seeks care only when very ill; Uses ER for care.		Seeks care in timely way; Inconsistent Tx follow-up.		Seeks care appropriately & follows treatment recommended.		Illness Dx, Tx & Rx is timely--cure or control obtained.
16		Maternal Family Planning (current)	Unprotected sex; Unplanned preg; No F.P. method used; Hx STD or TAB.		F.P. Method used rarely.		Occasionally or intermitt-ently uses F.P. method		Regularly uses F.P. method.		Vol. Spaces pregnancies; Uses F.P. method of choice & STD protection.
17		Child-Preventive Well Care	Never.		Seldom.		Occasional.		Has annual exam.		Has regular CHDP/well child appts.
18		Child-Sick Care	Medical neglect. No Dx/ TX acute or chronic conditions.		Has care only when very ill; Uses ER for care.		Timely care; Inconsistent Tx f/u.		Seeks care; follows treat-ment recommended.		Cure or control obtained.
19		Child Dental	No dental care; Serious dental disease; Poor hygiene/B.B. mouth.		No dental care; Inadequate hygiene--some caries.		Late Tx of caries.		Timely Tx of caries; Some preventive care.		Regular preventive care & timely Tx.
20		Child Immunizations	None.		IZ History uncertain; Records lost.		IZs begun, but incomplete.		Late/Overdue.		Complete or up-to-date.

THE MONTEREY LIFE SKILL PROGRESSION - PARENT SCALE

Family Record ID #_____ Indiv #_____

	ITEM:	SCORE	AREAS OF LIFE SKILL DEVELOPMENT	INADEQUATE---------- 1	1.5	2	2.5	3	3.5	4	4.5	----------COMPETENT 5
MENTAL HEALTH			**MENTAL HEALTH & SUBSTANCE ABUSE**									
	21		Substance Use/ Abuse (Drugs &/or Alcohol)	Chronic poly-drug/alc. addiction; (Hx + Tox, FAS, etc.)		Intermittent or binge use in pregnancy.		Occ. or experimental use; No apparent addiction; Stops w/pregnancy.		Occasional social use of legal substances; none in pregnancy.		No use or abuse or in active treatment; Maintains recovery & support system.
	22		Tobacco	Chain smokes; >2 pks/day		Non-chain or 2nd hand exposure.		Decreases # when pregnant; Controls 2nd hand exposure.		Stops when pregnant; No second hand exposure.		None or never.
	23		Depression Suicide	Hx chronic depression with suicide attempts.		Chronically depressed but without suicidal attempts.		Aware of depression; Open to help.		Seeks & utilizes Tx &/or medications.		Recovered or not depressed; Optimistic.
	24		Mental Illness	Severe symptoms of mental illness (with/ without diagnosis).		Diagnosed; treatment inconsistent, symptomatic ADL marginal.		Diagnosed; In treatment; Remains under control; ADL ok.		Situational causes; Short-term; Treatment effective; ADL ok.		None or recovered without relapse; Competent ADL.
	25		Self-Esteem	Poor; Critical of self; Depressed; Expects criticism from others.		Flat affect, copes; Not confident, often fearful.		Irritable/defensive, blames others to protect self from criticism.		Develops skills & confidence; Tries hard; Shy when praised.		Confident & expects/accepts love; Returns love; Enjoys life.
	26		Cognitive Ability	Susp. Dev. Delay; No Dx or support services; ADL difficult.		Diagnosed DD or LD with adequate support services; ADL marginal.		Diagnosed or suspect mild DD/LD; ADL ok with support.		Special Ed. or LD; ADL ok; Support not needed.		Average or above cognitive ability; Competent ADL.
BASIC ESSENTIALS			**BASIC ESSENTIALS**									
	27		Housing (current)	Homeless		Unstable housing; Frequent moves.		Shares rental space w/ strangers or friends.		Lives with family or extended family (own or FOB's).		Rents/owns apt. or house.
	28		Food/Nutrition	Relies on emergency food banks/charity; Runs out.		Inadequate resources; Worried about amount/ quality.		Regularly uses gov't. resources WIC &/or food stamps.		Low family income provides adequate amount/quality.		Income provides optimal amount and quality.
	29		Transportation	None & no resources.		Uses public transport.		Access to car/rides w/ others.		Family has car; Client has license.		Has own car & drives.
	30		Medical Coverage or Health Insurance	None/Unable to afford care.		Medi-Cal Pregnant or emergency only.		Medi-Cal with or without SOC.		Private pay; Subsidized coverage.		Insurance with or without copay self and dependents.
	31		Income	None		TANF &/or child support; SDI		Employed--low income; Seasonal/200% FPL.		Employed/Meets expenses most of time.		Adequate salary.
	32		Child Care	None or avoids use.		Multiple sources; Occasional use; Unsafe environment.		With relative with adequate care but low stimulation.		Regular, stable, stimulating environment.		High quality child care center.

THE MONTEREY LIFE SKILL PROGRESSION - INFANT/TODDLER SCALE

Child's Name _____ FM Record/Index # _____ Indiv # _____ Ages: ___/___ yr mo

☐ Initial ☐ Ongoing # _____ ☐ Closing Months of Service_____ (Parents)

PHN/Case Manager ID# and Initials _____ Date_____

	ITEM:	SCORE	AREAS OF LIFE SKILL DEVELOPMENT	INADEQUATE---1	1.5	2	2.5	3	3.5	4	4.5	---COMPETENT 5
			INFANT-TODDLER DEVELOPMENT (6 mo - 3 yr.)									
CHILD DEVELOPMENT	33		Speech and Language*	Below AA/CA and Early Start criteria; Referred to E.S.; Not enrolled or attending.		Delays met E.S. criteria; Referred; Enrolled; Sometimes attends.		Delays meet E.S. criteria; Referred; Enrolled; Attends regularly.		No delays; Development at AA or CA level.		Development above AA or CA level.
	34		Fine Motor*	Below AA/CA and Early Start criteria; Referred to E.S.; Not enrolled or attending.		Delays meet E.S. criteria; Referred; Enrolled; Sometimes attends.		Delays meet E.S. criteria; Referred; Enrolled; Attends regularly.		No delays; Development at AA or CA level.		Development above AA or CA level.
	35		Gross Motor*	Below AA/CA and Early Start criteria; Referred to E.S.; Not enrolled or attending.		Delays meet E.S. criteria; Referred; Enrolled; Sometimes attends.		Delays meet E.S. criteria; Referred; Enrolled; Attends regularly.		No delays; Development at AA or CA level.		Development above AA or CA level.
	36		Self-Help*	Below AA/CA and Early Start criteria; Referred to E.S.; Not enrolled or attending.		Delays meet E.S. criteria; Referred; Enrolled; Sometimes attends.		Delays meet E.S. criteria; Referred; Enrolled; Attends regularly.		No delays; Development at AA or CA level.		Development above AA or CA level.
	37		Temperament Emotional Development	Irritable; Hard to console; Cues unclear; Unresponsive; Poor self-regulation.		Passive/flat affect; Little exploration; Does not seek comfort or share delight.		Anxious or withdrawn; Limited exploration; Clingy; Some shared play.		Quiet or changeable moods; Seeks comfort; Explores & returns to share.		Happy, content; Easily consoled or distracted; Connected to parent; Explores and shares delight.

*Rating should be based on a Developmental Screening or Assessment (ex: DDST II, ASQ, Bayley, Brigance, etc.)

Life Options: A Comprehensive School-Based Approach to Pregnancy Prevention

by: Edward Saunders, Miriam Landsman, Brad Richardson, & Judy McRoberts

Introduction

Adolescent pregnancy prevention continues to be a major issue with a host of program approaches that attempt to address the problem. The Life Options program is based on a model developed by Dr. Michael Carrera of the Children's Aid Society of New York, and addresses the problem of adolescent pregnancy prevention by focusing not only on sexual behavior, but on the teen participants' education, job preparation, recreation, health and well-being. Through intensive after-school activities, as well as summer programming, participants are helped to see their futures and opportunities beyond the short-term perspectives that often lead to teen pregnancy.

Three years ago, the Des Moines, Iowa area initiated a Life Options program in one of its alternative schools. This program was a joint effort of the Des Moines Public Schools, Planned Parenthood of Greater Iowa, the Mid-Iowa Health Foundation, Young Women's Resource Center, the United Way of Central Iowa, Central Iowa Health System, the Greater Des Moines Foundation, and the University of Iowa. The participating organizations made it possible for 30 students to take part in a program to prevent adolescent pregnancy by improving the life options available to high-risk teenagers. The National Resource Center for Family Centered Practice conducted the evaluation of the project.

The Life Options Program consists of five components—education, family and life skills, job club, creative self-expression, and individual lifetime sports. Participants in the program took part in a variety of activities. Educational activities included tutoring, field trips, computer training and job shadowing. Students completed a family life-skills curriculum encompassing reproductive health and sexuality, personal relationships, personal boundaries, teen parenting and other related issues. The job club included workshops in resume writing, practice interviews and work-appropriate social skills. Creative activities were offered in music, dance, visual arts, and cooking. Sports activities included weightlifting, tennis, golf, bowling, horseback riding, and rollerskating. In addition, there were parties for students, families and staff at the beginning and end of the year and at holidays.

Participant Selection

The Life Options program began serving students in January 1998 with 30 students enrolled. The first full academic year of programming began in the fall of 1998, with the second beginning in the fall of 1999. Evaluation data was collected at the implementation of the program and during the two following school years for students enrolled in Life Options and in a comparison group.

Students were recruited by project staff. The participating students were selected based on parental willingness to have their children participate, evidence of low or declining academic achievement, social risk factors for dropping out of school and teen pregnancy, and an assessment of the student's willingness to make a three-year commitment to the program.

The evaluation used a nonequivalent control group design, comparing the students in the Life Options program with a group of students of similar academic and social backgrounds. These students were tested alongside the intervention group to indicate whether the intervention program was having a significant impact on the intervention group academically and socially. Comparison group members were paid a small stipend for completing the questionnaires and agreed to allow Life Options staff access to their school records.

In both the second and third year of the program, there was some attrition in the intervention and the comparison groups. The intervention group dropped from 30 to 23 to 15 students, while the comparison group dropped from 34 to 28 to 18 students. In the intervention group, this attrition was accounted for by students moving out of the area or leaving the Life Options program. The comparison group also experienced moves and withdrawal from the program, as well as several youth who dropped out of school. However, it was still possible to compare both the change from one year to the next within the comparison and intervention group and the differences between the two groups for a given year.

Initially, the two groups were demographically similar. Both had slightly over half females (60% for the intervention group and 53% for the comparison group). Mean age was 12.62 for the intervention group and 12.34 for the comparison group. Participants were allowed to choose more than one race. In each group, over half chose White (53.3% and 58.8%). A large proportion chose Black (53.3%, 41.2%), with a substantial number choosing Hispanic and American Indian. There were some demographic changes over the three years due to attrition. Gender was relatively stable, with about half of the comparison group being male (44%) and a slightly lower proportion of males in the intervention group (32%) in the third year. Age also remained comparable (15.87 for the intervention group and 15.61 for the comparison group), although both groups had aged over the course of the project. Racial composition of the group showed a drop in White participants in the third year in both the comparison (44.4%) and intervention group (36.0). The data also showed an increase in the proportion of Black participants and a decrease in other students of color over the three years.

Methodology

In December-January of each academic year, intervention and comparison group

students (and their parents) completed a set of questionnaires designed to register any changes in their family and educational situation, their knowledge and understanding of sexuality and pregnancy risks, their career beliefs, and their academic progress. Most of the instrumentation used was developed by Philiber Associates for use with the original Life Options program, modified only slightly to increase applicability to the Des Moines area.

This article will highlight the portions of the project that focus on the school-based program, including part of the Youth Survey, the Sexuality Survey, the Test of Adult Basic Education, and information on academic progress. The data presented below makes two sets of comparisons—between the intervention and comparison group and within each of these groups over the three years. When statistical comparisons are made between two years, only those students who completed both instruments are used in the comparisons. These are referred to in the report as "matched respondents."

Youth Survey

The Youth survey is the central evaluation instrument for the Life Options program. The 74-item questionnaire, given to both the intervention group and the comparison group, covers family background, plans for work and education, after-school activities, relationships with parents and other adults, employment experience, health care, high-risk behaviors, emotional well-being, and sexual activity. The youth survey was administered each of the three years of the project.

Family Background

Overall, both groups can be described as living primarily in single-parent homes and likely to be receiving some form of public assistance. Intervention group respondents were more likely to be receiving public assistance than are those in the comparison group. In the comparison group, at least one adult usually worked full-time, while the intervention group families were less likely to have a parent employed full-time. In each group, most respondents' mothers graduated from high school, and several went on to complete college. In several cases, respondents' mothers were still under 35 years old in the third year of the study. With an average age for respondents of 15.7, this implies that these respondents were born to teen mothers.

There was one significant change in the family background data for matched respondents over the three years. On both measures of receiving public assistance and unemployment, there was a trend toward increasing poverty in the intervention group respondents.

College and Work Plans

The comparison and intervention groups had somewhat different plans to go to college when they finished high school. More of the comparison group felt that they would go to college later, but the difference was not statistically significant. While the comparison group chose a number of reasons for not attending college, many of the intervention group chose the explanation that "I won't have the money." This may reflect the greater poverty among these respondents. There was no statistical difference between the amount of time spent on homework by the two groups; in both groups the majority spent less than 30 minutes per day on homework.

There were no statistically significant differences in the intervention group's college and work plans for matched respondents over the three years.

After-School Activities

The questions on after-school activities are understandably skewed by the fact that the intervention group all have the option of participating in the Life Options after-school program. Thus, while three quarters of the comparison group either go home, go to a friend's house, or hang out on the streets after school, less than half of the intervention group regularly do so, with the rest going to their after-school program.

Due most likely to their involvement with Life Options, the intervention group was far more likely to participate in more activities than was the comparison group, with the exception of group sports. The greatest difference between the two groups was the higher number of intervention respondents participating in tutoring, which was the only statistically significant difference.

There were no statistically significant differences in participation in activities for matched respondents over the three years.

Relationships with Parents

The intervention and comparison groups indicated that they have similar relationships with their mothers. In contrast, participants in the two groups differed substantially in their relationship with their fathers, particularly in the third year. Respondents in the intervention group were significantly more likely to have no contact with their fathers, which affected their feeling of closeness and open communication on all four measures. Both groups argued infrequently with parents about television, homework, or keeping parents informed. However, in the third year the comparison group was significantly more likely to argue with parents about dating than was the intervention group. While relationships between mother and child did not change significantly for matched respondents in the comparison group over the three years, the matched respondents in the intervention group felt significantly closer to their mothers in the third year and were significantly more likely to talk with them.

Sexuality

The teens were asked eighteen questions about their own sexual experience and attitudes towards sex. These questions were left blank in a number of cases, and responses to several questions were combined to determine the total who were sexually active. Each year there was a small increase in the amount of sexual activity of participants. By the third year about one third of the respondents in each group had had sexual intercourse—6 in the comparison group and 5 in the intervention group. One respondent in the intervention group and two in the comparison group reported non-consensual sex. In the third year the

median age at first intercourse was 12.58 years for the intervention group and 13.49 for the comparison group. All students except one in both groups reported that they used birth control, with condoms being the most frequent method reported. Although five of the comparison group and two of the intervention group respondents had been pregnant during the three years, none reported having any children. The two groups are not statistically significantly different by any of these measures, in part because of the overall low numbers of respondents who reported having had sexual intercourse. The same was true for changes from year to year.

Teen Sexuality Survey

The Teen Sexuality Survey included 76 items addressing their knowledge of human sexuality. Students could respond "yes", "no", or "don't know."

Overall, the number of correct responses was relatively low, with less than 50% of each group having a correct response on a number of items. Both the comparison and intervention group matched respondents improved in knowledge over the three years. In the first two years there was not a significant difference between the two groups, but in the third year the intervention group did significantly better than the comparison group. They averaged more total correct answers. They had a higher percent correct both with and without the "don't know" responses.

Test of Adult Basic Education Results

The Test of Adult Basic Education, a national standardized test which measures proficiency in reading, math, language skills, and spelling was administered each year. The intervention group average grade level on the test was 5.51 the first year, 6.34 the second year, and 7.42 the third year. For the comparison group the averages were 6.30 the first year, 7.06 the second year, and 8.11 the third year. In both cases the test showed the students to be a little over two years below their actual grade level at the outset. There was no significant difference between the comparison and intervention groups in terms of this tested versus actual difference.

Within each group, there were significant changes over the years between tests for matched respondents, with intervention students showing more improvement than comparison students in reading, math, and language.

Report Cards

Academic report cards were collected for both the comparison and the intervention group. During the third project year, intervention students completed an average of 11.86 semester classes and had an average GPA of 2.04. They were absent an average of 19 days during the year. Differences between the comparison and intervention group were not significant for any of the three measures.

There were no significant differences for matched students in the intervention group over the three years. However, the comparison group had significantly fewer semester classes and significantly more days absent in the third year. One other difference stands out. In both the second and third year, all ten of the students who dropped out for the full year were exclusively from the comparison group.

Conclusions

Results from the evaluation of the Life Options Program indicate several positive trends, some which are consistent over the three years of the project.

While a number of students have left both the comparison and intervention groups, the two groups remained similar in their demographics, with the exception that the intervention group was substantially more economically disadvantaged.

Sexual activity continued to increase slowly in both groups, although the number responding to the questions about sexuality was small. Most respondents in both groups reported using birth control. Five respondents in the comparison group and two in the intervention group had been pregnant, but none had had children.

Through the three years, students who participated in Life Options remained in school and have shown significant improvement in the Test of Adult Basic Skills and in knowledge of human sexuality, more so than comparison group youth. While the intervention group was still slightly lower than the comparison group in mean GPA in the third year, the differences are not statistically significant, and the comparison group lost ground in number of classes and number of days absent.

Overall, the findings to date show a steady increase in academic performance of students in the intervention group. It is particularly impressive that these students continued to improve in relation to the comparison group, given that they face greater barriers, such as past academic difficulties, poverty, and absent fathers. While little difference was seen in sexual behaviors, there is hope in the significantly greater knowledge about sexuality in the intervention group. It is apparent that the program has continued to make a difference in the lives of the participants in these important areas.

Abstinence-Only Vs. Comprehensive Sex-Education Programs in Iowa: Findings From the First Two Years

by: Edward Saunders, Miriam Landsman, Brad Richardson, & Judy McRoberts

Introduction

Sexuality education has become a part of school curricula in many areas. However, approaches to teaching about sexuality vary widely. As part of its 1996 welfare reform bill, Congress enacted a $50 million per year program to fund abstinence-only education programs from 1998 to 2002. In Iowa, the Department of Public Health (IDPH) is responsible for administering the abstinence-only programs. In its first year of the Federal grant, IDPH funded four education programs and two community-based programs. It chose the National Resource Center for Family Centered Practice (NRCFCP), School of Social Work, University of Iowa to conduct the evaluation of the programs. The NRCFCP already had a contract with the Iowa Department of Human Services to conduct the statewide evaluation of the comprehensive (Abstinence-PLUS) sex-ed programs. Given this relationship with both State agencies, the NRCFCP was in the unique position of analyzing both sets of data and making observations on the relative effectiveness of both approaches.

This article presents data on the first two years of the Abstinence-only education programs. Four education pilots in Iowa were evaluated. They were largely focused on information-giving about the value of abstinence using curricula (such as "Postponing Sexual Involvement"), videos, guest speakers, or through parent-child communication activities.

Some youth were exposed to messages about abstinence during an entire school year while other students in other sites participated in programs which ranged from one hour to approximately eight hours. This was also true of students participating in the "comprehensive programs:" most were one to three hours, but one program offered 5 to 7 sessions. Schools generally dictate the amount of time they are willing to offer to program sponsors (most of whom come from outside the school). This content generally falls into the "health" class of junior high school students. Given the brevity of most of these programs, long-term effects are not anticipated. Past studies have documented no (or few) long-term effects of short-term programs. Consequently, the results of this study reflect only short-term effects.

The Study Method

A pretest-posttest strategy was used to collect information from program participants in the abstinence-only programs (primarily junior high students, although some sessions were given to high school students). When educational programs were short-term (fewer than four sessions), a posttest-only instrument was used to collect data. The pretest-posttest form was adapted from a survey instrument originally developed by Marion Howard at the Adolescent Reproductive Health Center at Grady Memorial Hospital in Atlanta, GA. In addition to survey forms completed by students, one site—which promoted parent-child communication as an abstinence strategy—used a parent survey to elicit attitudes about sexuality and abstinence in the first year of the program.

During the first year of the Abstinence-Only Education Program, data were available for 1,227 youth participating in the pilots. Matching pre- and posttests were analyzed for 731 of these participants. In addition, 144 students were surveyed at posttest only. Eighty-five parents in one of the pilot sites were also participants in this study. During the second year, the total number reported was 1,480, with 1,257 students completing the pre- and posttests and 233 completing the posttest only.

Because of the brevity of these programs, it did not control for possible absenteeism among students. Also, because no comparison groups were used in this study, the findings must be viewed with caution since other factors may have accounted for the findings. For example, at posttest, students may simply have remembered the items from pretest or they may have been exposed to content from other sources (including friends and parents) which influenced their attitudes or behaviors.

Findings

During the first two years, a small number of items showed significant change from pretest to posttest and these varied among the abstinence-only programs. Paired t-tests were used to test for significant differences from pretest to posttest. Items which showed significant change (at the .05 level of significance) included:

- A belief that most teens are not ready to handle the problems that can arise from having sex (2 sites in 1999 and 2 sites in 2000)
- Frequency of talking with parents (or guardians) about expectations for sexual behavior (2 sites in 1999 and 3 sites in 2000)
- Talking a friend out of experimenting with sex (3 sites in 1999 and 2 sites in 2000)
- Greater admiration for girls and boys who choose to wait (3 sites in 1999 and 2 sites in 2000)
- A belief that teens who want to wait can resist peer pressure (2 sites in 1999 and 2 sites in 2000)
- The ability to tell the other person in a dating relationship where you want to stop (1 site in 1999 and 1 sites in 2000)

- "From now on," intentions to wait until marriage to have sex (1 site in 1999 and 2 sites in 2000).

Each site was provided information about the items that showed significant change from pretest to posttest so they could assess the merits of the content of their programs. The value of program evaluations for demonstration programs is helping them to understand "what" is working in their curricula (however briefly or tentatively) and what is not working to make adjustments to their content.

In the second year, the results were also examined with respect to gender and grade. Overall, Males had significantly more negative attitudes toward abstinence at both pretest and posttest by comparison with female students. When the amount of change was calculated, few significant differences were found between males and females. Similarly, students in older grades were significantly more negative in their attitudes toward abstinence than were students in younger grades at pretest and posttest, but very few differences were found in the amount of change as a result of the program.

In addition to using the core pretest-posttest items across sites, each program was asked to pick eight posttest-only items (from a pool of 32 items) which were developed to test the "comprehensive" sexuality education programs funded by the Iowa Department of Human Services. Because the abstinence-only and comprehensive programs were using the same evaluation items, it was possible to compare the relative effectiveness of each type of intervention.

The comparative findings, below, are based on a review of mean ("average") scores for all abstinence programs compared with the mean scores from the comprehensive programs that used the same item: higher mean scores suggest greater impact. In examining the mean scores for each group (provided in parenthesis), it was found that students in the Abstinence-Only programs (compared to students in the Comprehensive (Abstinence-Plus) Programs) were:

- slightly more likely to say they would postpone sex in 2000 (2.5 vs. 2.4)
- slightly more likely to understand why they should wait to have sex until marriage in 1999 (2.6 vs. 2.5) but equal in 2000 (2.6 vs. 2.6)
- slightly more clear about their attitudes toward pregnancy in 1999 (2.6 vs. 2.5) but equal in 2000 (2.6 vs 2.6)
- equally comfortable saying no to sex until they are older in 1999 (2.5 vs. 2.5) but somewhat more likely in 2000 (2.6 vs. 2.4)
- equally clear that alcohol and drugs can influence decisions about sex in 1999 (2.4 vs. 2.4) and in 2000 (2.5 vs. 2.5)
- equally clear that decisions about sex can change their future in 1999 (2.7 vs. 2.7) and slightly clearer in 2000 (2.7 vs. 2.6)
- equally clear that their goals should not include a pregnancy in 1999 (2.7 vs. 2.7) and slightly higher in 2000 (2.7 vs. 2.6)
- equally knowledgeable about the cost of an unwanted pregnancy in 1999 (2.6 vs. 2.6) and somewhat less knowledgeable in 2000 (2.6 vs. 2.8)
- equally able to feel better about themselves in 2000 (2.5 vs 2.5)
- equally aware of their unique qualities in 2000 (2.4 vs. 2.4)
- equally confident about their decisions in 2000 (2.6 vs. 2.6)
- somewhat less likely to talk to their parents about sex in 1999 (2.0 vs. 2.3) and in 2000 (2.1 vs. 2.3)
- somewhat less comfortable asking questions about sex in 1999 (1.9 vs. 2.2) and in 2000 (1.9 vs. 2.2)
- somewhat less likely to be clear about the meaning of "No means No" in 1999 (2.5 vs. 2.6) and in 2000 (2.4 vs. 2.6)
- somewhat less knowledgeable about body changes during puberty in 1999 (2.3 vs. 2.7) and in 2000 (2.2 vs. 2.6)
- somewhat less knowledgeable about the dangers of STD's and AIDS in 1999 (2.4 vs. 2.6) and equal in 2000 (2.5 vs. 2.5)
- slightly less knowledgeable about the consequences of having a baby as a teen in 1999 (2.6 vs. 2.7) and slightly more knowledgeable in 2000 (2.7 vs. 2.6)
- somewhat less sure that they had more skills to resist pressure to have sex in 1999 (2.3 vs. 2.5) and equal in 2000 (2.5 vs. 2.5)
- somewhat less likely to think that they do not need a boy/girlfriend in 1999 (2.1 vs. 2.6) and equal in 2000 (2.2 vs. 2.2).

A disturbing finding among the abstinence-only grantees were the number of youth who reported that they had not waited until marriage to have sex because of force or threats. Among the sites, 30 students in 1999 and 16 students in 2000 reported that they had sex because they were forced to, while 19 students in 1999 and 13 students in 2000 had sex because they were threatened.

Finally, the parent survey used in one site in 1999 was of some interest because it showed the large majority of parents of the junior high youth were not abstinent until marriage (the average difference from first intercourse to first marriage was 3.3 years). Fully 75% of the parents had had sex before high school graduation. When asked their beliefs about sex-education and abstinence (using 16 items developed by the researchers), the top rated item was "I want my child to know about protection from AIDS." The second highest scored item among the 16 items was "Programs which teach abstinence in schools are valuable."

Conclusion

Caution must be exercised in interpreting the data since factors such as age of the students, length of the program, and program content varied widely among both sets of grantees (abstinence-only and comprehensive). None of these factors were controlled in the first year analysis. In addition, statistical comparisons were not made between abstinence-only and comprehensive programs because of unequal group sizes among programs.

In both years, the abstinence-only programs have shown some changes in attitudes and intentions as a result of students' participation. Differences in responses by age and grade show that males and older teens are less inclined to favor abstinence overall, but change scores indicate that all groups experience a similar amount of gain from the educational programs.

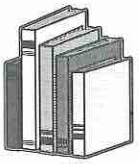
Given the findings regarding the number of youth who had forced or threatened sexual experiences, it is imperative to differentiate between sexual victimization and sexual activity, and to be sure that youth are not shamed for circumstances which are beyond their control. This must be an explicit message of both the abstinence-only and comprehensive program sponsors.

The results of the first year evaluation also highlighted some problems in wording on the questionnaires: for example, "having sex" was clarified in the second year to "sexual intercourse." Also, "postpone sex" was discontinued in favor of "wait to have sex."

Differences in outcomes between the abstinence-only and comprehensive programs varied somewhat between the two years. Those findings which were consistent for both years suggest that comprehensive programs seem to provide more factual information about students' bodies and more skills to resist peer pressure, including a better understanding of "No means No." Students in the comprehensive programs also report higher rates of talking to a parent or guardian and other adults about sexuality than those in the abstinence programs. Abstinence-only programs showed higher scores in 2000 on several questions regarding attitudes toward pregnancy, postponing sex, and setting other goals. Results from the current year's programs will indicate whether these are longer term trends.

The findings of the parental survey in one abstinence-only site suggest that parents value a range of messages which are designed to promote abstinence while giving students sufficient information to protect themselves, especially from the deadly disease of AIDS.

Resource Review



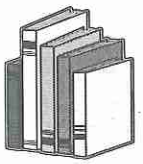
by: Darcy Andres, Graduate Intern, Judy McRoberts, Research Associate, & Pam Noel, Research Associate

National Research Council and Institute of Medicine (2000) *From Neurons to Neighborhoods: the Science of Early Childhood Development.* Committee on Integrating the Science of Early Childhood Development. Jack P. Shonkoff and Deborah A. Phillips, eds. Board on Children, Youth, and Families, Commission on Behavioral and Social Sciences and Education. Washington, D.C.: National Academy Press.

From Neurons to Neighborhoods is the end product of a two-and-one-half year effort by the above named committee as well as a host of others. This is truly an interdisciplinary effort. It is thorough, precise, and technical, while at the same time readable and practical. The work makes a valiant effort at closing the loop on assuring the best for children in their early years by the way it moves from foundation to recommendations. From Neurons to Neighborhoods starts laying down an excellent foundation of understanding through addressing the debate over nature versus nurture. It moves on to describe and explain causal relationships and the method by which the child moves from total dependence to acquiring self-regulation and the abilities to communicate and learn. The work also addresses the larger issues of peer relationships, the effect of family resources on child development, childcare, and neighborhoods. The report closes by suggesting a series of recommendations for change in the manner, method, and policies related to the care and treatment of children in their early years.

Kluger, Miriam P., Gina Alexander, and Patrick A. Curtis, eds. (2000). What Works in Child Welfare. Washington, DC: CWLA Pres. ISBN 0-87868-743-2.

This new publication of the Child Welfare League of America provides a clear and readable overview of recent research findings in many areas of child welfare practice. Findings are presented in brief articles by a number of authors who are well-known in their respective fields. Topics covered include: family preservation and family support, child protective services, out-of-home care, adoption services, child care, and services for adolescents. Several articles address specific service areas within each topic, such as permanency planning, open adoption, and adoption assistance under the topic of adoption. The articles detail a sample of recent research in that area and the findings of that research, as well as cost effectiveness information wherever it is available. An emphasis is placed on reporting those findings that show what works in the service area, but lack of progress is also noted when applicable. The text is supplemented with numerous helpful charts, and a brief summary of each research project reported is provided at the end of each article. Though readers looking for comprehensive reviews of research will not find such a level of detail in What Works in Child Welfare, the book is most useful as a survey of successful practices in child welfare for those new to the field and provides those more familiar with an update on recent trends and research.



Neff, Michael A. (2000). Permanency Planning, ASFA, and Best Practices: A Handbook for Caseworkers. New York: Michael A. Neff, P.C.

This handbook, written by an attorney with 25 years of experience in child welfare law, is a useful primer for child welfare caseworkers dealing with permanency planning. Michael Neff covers a number of issues related to permanency and the Adoption and Safe Families Act, including concurrent planning, processing information, components of planning, promoting change, service plan review, terminating parental rights, reunification, and the caseworker-attorney partnership. The book offers a comprehensive overview of the process of working with clients, gathering information, and preparing to make permanency decisions. Frequent references to legal requirements and explanations of the legal process are interwoven into each section and make this a particularly helpful reference for workers as they navigate the legal system. Helpful hints are offered on documentation of cases, preparation for hearings, and providing testimony. In addition, the author provides sample documents and an explanation of the successful New York Model Court project, which illustrates how ASFA principles can be used to facilitate the permanency process from initiation to conclusion.

Clark, Hewitt B., & Davis, Maryann. Transition to Adulthood: A Resource for Assisting Young People with Emotional or Behavioral Difficulties

Transition to Adulthood is an excellent resource for anyone involved in the lives of youth with emotional or behavioral difficulties. It uses a very humanistic approach to educate and enlighten the reader on a variety of issues pertinent to orchestrating the services necessary to help these youth move toward independent, more productive lives. Professionals will find many practical methods that they can incorporate into their own work with youth, for dealing with issues such as drug and alcohol use, peer and family relationships, anger and impulse control, low educational achievement and aspiration, homelessness, and unemployment. Administrators will find useful information on system development, policy and fundraising that they can apply to their own settings. Although, this book is geared more toward the professional, parents will also find the material helpful. The material is presented in such a way as to help the families of these youth feel supported and encouraged in their efforts to help their youth make a successful transition from childhood to adulthood.

Family Development Specialist Training

Family development is a model of family-based intervention designed to support and empower families. Work is done collaboratively with families to identify:

- the **family's** goals
- the strengths/challenges to reaching these goals
- realistic means for achieving them

For years, programs across the nation have struggled with how to help low-income families achieve economic independence and move toward self-sufficiency. Legislation and state policy make it even more critical to provide timely services that capitalize on family strengths and minimize the barriers.

Family development embraces the philosophy that all families have strengths. These strengths must be integrated into attainable family goals.

Training provided by the National Resource Center for Family Centered Practice develops the ability of many groups, i.e., Community Action, Head Start, JOBS programs, county extension, teachers, human service workers, community health nurses, and family support workers to provide family centered practice.

Family development training is not static. Every year new revisions are made to the curriculum based on what participants need and innovations in the field. Currently, we are revising our family centered assessment tools CD ROM, a resource tool for participants to a web-based training that will include self-evaluation and more exercises. Participants have really enjoyed taking the certification test at the end of the training on-line. Test scores are received immediately and participants can test on their own schedule.

Agencies may either contract with the National Resource Center for a training at their site or participants may join a class that is set up in their area. Classes have been held all over the nation. Please call for a schedule.

For further information on Family Development Training Programs contact:

National Resource Center for Family Centered Practice
University of Iowa, School of Social Work
100 Oakdale Campus, Rm. W206 OH
Iowa City, IA 52242-5000
Telephone: (319) 335-4965
FAX: (319) 335-4964
Web site: www.uiowa.edu/~nrcfcp

Field Seminar on Understanding and Valuing The Mexican Immigrant/Guest Worker

Patzcuaro, Mexico
July 24-31, 2001

The Field Seminar on Understanding and Valuing the Mexican Immigrant/Guest Worker is an opportunity to increase your understanding and appreciation of the Mexican immigrant/guest worker. The seminar to Mexico explores how the global socio-political economy impacts on family and community systems in countries like Mexico. There will be a special emphasis on Latino/Hispanic immigration to the United States and understanding and appreciating the Mexican immigrant/guest worker.

A combination of seminar style classes, guest speakers, and field visits are employed in the investigation of the effects of global macro forces over individual family systems in rural Mexico. The seminar concurrently looks at the impact of modernization of the Mexican economy on the poor and whether economic alternatives would foster greater social justice. The seminar participants will have one-on-one contact with selected Mexican families, social service agencies, and Mexican social workers.

Sponsored by The University of Iowa School of Social Work (website: www.uiowa.edu/~socialwk). The School of Social Work is an Iowa Board of Social Work Examiners approved provider #0034. This program is approved for 64 hours of continuing social work education.

For more information contact: Kate Kemp by phone at (319)335-1254, or email: kate-kemp@uiowa.edu

Save the Dates

National Resource Center for Family Centered Practice
Fourth National Training Institute

"Powering Up"
Strengthening Families, Communities, and Their Helpers

Embassy Suites Deerfield Beach Resort
October 10-12, 2001
Deerfield Beach, Florida

suites@embassyflorida.com

The ***Fourth National Training Institute*** is an opportunity for volunteers, front line workers, supervisors, and administrators involved in services for children and families to expand their skills in the areas of strength-based family centered practice. Participants will have their choice of one-, two-, or three-day sessions that focus on a variety of specialized topics. Sessions are designed to meet the needs of staff in the areas of child welfare, community action (including Head Start, Healthy Start, Even Start, Welfare to Work), private and public mental health, juvenile justice, and school based services. A special emphasis will be placed on practice, supervisory, and management skills needed to facilitate successful family outcomes.

Institutes will feature content on:

- ✧Empowering Teen Parents Through Self-Assessment
- ✧Family Centered Supervision
- ✧Coalition Building and Working With Boards and Committees
- ✧Family Centered Assessment
- ✧Solution-Focused Case Management
- ✧Family Group Conferencing
- ✧Beyond Family Development
- ✧The Role of Faith in Family Centered Practice
- ✧Stress-Free Outcomes and Evaluation
- ✧Safety, Reunification and Adoption
- ✧Mentoring
- ✧Crisis Management and Stress
- ✧Maximizing Worker Potential
- ✧Program Development
- ✧Outcome-Based Case Management
- ✧Mediation

Deerfield Beach Resort

(Information taken directly from The Embassy Suites Florida website).

Located in the heart of the sunny Gold Coast of South Florida one mile south of Boca Raton in Greater Fort Lauderdale, the Embassy Suites Deerfield Beach Resort offers 244 luxury oversized two room, two bath suites, each over 840 sq. ft.

Accommodations

Every suite offers a separate living room with sofa bed, armchair, remote control color TV with VCR, cable and in-room movies, dual-line telephone with modem hook-up and call waiting, refrigerator, wet bar, microwave, coffee maker with free coffee, hair dryer, iron and ironing board, and a well-lit dining/work table. The private bedroom features a king size or two double beds, a two-line telephone with modem, and remote control TV with VCR, two marble baths and breathtaking coastal views. Complimentary, full cooked-to-order breakfast served each morning in the sunlit Antigua Room. Complimentary, two-hour Manager's Reception each evening with your choice of beverages. Subject to state and local law.

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The 190-seat Cagney's Crabhouse features a variety of traditional fare with fresh South Florida seafood. Cagney's Lounge, seating 80 people, features a piano bar and is the ideal spot to unwind with your favorite cocktail.

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Hotel cost: $139/night--single or double occupancy. For reservations, contact the hotel directly. Be sure to mention *"National Resource Center Conference"* to receive the special rates.

The Embassy Suites
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950 SE 20th Avenue, (A1A)
Deerfield Beach, FL 33441
suites@embassyflorida.com
1-800-EMBASSY-----(954) 426-0478
FAX 954-360-0539

Training Institute Cost:
$350.00 for three days of training; $275.00 for two days of training; $150 for a single day of training paid on or before September 4, 2001. If paying after September 4, add a $25.00 charge to your registration. Lunch will be provided each day.

For more information, or to be placed on our mailing list for a registration brochure when they are available, please contact the National Resource Center:

100 Oakdale Campus, W206 OH
Iowa City, IA 52242-5000
Phone: (319) 335-4965
FAX (319) 335-4964
email: kimberly-nissen@uiowa.edu
Website: www.uiowa.edu/~nrcfcp

Materials available from the National Resource Center for Family Centered Practice

PRINTED MATERIALS

AUTOMATED ASSESSMENT OF FAMILY PROGRESS (1998-2000) $7.00
The Automated Assessment of Family Progress (1998-2000) documents the results from the use of the instrument over three years in Community Action Agencies throughout the state of Iowa. The AAFP instrument and procedures are contained in the booklet describing how the instrument serves as both a case management and outcome measures tool. Analyses include a needs assessment based on initial appearances by families across the state, and documents progress with families receiving ongoing services.

BEYOND THE BUZZWORDS: KEY PRINCIPLES IN EFFECTIVE FRONTLINE PRACTICE (1994) $4.00
This paper, by leading advocates and practitioners of family centered services, examines the practice literature across relevant disciplines, to define and explain the core principles of family centered practice.

CHARTING A COURSE: ASSESSING A COMMUNITY'S STRENGTHS AND NEEDS (1993) $4.00
This resource brief from the National Center for Service Integration addresses the basic components of an effective community assessment.

CHILDREN, FAMILIES, AND COMMUNITIES—A NEW APPROACH TO SOCIAL SERVICES (1994) $8.00
This publication from the Chapin Hall Center for Children presents a framework for community-based service systems that includes and builds upon community networks of support, community institutions, and more formal service providers.

CHILDREN, FAMILIES, AND COMMUNITIES: EARLY LESSONS FROM A NEW APPROACH TO SOCIAL SERVICES (1995) $5.00
This is a street level view of the experience of implementing a system of comprehensive community-based services. Another report in a series on the Chicago Community Trust demonstration.

CHRONIC NEGLECT IN PERSPECTIVE: A STUDY OF CHRONICALLY NEGLECTING FAMILIES IN A LARGE METROPOLITAN COUNTY
EXECUTIVE SUMMARY (1990) $1.00
FINAL REPORT (1990) $18.00
A research study examining three groups of families referred for child neglect: chronic neglect, new neglect, and unconfirmed neglect. The report presents descriptive data about these groups of families, changes over time and differences between the three groups. The study was conducted in Allegheny County, PA, and funded by OHDS and the Vira I. Heinz Endowment.

COMMUNITY RESPONSE TO HOMELESSNESS: EVALUATION OF THE HACAP TRANSITIONAL HOUSING PROGRAM
EXECUTIVE SUMMARY (1996) $2.00
FINAL REPORT (1996) $9.50
An evaluation of a HUD-funded demonstration project of the Hawkeye Area Community Action Program (1990-1995). This project provided transitional housing and supportive services for homeless families with the objectives of achieving housing stability and economic self-sufficiency. Data include background information from participants obtained through structured interviews, and self-sufficiency measures at intake, termination, and six month follow-up to evaluate progress in housing, job, education, and income stability.

COMMUNITY SOCIAL WORK: A PARADIGM FOR CHANGE (1988) $9.00
This book is a collective product of a work group in Great Britain set up to articulate core characteristics of community social work.

COST EFFECTIVENESS OF FAMILY-BASED SERVICES (1995) $3.50
This paper describes the data and cost calculation methods used to determine cost effectiveness in a study of three family preservation programs.

CROSS SITE EVALUATION OF IOWA'S PREGNANCY PREVENTION, INTERVENTION, AND COMMUNITY PROGRAM
EXECUTIVE SUMMARY (2000) $2.00
FINAL REPORT (2000) $14.00
This report covers the first year of the second round of funding for a comprehensive community-based pregnancy prevention initiative funded by the Iowa Department of Human Services. The program involves 13 sites and a wide variety of primary and secondary prevention approaches, as well as integrated community models.

DEVELOPING LINKAGES BETWEEN FAMILY SUPPORT & FAMILY PRESERVATION SERVICES: A BRIEFING PAPER FOR PLANNERS, PROVIDERS, AND PRACTITIONERS (1994) $2.50
This working paper explores the connections in policy, program design, and practice needed to enhance the chances for success of linked programs.

EMPOWERING FAMILIES: PAPERS FROM THE FIFTH ANNUAL CONFERENCE ON FAMILY-BASED SERVICES (1991) $6.00
A collection representing the third published proceedings from the annual Empowering Families Conference sponsored by the National Association for Family Based Services. There are five major sections: Training and Education, Research, Practice Issues, Program and Practice Issues, and Program and Policy Issues.

EMPOWERING FAMILIES: PAPERS FROM THE SIXTH ANNUAL CONFERENCE ON FAMILY-BASED SERVICES (1992) $6.00
A collection representing the fourth published proceedings from the annual Empowering Families Conference sponsored by the National Association for Family Based Services. Major sections address Diversity, Research, and Expansion in family-based services.

EMPOWERING FAMILIES: PAPERS FROM THE SEVENTH ANNUAL CONFERENCE ON FAMILY-BASED SERVICES (1993) $6.00
This is the latest collection of papers from the NAFBS conference in Ft. Lauderdale. Chapters address family empowerment and systems change, child protection and family preservation, determining outcomes for community-based services, and wraparound services for SED youth.

EMPOWERING FAMILIES: PAPERS FROM THE EIGHTH ANNUAL CONFERENCE ON FAMILY-BASED SERVICES (1994) $6.00
This collection presents the best from the national conference. Key issues include reunification practice, family-centered residential treatment, culture and therapy, and a variety of research and evaluation issues.

EMPOWERING FAMILIES: PAPERS FROM THE NINTH ANNUAL CONFERENCE ON FAMILY-BASED SERVICES (1995) $6.00
This is the seventh published proceeding from the annual Empowering Families Conference sponsored by the National Association for Family Based Services. Major sections address practice issues, program development, education and training, theory, and research and program evaluation.

EMPOWERMENT EVALUATION: KNOWLEDGE AND TOOLS FOR SELF-ASSESSMENT AND ACCOUNTABILITY (1996) $27.00
This volume derives from a conference of the American Evaluation Association. It addresses the concepts, methods, and tools needed to integrate evaluation into the everyday practices of running programs.

EVALUATING FAMILY BASED SERVICES (1995) $35.00
Major researchers in the field of family based services contribute chapters on all aspects of the evaluation process appropriate to a variety of program models.

EVALUATION OF ABSTINENCE ONLY EDUCATION (2000) $6.00
This report covers the second year of an abstinence-only pregnancy prevention education initiative. The program involves 4 sites in Iowa and several abstinence curricula. The report includes a comparison with Iowa's comprehensive pregnancy prevention initiative.

FAMILY-BASED SERVICES FOR JUVENILE OFFENDERS (1990) $1.00
An analysis of family characteristics, service characteristics, and case outcomes of families referred for status offenses or juvenile delinquency in eight family-based placement prevention programs. In *Children and Youth Services*, Vol. 12, No. 3, 1990.

FAMILY-CENTERED SERVICES: A HANDBOOK FOR PRACTITIONERS (1994) $18.00
This completely revised edition of the *Practitioners Handbook* addresses core issues in family centered practice, from assessment through terminating services. Also included are a series of chapters on various topics such as neglect, substance abuse, sexual abuse, and others.

FAMILY FUNCTIONING OF NEGLECTFUL FAMILIES: FAMILY ASSESSMENT MANUAL (1994) $6.00
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FAMILY FUNCTIONING OF NEGLECTFUL FAMILIES: FINAL REPORT (1994) $9.50
Final report from NCCAN-funded research study on family functioning and child neglect, conducted by the NRC/FBS in collaboration with the Northwest Indian Child Welfare Association. The study is based on structured interviews with neglecting and comparison families in Indian and non-Indian samples in two states.

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GUIDE FOR PLANNING: MAKING STRATEGIC USE OF THE FAMILY PRESERVATION AND SUPPORT SERVICES PROGRAM (1994) $8.00
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HEAD START OUTCOMES FOR HOMELESS FAMILIES & CHILDREN: EVALUATION OF THE HACAP HOMELESS HEAD START DEMONSTRATION PROJECT (1996) $7.00
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HOME-BASED SERVICES FOR TROUBLED CHILDREN (1995) $35.00
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IOWA MEDIATION FOR PERMANENCY REPORT: FINAL REPORT (2000) $12.00
This report describes a three-year federally funded demonstration project, which sought to implement a non-adversarial approach to resolving permanency for children involved with the Iowa Department of Human Services.

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Report of an experimental research study testing the effect of length of service on case outcomes and cost-effectiveness in three family based treatment programs.

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This monograph examines opportunities for family support in child care settings.

MAKING A DIFFERENCE: MOVING TO OUTCOME BASED ACCOUNTABILITY FOR COMPREHENSIVE SERVICE REFORMS (1994) $4.00
This resource brief from the National Center for Service Integration presents the basic components of a program level outcomes based accountability system.

MAKING IT SIMPLER: STREAMLINING INTAKE AND ELIGIBILITY SYSTEMS (1993) $4.00
This working paper from the National Center for Service Integration outlines a process for integrating intake and eligibility systems across agencies.

MANAGING CHANGE THROUGH INNOVATION: TOWARDS A MODEL FOR DEVELOPING AND REFORMING SOCIAL WORK PRACTICE AND SOCIAL SERVICE DELIVERY (1992) $9.00
This manual treats the dynamics of the change process in a variety of settings.

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This brief manual provides an overview of the multisystemic approach to treating serious antisocial behavior in adolescents and their multineed families. Dr. Henggeler outlines the focus of the approach on the family, the youth's peer group, the schools, and the individual youth, along with the structure of the family preservation program, and the research which documents the program's effectiveness.

NEW APPROACHES TO EVALUATING COMMUNITY INITIATIVES: CONCEPTS, METHODS, AND CONTEXTS (1995) $12.00
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This report describes the Permanency for Teens Project, a demonstration project funded by DHHS Adoption Opportunities Program from 1995-1998 and conducted by the Iowa Department of Human Services and Four Oaks, Inc. The project sought to achieve permanency for teens in Iowa who were legally freed for adoption. The final report includes a description of the program model, lessons learned from implementation, and findings from the external evaluation conducted by NRCFCP.

PREVENTING CHILD ABUSE AND NEGLECT THROUGH PARENT EDUCATION (1997) $25.95
Based on research of 25 parenting programs, this volume outlines how to develop and evaluate parent education programming to help prevent child maltreatment.

PUBLIC-PRIVATE PROVISION OF FAMILY-BASED SERVICES: RESEARCH FINDINGS (1989) $1.00
A paper presented at the NAFBS Third Annual Empowering Families Conference (Charlotte, NC) discussing research findings on differences between family-based services provided by public and private providers.

QUALITY IMPROVEMENT AND EVALUATION IN CHILD AND FAMILY SERVICES: MANAGING INTO THE NEXT CENTURY (1996) $23.00
This handbook describes how agency executives can address the changing world of services for children and families by practically applying quality improvement theory to assess and improve programs and services.

RACIAL INEQUALITY AND CHILD NEGLECT: FINDINGS IN A METROPOLITAN AREA (1993) $1.00
Despite contradictory evidence, child neglect is believed to occur with greater frequency among African-Americans for a variety of reasons. This article describes racial differences among 182 families referred for neglect in a large metropolitan area.

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This working paper positions the progressive children and family services reform agenda within a complex welter of change, and it poses a provocative answer to the question: "Where do we go from here?"

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This collection of articles explores aspects of the move towards a community-based service system. The book explores social work, economic development, school-linked services, and community policing. Crossing these different service sectors is a common understanding of community and family-centered practice.

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REPARE created a family based approach to residential treatment characterized by reduced length of stay, integration of family preservation and family support principles, and community based aftercare services to expedite permanency. The Final Report describes the conceptual approach and project design, lessons learned from implementation, and evaluation results (including instruments). [Funded by ACYF, Grant #90CW1072.]

RISING ABOVE GANGS AND DRUGS: HOW TO START A COMMUNITY RECLAMATION PROJECT (1990) $2.50
This is a how-to manual for building and sustaining a community collaboration focused on youth issues.

THE SELF-SUFFICIENCY PROJECT: FINAL REPORT (1992) $6.00
Final evaluation report of a federally-funded demonstration project in rural Oregon serving families experiencing recurring neglect. Includes background and description of project, findings from group and single subject analyses, and evaluation instruments. (See *The Self-Sufficiency Project: Practice Manual* below.)

THE SELF-SUFFICIENCY PROJECT: PRACTICE MANUAL (1992) $3.75
This manual describes a treatment program for working with families experiencing recurring neglect, based on a federally-funded demonstration project in rural Oregon. Includes project philosophy and design, staffing, discussion, and descriptive case studies (See *The Self-Sufficiency Project: Final Report* above.)

SOURCEBOOK: ANNOTATED RESOURCES FOR FAMILY BASED SERVICE PRACTICE: 4th Edition (1993) $6.00
Descriptions and ordering information for selected resources on: family therapy, FBS theory and practice, research and evaluation, legal issues, family-based services management, and training. Lists FBS service associations and program directories. Includes many unpublished materials prepared by social service departments, not generally available in libraries, which can be ordered from those agencies.

STRENGTHENING FAMILIES & NEIGHBORHOODS: A COMMUNITY-CENTERED APPROACH (1995) $9.50
This is the final report of the "Patch" demonstration project, a model for community-centered social work practice that is now generating national attention.

STRENGTHENING HIGH-RISK FAMILIES (A HANDBOOK FOR PRACTITIONERS); Authors: Lisa Kaplan and Judith L. Girard (1994) $40.00
This accessible handbook on family-centered practice addresses the range of issues to be considered in working with high-risk families. Practice strategies are set within the context of the development of family preservation services.

THREE MODELS OF FAMILY-CENTERED PLACEMENT PREVENTION SERVICES (1990) $1.00
An analysis that defines and compares family-centered services by identifying three models whose primary goal is tertiary prevention, the prevention of out-of-home placement of children from seriously troubled families, or reunification once placement has occurred. Also examines data from 11 family-centered placement prevention programs that further specifies and compares these models. Reprinted with permission from *Child Welfare*, Vol. LXIX: No. 1, (Jan/Feb 1990).

TRAINING MANUAL FOR FOSTER PARENTS (1990) $14.50
Created by Dr. Patricia Minuchin at Family Studies in New York, the manual includes a theoretical section describing the rationale, goals, themes and skills, and a training section that describes eight sessions. The activities of the sessions are experiential, including role playing, small groups, simulated cases, and discussions. The sessions are focused on understanding families and on exploring attitudes about families, on the skills of making and keeping contact with biological families, and on the liaison between foster parents and professional workers as they function in the foster care network.

WHO SHOULD KNOW WHAT? CONFIDENTIALITY AND INFORMATION SHARING IN SERVICE INTEGRATION (1993) $4.00
Analyzes issues pertaining to confidentiality in collaborative projects. The paper includes a checklist of key questions.

WISE COUNSEL: REDEFINING THE ROLE OF CONSUMERS, PROFESSIONALS, AND COMMUNITY WORKERS IN THE HELPING PROCESS; RESOURCE BRIEF #8 (1998) $8.00
This collection of readings examines the need for and benefit of changing relationships between professionals, community workers and consumer needs to implement true system reform and improve results.

AUDIOVISUAL MATERIALS

CIRCULARITY AND SEQUENCES OF BEHAVIOR (1992) $30.00
This 30-minute training videotape describes the family systems concepts of circularity and sequences of behavior, and then demonstrates how the concepts are utilized in a child protection interview with a family where inadequate supervision of young children is an issue. Useful for training family-centered practitioners in any human services program.

FAMILY-BASED SERVICES: A SPECIAL PRESENTATION (1990) $55.00
Videotape: 24 minutes. A lively introduction to the history, philosophy, and practice of family-based services featuring interviews with policy-makers, agency administrators, family-based service workers and families who have received services. For use by advocacy and civic groups, boards of directors, legislators and social service workers. A video guide accompanies the taped presentation.

This catalog/order form can also be accessed on our website: www.uiowa.edu/~nrcfcp. Orders can be placed online as well.

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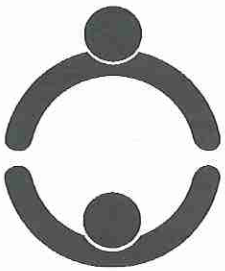

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