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Developing and Implementing Outcomes Training in the Field of Family Support: A Case Example

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Introduction

The development of family-focused prevention-oriented programs throughout the United States has surged during the past decade, primarily through the support of federal funding (Omnibus Budget Reconciliation Act of 1993, P.L. 103-66). These locally based efforts are often referred to as "family support programs" or "family resource centers" (North Carolina Division of Social Services, 2003). The programs attempt to address unique and evolving needs of individuals and families from diverse communities from a strengths perspective. In order to meet these needs, these programs and centers increasingly request additional training and technical assistance in program development or treatment areas, information management, and evaluation (Scales, 1997).

In North Carolina, the state Department of Health and Human Services (DHHS) contracted with a university to provide program development assistance and a web-based data entry system to be used by local family support and family resource center (FS/FRC) providers and state DHHS staff beginning in the mid-1990s (North Carolina Department of Human Resources, 1996). Over time, the needs of the both the state DHHS staff and local providers converged to focus on developing and refining outcomes for individuals and families served by FS/FRC programs, automating these outcomes and their related definitions, and linking individual program goals and objectives to outcomes. This article reports on this development process in the state of North Carolina. In addition, the development and delivery of training pertaining to these needs for local FS/FRC providers and state DHHS staff is discussed, including evaluation results of the training. Finally, a summary of next steps and continued training needs for North Carolina's FS/FRC Program and for the field of family support is provided.

Background

Many definitions exist for programs referred to as "family support" or "family resource centers." Comer and Fraser (1998) define family support programs, saying, Rooted more in prevention than in remediation, they focus on family participation and empowerment through joint decision making between the family and service providers. That is, family members determine the nature of the services that they are to receive. In the lexicon of traditional social services, family members are less "clients" than they are "consumers" of services (p. 134).

The roots of family support can be traced over the past 100 years. The concept often is attributed to the settlement house movement in the postindustrial era (Addams, 1960). In addition, parent education classes and the War on Poverty provided the impetus to the growth of family support (Manalo & Meezan, 2000). By the late 1970s, various theories also established the foundation for family support. These included:

(a) Bronfenbrenner's (1979) ecological theory of human development, which states that families must be viewed as entities that can react to environmental stress.

(b) Principles of primary prevention that stress

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building strength and coping resources through use of education and equipping people with environmental and personal resources rather than dealing with problems after they occur (Fraser, 1997).

These theories and movements contributed to the philosophy underlying family support by emphasizing that all segments of the society and community must support families as they rear their children and that the well being of all families is the corner stone of a healthy society. One type of support that families need in raising children is information and education. Thus, family support services empower families by providing them access to information (Manalo & Meezan, 2000). The services are focused on the family as a whole (Manalo & Meezan). Emphasis is placed on identifying, enhancing and respecting family strengths, and services must be community based and flexible to address emerging family and community issues (Manalo & Meezan).

Thousands of communities around the country have initiated family support and education programs in the past 30 years. State governments began to consider their role in the creation and funding of family support and education programs by the 1980s (Weiss, 1989). Minnesota was the first state to implement a statewide early childhood and family education program in 1984, followed by Missouri, Maryland, Hawaii, Illinois and Kentucky (Weiss). In Missouri and Minnesota, the programs were initiated under the Department of Education and placed emphasis on strengthening the child's early learning environment. In contrast, the Department of Social Services in Maryland and Connecticut initiated family support and stressed the importance of strengthening the family early as a way to prevent child and family dysfunction later (Weiss). In addition to these initiatives, numerous other states began family support following federal funding (Manalo & Meezan, 2000).

North Carolina Family Support Efforts

In North Carolina, in order to initiate the development of community-based family support and family resource center programs, DHHS contracted with the School of Social Work at the University of North Carolina Chapel Hill (UNC-CH) to conduct a comprehensive survey of gaps in preventive services across the state (North Carolina Department of Human Resources, 1996). Based on this survey, individual communities developed and submitted grant proposals to the state DHHS to create family support and family resource center programs. A few years later, the UNC-CH School of Social Work developed a web-based management information system that was designed primarily to provide the state DHHS with information to manage the statewide program, and to provide simple evaluative information to the state legislature (North Carolina Department of Human Resources).

One of the primary components of the FS/FRC Management Information System was an assessment tool known as the North Carolina Family Support Outcome Scales (NCFSOS). These scales had been developed from the North Carolina's Family Assessment Scale for use with the state Intensive Family Preservation Services (Reed-Ashcraft, Kirk, & Fraser, 2001). Local FS/FRC staff collaborated with DHHS staff in adapting the scale for use by providers. Definitions were not developed for individual items or domains in order to allow for maximum flexibility among individual workers as they rated families in activities such as parenting skills workshops, GED classes, and pre-kindergarten classes. Using the NCFSOS, FS/FRC staff rate individual families at intake when their participation in an activity begins, and at closing, when their participation concludes in that activity.

By 2000, state DHHS staff wanted to enhance the management information system (MIS) in order to make it more useful to local FS/FRC providers, and both state DHHS staff and local FS/FRC providers wanted to enhance consistency in the use of the NCFSOS across workers and local sites. The state DHHS staff contracted with staff at Appalachian State University's Bachelor's of Social

Work Program to enhance and manage the MIS. By the end of 2002, local FS/FRC providers, state DHHS staff and the Appalachian project team were interested in developing definitions for the NCFSOS in order to increase the reliability of ratings across workers. While formal reliability testing was not planned, developing and using the same definitions for items and subscales across different workers would increase the reliability of the tool.

After reviewing similar assessment tools including the Family Risk Scales (Magura, Moses, & Jones, 1987), and the Family Assessment Form (McCroskey & Meezan, 1997), Appalachian's project team developed a set of definitions for each of the subscales and for each item. The revised NCFSOS included the following subscales: Overall Child Functioning, Overall Parent Functioning, Overall Family Functioning, Overall Individual Functioning, and Family's Relationship to the Community.

The scales were reduced from 10 possible responses per item to five responses, ranging from *1, Weak Strength* to *5, Solid Strength.* Following the revisions, the new scale and definitions were distributed to seven FS/FRC providers for a field test. Following the field test, the scale and definitions were distributed to all of the FS/FRC programs for their review. After incorporating feedback, the revised NCFSOS and accompanying definitions were programmed into the existing MIS, and a field test was conducted at a local FS/FRC site.

Development of the Training Workshop for North Carolina's Family Support/Family Resource Center Program

Recognizing the variety of outcomes inherent in family support programs nationally, and within North Carolina, the Appalachian project team thought that it was important to develop an outcomes' training workshop. The primary goal of the workshop would be to allow face-to-face discussion of outcomes and the use of different outcomes with different families among FS/FRC providers, state DHHS staff, and Appalachian project team members. The team decided to develop a comprehensive training workshop to accomplish this goal. The team developed three training components, and assigned one component to each team member. Because FS/FRC staffs frequently include persons from diverse educational and professional backgrounds, including social workers and paraprofessionals who are former recipients of FS/FRC services, the training workshop needed to be flexible enough to meet all of the participants' needs. Thus, time for ample discussion among participants was considered integral to each component.

In developing the actual training, the team first decided that the training participants should have a chance to use the new definitions and revised scale and to participate in discussions regarding the use of the tool during the training. As a result, a number of case studies were created for participants to use as examples for scoring the scales. The case studies described different "typical" families that use FS/FRC services.

For the training, the new scale and definitions regarding client outcomes would be introduced to the participants. Then, the participants would break into small groups, and the groups would apply the new definitions and scale to the case studies, and discuss their use within their small groups. Once completed, the small groups then would reconvene into a larger group to share their discussions and decision-making processes. These discussions would include strengths and limitations of the outcomes, and the use of outcomes in different family support settings.

Second, a training component was designed to assist participants in understanding potential outcomes for local "activities" at the FS/FRC programs and to identify outcomes to track these activities. Further, this training component also was designed to assist FS/FRC programs to identify, select, and assess relevant outcomes for their particular activities since the FS/FRC programs would be "re-bidding" for state funding this year. In order

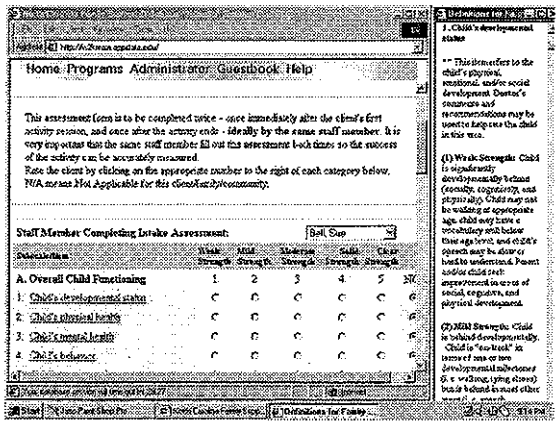
to accomplish these goals, an adapted logic model based on Alter and Egan's work (1997) was planned for use during an interactive discussion between the trainer and the participants. The trainer would explain the model, and facilitate the development of a logic model for a typical activity at a FS/FRC program with the training participants. In addition, the state staff wanted to include contract information with FS/FRC staff members. Thus, a state component also was added to the workshop agenda.

The third major component of the training dealt directly with the MIS, primarily the changes that had been made to the web-based system to accommodate the revised scale and new definitions. During this component, participants would be provided with hands-on experience working with the database system. Though it was not possible to have computers available at all of the workshops for all of the participants, individuals were selected at each workshop from the audience to navigate the system from a laptop that was projected onto a screen. There was technical instruction as well as technical assistance that would be provided during this component.

A primary benefit for the third component was that FS/FRC providers would have an easy and convenient way to print as many hard copies of the definitions as needed for new staff. Perhaps even more beneficial, the programming code was written to display contextual outcome scale definitions in a separate web browser window that is adjacent to the original web browser window. Staff members or "users," especially those with varying levels of computer skills and those who dislike referring to a lengthy printed document while engaging in computer data entry, would benefit from being able to refer to the definitions onscreen. Figure 1 illustrates one of the data screens associated with the new scale and definitions.

In addition to the three components, the project team is currently working on creating a video from the training sessions that will be attached to the database Website. This video will allow new staff members at various FS/FRC programs the opportunity to learn about the scale and the definitions as well as their use in tracking family-based outcomes.

Figure 1: Example of Scale and Definition in Browser Windows



Results

Three regional training workshops including the three training components were conducted in North Carolina from mid-May until June 2003. Verbal and survey feedback indicated positive responses to the trainings. The trainings included direct service providers and supervisors from FS/FRCs located throughout the state, state DHHS staff, and regional DHHS consultants. The first training was held in the Western region and included 23 participants, while the second training was held in the central Piedmont region and included 26 participants, and the final training was held in the Eastern region and included 52 participants. A total of 101 attendees participated in the three trainings.

During the training workshops, interactive discussions occurred between the project team and the training participants. The small groups highlighted some difficulties with the outcomes (i.e., is the

individual participant rated on certain items, or the entire family unit?). During the large group discussion, state DHHS staff and other groups provided guidance and feedback to these groups in response to these difficulties.

A training evaluation form was constructed and distributed at the conclusion of each training in order to indicate perceived strengths and weaknesses of the training according to the participants. The original evaluation form included 6 Likert-scaled questions, rated from a *1, Very Poor* to a *5, Very Good.* The questions ranged from "How would you rate the overall helpfulness of the training?" to "How would you rate Session I-Logic Models?" to "How would you rate the facilities/parking/food/time etc. for the training?" In addition, text space was provided under each question for narrative feedback, and a text space was provided at the end of the form for any additional comments from the participants.

Table 1: Results of Training Evaluation Forms

Question	N	M	SD
Rate Overall Helpfulness of Training	88	4.31	.70
Rate Session 1: Logic Models	17	3.94	.66
Rate Session II: Use of Definitions	87	4.24	.74
Rate Session III: Web-based System	83	4.24	.76
Rate Information From State DHHS	13	3.62	.77
Rate Facilities/Parking/Food/Time	84	4.39	.87

A total of 88 evaluation forms were returned, for an 87% response rate. Due to changes made following the first training, two questions were eliminated from the questionnaire, thus resulting in smaller sample sizes for these questions. In addition, a total of five forms were missing other responses. The findings for the other questions indicated that participants were positive about the training. Their ratings of the sections were between 4 good and 5 very good (Table 1).

Narrative feedback was also evaluated following the trainings. Positive feedback included "hands-on demonstrations were excellent," "trainers were very knowledgeable and very helpful," and "hand-outs were clear and understandable," while critical feedback included "[training was] too long," "need to have contract providers not day to day workers [present at the training]," and "need even more consistency [in uses of system across programs]." In addition, a number of participants included suggestions for web-based enhancements to the information system.

Due to the quantitative responses and the narrative feedback following the first training workshop, the logic model and state information components were eliminated to provide more time for the participants who were primarily direct service providers at the FS/FRCs. In addition, trainers and state DHHS staff are prioritizing the feedback from all three trainings regarding system enhancements.

Summary

Family-focused prevention programs have been developing throughout the United States as a means of preventive services on the local level with a focus on local needs. Arising from the philosophy underlying family support is the belief that all segments of society must support families and that the services must be focused on the family as a whole (Manalo & Meezan, 2000).

Following a survey by DHHS of local needs in North Carolina, local family support and family resource center programs were developed. To support these programs, a management information system (MIS) was developed for the purpose of providing information to DHHS and to the state legislature. Initially, flexibility was provided to individual workers in rating families, and, therefore, definitions were not developed. However, this limited the use of the MIS. Therefore, the North Carolina Family Support Outcome Scales were revised and definitions were developed for each subscale and item.

An outcomes-based training workshop that focused on the new definitions and the revised scale were developed and implemented by the

Appalachian State University project team that would meet the needs of both professional and paraprofessional staff of the FS/FRCs. Overall, the training workshops were well received by local FS/FRC staff. Many of the staff remarked that they would have liked such a workshop earlier in their program development efforts, and many said that they would like to continue to have similar, informative workshops.

As a result of feedback from the first workshop, training on the use of the logic model for identifying outcomes was dropped, as was the state information component. This enabled the trainers to provide more training time to the direct service providers.

Even so, both FS/FRC providers and state staff report that the model could be very useful if targeted to local FS/FRC program directors who often develop the grant proposals, and regional DHHS consultants who provide ongoing technical programmatic assistance to the programs. Discussions are currently underway to develop and implement such a workshop for the current fiscal year.

There were some limitations due to the evaluation design for the training. First, the evaluation form only was provided to participants after the training, resulting in a post-test only design. Second, comments about the training components were collected through text fields following each question. Thus, only narrative information volunteered by participants was collected anecdotally. An evaluation form administered at pre- and post-test, which includes quantitative questions related to the acquisition of specific types of knowledge would be a stronger design, and would enhance the information gained from the findings.

Nonetheless, there continues to be a desire among family support and family resource center staff in North Carolina and across the country for various training and staff development opportunities in the area of family support (Scales, 1997). However, with increasingly tight budgets, providing these opportunities is becoming a challenge for all states. Development of on-line training tools (i.e., the online NCFSOS and definitions, and the online training video) may be one option in creatively reaching new and existing staff across a large geographic area. It is important to note that this option may be most effective when conducting training in the area of management information systems rather than in other clinical program areas, and when some face-to-face training already has occurred. In addition to general training needs, there also is a great need across all family support/family resource center programs to try to develop some common outcomes to be expected from these diverse, prevention-oriented programs. Federal, state, and other funding sources are demanding a focus and articulation of family and community-based outcomes that can be expected from these programs. However, as Manalo and Meezan (2000) note, there are a number of difficulties in developing a set of outcomes given not only diverse programs, but also diverse goals and objectives within these programs. Thus, while the Appalachian project team, the state DHHS, and local FS/FRC providers are pleased with the development of common definitions and refinements to their primary outcome tool, all of the groups recognize that there is still work to be done in refining how and when to use the tool, and appropriate outcomes to be expected from other types of FS/FRC activities. In sum, like the evolution of the field of family support, these issues will most likely be addressed incrementally over time by North Carolina as well as other states and localities that continue to be on

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