

Statewide Implementation of an Intervention Program: Comprehensive Home-Based Services

Catalina Herrerías, MSW, Ph.D. *, Associate Professor,
Department of Human Relations
University of Oklahoma

J. A. Jones, M.A., Program Field Representative
Children and Family Services Division
Oklahoma Department of Human Services

This article discusses the process, structure, and outcome of an innovative intervention program implemented on a statewide basis in the south central United States. Findings from the first-year program audits are presented. Evaluation findings from an independent evaluation team are shared, as well as programmatic changes made over the course of the program. The article concludes with the use of technology and observations for future service program development and implementation.

Keywords: family preservation, reunification, program development, program implementation, information management

*All correspondence to be directed to senior author.

The implementation of a public, large-scale child welfare program is no small task. Despite sound planning and development, implementing a new service program involves addressing a plethora of challenges. On the positive side, the beginning of a new program often imbues its staff, consumers, and advocates with anticipation, excitement, and hope. Alternately, program implementation is many times fraught with any number of minor annoyances to major problems that can forestall its inception. A successful program will maximize the former and effectively manage the latter.

This article discusses the process, structure, and outcome of an innovative intervention program implemented on a statewide basis in the south central United States. Findings from the first-year

program audits are presented. Evaluation findings are shared, as well as the programmatic changes made as a result. The article concludes with lessons learned for future service program development and implementation.

History

In the Fall of 1997, the first author, a former child welfare programs administrator for the State of Oklahoma, convened a work group consisting of representatives from the Department of Human Services' (DHS) Division of Children and Family Services (DCFS) State Office, Field Operations, and its six Area Offices to discuss the need and potential scope for a new home-based intervention program to be implemented statewide. The child welfare system in Oklahoma is administered by the State via six Area

Offices that oversee services to the state's 77 counties.

At the culmination of the second work group meeting, the participants suggested the convener take the lead in designing a comprehensive, integrative approach to home-based services for at-risk children and their families given an overview presentation they had been provided. Comprehensive Home-Based Services (CHBS) was developed in early January 1998 and shared with every work group member, as well as with each of the DCFS, Field Operations, and Area Directors with the understanding the written document would not be disclosed to any potential private contractor to avert any semblance of conflict of interest or legal liability due to the perceived unfair advantage of one possible vendor over another before an invitation to bid (ITB) was formally announced (Herrerías, 1998).

The CHBS' program description became the subject of many factional discussions in the public agency. In general, child welfare staff did not agree with private providers having more control or a greater role relative to assessing and intervening with DHS' families. Up to that point, Oklahoma's child welfare system only minimally contracted out any services. While a number of wraparound programs (e.g., home visitation, tutoring, counseling, parent education) had been out sourced under a prior five-year contract called the Oklahoma Children's Initiative (OCI), the services provided under OCI were not comprehensive, well documented, or outcome oriented. The former approach was more purposeful than accidental as the intention was to help motivate a sufficiently large number of potential service providers to respond to the Request for Proposal (RFP), which

eventually became the contract. Hence the contract language was written somewhat loosely and made accountability a more illusive concept (L. Arnold, personal communication; F. Hill, personal communication; J. Murray, personal communication).

Although a wide array of services had been provided under the OCI contract, the lack of structure and unique manner each provider delivered the services rendered conducting a meaningful evaluation infeasible. Further, each unit of service was individually counted rather than aggregated for every child that was served. For example, if tutoring was being provided to a sibling group of three over a timeframe of four months, the number of clients served was reported as 48 (3 clients x 4 sessions per month x 4 months) rather than the number of clients served. In the end, it was not possible to accurately or reliably determine how many children and families had received services that were costing the State between \$4 to \$6 million annually.

A more comprehensive service with added structure, consistency, and accountability was needed to establish a higher standard of practice, as well as more responsible stewardship of the State's money. The new program met that need and laid the foundation for implementing the first statewide standardized program of its kind in the U.S. (Herrerías, 1998). Eight contracts were awarded totaling \$7.2 million effective July 1, 1998 as a result of a competitive invitation to bid published March 27, 1998 by the State of Oklahoma for what was called *Oklahoma Children's Services (OCS)*. Comprehensive Home-Based Services (CHBS) was 80 percent of OCS' monies. Independent Living Services

(ILS) comprised the remainder of the funds and is excluded from this article.

Focus Of The Program

The goal of CHBS is to help preserve, strengthen, and/or restore the integrity of the family unit. The conceptual basis of the CHBS approach is family-focused, child-centered in-home services where the child (ages 0-18 years), family, and community are a part of a dynamic system. The program is comprehensive in that it explores the key areas of safety, social functioning, health, education, mental health, employment/vocational training, and recreation with every client family. Service duration is six months, and extensions may be approved under extenuating circumstances for an additional six months.

There are three components of home-based services in CHBS: preventive, remedial, and reunification. A referral for service is made by the public Child Welfare (CW) worker. There are three criteria under which service may be provided:

1. Child is currently in his/her own home and is determined to be at imminent risk of removal due to abuse or neglect (preventive).
2. Child is currently in a kinship or adoptive home where compelling issues or acting-out behaviors may likely cause placement disruption and recidivism to a more restrictive placement (remedial).
3. Child is currently in out-of-home placement where the goal is to return to his/her own-home within 30-90 days of the referral for service (reunification).

Program Structure

Service Providers

Six private, local social service organizations,—five were non-profit, entities were awarded eight contracts to serve the entire State. While DHS divides Oklahoma into six service areas, the two largest metropolitan areas (Oklahoma City and Tulsa) were designated separate service areas for contractual purposes and to help more effectively manage an anticipated high volume of service needs. Through the use of subcontracts, providers were able to serve eligible children and their families statewide. The author designed and provided [mandatory] three-day training to 140 participants that included program directors, supervisors and case managers. This was to ensure that everyone was given the same information to help facilitate program implementation.

Contract case managers (CCMs) are expected to work a flexible 40-hour schedule that frequently includes some evening or weekend hours to better meet the needs of the client system. The title of CCM is used to distinguish between public CW and contracted staffs. Caseload size varies from four to ten families dependent upon the complexity, stage (e.g., beginning, middle, or ending) of the CCM/client working relationship, or geographic distances between client families. The CCM and client must have a minimum of two hours in face-to-face contact weekly with half of all contacts taking place in the client's home. The standard to be met is 39 hours in any 13-week quarter.

Process and Documentation

The CHBS' timetable for service delivery and its documentation

requirements include:

1. **Intake Staffing**, which is accomplished within five working days following the referral for service and involves the referring CW worker, the CCM, and the CCM's supervisor. The meeting usually takes place in the client's home, where the three staff reviews the risk-related issues that prompted the client's referral for services, encourage the client's active participation in the discussion, provide contact information for the three workers, and generally set the tone for future services. It is key to obtain the client's cooperation as a precursor to engaging families in child welfare services (Altman, 2003, 2008; Kemp, Marcenko, Hoagwood & Vesneski, 2009).
2. **Multi-level Assessment**, which is completed on all families referred for services within 30 days of service commencement. The assessment includes:
 - a. *Family Inventory of Needs Determination (FIND)* that assesses strengths and needs of the parent or primary caretaker, as well as yields a resource assessment for each child in the family. The FIND represents a biopsychosocial assessment that is also used as a client engagement tool (Herrerías, 1998).
 - b. *Parent's Attitude toward Child (PAC)*, a pencil-and-paper self-report that measures the degree of a problem in the parent's relationship with his or her child (Herrerías, 1993).
 - c. *Generalized Contentment Scale (GCS)*, a pencil-and-paper self-report that measures the degree of a problem with nonpsychotic depression (Hudson, 1982).
 - d. *Index of Drug Involvement (IDI)*, a pencil-and-paper self-report that measures the degree of a problem with the use of alcohol or drugs (Hudson, 1982).
 - e. *Child and Adolescent Strengths Assessment (CASA)*, a pencil-and-paper evaluation that is completed by the CCM based on the parent's observation of his or her child (Lyons, Kisiel & West, 1997).
3. **Family Intervention Plan (FIP)** that represents the treatment plan written by the CCM in conjunction with the clients involved within 45 days of the commencement of service. This document projects what will be addressed during the course of service. The CCM employs an empowerment case management perspective that encourages the family's active involvement in the identification of needs, the non-risk-related goals and measurement of those goals, potential obstacles to goal attainment, and strategies for minimizing obstacles toward achieving goals (Herrerías, 1998).
4. **Quarterly Report (QR)** that is completed by the CCM at 90-day intervals from commencement of CHBS over the course of service. The QR is a retrospective analysis that determines to what extent the treatment plan was accomplished (Herrerías, 1998).
5. **Final Report (FR)** that is similar to the QR with the exception that it is completed at the termination of service. The FR summarizes the intervention and its outcomes. Most importantly, the FR determines whether the client successfully met the risk-related goals that prompted

the initial service referral. The FR also lists every outside referral or community resource utilized by family members. Copies of the FIP, QR, and FR are provided to clients (Herrerías, 1998).

6. Special Funding is available in the amount of up to \$400 for each client family for the purchase of concrete goods or services that are deemed necessary to help preserve, remediate, or reunify the family. Informal resources are accessed first, with special funds being utilized as a last resort, depending upon the situation. Not all families may require the use of special funds (Herrerías, 1998).

7. Client Satisfaction Survey (CSS) that is provided to every client age 12 years and older for completion and mailing in a postage-paid, addressed mailer to the CHBS' programs administrator (Herrerías, 1998).

Other CHBS program requirements include the CCM completing a critical incident report (CIR) and notifying CW via telephone and in writing within 48 hours of a reportable incident. A reportable incident may include serious illness, hospitalization, or death of a client family member; any type of injury sustained by a child requiring medical attention; parental abandonment; refusal of CHBS'; and unannounced residential move with no forwarding address. Another requirement is the timely completion of all daily progress notes within five days of contact with the client or CCM's concrete effort on behalf of the client (e.g., contacts child welfare worker for discussion about client or obtains a resource for the client), or other client-related event. Yet another requirement is that CCMs are formally

supervised at least one hour on a bi-weekly basis accompanied by a written summary by the supervisor. Moreover, each CHBS supervisor is required to write a monthly case review on every open case under his or her supervision.

Issues Covered by the Program

The structured interventions for clients include providing or facilitating the provision of one or more support or supplemental services to include parenting education and skills development; supportive counseling; crisis intervention and teaching the family how to use the problem-solving model as a way to help resolve or avert future challenges; self-esteem building activities; substance abuse assessment, education, and referral; budgeting and financial management; household management and preventive home maintenance; preventive health (e.g., medical, dental, eye care); preventive mental health; educational/vocational assessment and planning; resource generation, identification, and referral; developing linkages with other support systems; parent/family and child reunification from out-of-home placement; and/or advocacy. Services are provided as needed.

One of the requirements under the six service contracts required that providers submit a Monthly Service Utilization Report (MSUR) containing client's name; DHS identification number; date of birth; racial/ethnic background; number of children; reason for referral; date of referral; dates of intake staffing; completed quarterly and/or final reports; amount of special funds utilized; ending date of service; and to what extent the client had successfully addressed the risk-related issues that prompted the service referral. It was a daunting task to verify the accuracy of

these data elements and request corrected data.

The first year for the DCFS program staff was largely spent making program or reporting refinements, converting the paper forms into machine-readable Scantron™ forms, and preparing for the first program audit of each service provider to determine the extent of program implementation. Needless to say, while the program was implemented almost immediately following the training provided to the vendors and their subcontractors, the challenges, frustrations, and 'kinks' kept everyone working overtime.

Program Infrastructure

The implementation of CHBS required DCFS program staff gives attention to numerous issues needing to be completed within a timeframe of six months before the start of the new State fiscal year. These different tasks represented an intensive effort to ensure everything was accomplished timely and that the necessary infrastructure to support the new program was in place. Major tasks accomplished to facilitate program implementation included:

1. Developing all of the standardized documents to be used in conjunction with the program needed to be developed. This effort resulted in 14 original forms ranging in length from 1 to 20 pages.
2. Developing a process for making, documenting, and approving referrals of families for service. Oklahoma DHS CW workers would identify potential families needing CHBS and complete a referral form showing child and family identifying information, the nature of the referral

(e.g., preventive, maintaining placement, or reunification), and the reasons precipitating the request for services. A Child Welfare supervisor provides first level approval and then forwards to the relevant contract provider serving his/her county.

3. Designing the OCS-1 referral form along with written instructions to staff. This official form needed to be reviewed by the appropriate office to ensure compliance with the Department's Administrative Procedures Act before being approved for use.
4. Writing the *policy bulletin* to the Field Offices throughout the State that briefly explained the new program and the process for making service referrals. The OCS-1 referral form was provided as an attachment.
5. Writing new policy to reflect the incorporation of CHBS into the Department's service array. The numerous pages of policy were integrated throughout the various sections in the State's Child Welfare manual. First, the Administrative Services Unit reviewed the material for clarity, correctness, and consistency with existing policy. Second, new and/or revised policy needed to be approved by the DHS Commission, the Department's governing body, at its monthly meeting.
6. Writing and compiling training curriculum plus handout materials for private service providers. Binders containing training outlines and accompanying handouts were produced for 140 staff from provider agencies. The training was conducted in a central location over four-days. Information about the

service program and its documentation were provided during three days to program directors, supervisors, and contract case managers. Data concerning financial documentation, reimbursement procedures, and invoicing were provided to relevant fiscal and administrative staff in one 6-hour training session.

7. Writing the Invitation-To-Bid, that also served as the contract. This required close coordination with the Department's Finance Division, as well as the State's Office of Central Services to ensure legalities were appropriately attended to and accurately conveyed in the contract document. The ITB was 62 pages in length exclusive of attachments (Herrerías, 1998).

8. Visiting DHS CW county offices by the author and two staff in order to orient CW staff to the new program initiative, the client referral process, and contact people whom they would call for assistance.

Program Audits

Approximately one year following program implementation, the authors and four staff members visited each of the principal contract providers in order to conduct a program audit of their respective service area. Since each of the contract providers, in turn, subcontracted with any number of others, client's records were transported to the principal provider's location. Ten percent of the client's records were randomly selected for the audit. Case managers' and supervisors' personnel records were also audited to ensure compliance with contractual requirements regarding background checks, level of education, and annually required professional development.

While each of the service providers met the contract requirements at the

100% level in a number of the program elements, all fell short of the overall 85% standard compliance rate. The CCMs were out of compliance with the number hours of service they were expected to provide their clients, the incorporation of risk-related goals in the intervention plans, and record of CW staffing of the cases. It was discussed there was a possibility that in their haste, they could have missed documenting some of their contacts. It was reiterated that documentation is of critical importance to demonstrate the work is accomplished. Another area of low compliance was timeliness of reporting. There is a strict schedule of when the intervention plan is completed following the multilevel assessment, followed by the quarterly and final reports. These were frequently done late. Accompanying these reports are the clinical scales that are to be repeated at set intervals to determine changes in behavior and crucial to assessing treatment efficacy.

The worst offender was a service provider who made a decision, without consulting with DHS, to complete the FIP (intervention plan) in advance of the FIND (family assessment) because it was expedient in terms of obtaining third party reimbursement. This was unacceptable and that organization came close to losing its multimillion dollar contract.

Compliance ranged from service provider to service provider. Some focused more attention to detail than others. Some had more technological sophistication than others, which helped mitigate lack of compliance. Only one organization had a compliance rate above 50%. They also had the lowest employee turnover. The first year compliance rates are shown below:

Program Audit Compliance Rates

Organization A	57.9%	Organization E	28.5%
Organization B	39.4%	Organization F	21.4%
Organization C	27.5%	Organization G	17.8%
Organization D	22.2%	Organization H	24.4%

Compliance rates were not computed for subsequent program audits as the conduct of the audits was changed following the first year from objective to subjective measurement. It was rationalized that if service providers were found to be out of compliance then they could not technically keep their contracts. There were not other service providers with the available resources to bid for the contract in the affected service areas. If the principal providers did not have their contracts then children and families would not be served in the respective service areas. This was not acceptable; therefore, the determination of compliance was changed to one of identifying strengths and weaknesses.

Evaluation of Program Outcomes

An independent evaluation team (IET) from the University of Oklahoma Health Sciences Center was contracted to help develop the plan for evaluation of CHBS. Part of the initial plan was to convert each of the assessment tools into Scantron™ forms to develop an extensive database. Until this was accomplished, the DHS programs administrator was the recipient of the assessment forms completed by CCMs and the client families. This constituted a significant undertaking on the part of providers' staff who had to duplicate every form, on the author who was the recipient of the voluminous paper, and on the IET as it attempted to store the paperwork until the specially formatted forms were printed in order to

transfer the data into an acceptable form prior to data entry. The intent was to preserve the data in order to inform program refinements, identify potentially problematic areas, and enhance service delivery. The IET conducted thorough annual evaluations for the years 1999-2005.

Bonner et al. (2000) found an 89% success rate one year after the FIND was completed of 2,089 families. The number of caregivers who have received CHBS was slightly more than 10% that were confirmed as perpetrators after 800 days that the FIND was completed. They also found that families that had met all of their treatment goals were less likely to have subsequent referrals (13%), whereas those that met none to few goals had 50% subsequent referrals.

Hecht et al. (2001) found an 85% success rate 1300 days after completion of the FIND of 2,704 families. The number of caregivers receiving CHBS was 16.7% that were confirmed as perpetrators. Those that had been referred for child maltreatment, however, had an over 50% rate of subsequent report. Families that received Temporary Assistance for Needy Families (TANF) had a higher recidivism rate (39%) than non-TANF (28%). In cases where children had been reunified with their families, there was a 70% subsequent referral rate to children's protective services two years pursuant to reunification. This can be explained as CW sending their most difficult cases to OCS for a last chance effort at

reunification. In fact, the reunification service is supposed to be reserved for those families who have the best chance for reunification. It is not intended to put the child at risk.

Hecht et al. (2003) found an 8% recidivism rate at 720 days after completion of the FIND of 2,869 families. Of those families referred for child maltreatment, their recidivism rate was 54%. In terms of the families that were reunified with their children, their recidivism rate 720 days after completion of the FIND was 22%.

Hecht et al. (2005) indicated that 4,244 families were served during the 2003-2005 contract period that were mostly female, Caucasian, and single, who had not completed high school, and unemployed. Fifty-nine percent were referred for individual treatment given findings from the Beck Depression Index. The GAGE showed potential abuse for about 11%. There was a confirmed report of child abuse 810 days after completion of the FIND of 26%. Twenty-five percent of reunification cases had a maltreatment report during the CHBS service period. The IET found that the number of prior reports was a significant predictor of future ones.

Program Changes

Clinical Measures

There were a number of changes made to the program pursuant to the program audits and external evaluation. These changes had to do with changing several of the clinical measurement instruments in 2002. The GCS was replaced with the Beck Depression Inventory (BDI) (Beck, Steer, & Brown, 1996). The CASA was replaced with the Child Behavior Checklist (Achenbach, 1991, Hecht et al., 2005). The IDI was

replaced with the Diagnostic Inventory Schedule (DIS) Alcohol and Drug Modules (Hecht et al., 2005), and the PAC was replaced by the Child Well-Being Scale (Hecht et al., 2005). The Family Resource Scale (Hecht et al., 2005) was added in 2003. In 2004, the Diagnostic Inventory Schedule (DIS) and Drug Modules was replaced by the CAGE (Hecht et al., 2005; Mayfield, McLeod, & Hall, 1974).

The program audits were found to be labor intensive and reduced in scope from a numerical rating for each major area to whether there is compliance or noncompliance with the spirit and intent of the language in the contract. For example, instead of determining a numerical rating for the FIND (strengths and needs of the caretaker{s} and child{ren}) the evaluator writes specific comments regarding the family's composition, its history, strengths, concerns and whether there are adequate comments to develop a FIP (treatment plan). These comments are written based on the evaluator's review of the data captured from the family by the CCM. When there are inadequate comments to develop a FIP, based upon whether an evaluator finds a sufficient number in his or her case sample, there is a DCFS team decision to require or not require a written corrective response. The staff's personnel records continues to be monitored, they are mailed or transported to DCFS, as is the quality and timeliness of documentation and the content of the reporting. The change in determining compliance was more subjective than objective. Even so, there was not a steady improvement—it appeared to vary from year to year.

Use Of Technology

A significant change occurred in 2000 when an electronic computer network referred to as eKIDS was developed to connect contractors to the DHS statewide child welfare computer network without contractors having access to CW confidential files. The first author conceived the idea of eKIDS as a filing cabinet that contract providers could input data to which CW workers would have simultaneous access. This effectively put an end to the paperwork service providers were forwarding to the program administrator, Child Welfare, and, in turn, the IET. With the exception of original signature pages, the files were now paperless. A by-product of this meant future audits could be conducted from the DHS State Office at a significant cost saving in travel dollars, personnel, and time. Beginning in 2000, an evaluation team no longer made onsite visits to complete the evaluation protocol—it is completed in the evaluator's office via eKIDS.

Concluding Observations

Implementing a complex, large scale child welfare program with a statewide scope was an enormous task that was surprisingly and thoroughly handled with the assistance of highly competent, dedicated staff. Clearly this process contains details that far exceed the allotted time or space to describe. Copies of most of the assessment instruments, as well as the written program description were provided to the workshop participants during the initial training session.

One of the most important results of this program implementation has been the truly valuable data that will help inform future service provision, client

intervention, and the justification for increased funding. Just having an accurate number of the children and families served is more than was available in years past. During the contract's first year, 1,769 families comprising 4,040 children received CHBS statewide. Almost 60 percent of the services were preventive in nature, followed by family reunification in 26 percent of the cases. The reasons for referral for CHBS were neglect (30.7%), drug and alcohol abuse (22.1%), physical abuse (21.8%), environmental neglect (17.5%), and sexual abuse (7.9%). At once the most concerning and informative data learned relates to mental health challenges. Almost 31 percent of primary caretakers indicated having a history of "mental health problems." Nearly 19 percent of primary caretakers take psychiatric medication. Of the children who were specifically identified on the referral for service, 22 percent of them have a history of mental health problems, and 10 percent take psychiatric medication. Thirteen percent of the children were identified as having some form of physical challenge.

Most service providers are exclusively focused on providing the needed programs and services to their clients. Others may dread the mounting paperwork requirements and demands for added and increasingly more specific documentation. In order to better inform and improve the quality and effectiveness of assessment and intervention of at-risk children and their families, mechanisms must be built into every program that help maximize the collection of meaningful data without sacrificing the necessary attention, services, or intervention warranted by those being served. Moreover, better specification of different

interventions employed is imperative to help identify the most effective aspects of treatment. Systematic data collection is only reliable and useful if those gathering the information are committed to doing so in a consistent, clear, and comprehensive manner. It is shortsighted to solely rely on outcomes to the exclusion of having a sound understanding of *what* yields desired results—if for no other reason than to more effectively ensure the increase of more positive outcomes for at-risk children and their families.

References

- Achenbach, T. (1991). Manual for child behavior checklist/4-18 & 1991 Profile. University of Vermont, Department of Psychiatry.
- Altman, J. C. (2003). A qualitative examination of client participation in agency-initiated services. *Families in Society, 84*(4), 471-479.
- Altman, J. C. (2008, May/June). Engaging families in child welfare services: Worker versus client perspectives. *Child Welfare, 87*(3), 41-61.
- Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Beck Depression Inventory*®. Boston: Pearson.
- Bonner, B. L., Silovsky, J. F., Chaffin, M. J., Hill, R. F., & Hecht, D. B. (2000). *1999-2000 annual report: Evaluation of Oklahoma Children's Services*. Oklahoma City: Center on Child Abuse and Neglect, University of Oklahoma Health Sciences Center.
- Cohen, B. J. (2005). Reforming the child welfare system: Competing paradigms of change. *Children and Youth Services Review, 27*, 653-666.
- Hecht, D. B., Silovsky, J. F., Chaffin, M. J., Hill, R. F., & Bonner, B. L. (2001). *2000-2001 annual report: Evaluation of Oklahoma Children's Services*. Oklahoma City: Center on Child Abuse and Neglect, University of Oklahoma Health Sciences Center.
- Hecht, D. B., Chaffin, M. J., Silovsky, J. F., & Bard, D. (2005). *Final report: Evaluation of Oklahoma Children's Services*. Oklahoma City: Center on Child Abuse and Neglect, University of Oklahoma Health Sciences Center.
- Herrerias, C. (1998, March 27). Oklahoma Children's Services (OCS). Invitation to bid #J001383. Oklahoma Department of Human Services, Oklahoma City, OK.
- Hudson, W. W. (1982). *The clinical measurement package*. Homewood, IL: Dorsey Press.
- Kemp, S. P., Marcenko, M. O., Hoagwood, K., & Vesneski, W. (2009, January/February). Engaging parents in child welfare services: Bridging family needs and child welfare mandates. *Child Welfare, 88*, 101-126.
- Lyons, J. S., Kisiel, C., & West, C. (1997, Fall). Child and adolescent strengths assessment: A pilot study. Robert Wood Johnson Foundation. *Family Matters, 30-32*.