IMPROVING OUTCOMES FOR FAMILIES INVOLVED IN CHILD PROTECTIVE SERVICES THROUGH AN ENHANCED UNDERSTANDING OF RESIDENTIAL MOBILITY'S IMPACT ON CAREGIVER-CHILD RELATIONSHIPS

by

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A dissertation submitted to the faculty of
The University of North Carolina at Charlotte
in partial fulfillment of the requirements
for the degree of Doctor of Philosophy in
Health Psychology

Charlotte

2016

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ABSTRACT

VIRGINIA ANNE JOHNSON. Improving outcomes for families involved in Child Protective Services through an enhanced understanding of residential mobility's impact on caregiver-child relationships. (Under the direction of DR. JAMES R. COOK)

Reducing residential mobility among families involved in Child Protective Services (CPS) has the potential to alleviate some of the negative consequences associated with child maltreatment by reducing families' stress and minimizing disruptions in their relationships with others. However, there is very little research that informs CPS decision-making and guides interventions that balance housing and neighborhood quality considerations *and* the potentially negative impact of residential mobility. Thus, the present study focuses on understanding the specific contributions of residential mobility and neighborhood quality to caregiver-child relationships and how a Family Partner program may potentially address frequent residential mobility with CPS-involved families.

Study findings indicate that residential mobility is a symptom of a much larger issue among CPS-involved caregivers who tend to lack financial resources for meeting their families' needs. A key way to reduce residential mobility is to address their financial needs or help them secure more affordable, long-term housing. CPS interventions aimed at resolving families' lack of financial resources are critical because most of the social support or Family Partner assistance that caregivers receive typically do not assist caregivers with their financial needs. Additionally, caregivers' generally limited options do not afford the opportunity to incorporate neighborhood quality or social support considerations into the housing that they identify, and CPS workers could

aid families in this area to ensure that residential mobility results in quality of life improvements for families, ultimately with the goal of reducing the risk of subsequent child maltreatment.

ACKNOWLEDGMENTS

A special thanks to Thompson for making this work possible. I am sincerely grateful for the opportunities Thompson has provided for learning more about the children and families that they serve.

I would like to extend a most heartfelt appreciation to my committee members, without whom I could not have completed this study. A special thanks to my advisors, Dr. Jim Cook, Dr. Ryan Kilmer, and Dr. Maggie Quinlan whose mentorship and wisdom have been invaluable. Your guidance over the years has made this an incredibly rewarding journey.

To Nancy Johnson, thank you for constantly encouraging me and never letting me give up on my dreams. I can never thank you enough for your unwavering support and belief in me.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1: INTRODUCTION

Stable, safe, and affordable housing is a common need among families investigated by Child Protective Services (CPS). CPS typically assesses families' housing quality but not the stability of families' housing, despite the fact that CPS-involved families have much higher rates of residential mobility, defined as the frequent change of residence, than the general U.S. population (Courtney, McMurtry, & Zinn 2004; Culhane, 2003; Farrell, Britner, Guzzardo & Goodrich, 2010; Font & Warren, 2013). In fact, CPS housing interventions often increase families' mobility by requiring them to move to residences with better housing conditions without full consideration of the potentially negative impact and disruptiveness that residential mobility may have on families. Yet, children who experience residential mobility tend to have worse health outcomes, poorer school functioning, and more mental health concerns (Gillespie, 2014; Haynie & South, 2005). However, minimal research informs CPS decision-making and guides interventions that balance housing and neighborhood quality considerations *and* the potentially negative impact of residential mobility. Improving housing stability among CPS-involved families by reducing residential mobility has the potential to alleviate some of the negative consequences associated with child maltreatment by reducing families' stress and minimizing disruptions in their relationships with others. Increasing residential stability could also reduce the likelihood of future child maltreatment, an area that the current study will not examine but that warrants further study. Thus, the present research

focused on understanding the specific contributions of frequent residential mobility (i.e. moving multiple times a year) and neighborhood quality to CPS-involved caregiver-child relationships and how a Family Partner program – i.e., a program with trained paraprofessionals who assist CPS-involved families through collaboration, advocacy, and knowledge about the CPS system and other community resources available to families - may potentially address residential mobility among CPS-involved families.

Within the child maltreatment literature, residential mobility is typically framed as an indicator of neighborhood quality. For instance, neighborhoods with more short-term renters and higher rates of resident turnover also tend to have higher rates of substantiated child maltreatment (Coulton, Corbin & Su, 1995; Coulton, Crampton, Irwin, Spilsbury & Korbin, 2007; Zielinski & Bradshaw, 2006; Zuravin, 1989). Residential mobility is commonly studied as a neighborhood quality characteristic because frequent turnover among residents can disrupt shared social norms and values, often resulting in higher crime rates and less neighborhood investment in shared spaces like parks or community gardens; such factors all contribute to lower neighborhood quality (Curley, 2010; Roy, McCoy, & Raver, 2014). However, conceptualizing residential mobility as a characteristic of neighborhood quality limits understanding of the specific contributions of *both* neighborhood quality and residential mobility to caregiver-child relationships among CPS-involved families. For instance, living in a neighborhood with high crime rates may contribute to caregiver stress and worse family functioning, but the disruptiveness of moving among neighborhoods with high crime rates may pose an additional stress for families. Understanding the impact of both neighborhood conditions *and* residential mobility can inform CPS decision-making about

the relative benefits of families moving to better quality neighborhoods or remaining in a current residence and focusing on improving conditions in that place. The current research explored residential mobility as a family level variable (i.e., number of times a family moves) so that the specific contributions of residential mobility and neighborhood quality on the caregiver-child relationship could be examined. Additionally, the study explored how a Family Partner program could improve family outcomes by providing needed support to residentially mobile families.

1.2 Child Maltreatment in the United States

Child maltreatment is defined by the U.S. Department of Health and Human Services as physical, sexual, or emotional abuse or neglect of a child under the age of 18 by a person in a custodial role (DHHS, 2011). In the U.S., Child Protective Services (CPS) offices throughout the country received an estimated 3.4 million reports of alleged maltreatment in 2012, involving approximately 6.3 million children. During the same year, despite CPS agencies' work, a total of 1,593 children died as a result of their maltreatment (DHHS, 2012). While these numbers seem staggeringly high, they likely underestimate the true scope of child maltreatment in the United States because many cases are never reported to authorities. For example, data from a 2010 nationally representative survey of children and caregivers estimated that 13.8% of children are maltreated each year and 25.6% of children experience maltreatment at some point during their childhood (Turner, Finkelhor, Hamby, & Shattuck, 2013). Thus, child maltreatment continues to occur at alarming rates and the effectiveness of interventions intended to prevent maltreatment, such as the Family Partner Program examined in the current research, warrant continued study.

Experiencing abuse and neglect during childhood is consistently associated with an increased risk for impaired psychological, social, and behavioral development (Cicchetti, 2013; Cicchetti & Toth, 1995; Margolin & Gordis, 2000). Research indicates that maltreated children are more likely to exhibit externalizing (e.g., acting out, aggression) and oppositional behaviors, develop conduct disorders, and engage in delinquent or criminal acts (Kotch et al., 2008; Sternberg, Lamb, Guterman, & Abbott, 2006). Children who have been maltreated are also more likely to evidence internalizing problems such as anxiety, depression, withdrawal, and post-traumatic stress symptoms (Cicchetti, 2013; McHolm, MacMillan, & Jamieson, 2003; Widom, Dumont, & Czaja, 2007). The emotional difficulties that maltreated children experience can be so severe that they result in self-harming behaviors (Yates, Carlson, & Egeland, 2008) and suicidal ideation (Evans, Hawton, & Rodham, 2005). Unfortunately, long after the abuse or neglect ends, many maltreated children continue to have low self-esteem, less positive self-concepts, and worse relationships with others (Bolger & Patterson, 2001; Courtney et al., 2011; Meadows, Brown & Elder, 2006).

As early as kindergarten, maltreated children's emotional and behavioral difficulties can affect school functioning and academic performance. Pears and colleagues (2010) found that maltreated children who were placed in foster care had lower levels of academic competence (i.e., teachers' ratings of their abilities, skills, and comprehension) than their kindergarten peers. Maltreated children in the study also had poor relationships with their classroom peers, perhaps attributable to their lower levels of social-emotional competence and social skills than their non-maltreated counterparts. Moreover, their academic outcomes appear to be affected as well – maltreated children

tend to earn significantly lower grades and lower standardized test scores than their non-maltreated peers, often resulting in repeating grades more frequently than children who have not experienced maltreatment (Cicchetti, 2013; Dodge-Reyome, 1994; Eckenrode, Laird, & Doris, 1993; Kurtz, Gaudin, Wodarski, & Howing, 1993). Maltreated children also exhibit behaviors in school, such as aggression, that result in disciplinary actions that impede their academic progress. Eckenrode and colleagues (1993) found that maltreated children have significantly more referrals to the principal's office and, ultimately, more suspensions relative to their non-maltreated peers. Clearly, child maltreatment can have a profound, negative impact on children's academic progress and educational outcomes.

Residential mobility may exacerbate maltreated children's difficulties in school. Outside the immediate family, the school setting is one of the most consistent and stable institutions in children's lives (Cicchetti & Toth, 1997; Garbarino, Dubrow, Kostelny & Pardow, 1992). Maltreated children, in particular, can benefit from stability at school because their home life is often tumultuous and uncertain. However, residential mobility may disrupt the potential stability and continuity that maltreated children experience because moving often requires children to change schools. In fact, frequent residential mobility may account for some of maltreated children's academic struggles. To that end, Eckenrode and colleagues (1995) found that residential mobility mediated the relationship between child maltreatment and academic outcomes among 5- to 15-year-old students. They found that while children who have experienced maltreatment typically performed worse academically, between 15% and 33% of maltreated children's school performance could be accounted for by family mobility (Eckenrode, Rowe, Laird, & Brathwaite, 1995). Specifically, while in the process of moving and during the period of

adjustment to a new school, children may miss out on instruction, causing them to fall behind their peers. One meta-analysis estimated that highly mobile students are typically about four months behind their peers in reading and math achievement (Mehana & Reynolds, 2004). Clearly, reducing residential mobility among CPS-involved families may be beneficial for children who are already at risk for poor school outcomes. Thus, the current study examined how a Family Partner program could potentially alleviate the negative consequences associated with residential mobility and possibly prevent future mobility.

1.3 Ecological Model

The present study was guided by Bronfrenbrenner's (1977, 1979) ecological model. Given the ecological model's focus on the critical nature of context and the individual's ongoing mutually-influential interactions with others or with diverse factors or conditions in their environment, the National Research Council has identified it as the framework best suited for clarifying the causes, consequences, and treatment for child maltreatment (U.S. Department of Health and Human Services, 1997). The ecological model posits that a child's development and adaptation are the result of multiple, dynamic systems which are "nested" within one another (Bronfenbrenner, 2005). The individual child is situated at the center of these systems, arranged from closest to furthest, which include: the ontogenic or individual level; the microsystem or the groups that more immediately (and directly) impact a child's development (e.g., family, peers, supportive neighbors); the mesosystem level, which includes interconnections between the structures of a child's microsystems (e.g., relationships within a neighborhood or between caregivers and teachers); the exosystem level or social systems that indirectly

impact a child (e.g., parents' workplaces), and the macrosystem or societal level. In the ecological model, influences and settings that are located more proximally to children and the immediate caregiving process (individual level, microsystem, and mesosystem) have a direct effect and, in turn, a greater impact on children's development, whereas more distal influences (exosystem and macrosystem) would be expected to have a less pronounced, indirect effect (Zielinski & Bradshaw, 2006). According to this perspective, over time, a child influences and is influenced by these different systems, as part of an ongoing, dynamic process. The ecological model, and the current research, emphasize that, rather than one determinant, multiple systems interact across numerous contexts to contribute to child maltreatment and its consequences.

The current study focused on residential mobility's relationship to the microsystem and mesosystem factors which influence child maltreatment, and subsequently, elements that can be targeted by Family Partner interventions to reduce the negative consequences associated with child maltreatment. The microsystem includes children's home environment and relationships with their immediate family. The caregiver-child relationship is an important, central component of the microsystem, and numerous studies have reported a connection between the quality of the caregiver-child relationship and the risk for child maltreatment (Azar, 1997; Crittenden, Partridge, Claussen, 1991). In the present research, the microsystem variables of caregiver stress and the quality of the caregiver-child relationship were examined in relationship to residential mobility. It was anticipated that mesosystem factors, which include supportive individuals outside of the family as well as neighborhood quality, would have a direct influence on caregiver stress, and subsequently, the quality of the caregiver-child

relationship. The following paragraphs outline the relationship between and among the micro- and mesosystem factors in the present study and their connection to residential mobility.

1.4 Microsystem: Caregiver-Child Relationship

The caregiver-child relationship is one of the most important, if not the most important, influence on children's development. Children's experiences with their primary caregivers, and caregivers' responsiveness to their needs, influence a child's relational style, and affect regulation, communication, and psychological and personality development (Bowlby, 1988; Carlson, Sroufe & Egeland, 2004; Masten & Coatsworth, 1998; Morris, Silk, Steinburg, Myers & Robinson, 2007). One way children seek physical and emotional closeness (or attachment) to caregivers is by crying, reaching out, or protesting separation. Over time, caregivers' warm and nurturant behaviors (or lack thereof), degree of emotional responsivity, and, broadly, responses to their child's behaviors, are the basis for a child's "attachment style", which can include: secure attachment, ambivalent attachment, disorganized attachment and anxious/avoidant attachment (Ainsworth, 1979; Cicchetti, Rogosch & Toth, 2006; Main & Solomon, 1986). These attachment styles represent a child's working model of the world and other relationships (Bowlby, 1988; Bretherton, 1985). In general, children's styles of attachment to their caregiver are particularly evident when a caregiver leaves their child and when children reunify after the separation (Ainsworth & Bowlby, 1991; Sanders et al., 2004). For example, children with secure attachments tend to use their caregivers as a safe base for exploration, are distressed when separated from their caregivers, but can be comforted by others, and then warmly greet their caregivers when they are reunited

(Ainsworth & Bowlby, 1991; Sanders et al., 2004). In contrast, infants who exhibit insecure attachment styles (e.g., anxious/avoidant, ambivalent, or disorganized) do not use their caregivers as a secure base and exhibit less adaptive behavior when they are separated from and then reunited with their caregivers (Bowlby, 1998; Main & Solomon, 1986). Unfortunately, child maltreatment disrupts attachment relationships between children and their caregivers, and maltreated children are much less likely to have secure attachments with their caregivers (Baer & Martinez, 2006; Cicchetti & Rogosch, 1994). Unfortunately, maltreated children's issues in their attachment system place them at an increased risk for problematic trajectories throughout their development because establishing a secure, early attachment is viewed as the stage salient task of children's development, one that has meaningful implications for subsequent development and adaptation (Baer & Martinez, 2006; Oshri, Sutton, Clay-Warner & Miller, 2015; Sroufe, 2005; Stronach et al, 2011).

CPS-involved caregivers tend to be less sensitive and less responsive to their child's behavioral and emotional needs, which is harmful to attachment patterns and the caregiver-child relationship (Carlson, Cicchetti, Barnett & Braunwald, 1989; Cicchetti et al., 2006). CPS-involved caregivers' reduced ability to effectively understand and appropriately respond to their child's needs depends on situational factors, caregiver characteristics (e.g., emotional regulation, mental health functioning), as well as child characteristics (e.g., age, health) (Lieberman, Van Horn, & Ozer, 2005; Plummer & Eastin, 2007). It is not possible for the present review to address the diverse findings regarding the array of individual-level factors and characteristics that contribute to the caregiver-child relationship, and ultimately child maltreatment risk; they are too

numerous for the present purposes. However, Zielinski and Bradshaw (2006) and Freisthler, Merritt, and LaScala (2006) provide more comprehensive summaries of individual-level factors associated with maltreatment risk. Instead, the present study focused on residential mobility's impact on families' social support, caregiver stress, and the overall quality of the caregiver-child relationship. Additionally, the study explored the relationship between residential mobility and neighborhood quality in order to determine the degree to which they differ in their relationship to social support, caregiver stress, and the quality of the caregiver-child relationship. In sum, the research provides an enhanced understanding of how housing conditions *and* housing stability uniquely contribute to child well-being among CPS-involved families.

1.5 Microsystem: Caregiver Stress

Researchers have consistently linked high levels of reported parenting stress with an increased risk of child maltreatment (Curenton, McWey & Bolen, 2009). CPS-involved families often have multiple needs in the most fundamental life areas like income, education, health, childcare, and family relationships, which can all contribute to caregiver stress (Barth, Wildfire & Green, 2006). "Stress" or "stressor" can be defined as any environmental, social, or internal demand which requires an individual to readjust his or her usual behavioral patterns (Holmes & Rahe, 1967). When caregivers experience considerable stress, often as multiple stressors accumulate, they are more likely to use harsh parenting techniques (Webster-Stratton & Hammond, 1990) and severe disciplinary practices, contributing to a higher likelihood of child maltreatment (Pinderhughes, Dodge, Bates, Pattit & Zelli, 2000). Conger and colleagues (1994), developed the family stress model to account for the diminished coping resources that caregivers have when

they experience a great deal of stress, particularly financial-related strain or deprivation. Across a broad body of work in this area, family stress model findings support that, during times of stress, caregivers are also less attuned to their child's needs, demonstrate less parental warmth, and frequently perceive their child's behavior as more disruptive and intentional (Bauer & Twentyman, 1985; Belsky, 1984; Conger, Conger, Elder, Lonrez, Simmons & Whitbeck, 1992; Conger et al., 2002; Rodgers, 1993; also see Luthar, 1999 for a focus on these processes among impoverished families). Taken together, stressed caregivers' reduced sensitivity to their child's needs and the increased likelihood of using harsh discipline techniques can severely damage the quality of the caregiver-child relationship and increase the risk for child maltreatment (Conger et al., 2002; Curenton et al., 2009).

Residential mobility potentially adds to the stress experienced by CPS-involved families. Residential mobility can be stressful for both caregivers and children because it requires changes in routines, roles, and identities (Oishi, 2010). After a move, caregivers are more likely to be physically and emotionally exhausted, and less emotionally available to their children (Drummet, Coleman & Cable, 2003; Haynie & South, 2005; Kelley, Finkel & Ashby, 2003). Frequent moving can also be stressful for children. Children who move a lot tend to perform poorly in school and report worse physical and mental health (Adam, 2004; Jelleyman & Spencer, 2008). Within the foster care literature, a child's experience of multiple foster care placements relates to a number of negative outcomes, including later criminal activity (Jonson-Reid & Barth, 2000), dating violence, early pregnancy, and homelessness (Reilly, 2003). However, very few studies have examined the impact of residential mobility among CPS-involved families when the

child remains in their parents' care. The present study explored the relationship between residential mobility, caregiver stress, and family well-being. It was anticipated that frequent residential mobility would be associated with increased caregiver stress and worse family well-being, but that the stress associated with residential mobility would be mediated by caregivers' social support, neighborhood quality, and Family Partner involvement.

1.6 Mesosystem: Social Support

Social support, defined as the assistance that is available to a person from other individuals, can buffer and alleviate the stress that caregivers experience (Turner & Brown, 2010). Assistance via social support can take many forms: emotional comfort; tangible (instrumental) aid like money, food, clothing; information or advice, or help in decision-making (Thoits, 1995). Social support can reduce caregiver stress indirectly (perceived support) and directly (received support; Cohen & Wills, 1985; Helgeson, 1993). According to the stress-buffering hypothesis, caregivers who perceive that they have adequate social support appraise stressful events less negatively (Cohen & Willis, 1985). Caregivers' perceptions that support is available if needed provides comfort, improves their ability to cope, and leads to reduced perceptions of stress (Bolger, Zuckerman, & Kessler, 2000). Indeed, more perceived social support is associated with better family functioning often because it reduces caregiver strain and improves overall caregiver well-being (Ergh, Rapport, Coleman, & Hanks, 2002; Palamaro, Kilmer, Cook & Reeve, 2012). Actual, received support can also directly reduce caregiver stress by providing the emotional, tangible, or other support that caregivers may need. In one study, mothers who received social support from other adults were more sensitive to their

children and could more readily cope with their children's difficult behaviors (Crockenberg & McCluskey, 1986). Lyons and colleagues (2004) found that among maltreating mothers, more social support was associated with lower levels of maternal depression and stress as well as increased use of positive parenting practices. Thus, greater perceived social support can buffer the negative experience of stress, while actual, received support can provide assistance that caregivers can rely on in times of need.

Research has established that CPS-involved families report significantly less social support than others (Coohey, 2007). In general, CPS-involved caregivers are socially isolated and their connections with individuals tend to be non-reciprocal and short-term relationships (Crittenden, 1985). Bishop and Leadbetter (1999) studied the relationship between parental social support among mothers with pre-school age children and found that mothers with a history of child maltreatment listed fewer friends, reported less contact with friends, and gave lower ratings about the quality of support that they received from their friends. Maltreating caregivers also tend to have less frequent contact with their family and receive less help from their family and friends, relative to similar, non-maltreating caregivers (Starr, 1982; Zuravin & Greif, 1989). The finding of fewer connections with their own family members is not unexpected, given that many caregivers who have maltreated their children were also victims of abuse or neglect in their own childhoods (Craig & Sprang, 2007). As one case in point, Cicchetti and collegues (2006) found that maltreating mothers reported greater abuse and neglect in their childhood, compared with non-maltreating peers, and subsequently more insecure attachments with and less support from their own mothers. In fact, researchers and policy-makers are focusing on CPS prevention and intervention efforts that improve

families' available social support as an important component of reducing the risk for child maltreatment and breaking family cycles of abuse (Thompson, 2015).

Among CPS-involved families, residential mobility may further reduce their available social support, or it may strengthen connections with others, depending on the nature of the move (Belsky, 1993; South & Haynie, 2004). Residential mobility can isolate families from their existing social ties, particularly if the move is to a new school district or an unfamiliar neighborhood, or if the new residence is farther away from family and friends. In fact, reduction in the size and quality of the family's social support network constitutes one of the primary ways by which residential mobility may affect the developmental outcomes of children who have experienced maltreatment (Belsky, 1993). With greater social isolation as a result of frequent moves, caregivers may lack an important buffer between their level of stress and their parenting behavior. For instance, after a move, caregivers may no longer have friends or family members who can help babysit or provide temporary respite. Frequent family mobility also affects the social networks of children by moving away from friends or caring adults who may be able to provide needed support and security (Coulton et al., 1999; Melton, 2006; Zielinski & Bradsaw, 2006). Under these circumstances, caregiver and child stress may increase because the family is adapting to unfamiliar surroundings and the family may have reduced contact with supportive individuals who are now farther away. Conversely, residential mobility may improve family outcomes if the move is closer to family or friends who can provide respite care for parents or additional support for children.

The current study explored the nature of the relationship between social support and residential mobility among CPS-involved families. It was hypothesized that the

impact of residential mobility on caregiver stress and, subsequently, child and family outcomes, would be mediated by caregivers' perceived social support. It was anticipated that families with more social support, or those moving closer to supportive others, would have better child and family outcomes than families' without such social connections.

1.7 Mesosystem: Neighborhood Characteristics

Neighborhood characteristics have a significant influence on families' daily lives and are consistently related to the risk for child maltreatment (Freisthler, Merritt & LaScala, 2006). Neighborhoods with more bars, drug possession arrests, vacant housing, and higher unemployment rates, tend to have higher rates of child maltreatment (Freisthler, 2004; Zuravin, 1989). Positive features of neighborhoods are also related to child maltreatment rates. For example, higher levels of access to childcare also relate to lower neighborhood child maltreatment rates, even after controlling for other neighborhood characteristics such as the average household income (Coulton, Korbin, Su & Chow, 1995).

When families are investigated for child maltreatment, CPS assesses the quality of the family's housing and neighborhood conditions. When housing or neighborhood conditions threaten a child's safety and well-being, CPS will require that families move to a safer residence, with failure to do so resulting in the child potentially being removed from the home. Studies estimate that approximately 30% of children in foster care were removed from their parents' custody because unsafe housing conditions (e.g., homelessness, lack of heat in the home, overcrowding, etc.) were a central concern (Doerre & Mihaly, 1996; Hagedorn, 1995; Harburger & White, 2004). Unfortunately, CPS' recommendation that families move to another residence further contributes to

CPS-involved families' already high rates of residential mobility, and moving puts additional stress on the family.

Although housing and neighborhood conditions have a considerable, established impact on the caregiver-child relationship, it is likely that residential mobility is a unique source of stress for families, distinct from housing conditions (Coulton et al., 1995; Coulton, Korbin, & Su, 1999; Deccio, Horner, & Wilson, 1994; Garbarino & Kostelny, 1992). For example, Gillespie (2014) found that moving is associated with changes in caregivers' parenting styles and that authoritarian approaches were used more frequently during times of acute stress, such as moving. Additionally, residential mobility can often put children in a more dependent, and less autonomous, relationship with their caregiver because they are unfamiliar with their new surroundings (Belsky, 1993). Moving to a new neighborhood frequently means that children have fewer friends and supportive individuals' close by, so they must rely more on their relationship with their caregiver for support. Understanding the impact of both neighborhood conditions *and* residential mobility could inform CPS decision-making about the relative benefits of families moving to better quality neighborhoods or remaining in a current residence and focusing on improving conditions in that place.

Because residential mobility is typically examined as a neighborhood-level risk factor for child maltreatment, little is known about the degree to which neighborhood quality and residential mobility differ in their relationship to child well-being. Interpreting findings in this area is complicated by the varying ways in which residential mobility has been operationalized. For instance, residential mobility has previously been measured as the percentage of new residents in a neighborhood (i.e., in the current home

for less than a year), the amount of vacant housing in a neighborhood, and the percentage of short-term renters in a neighborhood (Coulton et al., 1995; Zuravin, 1989). Stable neighborhoods, areas in which high proportions of residences are occupied by the same individuals or families for long periods of time, tend to have lower rates of child maltreatment, relative to neighborhoods with frequent resident turnover (Zuravin, 1989). However, framing residential mobility as an element of neighborhood quality limits understanding of the degree to which residential mobility and neighborhood quality may each relate uniquely to child well-being. For instance, very few studies examine if the stress associated with residential mobility is influenced by the change (positive or negative) in neighborhood quality. CPS interventions can require families to move to better quality neighborhood/housing conditions (e.g., areas with less drug activity, housing that is less overcrowded, etc.), but it is unclear if the stress and disruption of residential mobility is harmful and may contribute to an increased likelihood of child maltreatment. Understanding the degree to which neighborhood quality and residential mobility differ in their relationship to child and family well-being can inform CPS-interventions which are designed to promote the optimal child and family outcomes.

In conclusion, the present study attempted to disentangle the relationship between residential mobility and child and family outcomes by examining the role of mobility and neighborhood characteristics. It was anticipated that the relationship between residential mobility and child and family well-being would be mediated by neighborhood quality. Specifically, it was expected that residential mobility would be less harmful to the caregiver-child relationship if the move is to a higher quality (i.e., reduced crime,

improved access to resources, etc.) neighborhood or closer to other supportive individuals.

1.8 Family Partner Program

Family Partner (FP) programs have become a major focus within child welfare systems as a non-adversarial and empowering approach for intervening with families (Tilbury, 2005). Family Partners are trained paraprofessionals who assist CPS-involved families through collaboration, advocacy, and knowledge about the CPS system and other community resources available to families. The present study explored one FP program's effectiveness in improving family outcomes (i.e., social support, family resources, caregiver stress, and residential mobility).

CPS workers frequently do not have the time to help caregivers with long-term, stable housing or to address all of the factors that may contribute to their residential mobility (Shdaimah, 2009). Instead, CPS workers have to prioritize which family needs most directly threaten the well-being of the children in the household, leaving some areas of need potentially unaddressed. CPS-involved caregivers are also unlikely to share more than what is required with social workers because they fear that their children will be removed from their care (Diorio, 1992). Thus, even if social workers had time to address the complexities of residential mobility, families are unlikely to provide social workers with the depth of information that is needed to thoroughly resolve the issue.

Unlike CPS workers, FPs are uniquely positioned to understand caregivers' needs and empower families. It is common for families involved with CPS, especially early in their involvement, to feel hopeless about their circumstances and their ability to change them (Kapp & Propp, 2002; Shim & Haight, 2006). Feeling helpless and overwhelmed

can hinder caregivers' ability to engage in case planning and services, which may subsequently increase the likelihood that their children will be removed from the home (Littell, 2001; Littell, Alexander & Reynolds, 2001). FPs can alleviate some of the fear and hopelessness that families experience by building trusting relationships and offering support. Furthermore, they can provide specific information about child welfare procedures as well as caregivers' roles and responsibilities in team planning meetings, helping caregivers know what to expect in the process as they navigate the system. Additionally, FPs can gain valuable insight into families' needs and strengths because, unlike a CPS social worker who is tasked with making custody decisions, they are not viewed as having a potentially adversarial role (Ireys, Devet, & Sakwa, 2002). FPs, then, can work with families to resolve many of the factors that contribute to residential mobility. Taken together, a thorough understanding of the array of needs and challenges experienced by families, as well as improved caregiver engagement in the process, increases the likelihood that residential mobility and families' needs can be resolved. Thus, FPs may be able to address many of the factors that contribute to residential mobility by partnering with families in a nonjudgmental, empowering way. The current study explored the relationship between Family Partner involvement and caregivers' needs. It was anticipated that families with an FP would experience less subsequent residential mobility because the FPs address a range of family needs (e.g., transportation, employment, etc.) that, taken together, contribute to frequent residential mobility.

1.9 Overview of Current Research

The present study had three primary goals: 1) provide an enhanced understanding about the nature of residential mobility among CPS-involved families, 2) understand the

role of social support in potentially attenuating negative child and family outcomes when residential mobility occurs, 3) determine if a Family Partner (FP) program can alleviate the negative consequences associated with residential mobility among CPS-involved families. The research was guided by five research questions:

RQ1: What is the nature of residential mobility among families involved with Child Protective Services (CPS)?

RQ2: To what degree are residential mobility and neighborhood quality uniquely related to caregiver stress and the caregiver-child relationship?

RQ3: What is the nature of the relationship between social support and residential mobility among CPS-involved families?

RQ4: If social support is related to the quality of the caregiver-child relationship, to what extent does residential mobility influence the effects of social support on the caregiver-child relationship?

RQ5: What is the relationship between Family Partner involvement and caregivers' needs (i.e., family resources, caregiver-child relationship, and residential mobility)?

CHAPTER 2: METHODS

The current study was conducted in partnership with Thompson Child & Family Focus (Thompson), a non-profit agency in Charlotte, North Carolina. Thompson provides clinical and prevention services to children and families in the Carolinas and has collaborated with the University of North Carolina at Charlotte's psychology faculty and students for more than six years on research and evaluation projects. Charlotte is served by Mecklenburg County's CPS, also known as Youth and Family Services (YFS), which contracts with Thompson to provide Family Partner and Family Education classes to CPS-involved families. Thompson's de-identified demographic and program evaluation survey data of CPS-involved caregivers were used for the present study's analyses.

2.1 Participants

All 62 CPS-involved caregivers who participated in Thompson's Family Education program or Family Partner program and completed Thompson's program evaluation surveys were included in the current research study. Because Thompson's surveys were available only in English, responses are not representative of CPS-involved caregivers for whom English is not the primary language. When more than one spouse or partner participated in Thompson's Family Education program or Family Partner program, they were given the opportunity to complete surveys separately or together, depending on their preference. For this study, only one survey per household (i.e., same address of residence) was used for analyses and two surveys were excluded on this basis.

The survey with the most complete data was chosen as the survey for the two households that were identified as having more than one survey.

2.2 Procedures

During October-November 2015, Thompson conducted a survey of its current clients (those completing services during those months) and also conducted follow-up phone surveys with clients who completed Family Partner and Family Education programs in the previous three to six months. These surveys were part of Thompson's ongoing efforts to evaluate their services.

For clients completing services, the survey and consent forms were provided by a Family Partner at the families' last or second-to-last home visit, to assess their experiences in the FP program. Family Partners, rather than Thompson's evaluator, provided families with the surveys as part of their continuing contact with families, so that it was minimally disruptive to families' services. To ensure administration consistency, prior to offering the survey to families, FPs received two trainings and ongoing support from Thompson's evaluator. Trainings with the five Thompson Family Partners focused on clarifying the purpose of the survey, reviewing the informed consent with clients, and answering potential questions that caregivers may have about the survey.

At the home visit, Family Partners provided information about the survey verbally and in a written handout. If caregivers were interested in participating, FPs reviewed the consent form, asking them to sign if they agreed to participate. FPs emphasized that caregivers' participation was completely voluntary, caregivers' decision to participate (or not) would not affect any of the services that they were receiving, and that all individual

responses were completely confidential. The FPs also signed and dated the form to acknowledge that they had reviewed and discussed the consent form with caregivers. FPs provided participants with the survey and an envelope into which the caregivers could directly place the survey once they had provided their responses. Caregivers were instructed to seal the envelope themselves, ensuring that FPs did not see any of their responses. Upon completion of the survey, participants were given a $5 Walmart gift card for their participation and contact information for Thompson's evaluation staff if they had any questions or concerns about the study.

Thompson's six Family Education class leaders received the same trainings as Family Partners, and they too introduced the survey to caregivers. The survey was offered to caregivers at their last or second to last class, depending on the class schedule. Thompson's evaluation staff provided class leaders with support during survey administration by collecting surveys and informed consents, distributing gift cards, and providing their contact information for any future questions or concerns.

During the same timeframe, Thompson evaluation staff also sought to conduct phone surveys with clients who had completed the Family Partner or Family Education program in the previous three to six months in order to assess the long-term impact of their program. Because phone calls occurred during the same time as surveys to clients ending services, all data comparisons between groups is cross-sectional. Thompson called all eligible families at least once and, if no one was reached the first time, a voicemail was left (when voicemail was available) briefly describing Thompson's program evaluation project. Caregivers who did not return Thompson's phone call within

a week were contacted up to two additional times before they were removed from the call list.

If a caregiver were successfully reached via phone, Thompson's evaluation staff provided a brief explanation of the project, verbally reviewed the informed consent form, and asked caregivers if they agreed to participate before administering the survey questions. At the conclusion of the survey, caregivers were asked to provide their current mailing address so that a $5 Walmart gift card could be sent to them.

2.3 Measures

This study focused on survey responses from five primary areas: residential mobility, social support, caregiver stress, family resources/needs, and child and family well-being. Please see Appendices A-D for complete copies of the surveys. Neighborhood quality measures, based on the addresses that caregivers provided, come from the Charlotte Quality of Life Explorer (City of Charlotte & Mecklenburg County, 2015).

Residential Mobility: Several different items were used to capture the nature of residential mobility among CPS-involved families. To determine the frequency of residential mobility, caregivers were asked how many times their family had moved during the previous two years. If caregivers had moved in the last two years, they also provided the addresses of each of the moves and if the new address was "closer", "farther", or the "same" distance from supportive individuals. Additionally, caregivers provided the reason for each of their moves during the past two years. The total number of moves, the reason for the move (coded into common categories), and the description of

the distance (e.g., "farther", "closer", or "the same") of their most recent move from supportive others were used for analyses.

Social Support: An abbreviated version of the Assessment of Social Connectedness (ASC; Cook & Kilmer, 2010) was used to assess participants' perceived social support. The ASC was developed and piloted through a collaborative effort in Mecklenburg County, North Carolina as part of the National Longitudinal Study of Systems of Care (SOC). The 5-item measure assesses perceptions of available support across five dimensions, i.e., *tangible* (e.g., transportation, food), *financial* (e.g., help paying bills), *emotional* (e.g., reassurance, encouragement), *information* (e.g., someone to give you advice), and *help getting through a crisis* (e.g., someone to call in an emergency). Caregivers were asked to indicate "yes" or "no" if they had received each form of support in the last six months. If caregivers responded that they had received that form of support, they were asked to specify who provided the support. Several sources of social support were listed (e.g., family, spouse/partner, co-worker, church, friends, etc.) so that caregivers could select as many as were applicable and could write-in sources that were not listed but who may have provided support. Total scores of the number of sources of support and types of support were used for analyses.

Caregiver Stress: Caregiver stress was assessed using participants' responses to two survey questions. First, caregivers indicated their overall level of stress on a scale of one (no stress) to ten (extremely stressed). Then, the survey included an open-ended item that asked caregivers "what is your primary source of stress right now?". Responses were coded into common categories, following a constant comparative method. The primary investigator (PI) for the present study identified emergent themes and categories based on

common and recurring caregiver responses. Once all of the categories were identified, the PI assigned each response to a group. Two fellow graduate students independently reviewed the responses and categorized them into groupings of the common themes that they identified. Then, the PI and the two independent raters discussed their categorizations and re-evaluated the classifications until a consensus about all survey responses was reached. All raters agreed on the initial classifications and re-evaluation was not needed due to the consensus among raters.

Family Resources: Caregivers' perception of their resources and ongoing needs were assessed using the Family Resource Scale (FRS; Dunst & Leet, 1987). On the 28-item version of the FRS used in the current research, caregivers use a five-point scale to rate the adequacy of resources available to meet the family's needs. The range of resources included access to basic needs (e.g., food, shelter, etc.), financial resources, transportation, health care, child care, and time to be alone or with others. For this study, the subscales that were validated in Van Horn and colleagues' study (2001) were used provide an assessment of the perceived adequacy of families' resources in each area. In addition, for each resource, caregivers who worked with a Family Partner also indicated if it was something that their FP had helped them address; this adaptation to the FRS was made to facilitate understanding of the needs Family Partners' areas of focus with families. The coefficient alpha reliability for the FRS = .92, the split-half reliability coefficient with a Spearman-Brown correction for length = .95, and the test-retest reliability correlation for a 2 to 3 month period = .50, indicate that the FRS is an empirically valid and reliable rating scale (Dunst & Leet, 1987). Each total subscale score was used for analyses.

Child and Family Well-Being: The final domain, child and family well-being, was measured using the Protective Factors Survey (PFS). The PFS is an empirically valid and reliable rating scale that was designed to assess multiple protective factors related to child maltreatment, i.e., factors or conditions that reduce the risk for child maltreatment (Counts, Buffington, Change-Rios, Rasmussen & Preacher, 2010). Caregivers rate statements about their family on a seven-point frequency/agreement scale, resulting in five protective factor scores of domains associated with a lower incidence of child maltreatment. Subscale scores demonstrate high internal consistency (alpha = .76- .89) and adequate test-retest reliability (.52 - .75). The family functioning, child development/knowledge of parenting, and nurturing and attachment subscales of the PFS were included in the present survey and used in analyses. The family functioning subscale assesses the presence of families' adaptive skills and strategies when problems arise (e.g., we talk about problems, we take time to listen to each other, we are able to solve problems together). The child development/knowledge of parenting subscale gauges caregivers' understanding and use of effective approaches to managing child behavior and the presence of age-appropriate expectations for children's abilities (e.g., I know how to help my child learn, there are times I don't know what to do as a parent, I praise my child when he/she behaves well). Finally, the nurturing and attachment subscale assesses the emotional connection and amount of positive interactions between a caregiver and their child (e.g., my child and I are very close to each other, I am happy being with my child, I am able to soothe me child when he/she is upset).

Neighborhood Quality: The addresses that caregivers provided were linked to Charlotte's Neighborhood Quality of Life Explorer in order to determine the

neighborhood quality of caregivers' residences. The Neighborhood Quality of Life Explorer is an online database created in partnership between the City of Charlotte, Mecklenburg County, and the UNC Charlotte Urban Institute. The Explorer data capture social, housing, economic, environment, and safety conditions in Charlotte's neighborhoods (City of Charlotte & Mecklenburg County, 2015). In the Quality of Life Explorer, neighborhoods are defined as Neighborhood Profile Areas (NPA) that are based on census tracks but have been modified into smaller areas that are consistent with residents' views of neighborhood boundaries. Over 80 variables provide detailed information about each neighborhood that is organized into nine dimensions (City of Charlotte & Mecklenburg County, 2015). The current study used variables from the following dimensions: neighborhood economic characteristics (average household income and employment rate), safety (property and violent crime rates), housing (residential occupancy, rental costs, housing density, foreclosures, and home ownership rates), health (births to adolescents), education (proximity to child care and student absenteeism) and engagement (number of neighborhood organizations). If a participant provided multiple addresses for residences in which they have lived over the last two years, change scores for each of the neighborhood variables were calculated to determine the differences in neighborhood quality from one move to the next.

CHAPTER 3: RESULTS

In sum, 131 caregivers participated in Thompson's program evaluation surveys and, of those, only the 62 CPS-involved caregivers' responses (25 Family Education participants, 37 FP participants) were used in the present research ; families completing the courses voluntarily (69 total participants) were not included in the study's analyses. The majority of participants were women (84%), with an average age of 30 years (M = 29.71, SD = 8.16), although caregivers ranged in age from 17-62. Participants reported an average of three children in their home (M = 3.25, SD = .96). Ethnicity and income information were not available for the current sample. There were not significant differences in the available participant characteristics between the Family Partner and Family Education caregivers.

3.1 The Nature of CPS-Involved Caregivers' Residential Mobility

Descriptive statistics (e.g., means, standard deviations) were computed using IBM SPSS Statistical software to assess the frequency of residential mobility among CPS-involved families in the study. Caregivers were asked to indicate the number of moves that they had made in the past two years, ranging from 0 to "6+"which was coded as six moves for analyses. On average, caregivers reported two moves in the previous two years (M = 1.88, SD = .06), though this is likely a slight underestimate, given that 5 caregivers endorsed "6+" moves. While approximately half of participants had not moved in the

prior two years or had moved only once, a subset of caregivers (~15%) reported moving every few months. Table 1 illustrates the frequency of moves reported by participants. There were not statistically significant differences in the number of moves between FP participants (M = 1.89, SD = 2.05) and Family Education participants (M = 1.80, SD = 2.39), [$t(40) = .09$, $p = .93$]. Thus, CPS-involved caregivers in the study move, on average, once a year, with a small percentage of caregivers moving even more frequently.

Caregivers were asked to specify their reasons for moving during the past two years, and their qualitative responses were coded into categories by independent raters. Table 2 shows the frequencies of each category. In general, caregivers' primary reasons for moving were: limited financial resources, e.g., caregivers were evicted or the housing was not affordable (32%); temporary housing circumstances, e.g., living in a hotel, overcrowding because of doubling up, (29%); or unsafe housing, e.g., bad neighborhood, criminal activity (24%). In some instances, caregivers were able to secure better housing (e.g., better quality, more convenient location); however, this "upward mobility" was only reported approximately 13% of the time. Instead, in most instances, caregivers' moves could be considered "downward mobility" or "lateral moves" with no clear gains.

While income information was not available, the Family Resource Scale (FRS) provides some insight into caregivers' perceptions about the adequacy of their resources, and, in fact, participants rated the subscale of Money substantially lower (indicative of fewer perceived resources) than any of the other resource subscales. Additionally, the subscale was bimodally distributed, with 34% of caregivers rating the perceived adequacy of their financial resources as less than a 2 on a scale of 1 to 5, and 40% rating

the adequacy of their resources as 4 or above. Table 3 summarizes FRS descriptive statistics.

While CPS-involved caregivers tend to move because they lack the necessary financial resources to secure stable housing, changes in neighborhood quality indicators between moves were calculated to determine if moving results in any improved quality of life for families, at least at the neighborhood level. If caregivers had moved in the last two years, they provided the addresses of their three most recent residences. Neighborhood quality indicators were linked to each address and difference scores between the quality indicators were calculated for caregivers' most recent move. An examination of the change scores revealed that, on average, there is very little variation in caregivers' neighborhood quality after moving (see Table 4). This finding is consistent with caregivers' reports that moving is often due to a lack of financial resources to secure stable housing, rather than based on an opportunity for an improved neighborhood or better housing quality. Thus, while CPS-involved caregivers move, on average, once a year, they are gaining limited benefits, in terms of neighborhood quality, from their multiple changes in address because they are frequently moving between transitional living arrangements or because they lack the financial resources to remain in their current residence, rather than moving due to improved housing opportunities.

3.2 Caregiver Stress, Mobility, and Neighborhood Quality

Caregivers were asked to rate their stress on a scale of 1 to 10, with higher ratings indicative of more stress. On average, caregivers rated their stress a 7.00 (SD = 2.95). Notably 35% of caregivers rated their stress a 10. Overall, greater caregiver stress was associated with worse reported family functioning on the Protective Factors Survey,

[$r(29) = -.62$, $p < .001$]. Thus, CPS-involved caregivers report a great deal of stress, which is related to worse family functioning.

In order to determine the common sources of CPS-involved caregivers' stress, participants' responses to the survey question "what is your biggest source of stress/worry right now?" were coded into categories. The most frequently reported sources of caregivers' stress were: their CPS case, housing concerns, and finances. Table 5 lists the frequencies of each category. CPS-involvement and fear of losing custody of their child(ren) were common sources of stress for caregivers. Many caregivers' children had already been removed from the home and they reported that the loss of contact with their children was a major day-to-day stress. Additionally, unstable housing and moving were also primary sources of stress for these CPS-involved caregivers. Bivariate calculations further clarified that families with more moves also tended to report greater caregiver stress, but this relationship was not significant, [$r(35) = .22$, $p = .19$]. Finally, finances and, relatedly, employment were common categories of CPS-involved caregivers' stress. In fact, fewer perceived resources in any FRS domain (Basic Needs, Money, Time for Family, and Time for Self) were associated with more caregiver stress, although this relationship was not significant for Time for Family. Table 6 displays correlations among caregiver stress and the FRS domains of family resources. In sum, CPS-involved caregivers experience a great deal of stress in their everyday lives related to their CPS case, housing concerns, and finances and fewer perceived resources are associated with increased stress among CPS-involved caregivers.

Correlations between caregivers' stress rating and neighborhood quality indicators were computed, with the expectation that worse neighborhood quality would be related to

increased caregiver stress. One outlier, a caregiver living in a neighborhood with substantially better quality indicators than all others in the sample, was excluded from analyses about neighborhood quality. Notably, of all the neighborhood quality dimensions examined, none of the indicators were closely associated with caregiver stress. Table 7 displays correlations among neighborhood quality indicators and caregivers' stress ratings. While poor neighborhood quality can be a stressor for families, it appears that concerns about meeting basic family needs (e.g., stable housing, finances) are more closely related to CPS-involved caregiver stress. This lack of family resources is CPS-involved caregivers' greatest source of stress, and the current data suggest that it can contribute to an increased risk of residential mobility.

3.3 Caregiver-Child Relationship, Mobility and Neighborhood Quality

Because a hypothesis guiding the present study was that neighborhood quality and residential mobility would relate uniquely to the caregiver-child relationship, correlations were computed between the number of caregiver moves, neighborhood quality indicators, and the caregiver-child relationship (PFS) scores. More frequent residential mobility was not significantly associated with worse family functioning, [$r(34) = -.17$, $p = .32$] or poorer child development/knowledge of parenting, [$r(29) = -.22$, $p = .23$]. Conversely, however, moving more frequently was marginally associated with improved nurturing and attachment, [$r(29) = .34$, $p = .06$], with the correlation approaching statistical significance. In other words, CPS-involved caregivers who moved more often tended to report feeling better connected to their child (e.g., able to soothe them when they are upset, feel happy being with their child, and spend more time with their child). Frequent moving can disrupt family routines, and caregivers and children may develop a strong

connection to one another because they are unfamiliar with their new surroundings, or because other supportive individuals may no longer be close by (Belsky, 1993). Thus, the expected negative relationships between residential mobility and caregiver stress, family functioning, or poorer child development/ knowledge of parenting were not found. Contrary to expectations, however, caregivers moving more frequently had marginally better nurturing and attachment (PFS) with their child(ren).

Of all the neighborhood quality indicators explored, the number of neighborhood organizations was the only indicator that demonstrated a statistically significant correlation with the caregiver-child relationship. Specifically, the presence of more neighborhood associations was associated with caregiver reports of improved child development/knowledge of parenting on the PFS, [$r(24) = .51$, $p < .001$]. In other words, caregivers living in areas with more neighborhood associations were more likely to feel confident that they know how to help their child and respond to their child's needs. It is possible that the presence of neighborhood organizations provides increased opportunities to connect with other caregivers, however, the correlation between number of neighborhood associations and caregivers' reports of receiving some form of support from their neighbors in the previous six months (via the ASC) was not statistically significant, [$r(31) = .18$, $p = .32$].

After finding that the number of neighborhood organizations was the neighborhood quality indicator most strongly related to caregiver-child relationship, two hierarchical regressions were used to further clarify the relationships among child development/knowledge of parenting, neighborhood quality, and residential mobility. In the first regression, the number of neighborhood organizations was entered into the

model as the first predictor of child development/knowledge of parenting, and the number of moves in the previous two years was entered second. The results of the regression indicated that number of neighborhood organizations was a statistically significant predictor of child development/knowledge of parenting, explaining 23% of the variance in child development/knowledge of parenting, [$F(1,24) = 8.74$, $p < .01$]. However, after accounting for neighborhood organizations, residential mobility was not a significant predictor of the variance in child development/knowledge of parenting and was not part of the final model. In the second regression, the order of predictors was reversed, with residential mobility entered as the first predictor and neighborhood organizations as the second predictor. In this analysis, residential mobility did not reach significance and was excluded from the final model; the number of neighborhood organizations was the primary predictor of the variance in child development/knowledge of parenting. Thus, living in a neighborhood with more neighborhood organizations was predictive of better child development/ knowledge of parenting among CPS-involved caregivers.

3.4 The Nature of CPS-Involved Caregivers' Social Support

Descriptive statistics (e.g., means, standard deviations, frequencies) were computed to explore the total amount, the different types, and the various sources of social support that caregivers report (e.g., family, friends, church, etc.). Although approximately 12% of caregivers reported that they did not receive any form of social support in the previous six months, most caregivers reported an average of four sources of support ($M = 3.95$, $SD = 2.55$) with family members (64% had received some form of support from them) reported to be the most frequent source, followed by friends (57%

had received support), a spouse or partner (50%), and service providers (50%). Caregivers were less likely to report that they had received support from a family support group (29%), church members (26%), their neighbors (24%), or coworkers (18%). Caregivers had received an average of 3-4 types of support in the last six months (M = 3.49, SD = 1.70). The most common forms of support that families received in the previous six months were emotional support (85%), advice or information (79%), help getting through a crisis (62%) or tangible support (62%). Caregivers were less likely to report that they had received financial support in the previous six months (45% received financial support). Thus, CPS-involved caregivers most often receive social support from friends, family, and their significant others, and this assistance is frequently in the form of emotional support, advice, or help getting through a crisis.

Caregivers in the Family Partner program also specified if Family Partners were a source of social support in different areas (e.g., tangible, financial, advice, etc.). On average, caregivers felt that they had received 1-2 forms of support from FPs (M = 1.46, SD = 1.44). Caregivers' social support ratings indicate that Family Partners most often provided advice or information (54%), emotional support (49%), and crisis support (24%). Caregivers were less likely to receive financial support (3%) or tangible support (16%) from Family Partners. Thus, the present findings suggest that, regardless of the source, caregivers are mostly likely to receive emotional support as well as advice and information. Despite CPS-involved caregivers' needs for additional financial assistance, it is the form of support that they were least likely to receive in the previous six months.

It was anticipated that more social support would be associated with lower stress ratings because caregivers would have a supportive network to rely on in times of need.

Instead, bivariate correlations revealed that caregivers' rating of their stress was significantly associated with the total number of different types of support (e.g., tangible, emotional, financial) that they received [$r(34) = .53$, $p < .01$] but unrelated to the total number of sources of support [$r(35) = .05$, $p = .79$]. In other words, caregivers experiencing high levels of stress are more likely than caregivers with lower stress ratings to have received several different forms of social support in the previous six months. Total number of different types of support was not significantly associated with family functioning [$r(34) = -.02$, $p = .90$], attachment [$r(30) = -.02$, $p = .92$], or child development/knowledge of parenting [$r(29) = -.19$, $p = .32$]. Similarly, total number of different sources of support was not significantly associated with family functioning [$r(35) = .27$, $p = .11$], attachment [$r(31) = .05$, $p = .78$], or child development/knowledge of parenting [$r(30) = .06$, $p = .76$]. Thus, CPS-involved caregivers with the highest stress ratings report receiving support in numerous areas, likely because they have particularly high levels of needs and the support that they receive may not be adequate for meeting all of their needs.

3.5 Social Support and Residential Mobility

It was anticipated that residential mobility would be particularly deleterious to the caregiver-child relationship when it results in a reduction in families' available social support. A hierarchical multiple regression was planned to establish the relationship between social support and residential mobility as predictors of the caregiver-child relationship. However, bivariate correlations revealed that there was not a significant relationship between the number of moves that caregivers reported in the last two years, the total number of sources of support [$r(40) = .12$, $p = .43$], or the types of support that

caregivers had received in the previous six months [$r(39) = .13$, $p = .42$]. As such, that multiple regression was not conducted.

The majority of the time, CPS-involved caregivers' moves were not to residences closer to their social supports. By caregivers' account, approximately 41% of their moves were to residences closer to supportive individuals, 36% were to residences the same distance away, and 23% were to housing further away from supportive family and friends. A one-way analysis of variance (ANOVA) was used to assess if caregivers' who reported their most recent move as distancing them from their social supports were more likely to report poorer relationships with their children (via the Family Functioning, Child Development/Knowledge of Parenting, and Attachment scales of the PFS). Caregivers' reported distance from support as a result of the move (i.e., farther, closer, the same) was not significantly related to family functioning [$F(2, 17) = 1.69$, $p = .21$], child development [$F(2, 14) = 1.06$, $p = .37$], or child attachment [$F(2, 14) = 3.00$, $p = .08$]. The present findings suggest that increasing social support is not a common reason CPS-involved caregivers move – only 8% of caregivers listed moving in with family as the primary reason for their move, and no participant reported that social support was the primary reason for any of their moves. Thus, within the current sample, the distance from social supports when CPS-involved caregivers move does not appear to have a significant impact on child and family outcomes and, in general, increasing social support is not a primary reason for residential mobility among CPS-involved caregivers. Instead, caregiver reports indicate that moving tends to be more related to finding a safe, affordable place to live.

3.6 Family Partner Involvement and Caregivers' Needs

When caregivers rated their needs on the Family Resource Scale they also indicated if their Family Partner had helped them in that area. On average, Family Partners assist families in four areas of need (M = 3.95, SD = 4.11), out of a possible 28 items listed on the FRS. Some of the most common areas of FP assistance were: someone to talk to (35%), employment assistance (27%), providing toys for their children (24%), and help obtaining public assistance (e.g., Supplemental Security Income (SSI), Supplemental Nutrition Assistance Program (SNAP), Medicaid; 19%). FPs were less likely to provide support in specific areas such as vacation time, helping caregivers find time to be alone or with others, or with medical or dental care. In general, caregivers rated the assistance provided by FPs as helpful: On a scale from (1) "very unhelpful" to (5) "very helpful", 88% of caregivers rated their FP as "very helpful" (M = 4.79, SD = .73*)*. Thus, Family Partners provide support for families in multiple different areas that are helpful for CPS-involved caregivers in the Family Partner program.

Follow-up Surveys: To provide information about longer-term family outcomes, survey responses of caregivers who recently completed the FP program were compared to families that completed the program three to six months ago for a cross-sectional examination. *T*-tests were computed to determine if clients who completed the program three to six months ago have more family resources (FRS), less caregiver stress (overall rating 1 to 10), and better family functioning (PFS) than participants who only recently completed the program. Table 7 includes all descriptives and *t*-test results. Using these cross-sectional data, only one difference between caregivers who recently completed the program versus those who ended their involvement months ago was statistically

significant. Specifically, caregivers who had completed their FP involvement three to six months ago rated the amount of time that they are able to spend with their family as more adequate than caregivers who had recently completed the FP program. Given that many participants who were completing the FP program reported that their child had been removed from their home during the ongoing investigation, it is not unexpected that, at follow-up, after the case is closed and children are returned to the home, caregivers would feel that they have more time to spend with their family.

It was anticipated that former FP participants would not move as frequently after their FP involvement because FPs had helped address residential mobility concerns with families. Within the current sample, FPs helped 16% of clients find housing or address their housing needs. Additionally, FPs provided assistance in many other areas of family need, such as seeking employment and accessing social services, which can often contribute indirectly to CPS-involved caregivers' residential stability.

In order to determine how many families had subsequently moved again, after FP involvement, the home address that participants provided to Thompson's evaluation staff at follow-up was compared with the home address caregivers had at discharge from the FP program. Descriptive statistics indicate that 67% of caregivers had moved at follow-up (6 out of 9). Thus, even after FP engagement, CPS-involved caregivers within the sample appear to still have high rates of residential mobility.

3.7 Summary

CPS-involved caregivers experience a great deal of stress in their everyday lives, with much of the stress related to not having enough resources, particularly financial resources, to meet their family's needs. Increased stress among caregivers within the

sample was associated with worse family functioning (PFS). Residential mobility is an additional stressor for CPS-involved caregivers, as they move, on average, once a year, with a subset of families moving every few months. CPS-involved caregivers are gaining limited benefits, in terms of neighborhood quality, from their multiple changes in address because they are frequently moving between transitional living arrangements or because they lack the financial resources to remain in their current residence, rather than moving to improve their housing or neighborhood quality. In fact, while poor neighborhood quality can be a stressor for families, it appears that the concerns for meeting basic family needs are much more salient and direct contributors to CPS-involved caregiver stress, as none of the neighborhood quality indicators explored were closely associated with caregiver stress. The study's findings are consistent with the ecological model in which influences and settings that are located more proximally to children and the immediate caregiving process (e.g., basic family needs, housing) have a direct effect and, in turn, a greater impact on children's development and family functioning, whereas more distal influences (e.g., features of neighborhood quality) would be expected to have a less pronounced, indirect effect (Zielinski & Bradshaw, 2006). Thus, CPS interventions aimed at improving family resources or finances through employment opportunities or affordable housing opportunities could potentially have the greatest impact on improving family functioning and child outcomes through a reduction in caregiver stress, a known risk factor for child maltreatment.

More frequent residential mobility was not significantly related to worse family functioning (FRS) or poorer child development/knowledge of parenting (FRS); however, the association between moving more frequently and improved nurturing and attachment

(FRS) approached statistical significance. In other words, CPS-involved caregivers who move more report that they tend to feel better connected to their child (e.g., able to soothe them when they are upset, feel happy being with their child, spend a lot of time with their child), although more research is needed. For example, increased reliance and dependency may not be beneficial for children, who may be responsible for supporting their caregivers and taking on developmentally inappropriate roles. Thus, more research is needed to determine if increased attachment during times of residential instability is related to children deferring their own developmental needs to accommodate their caregivers' needs for instrumental and emotional support, which, over time, can result in increased stress and worse psychosocial adjustment (Chase, 1999; McMahon & Luthar, 2007).

CPS-involved caregivers living in areas with more neighborhood associations are more likely to feel confident that they know how to help their child and respond to their child's needs. Despite the potential benefit for caregivers, neighborhood associations or opportunities for social support from others was not frequently considered in caregivers' moving decisions. Instead, it appears that moving tends to be more related to finding an affordable place to live that is safe, rather than in a location near social supports. This suggests that CPS workers may want to help families consider housing options that are safe and affordable but also provide opportunities for caregivers to connect with other parents.

CPS-involved caregivers receiving more support actually have the highest levels of stress, likely because they also report the highest levels of need. For example, CPS-involved caregivers most often receive social support from friends, family, and their

significant others, and assistance is frequently in the form of emotional support, advice, or help getting through a crisis. CPS-involved caregivers may be receiving considerable support, especially during times of crisis, but they may still feel stressed because the received support is not meeting the primary source of stress related to financial needs. Future studies that incorporate caregivers' satisfaction with received support may further clarify the relationship between CPS-involved caregiver stress and social support networks.

By their account, CPS-involved caregivers experienced Family Partners as a helpful source of support, most frequently providing advice or information and emotional support. FPs also worked with families to understand and address multiple needs that they have, on average, collaborating around three to four different areas of concern. Most often, FPs provided families with employment assistance and help obtaining public assistance, both of which can contribute to caregivers' financial stability, a clear area of family need and caregiver stress. However, in a cross-sectional sample, indicators of family functioning (e.g., resources, quality of the caregiver-child relationship, rates of residential mobility) had not improved three to six months after clients had completed the program, with the exception that caregivers felt that they had more time to spend with their family (which may be due to the children being reunited with their parents).Thus, while it is perceived as helpful by caregivers, the FP program is a very short-term, time specific program that may not be able to address and resolve critical family needs within the 90-day period that FPs typically work with families.

CHAPTER 4: DISCUSSION

The present study sought to understand the nature of residential mobility among CPS-involved caregivers and its impact on the caregiver-child relationship, with the goal of illuminating factors that may reduce the risk of child maltreatment. Existing literature has demonstrated that residential mobility can result in increased caregiver stress, reduced connections with others, and, ultimately, potentially worse child outcomes. However, very few studies have examined residential mobility among CPS-involved caregivers, and even fewer have explored residential mobility as defined by the number of moves made by families rather than as a characteristic of the neighborhood (e.g., percentage of short-term renters, home ownership rates). The present study attempted to elucidate the mechanisms that may mediate the relationship between residential mobility, namely caregiver stress and social support, by exploring neighborhood quality and residential mobility as distinct potential stressors. Thus, the current research sought to understand the impact of both neighborhood conditions *and* residential mobility in order to inform CPS decision-making about the relative benefits of families moving to better quality neighborhoods or remaining in a current residence and focusing on improving conditions in that place. Additionally, the study explored the impact of a Family Partner program on potentially improving family outcomes and reducing the likelihood of subsequent residential mobility.

Although the research was not able to examine some key questions of interest due to some of the study's limitations, there were four key findings that can inform future research about residential mobility among CPS-involved families. First, much of CPS-involved caregivers' residential mobility is related to lack of financial resources to secure stable, affordable housing. Second, residential mobility does not typically result in improved neighborhood quality for families. Third, more social support is associated with higher levels of caregiver stress, and finally, although Family Partners assist families in multiple areas and are viewed by caregivers as helpful, their support does not appear to lead to longer-term benefits for families (because FP-involved families report many of the same resource-related challenges three to six months later). The paragraphs that follow will further clarify these study findings as well as discuss future directions.

4.1 Residential Mobility and Neighborhood Quality

One of the study's guiding research questions was, what is the nature of residential mobility among families involved with CPS? Findings indicate that a key way to reduce residential mobility among CPS-involved families is to address their financial needs or help them secure more affordable, long-term housing. Caregivers' reports that financial resources were inadequate for meeting their family's needs is consistent with existing research demonstrating that children from lower income families are more likely to be involved in CPS, and that limited access to economic resources is a primary risk factor for child maltreatment (Berger, 2004; Lee & Goerge, 1999). Caregivers' limited financial resources interfere with their ability to obtain stable, affordable housing. Efforts to reduce residential mobility must, then, focus on improving the long-term availability of affordable family housing.

Because families had limited finances for housing, it is perhaps not surprising that, when families moved, they were unlikely to move to better quality residences. In general, caregivers' limited options do not allow them to consider moving closer to supportive family members or friends, or to better quality housing or neighborhoods. CPS workers who may encourage families to move away from harmful circumstances should take steps to ensure that the housing options that families consider result in improvements in their living arrangements. Additionally, when caregivers are identifying new residences, CPS workers should encourage caregivers to consider moving to locations with neighborhood organizations. Neighborhood organizations potentially provide caregivers with the opportunity to connect with other parents and can support caregivers' confidence in their parenting ability and knowledge of parenting. However, the connection between the presence of more neighborhood organizations and improved parenting knowledge is preliminary and further research is needed to clarify and better understand the relationship.

4.2 Caregiver Resources, Stress and Residential Mobility

One goal of the present research was to understand the relationship between residential mobility and caregiver stress because research has consistently linked high-levels of reported parenting stress with an increased risk of child maltreatment (Curenton et al, 2009). CPS interventions aimed at improving family resources or finances through better employment opportunities, child care resources, or affordable housing could potentially have the greatest impact on improving family functioning and child outcomes through a reduction in caregiver stress. While poor neighborhood quality and residential mobility can be sources of stress for families, it appears that the concerns for meeting

basic family needs are much more salient and direct contributors to CPS-involved caregivers' stress and family outcomes. The study's findings are consistent with the ecological model in which influences and settings that are located more proximally to children and the immediate caregiving process (e.g., basic family needs, housing) have a direct effect and, in turn, a greater impact on children's development and family functioning, whereas more distal influences (e.g., features of neighborhood quality) would be expected to have a less pronounced, indirect effect (Zielinski & Bradshaw, 2006). Neighborhood characteristics, both positive and negative features of an area, have a significant influence on families' daily lives and are consistently related to the risk for child maltreatment (Fresisthler et al., 2006). Efforts to ensure that families are living in neighborhoods with more contextual resources (e.g., improved child care access, neighborhood organizations) and strengths like higher levels of connectedness and a greater sense of community should be important components of CPS-interventions. However, improving the adequacy of CPS-involved caregivers' resources to meet their needs is a substantive first step toward improved residential stability and one that may have the greatest impact on reducing caregiver stress and, ultimately, improving child and family outcomes. Future studies should explore the relationship between residential mobility and neighborhood quality's impact on multiple different dimensions of stress and incorporate qualitative approaches to understanding caregivers' perceptions of residential instability. The current study only used a single rating of caregiver stress (on a scale of 0 to 10), which does not capture the multifaceted nature of stress. Caregivers experience diverse stressful life events, circumstances, and conditions, but their subjective appraisals (i.e., interpretations of the stressor) combined with adequate coping

strategies may affect the degree to which such adversities impact the caregiver-child relationships or family functioning. Research studies have demonstrated that caregivers' perceptions about different elements of the stressor such as perceived control, anticipated duration, and the familiarity with the stressor, all contribute to how distressing stressful events may be for caregivers (Vitaliano, Russo, Weber & Celum, 1993). For example, residential mobility may be very stressful for families but, because it is time limited or relatively common, it may not have an immediate, negative impact on caregivers' stress. Additionally, qualitative studies of caregivers' experiences of residential instability could provide insight into its unique impact on the caregiver-child relationship. In the present work, more residential mobility was marginally, and unexpectedly, associated with caregivers' ratings of higher levels of nurturing and attachment. Thus, future studies that incorporate multiple dimensions of stress and caregivers' qualitative experiences of housing instability will enhance our understanding of the relationship between residential mobility and stress.

4.3 Social Support

Findings indicate that residential mobility is more closely related to finding a safe, affordable place to live, rather than finding a location that is near social supports. The current research explored the nature of the relationship between social support and residential mobility among CPS-involved families. The impact of frequent residential mobility on caregivers' relationships with supportive others is unclear based on the current study; the present results indicate that a substantial proportion of moves do not bring caregivers closer (in terms of distance) to potentially supportive others, and caregivers reported that supportive others were not a primary reason for moving. Future

studies should examine caregivers' perceptions about the changes in their relationships with supportive others before, during, and after moves as well as periods of high residential mobility (e.g., multiple moves in a year). The current study only examined the distance from supportive others of CPS-involved caregivers' most recent move. Additionally, relationships with supportive individuals may be disrupted by factors other than distance of the move. For example, if caregivers are living doubled up with other family members, moving further away to their own residence may be beneficial for their relationships. Thus, further research is needed to understand the impact of residential mobility on CPS-involved caregivers' social networks.

The current study's findings also suggest that the social support that caregivers' receive is likely insufficient, as it may meet part of their needs for emotional or informational support, but it is inadequate for alleviating the most common source of their stress, financial concerns. The family stress model describes a process by which financial-related strain and deprivation, in particular, can be detrimental to the caregiver-child relationship because of diminished caregiver coping resources (Conger et al., 2002). The experience of severe economic pressure, which many caregivers in the current study report experiencing, undermines caregivers' mental health and the quality of the caregiver-child relationship. CPS workers should conduct ongoing assessments of, not only the amount of social support that caregivers receive, but also how well-matched the support is to caregivers' current needs. Identifying ways in which social support networks are inadequate for meeting caregivers' needs and providing targeted resources to supplement social support networks could result in improved family outcomes. Additionally, future studies that incorporate caregivers' satisfaction with received support

may further clarify the relationship between CPS-involved caregiver stress and social support networks.

4.4 Family Partner Support

Family Partners assist CPS-involved families in a number of different areas and are viewed as a helpful resource; however, based on the present cross-sectional survey data, families' circumstances were not significantly different from case closure to three to six months after involvement in the program. Unlike CPS workers, Family Partners are trained paraprofessionals who are uniquely positioned to understand families' needs and empower families because they collaborate in a strengths-based way with caregivers. The present study sought to answer, what is the relationship between Family Partner involvement and caregivers' needs (i.e. family resources, caregiver-child relationship, and residential mobility)? Caregivers did, indeed, report that FPs were very helpful partners throughout their CPS case, providing mostly advice or information and emotional support to help address multiple family needs (on average 3 to 4 different areas). However, the cross-sectional examination of families' outcomes (e.g., rates of residential mobility, family needs, quality of caregiver-child relationship) at case closure and three to six months after program involvement did not significantly differ. Due to the small sample size, it is unclear how representative the two sets of respondents were of their respective groups. However, the findings preliminarily suggest that families' circumstances, even after FP involvement, remain relatively the same.

Future research involving a larger sample, followed longitudinally, should explore if longer-term Family Partner involvement improves family functioning and broader family outcomes and reduces the likelihood of subsequent child maltreatment. The FP

program is clearly a valuable resource for CPS-involved families to help alleviate some of their fear and hopelessness by building trusting relationships and offering support in order to promote the best child and family outcomes. However, the program is a very short-term, circumscribed program that may not be able to address and resolve critical family needs within the 90-day period that FPs typically work with families. Caregiver stress and family resources had not notably changed at follow-up three to six months later, with the exception of caregivers being able to spend more time with their family. It is perhaps unsurprising that families' circumstances had not significantly changed because caregiver stress and family resources are multiply determined and complex issues for any program to attempt to address. Future studies should explore if expanding FP programs or other CPS interventions to address caregivers' greatest area of need, financial support, may also improve families' long-term outcomes. It bears mention that the current study only incorporated caregivers' self-reports and did not incorporate information collected by CPS (e.g., family risk level, number of CPS involvements) into the examination of family outcomes. In order to strengthen the understanding of FP programs' impact, future studies should assess if FP involvement reduces the likelihood of subsequent CPS-involvement and reports of child maltreatment.

4.5 Limitations and Conclusions

There were several limitations of the current research. Most significantly, the relatively small sample size limited statistical power and may have contributed to the difficulty establishing significant relationships among variables of interest. The small sample size was further reduced by a great deal of missing information from incomplete survey responses. Despite efforts to ensure confidentiality, the majority of caregivers in

the study were currently involved in CPS and fears of losing custody of their child(ren) may have contributed to participants leaving items blank or providing more positive reports of family circumstances. Additionally, because participants were all receiving services at Thompson, it is impossible to ascertain whether participants in this study's sample are representative of CPS-involved caregivers.

The surveys captured a great deal of information, however, ideally future research would incorporate questions about families' income, participants' perspectives of their neighborhood, and more information about the other services that caregivers are receiving (e.g., substance abuse services, housing vouchers). Ideally future research should also incorporate objective indicators of what specific kinds of services FPs provided from agency records in addition to caregivers' perceptions of the services that they received, because the study's sole on caregivers' self-reports are subject to individual biases. Additionally, incorporating children's perspectives about their needs and family functioning would also enhance our understanding about the potentially unique impact of residential mobility on each family member. All caregiver responses reflect a single time point of data collection, however, relationships among residential mobility, neighborhood quality, and the caregiver-child relationship are likely complex. It may well be that future longitudinal explorations that take into account changes in residential mobility, family resources, social support, neighborhood quality, and the caregiver-child relationship over time reveal additional aspects regarding the nature of the relationships among these variables.

Despite the limitations, the present results do have implications for practice. Residential mobility is a symptom of a much larger issue among CPS-involved caregivers

who tend to lack financial resources for meeting their families' needs. A key way to reduce residential mobility is to address their financial needs or help them secure more affordable, long-term housing. In addition to reducing residential mobility, CPS interventions aimed at improving family resources or finances through better employment opportunities, childcare resources, or affordable housing could reduce caregiver stress, a known risk factor for child maltreatment. CPS interventions targeted to address families' lack of financial resources are critical because most of the social support that caregivers receive and CPS programs like the Family Partner program typically do not assist caregivers with their financial needs. Thus, CPS interventions that incorporate ways to improve the adequacy of financial resources available for meeting families' needs could reduce caregiver stress, improve family functioning, and reduce residential mobility, potentially decreasing the risk for subsequent child maltreatment.

When CPS workers require families move to new residences, they should assist families with ensuring that there are options for social support within the neighborhood like neighborhood associations, the housing is affordable long-term, and it results in improved neighborhood quality. The present study sought to understand the unique contributions of residential mobility and neighborhood quality; however, among CPS-involved caregivers, residential mobility was mostly unrelated to neighborhood quality considerations. Because of lack of resources, families typically do not have the luxury of incorporating considerations about the distance from social supports or the quality of neighborhood conditions. CPS workers should assist families with incorporating other considerations in their move and provide resources so that families are moving to options

that will not result in subsequent mobility because they become unaffordable or because do not result in a significant improvement in families' circumstances

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TABLES

TABLE 1: Number of moves in previous two years among CPS-involved caregivers

	Frequency
Did not move	14 (33%)
1 move	10 (24%)
2 moves	6 (14%)
3 moves	3 (7%)
4 moves	2 (5%)
5 moves	2 (5%)
6+ moves	5 (12%)

N = 42 caregivers; 20 participants did not provide responses to the question

TABLE 2: Frequencies of the coded responses to reasons for moving

	Frequency
Eviction/No Option to Stay	8
Safety	4
Crowded	4
Temporary Living Arrangement	3
Moved in with Family	3
Better Quality Housing	3
Not Affordable	3
Fire	3
More Convenient Location	2
Bad Memories in Home	1
Unknown/Unable to Code	4

Note. N = 21 caregivers provided 38 responses. Participants provided a reason for each move (up to three)

TABLE 3: Family Resource Scale (FRS) descriptives

	M (SD)	Scale range
Money	3.01 (1.52)	1-5
Basic Needs	4.27 (.89)	1-5
Time for Family	4.33 (.87)	1-5
Time for Self	3.71 (1.12)	1-5

Note. Sample size = 40-41; Higher scores indicate more adequate resources

TABLE 4: Descriptive statistics of caregivers' current neighborhood quality, difference scores from previous move, and county averages

	M (SD)	Diff score (*M, SD)*	County avg.
Housing Density (units per acre)	2.07 (1.03)	.12 (.80)	1.2
Home Ownership (% of units)	42.40 (20.74)	4.7 (27.28)	59.5%
Rental Costs (median gross rent)	$845.26 (203.19)	$49.30 (220.46)	$921
Residential Occupancy (% of occupied units)	88.26% (6.18)	1.00 (9.15)	91.1%
Employment Rate (% in workforce)	82.10% (11.88)	7.9 (14.83)	89%
Number of Neighborhood Orgs.	1.9 (1.88)	-.20 (2.44)	--
Avg. Household Income (median)	$39,121 (18,459)	$159.70 (20,934)	$63,798
Property Crime (per 1,000 residents)	48.66 (30.33)	-.84 (42.62)	33.5
Violent Crime (per 1,000 residents)	10.15 (8.67)	.36 (16.36)	4.4
Child Care Proximity (units within ½ mile of licensed early care)	79.78 (32.32)	9.2 (27.15)	65.6
Student Absenteeism (% absent 10 days or more)	11.46% (4.05)	-1.9 (4.31)	8.2%
Foreclosure rate (% of housing units)	1.34% (.82)	.77 (.81)	1.1%

Births to Adolescents (% of births to females under 19)	6.36% (4)	.38 (2.86)	3.5%

Note. Sample size = 50 participants provided addresses that could be linked to NPA characteristics; 10 participants provided enough data to calculate difference scores between moves; There are 689 neighborhood organizations but data for averages are not available

TABLE 5: Frequencies of coded caregiver reported primary sources of stress

	Frequency
Finances	8
YFS Case/Custody Decisions	7
Housing	7
Employment	7
Physical Health Concerns	3
Child(ren)'s Well-Being	3
Children Were Removed From Home	3
Relationships With Family	2
Moving	2
Mental Health Concerns	2
Safety	1
Transportation	1
Self-Sufficiency	1
Other	2

Note. N = 35 caregivers provided 52 responses; *caregivers sometimes provided more than one response to the question.*

TABLE 6: Correlations among caregivers' self-rated stress and FRS

Variable	1	2	3	4	5
1. Stress level	-	-.41*	-.60**	-.25	-.41*
2. Basic Needs		-	.67**	.46**	.56**
3. Money			-	.39*	.39*
4. Time for Family				-	-.39*
5. Time for Self					

Note: N = 36-41. *=$p < .05$, ** = $p < .01$

TABLE 7: Correlations among caregivers' self-rated stress and neighborhood quality indicators

	r with Caregiver Stress
Housing Density (units per acre)	-.09
Home Ownership (% of units)	-.13
Rental Costs (median gross rent)	-.22
Residential Occupancy (% of occupied units)	-.01
Employment Rate (% in workforce)	-.12
Number of Neighborhood Orgs.	-.26
Avg. Household Income (median)	-.05
Property Crime (per 1,000 residents)	.10
Violent Crime (per 1,000 residents)	,18
Child Care Proximity (units within ½ mile of licensed early care)	-.15
Student Absenteeism (% absent 10 days or more)	.18
Foreclosure rate (% of housing units)	-.17
Births to Adolescents (% of births to females under 19)	.04

N = 28; Not all participants provided addresses or addresses that could be linked to NPAs; No correlation was significant at the $p \leq .05$ or $p \leq .01$ lev

TABLE 8: Descriptive statistics and significance tests for caregivers' PFS, FRS, and stress level ratings

Outcome	Group						95% CI for Mean Difference		
	Case Closure			Follow-Up					
	M	SD	n	M	SD	n		t	df
Family Functioning	5.49	1.40	25	5.70	0.99	10	-1.20, 0.79	-0.42	33
Nurturing & Attachment	6.44	0.94	24	6.84	0.23	8	-0.83, 0.02	1.95	30
Child Development	5.67	1.02	23	5.83	0.58	8	-0.94, 0.63	-0.40	29
Basic Needs	4.22	0.92	26	4.68	0.48	9	-1.13, 0.19	1.44	33
Money	3.06	1.50	26	3.22	1.68	10	-1.33, 1.01	-0.28	34
Time for Family	4.25	0.94	26	4.75	0.42	10	-0.96, -0.04	2.19*	34
Time for Self	3.84	1.09	25	3.77	1.10	10	-0.76, 0.91	0.17	33
Stress Rating	7.13	2.67	23	7.10	3.45	10	-2.22, 2.66	0.03	31

** $p < .05$.*

APPENDIX A: FAMILY PARTNER SURVEY AT CASE CLOSURE

FAMILY PARTNER
Caregiver Questionnaire

These questions are to find out about your experience with your Family Partner. Please circle your response to questions below.

1. Is this the first or second time your Family Partner has come to your home?

1st visit 2nd visit

2. How many times did you interact with your Family Partner BEFORE your CFT meeting?

0 1 2 3+

3. Did your Family Partner do a good job preparing you for the CFT?

YES NO N/A (no contact before)

4. How helpful for you was it to have your Family Partner at your CFT?

Very unhelpful	*Somewhat unhelpful*	*Neither helpful nor unhelpful*	*Somewhat Helpful*	*Very Helpful*	***N/A**, Not at CFT*

5. Overall, how helpful the Family Partner has been to you and your family?

Very unhelpful	*Somewhat unhelpful*	*Neither helpful nor unhelpful*	*Somewhat Helpful*	*Very Helpful*

6. Overall, how *responsive* (i.e., available and willing to talk) has the Family Partner been?

Very unresponsive	*Somewhat unresponsive*	*Neither*	*Somewhat responsive*	*Very responsive*

8. How could the Family Partner program be improved? _____

_____

_____

9. Overall, since you started the Family Partner program, would you say problems/difficulties with your child(ren)'s behavior have gotten ***better, worse, or stayed the same?***

Better *Worse* *Same*

Families have many needs. These next questions address whether or not your family has adequate (enough) resources to meet your needs.

a. Circle the response that fits your family's level of need.
b. Circle whether your Family Partner helped you address that need.

	Not at all adequate		*Sometimes Adequate*		*Almost always adequate*	Is this something your FP helped with*?*
10. Enough food for two meals a day	1	2	3	4	5	Yes No
11. House or apartment	1	2	3	4	5	Yes No
12. Money to buy necessities	1	2	3	4	5	Yes No
13. Enough clothes for your family	1	2	3	4	5	Yes No
14. Heat/AC for your house or apartment	1	2	3	4	5	Yes No
15. Indoor plumbing/water	1	2	3	4	5	Yes No
16. Money to pay monthly bills	1	2	3	4	5	Yes No
17. Good job for yourself or spouse	1	2	3	4	5	Yes No
18. Medical care for your family	1	2	3	4	5	Yes No
19. Public assistance (SSI, AFDC, Medicaid)	1	2	3	4	5	Yes No
20. Dependable transportation (own car or provided by others)	1	2	3	4	5	Yes No
21. Time to get enough sleep and rest	1	2	3	4	5	Yes No
22. Furniture for your home or apartment	1	2	3	4	5	Yes No
23. Time to be by self	1	2	3	4	5	Yes No
24. Time for family to be together	1	2	3	4	5	Yes No
25. Time to be with your children	1	2	3	4	5	Yes No

26. Time to be with spouse or close friend	1	2	3	4	5	Yes No
27. Telephone or access to a phone	1	2	3	4	5	Yes No
28. Childcare/daycare for your child(ren)	1	2	3	4	5	Yes No
29. Dental care for your family	1	2	3	4	5	Yes No
30. Someone to talk to	1	2	3	4	5	Yes No
31. Time to socialize	1	2	3	4	5	Yes No
32. Time to keep in shape and looking nice	1	2	3	4	5	Yes No
33. Toys for your child(ren)	1	2	3	4	5	Yes No
34. Money to buy things for self	1	2	3	4	5	Yes No
35. Money for family entertainment	1	2	3	4	5	Yes No
36. Money to save	1	2	3	4	5	Yes No
37. Travel/vacation	1	2	3	4	5	Yes No
38. Of those areas above that a Family Partner assisted with, what support was the **most helpful**?						

39. Were there things that your Family Partner addressed that your social worker did not?

YES NO

If yes, what were they?

_____
_____
_____

The questions below are to get an idea of what your family's living situation has been like recently.

40. In the past 2 years, how many times has your family moved? (circle)

None 1 2 3 4 5 6+

IF YOU ANSWERED "NONE" SKIP THE REST OF THIS PAGE AND GO ON TO THE NEXT PAGE (4). OTHERWISE, CONTINUE BELOW.

41. Please list up to 3 previous addresses of where you have lived in the past 2 years.

PREVIOUS ADDRESS	REASON FOR MOVING	**Compared to where you live now,** how far were you from supportive friends/ family? (circle)		
1.		Farther	Closer	The same
2.		Farther	Closer	The same
3.		Farther	Closer	The same

42. Overall, how stressed have you been during the past few months?

1 2 3 4 5 6 7 8 9 10

No stress *Somewhat stressed* *Extremely stressed*

43. What is your biggest source of stress/worry right now?

Circle the number that describes <u>how often</u> the statements are true for you or your family.

	Never	Very Rarely	Rarely	About half the time	Frequently	Very frequently	Always
44. In my family, we talk about problems.	1	2	3	4	5	6	7
45. When we argue, my family listens to "both sides of the story."	1	2	3	4	5	6	7
46. In my family, we take time to listen to each other.	1	2	3	4	5	6	7

47. My family pulls together when things are stressful.	1	2	3	4	5	6	7
48. My family is able to solve our problems.	1	2	3	4	5	6	7

[SKIP TO THE NEXT PAGE IF YOU DON'T HAVE ANY CHILDREN AT HOME]

Circle the number that best describes how much you <u>agree or disagree</u> with the statement.

	Strongly Disagree	Mostly Disagree	Slightly Disagree	Neutral	Slightly Agree	Mostly Agree	Strongly Agree
49. I have others who will listen when I need to talk about my problems.	1	2	3	4	5	6	7
50. There are many times when I don't know what to do as a parent.*	1	2	3	4	5	6	7
51. I know how to help my child(ren) learn.	1	2	3	4	5	6	7
52. My child(ren) misbehaves just to upset me.*	1	2	3	4	5	6	7

Circle the number that describes how <u>often</u> the statements are true for you or your family.

	Never	Very Rarely	Rarely	About half the time	Frequently	Very frequently	Always
53. I praise my child(ren) when he/she behaves well.	1	2	3	4	5	6	7
54. When I discipline my child(ren), I lose control.*	1	2	3	4	5	6	7
55. I am happy being with my child(ren).	1	2	3	4	5	6	7
56. My child(ren) and I are very close to each other.	1	2	3	4	5	6	7
57. I am able to soothe my child(ren) when he/she is upset.	1	2	3	4	5	6	7
58. I spend time with my child(ren) doing what he/she likes to do.	1	2	3	4	5	6	7

*reverse scored item. *[Protective factors survey]*

These last questions are about different kinds of support you may have received in the past 6 months. In the past 6 months, have you received:

59. Advice or information from someone? YES NO

If YES, who gave you advice or information? (Check all that apply)

□ Spouse/Partner □ Friends

□ Family □ Church

□ Family Partner □ Co-workers at job

□ Neighbors □ Family support group

□ Mental health/service provider □ Other _____

60. Emotional support from someone? YES NO

If YES, who gave you emotional support? (Check all that apply)

□ Spouse/Partner □ Friends

□ Family □ Church

□ Family Partner □ Co-workers at job

□ Neighbors □ Family support group

□ Mental health/service provider □ Other _____

61. Help with finances (help paying bills, gave money)? YES NO

If YES, who gave you help with finances? (Check all that apply)

□ Spouse/Partner □ Friends

□ Family □ Church

□ Family Partner □ Co-workers at job

□ Neighbors □ Family support group

□ Mental health/service provider □ Other _____

62. Tangible support like transportation, food, or housing? YES NO

If YES, who gave you tangible support? (Check all that apply)

□ Spouse/Partner □ Friends

□ Family □ Church

□ Family Partner □ Co-workers at job

□ Neighbors □ Family support group

□ Mental health/service provider □ Other _____

63. Help getting through a crisis? YES NO

If YES, who gave you help getting through a crisis? (Check all that apply)

□ Spouse/Partner □ Friends

□ Family □ Church

□ Family Partner □ Co-workers at job

□ Neighbors □ Family support group

□ Mental health/service provider □ Other _____

THANK YOU for your time and input!

APPENDIX B: FAMILY PARTNER FOLLOW-UP SURVEY

FAMILY PARTNER
Caregiver Questionnaire Follow-up

Caregiver Name _____ Date_____/_____/_____

Okay. So the first question I have for you is….

1. Did you have enough time with your Family Partner before the Child and Family Team (CFT) meeting?

YES NO

If no, Why not? _____

2. Did your Family Partner do a good job preparing you for the CFT?

YES NO N/A (no contact before)

3. Did your Family Partner attend the CFT meeting with you?

YES NO

4. How helpful for you was it to have your Family Partner at your CFT, on a scale from *very unhelpful, somewhat unhelpful, neither helpful nor unhelpful, somewhat helpful, or very helpful?*

Very unhelpful	*Somewhat unhelpful*	*Neither helpful nor unhelpful*	*Somewhat Helpful*	*Very Helpful*	***N/A**, Not at CFT*

5. Overall, how helpful was the Family Partner to you and your family on scale from *very unhelpful, somewhat unhelpful, neither helpful nor unhelpful, somewhat helpful, or very helpful?*

Very unhelpful	*Somewhat unhelpful*	*Neither helpful nor unhelpful*	*Somewhat Helpful*	*Very Helpful*

6. Overall, how *responsive* (i.e., available and willing to talk) was the Family Partner, on a scale from *Very unresponsive, Somewhat unresponsive, Neither, Somewhat responsive, Very responsive*?

Very unresponsive *Somewhat unresponsive* *Neither* *Somewhat responsive* *Very responsive*

7. Are you currently a primary caregiver of a child living in your home?

YES NO

If yes, *how many children?* 1 2 3 4 5+

8. ***[IF YES TO ABOVE]*** Overall, since participating in the Family Partner program, would you say problems/difficulties with your child(ren)'s behavior have gotten ***better, worse, or stayed the same?***

Better *Worse* *Same*

9. Did you complete the FP program? (completion is CFT + 2 home visits) YES NO

   a. **If no,** why not? _____
   b. What could anything have been done to help you complete it, if anything?

_____

10. How do you think the Family Partner program could be improved?_____

_____

These next questions are about needs that your family may have and resources to address those needs. I'll first ask you to tell me whether your family has enough resources to address these needs, from (1) not at all adequate to (5) almost always adequate. Next, I'll ask you whether this need is something your Family Partner helped you address.

	Not at all adequate	*A little bit adequate*	*Sometimes Adequate*	*Usually adequate*	*Almost always adequate*	Is this something your FP helped with?
11. Enough food for two meals a day	1	2	3	4	5	Yes No
12. House or apartment	1	2	3	4	5	Yes No
13. Money to buy necessities	1	2	3	4	5	Yes No
14. Enough clothes for your family	1	2	3	4	5	Yes No
15. Heat/AC for your house or apartment	1	2	3	4	5	Yes No
16. Indoor plumbing/water	1	2	3	4	5	Yes No
17. Money to pay monthly bills	1	2	3	4	5	Yes No
18. Good job for yourself or spouse	1	2	3	4	5	Yes No
19. Medical care for your family	1	2	3	4	5	Yes No
20. Public assistance (SSI, AFDC, Medicaid)	1	2	3	4	5	Yes No
21. Dependable transportation (own car or provided by others)	1	2	3	4	5	Yes No
22. Time to get enough sleep and rest	1	2	3	4	5	Yes No

23. Furniture for your home or apartment	1	2	3	4	5	Yes No
24. Time to be by self	1	2	3	4	5	Yes No
25. Time for family to be together	1	2	3	4	5	Yes No
26. Time to be with your children	1	2	3	4	5	Yes No
27. Time to be with spouse or close friend	1	2	3	4	5	Yes No
28. Telephone or access to a phone	1	2	3	4	5	Yes No
[SKIP IF NO CHILD IN HOME] 29. Childcare/daycare for your child(ren)	1	2	3	4	5	Yes No
30. Dental care for your family	1	2	3	4	5	Yes No
31. Someone to talk to	1	2	3	4	5	Yes No
32. Time to socialize	1	2	3	4	5	Yes No
33. Time to keep in shape and looking nice	1	2	3	4	5	Yes No
	Not at all adequate	*A little bit adequate*	*Sometimes Adequate*	*Usually adequate*	*Almost always adequate*	Is this something your FP helped with*?*
[SKIP IF NO CHILD IN HOME] 34. Toys for your child(ren)	1	2	3	4	5	Yes No
35. Money to buy things for self	1	2	3	4	5	Yes No
36. Money for family entertainment	1	2	3	4	5	Yes No
37. Money to save	1	2	3	4	5	Yes No
38. Travel/vacation	1	2	3	4	5	Yes No

39. Of all the areas that a Family Partner assisted with, what support was the **most helpful**?

40. Were there things that your Family Partner addressed that your social worker did not?

YES NO

If yes, what were they?

Thanks so much. The next questions are to get an idea of what your family's living situation has been like recently.

41. In the past 2 years, how many times has your family moved? (circle)

None 1 2 3 4 5 6+

IF THEY ANSWER "NONE" SKIP THE REST OF THIS PAGE AND GO ON TO THE NEXT PAGE. OTHERWISE, CONTINUE BELOW.

42. ***I'd like to ask about some of the places you lived before now. Do you know the address of the last place you lived?*** *[**even if they don't know the address, still ask their reason for moving and whether it was farther/closer/the same to supportive others**]*

    a. ***[IF YES] Okay what was the address? What was your reason for moving? Compared to where you live now, how far were you from supportive family/friends?***

    b. ***[IF APPLICABLE] you mentioned you've lived another place in the past 2 years. What was the address? What was your reason for moving? Compared to where you live now, how far were you from supportive family/friends?***

    c. ***[IF APPLICABLE] you mentioned you've lived another place in the past 2 years. What was the address? What was your reason for moving? Compared to where you live now, how far were you from supportive family/friends?***

PREVIOUS ADDRESS	REASON FOR MOVING (specific as possible)	**Compared to where you live now,** how far were you from supportive friends/ family? (circle)		
1.		Farther	Closer	The same
2.		Farther	Closer	The same
3.		Farther	Closer	The same

43. On a scale of 1-10 (1 being no stress and 10 being extremely stressed) what would you say your stress level has been during the past few months?

44. What is your biggest source of stress/worry right now?

Thanks for hanging in there. The next questions are about what your family is like. I'll ask you how often the statements are true for your family, on a scale from (1) never to (7) always.

	Never	Very Rarely	Rarely	About half the time	Frequently	Very frequently	Always
45. In your family, you talk about problems.	1	2	3	4	5	6	7
46. When you argue, your family listens to "both sides of the story."	1	2	3	4	5	6	7
47. In your family, you take time to listen to each other.	1	2	3	4	5	6	7
48. Your family pulls together when things are stressful.	1	2	3	4	5	6	7
49. Your family is able to solve your problems.	1	2	3	4	5	6	7

[SKIP IF NO CHILD IN HOME] These next questions are about you and your children. On the same scale from (1) never to (7) always, how often would you say you…

	Never	Very Rarely	Rarely	About half the time	Frequently	Very frequently	Always
50. You praise your child(ren) when he/she behaves well.	1	2	3	4	5	6	7
51. When you discipline my child(ren), you lose control.*	1	2	3	4	5	6	7
52. You are happy being with your child(ren).	1	2	3	4	5	6	7
53. You and your child(ren) are very close to each other.	1	2	3	4	5	6	7
54. You are able to soothe your child(ren) when he/she is upset.	1	2	3	4	5	6	7
55. You spend time with your child(ren) doing what he/she likes to do.	1	2	3	4	5	6	7

[SKIP IF NO CHILD IN HOME] Now I'm going to ask about how much you <u>agree or disagree</u> with each statement, on a scale from 1 to 7 where (1) is strongly disagree (4) is neutral and (7) is strongly agree.. I can repeat those as you wish.

	Strongly Disagree	Mostly Disagree	Slightly Disagree	Neutral	Slightly Agree	Mostly Agree	Strongly Agree
56. You have others who will listen when you need to talk about your problems.	1	2	3	4	5	6	7
57. There are many times when you don't know what to do as a parent.*	1	2	3	4	5	6	7

58. You know how to help your child(ren) learn.	1	2	3	4	5	6	7
59. Your child(ren) misbehaves just to upset you.*	1	2	3	4	5	6	7

*reverse scored item.

I just have a few last questions. These questions are about different kinds of support you may have received in the past 6 months. I'll then ask you about sources of support you might have had, and you can just say yes or no. In the past 6 months, have you received:

60. Advice or information from someone? YES NO

If YES, who gave you advice or information? (Check all that apply)

□ Spouse/Partner □ Friends

□ Family □ Church

□ Family Partner □ Co-workers at job

□ Neighbors □ Family support group

□ Mental health/service provider □ Other _____

61. Emotional support from someone? YES NO

If YES, who gave you emotional support? (Check all that apply)

□ Spouse/Partner □ Friends

□ Family □ Church

□ Family Partner □ Co-workers at job

□ Neighbors □ Family support group

□ Mental health/service provider □ Other _____

62. Help with finances (money or help paying bills) from someone? YES NO

If YES, who gave you help with finances? (Check all that apply)

□ Spouse/Partner □ Friends

□ Family □ Church

□ Family Partner □ Co-workers at job

□ Neighbors □ Family support group

□ Mental health/service provider □ Other _____

63. Tangible support like transportation, food, or housing? YES NO

If YES, who gave you tangible suppot? (Check all that apply)

□ Spouse/Partner □ Friends

□ Family □ Church

□ Family Partner □ Co-workers at job

□ Neighbors □ Family support group

□ Mental health/service provider □ Other _____

64. Help getting through a crisis? YES NO

If YES, who gave you help getting through a crisis? (Check all that apply)

□ Spouse/Partner □ Friends

□ Family □ Church

□ Family Partner □ Co-workers at job

□ Neighbors □ Family support group

□ Mental health/service provider □ Other _____

That's all the questions I have for you today. Thank you so much for your time and input.

I want to makes sure I get your correct address so that I can mail the $5 gift card to you. What is your address? [repeat back to check]_____

_____

Great! Thanks so much. I'll get that out in the mail. Have a great day.

APPENDIX C: FAMILY EDUCATION SURVEY AT CASE CLOSURE

FAMILY EDUCATION
Caregiver Survey

This class may have helped you in several ways. How much, if at all, have the classes helped you to:

	Helped a lot	*Helped a little*	*Didn't help / no change*	*Made it worse*
1. Learn new skills as a parent	4	3	2	1
2. Find better ways to discipline your child(ren)	4	3	2	1
3. Get support and understanding for feelings	4	3	2	1
4. Learn how to care for yourself	4	3	2	1
5. Learn how to better handle stress	4	3	2	1

6. Overall, how helpful has this class been for you and your family?

Very unhelpful	*Somewhat unhelpful*	*Neither helpful nor unhelpful*	*Somewhat Helpful*	*Very Helpful*

7. What was the most helpful thing about this class?

8. What would improve this class?

9. Are you currently a primary caregiver of child who lives in your home? YES NO

If YES, PLEASE CONTINUE BELOW. IF NO, SKIP TO PAGE #4

Below are a series of phrases that may describe your child/children's behavior. If you have more than one child, please answer about your children in general. Please:

(1) Circle the number describing how often the behavior currently occurs with your child, and

(2) Circle either "yes" or "no" to indicate whether the behavior is currently a problem for you.

	Never	*Seldom*	*Sometimes*	*Often*	*Always*			Is this a problem for you?	
10. Dawdles in getting dressed	1	2	3	4	5	6	7	Yes	No
11. Dawdles or lingers at mealtime	1	2	3	4	5	6	7	Yes	No
12. Has poor table manners	1	2	3	4	5	6	7	Yes	No
13. Refuses to eat food presented	1	2	3	4	5	6	7	Yes	No
14. Refuses to do chores when asked	1	2	3	4	5	6	7	Yes	No
15. Slow in getting ready for bed	1	2	3	4	5	6	7	Yes	No
16. Refuses to go to bed on time	1	2	3	4	5	6	7	Yes	No
17. Does not obey house rules on own	1	2	3	4	5	6	7	Yes	No
18. Refuses to obey until threatened with punishment	1	2	3	4	5	6	7	Yes	No
19. Acts defiant when told to do something	1	2	3	4	5	6	7	Yes	No
20. Argues about rules	1	2	3	4	5	6	7	Yes	No
21. Gets angry when doesn't get own way	1	2	3	4	5	6	7	Yes	No
22. Has temper tantrums	1	2	3	4	5	6	7	Yes	No
23. Sasses adults	1	2	3	4	5	6	7	Yes	No
24. Whines	1	2	3	4	5	6	7	Yes	No
25. Cries easily	1	2	3	4	5	6	7	Yes	No
26. Yells or screams	1	2	3	4	5	6	7	Yes	No
27. Hits caregivers	1	2	3	4	5	6	7	Yes	No
28. Destroys toys or other objects	1	2	3	4	5	6	7	Yes	No

	Never	*Seldom*	*Sometimes*	*Often*	*Always*			Is this a problem for you?	
29. Is careless with toys and other objects	1	2	3	4	5	6	7	Yes	No

30. Steals	1	2	3	4	5	6	7	Yes	No
31. Lies	1	2	3	4	5	6	7	Yes	No
32. Teases or provokes other children	1	2	3	4	5	6	7	Yes	No
33. Verbally fights with friends own age	1	2	3	4	5	6	7	Yes	No
34. Verbally fights with siblings(if applicable)	1	2	3	4	5	6	7	Yes	No
35. Physically fights with friends own age	1	2	3	4	5	6	7	Yes	No
36. Physically fights with siblings (if applicable)	1	2	3	4	5	6	7	Yes	No
37. Constantly seeks attention	1	2	3	4	5	6	7	Yes	No
38. Interrupts	1	2	3	4	5	6	7	Yes	No
39. Is easily distracted	1	2	3	4	5	6	7	Yes	No
40. Has a short attention span	1	2	3	4	5	6	7	Yes	No
41. Fails to finish tasks or projects	1	2	3	4	5	6	7	Yes	No
42. Has difficulty entertaining self alone	1	2	3	4	5	6	7	Yes	No
43. Has difficulty concentrating on one thing	1	2	3	4	5	6	7	Yes	No
44. Is overactive or restless	1	2	3	4	5	6	7	Yes	No
45. Wets the bed	1	2	3	4	5	6	7	Yes	No

The questions below are to get an idea of what your family's living situation has been like recently.

46. In the past 2 years, how many times has your family moved? (circle)

None 1 2 3 4 5 6+

IF YOU ANSWERED "NONE" SKIP THE REST OF THIS PAGE AND GO ON TO THE NEXT PAGE (5). OTHERWISE, CONTINUE BELOW.

47. Please list up to 3 previous addresses of where you have lived in the past 2 years.

PREVIOUS ADDRESS	REASON FOR MOVING	**Compared to where you live now,** how far were you from supportive friends/ family? (circle)		
1.		Farther	Closer	The same
2.		Farther	Closer	The same
3.		Farther	Closer	The same

48. Overall, how stressed have you been during the past few months?

1	2	3	4	5	6	7	8	9	10
No stress				*Somewhat stressed*					*Extremely stressed*

49. What is your biggest source of stress/worry right now?

Families have many needs. These next questions address whether or not your family has adequate (enough) resources to meet your needs. Circle the response that best fits your family.

	Not at all adequate		*Sometimes Adequate*		*Almost always adequate*
50. Enough food for two meals a day	1	2	3	4	5
51. House or apartment	1	2	3	4	5
52. Money to buy necessities	1	2	3	4	5

53. Enough clothes for your family	1	2	3	4	5
54. Heat/AC for your house or apartment	1	2	3	4	5
55. Indoor plumbing/water	1	2	3	4	5
56. Money to pay monthly bills	1	2	3	4	5
57. Good job for yourself or spouse	1	2	3	4	5
58. Medical care for your family	1	2	3	4	5
59. Public assistance (SSI, AFDC, Medicaid)	1	2	3	4	5
60. Dependable transportation (own car or provided by others)	1	2	3	4	5
61. Time to get enough sleep and rest	1	2	3	4	5
62. Furniture for your home or apartment	1	2	3	4	5
63. Time to be by self	1	2	3	4	5
64. Time for family to be together	1	2	3	4	5
65. Time to be with your children	1	2	3	4	5
66. Time to be with spouse or close friend	1	2	3	4	5
67. Telephone or access to a phone	1	2	3	4	5
68. Childcare/daycare for your child(ren)	1	2	3	4	5
69. Dental care for your family	1	2	3	4	5
70. Someone to talk to	1	2	3	4	5
71. Time to socialize	1	2	3	4	5
72. Time to keep in shape and looking nice	1	2	3	4	5
73. Toys for your child(ren)	1	2	3	4	5
74. Money to buy things for self	1	2	3	4	5
75. Money for family entertainment	1	2	3	4	5
76. Money to save	1	2	3	4	5
77. Travel/vacation	1	2	3	4	5

[Family Resource Scale]

These last questions are about different kinds of support you may have received in the past 6 months. In the past 6 months, have you received:

78. Advice or information from someone? YES NO

If YES, who gave you advice or information? (Check all that apply)

□ Spouse/Partner □ Friends

□ Family □ Church

□ Thompson Family Partner □ Co-workers at job

□ Neighbors □ Family support group

□ Mental health/service provider □ Other _____

79. Emotional support from someone? YES NO

If YES, who gave you emotional support? (Check all that apply)

□ Spouse/Partner □ Friends

□ Family □ Church

□ Thompson Family Partner □ Co-workers at job

□ Neighbors □ Family support group

□ Mental health/service provider □ Other _____

80. Help with finances (money or help paying bills) YES NO

If YES, who gave you help with finances? (Check all that apply)

□ Spouse/Partner □ Friends

□ Family □ Church

□ Thompson Family Partner □ Co-workers at job

□ Neighbors □ Family support group

□ Mental health/service provider □ Other _____

81. Tangible support like transportation, food, or housing? YES NO

If YES, who gave you tangible support? (Check all that apply)

□ Spouse/Partner □ Friends

□ Family □ Church

□ Thompson Family Partner □ Co-workers at job

□ Neighbors □ Family support group

□ Mental health/service provider □ Other _____

82. Help getting through a crisis? YES NO

If YES, who gave you help getting through a crisis? (Check all that apply)

□ Spouse/Partner □ Friends

□ Family □ Church

□ Thompson Family Partner □ Co-workers at job

□ Neighbors □ Family support group

□ Mental health/service provider □ Other _____

THANK YOU for your time and input!

APPENDIX D: FAMILY EDUCATION FOLLOW-UP SURVEY

FAMILY EDUCATION
Caregiver Follow-up Survey

Caregiver Name _____ Date_____/_____/_____

The class you took may have helped you in several ways. How much did the class help you to do the following things on a scale ranging from: (1) made it worse, (2) no change, (3) helped a little to (4) helped a lot.

So on a scale from (1) made it worse to (4) helped a lot, how much would you say this class helped you…	*Made it worse*	*No change (didn't help)*	*Helped a little*	*Helped a lot*
1. Learn new skills as a parent	1	2	3	4
2. Find better ways to discipline your child(ren)	1	2	3	4
3. Get support and understanding for feelings	1	2	3	4
4. Learn how to care for yourself	1	2	3	4
5. Learn how to better handle stress	1	2	3	4

6. Okay. This next question on a different scale. Overall, how helpful was this class been for you and your family, on a scale from *very unhelpful, somewhat unhelpful, neither helpful nor unhelpful, somewhat helpful to very helpful?*

Very unhelpful	*Somewhat unhelpful*	*Neither helpful nor unhelpful*	*Somewhat Helpful*	*Very Helpful*

7. What do you think was the most helpful thing about the class?

_____

_____

8. What would improve the class?

_____

_____

9. Are you currently a primary caregiver of a child or children who live in your home?

YES NO

If yes, how many children? 1 2 3 4 5+

If YES HAS CHILDREN, CONTINUE BELOW. IF NO, SKIP TO PAGE #4

I am going to describe some behaviors that children sometimes have. I'll ask you how often your child shows that behavior and whether that behavior is a problem for you. If you have more than one child, please answer the question about your children in general.

[FOR EACH ITEM BELOW ASK BOTH OF THESE]

A. On a scale from 1 to 7 where 1 is never and 7 is always, how often does your child/children…

B. Is this a problem for you?

	Never	*Seldom*	*Sometimes*	*Often*	*Always*			Is this a problem for you?	
10. Dawdles in getting dressed	1	2	3	4	5	6	7	Yes	No
11. Dawdles or lingers at mealtime	1	2	3	4	5	6	7	Yes	No
12. Has poor table manners	1	2	3	4	5	6	7	Yes	No
13. Refuses to eat food presented	1	2	3	4	5	6	7	Yes	No
14. Refuses to do chores when asked	1	2	3	4	5	6	7	Yes	No
15. Slow in getting ready for bed	1	2	3	4	5	6	7	Yes	No
16. Refuses to go to bed on time	1	2	3	4	5	6	7	Yes	No
17. Does not obey house rules on own	1	2	3	4	5	6	7	Yes	No
18. Refuses to obey until threatened with punishment	1	2	3	4	5	6	7	Yes	No
19. Acts defiant when told to do something	1	2	3	4	5	6	7	Yes	No
20. Argues about rules	1	2	3	4	5	6	7	Yes	No
21. Gets angry when doesn't get own way	1	2	3	4	5	6	7	Yes	No
22. Has temper tantrums	1	2	3	4	5	6	7	Yes	No

23. Sasses adults	1	2	3	4	5	6	7	Yes	No
24. Whines	1	2	3	4	5	6	7	Yes	No
25. Cries easily	1	2	3	4	5	6	7	Yes	No
26. Yells or screams	1	2	3	4	5	6	7	Yes	No
27. Hits caregivers	1	2	3	4	5	6	7	Yes	No
28. Destroys toys or other objects	1	2	3	4	5	6	7	Yes	No

	Never	*Seldom*	*Sometimes*	*Often*	*Always*			Is this a problem for you?	
29. Is careless with toys and other objects	1	2	3	4	5	6	7	Yes	No
30. Steals	1	2	3	4	5	6	7	Yes	No
31. Lies	1	2	3	4	5	6	7	Yes	No
32. Teases or provokes other children	1	2	3	4	5	6	7	Yes	No
33. Verbally fights with friends own age	1	2	3	4	5	6	7	Yes	No
34. Verbally fights with siblings(if applicable)	1	2	3	4	5	6	7	Yes	No
35. Physically fights with friends own age	1	2	3	4	5	6	7	Yes	No
36. Physically fights with siblings (if applicable)	1	2	3	4	5	6	7	Yes	No
37. Constantly seeks attention	1	2	3	4	5	6	7	Yes	No
38. Interrupts	1	2	3	4	5	6	7	Yes	No
39. Is easily distracted	1	2	3	4	5	6	7	Yes	No
40. Has a short attention span	1	2	3	4	5	6	7	Yes	No
41. Fails to finish tasks or projects	1	2	3	4	5	6	7	Yes	No
42. Has difficulty entertaining self alone	1	2	3	4	5	6	7	Yes	No
43. Has difficulty concentrating on one thing	1	2	3	4	5	6	7	Yes	No
44. Is overactive or restless	1	2	3	4	5	6	7	Yes	No
45. Wets the bed	1	2	3	4	5	6	7	Yes	No

The next questions are to get an idea of what your family's living situation has been like recently.

46. In the past 2 years, how many times has your family moved? (circle)

None 1 2 3 4 5 6+

IF THEY ANSWER "NONE" SKIP THE REST OF THIS PAGE AND GO ON TO THE NEXT PAGE (5). OTHERWISE, CONTINUE BELOW.

47. I'd like to ask about some of the places you lived before now. Do you know the address of the last place you lived? *[**even if they don't know the address, still ask their reason for moving and whether it was farther/closer/the same to supportive others**]*

- ***a. [IF YES] Okay what was the address? What was your reason for moving? Compared to where you live now, how far were you from supportive family/friends?***
- ***b. [IF APPLICABLE] you mentioned you've lived another place in the past 2 years. What was the address? What was your reason for moving? Compared to where you live now, how far were you from supportive family/friends?***
- ***c. [IF APPLICABLE] you mentioned you've lived another place in the past 2 years. What was the address? What was your reason for moving? Compared to where you live now, how far were you from supportive family/friends?***

PREVIOUS ADDRESS	REASON FOR MOVING (specific as possible)	**Compared to where you live now,** how far were you from supportive friends/ family? (circle)		
1.		Farther	Closer	The same
2.		Farther	Closer	The same
3.		Farther	Closer	The same

48. On a scale of 1-10 (1 being no stress and 10 being extremely stressed) what would you say your stress level has been during the past few months?

49. What is your biggest source of stress/worry right now? _____

_____

These next questions are about needs that your family may have and resources to address those needs. Please tell me whether your family has enough resources to address these needs, from (1) not at all adequate to (5) almost always adequate.

	Not at all adequate	*A little bit adequate*	*Sometimes Adequate*	*Usually adequate*	*Almost always adequate*
50. Enough food for two meals a day	1	2	3	4	5
51. House or apartment	1	2	3	4	5
52. Money to buy necessities	1	2	3	4	5
53. Enough clothes for your family	1	2	3	4	5
54. Heat/AC for your house or apartment	1	2	3	4	5
55. Indoor plumbing/water	1	2	3	4	5
56. Money to pay monthly bills	1	2	3	4	5
57. Good job for yourself or spouse	1	2	3	4	5
58. Medical care for your family	1	2	3	4	5
59. Public assistance (SSI, AFDC, Medicaid)	1	2	3	4	5
60. Dependable transportation (own car or provided by others)	1	2	3	4	5
61. Time to get enough sleep and rest	1	2	3	4	5
62. Furniture for your home or apartment	1	2	3	4	5
63. Time to be by self	1	2	3	4	5
64. Time for family to be together	1	2	3	4	5
65. Time to be with your children	1	2	3	4	5
66. Time to be with spouse or close friend	1	2	3	4	5
67. Telephone or access to a phone	1	2	3	4	5
[SKIP IF NO CHILD IN HOME] 68. Childcare/daycare for your child(ren)	1	2	3	4	5
69. Dental care for your family	1	2	3	4	5
70. Someone to talk to	1	2	3	4	5
71. Time to socialize	1	2	3	4	5
72. Time to keep in shape and looking nice	1	2	3	4	5
[**SKIP IF NO CHILD IN HOME]** 73. Toys for your child(ren)	1	2	3	4	5
74. Money to buy things for self	1	2	3	4	5

75. Money for family entertainment	1	2	3	4	5
76. Money to save	1	2	3	4	5
77. Travel/vacation	1	2	3	4	5

I just have a few last questions. These questions are about different kinds of support you may have received in the past 6 months. I'll then ask you about sources of support you might have had, and you can just say yes or no. In the past 6 months, have you received:

78. Advice or information from someone? YES NO

If YES, who gave you advice or information? (Check all that apply)

□ Spouse/Partner □ Friends

□ Family □ Church

□ (Thompson) Family Partner □ Co-workers at job

□ Neighbors □ Family support group

□ Mental health/service provider □ Other _____

79. Emotional support from someone? YES NO

If YES, who gave you emotional support? (Check all that apply)

□ Spouse/Partner □ Friends

□ Family □ Church

□ Family Partner □ Co-workers at job

□ Neighbors □ Family support group

□ Mental health/service provider □ Other _____

80. Help with finances (money or help paying bills)? YES NO

If YES, who gave you help with finances? (Check all that apply)

□ Spouse/Partner □ Friends

□ Family □ Church

□ Family Partner □ Co-workers at job

□ Neighbors □ Family support group

□ Mental health/service provider □ Other _____

81. Tangible support like transportation, food, or housing? YES NO

If YES, who gave you tangible support? (Check all that apply)

□ Spouse/Partner □ Friends

□ Family □ Church

□ Family Partner □ Co-workers at job

□ Neighbors □ Family support group

□ Mental health/service provider □ Other _____

82. Help getting through a crisis? YES NO

If YES, who gave you help getting through a crisis? (Check all that apply)

□ Spouse/Partner □ Friends

□ Family □ Church

□ Family Partner □ Co-workers at job

□ Neighbors □ Family support group

□ Mental health/service provider □ Other _____

That's all the questions I have for you today. Thank you so much for your time and input.

I want to makes sure I get your correct address so that I can mail the $5 gift card to you. What is your address? [repeat back to check]_____

_____

Great! Thanks so much. I'll get that out in the mail. Have a great day.