FAMILY STABILIZATION PROGRAM
EVALUATION REPORT
OSIRIS GROUP, INC.

January 11, 2010

Prepared by David S. Robinson, Ed.D.
Simmons School of Social Work
300 The Fenway
Boston, MA 02115

Prepared for Larry Higginbottom, LICSW
Osiris Group, Inc.
184 Dudley Street
Roxbury, MA 02119
ACKNOWLEDGEMENT

I would like to thank Simmons School of Social Work for the opportunity to develop and study the Osiris Group Family Stabilization and Support Program. During this evaluation many individuals contributed to the work including Johnnie Hamilton Mason, Stefan Krug, Abbie Frost, and Allyson Livingston. The CEO of Osiris Group, Larry Higginbottom, who was very generous in sharing information about Osiris Group background, and allowing access to workers and clients. All of the Osiris Group clinicians and mentors were very attentive to our presentations, questions and observations, and I want to thank them for allowing us to suggest methods to document service delivery and outcomes. I also want to thank my class, Rebecca Mirick, Jonghyun Lee, and Philip Decter, each contributed a great deal to the evaluation design and reporting. Finally, we could not have completed this evaluation report without the willing and voluntary participation of the parents and teens who completed questionnaires about their behaviors and feelings – this couldn’t not have been easy. I hope they know how valuable their feedback is to improving all of our efforts to help families become successful.
<table>
<thead>
<tr>
<th>TABLE OF CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgement .................................................................................................................. 2</td>
</tr>
<tr>
<td>Table of Contents ..................................................................................................................... 3</td>
</tr>
<tr>
<td>Table of tables ......................................................................................................................... 5</td>
</tr>
<tr>
<td>Table of figures .......................................................................................................................... 6</td>
</tr>
<tr>
<td>Executive Summary ..................................................................................................................... 7</td>
</tr>
<tr>
<td>Background and significance ...................................................................................................... 9</td>
</tr>
<tr>
<td>Family stabilization and support programs .................................................................................. 10</td>
</tr>
<tr>
<td>Brief Literature review of family stabilization services for african american families ....... 11</td>
</tr>
<tr>
<td>Methods ......................................................................................................................................... 15</td>
</tr>
<tr>
<td>Purpose of evaluation ............................................................................................................... 15</td>
</tr>
<tr>
<td>Evaluation questions ............................................................................................................... 15</td>
</tr>
<tr>
<td>Evaluation design: piloting a mixed methods approach ......................................................... 17</td>
</tr>
<tr>
<td>Measures ..................................................................................................................................... 19</td>
</tr>
<tr>
<td>Samples ....................................................................................................................................... 20</td>
</tr>
<tr>
<td>Demographic Characteristics of Parents ................................................................................ 21</td>
</tr>
<tr>
<td>Demographic Characteristics of Osiris Group Clinicians and Mentors ................................ 21</td>
</tr>
<tr>
<td>Similar Demographic and Cultural Characteristics of OG Staff and Parents ...................... 21</td>
</tr>
<tr>
<td>Analysis ....................................................................................................................................... 22</td>
</tr>
<tr>
<td>Online Surveys of Osiris Group Members .............................................................................. 22</td>
</tr>
<tr>
<td>Online surveys of DSS Referral Sources .............................................................................. 22</td>
</tr>
<tr>
<td>Osiris Group Activity Database ............................................................................................... 22</td>
</tr>
<tr>
<td>Parent, Teen and Osiris Group Member Questionnaires ....................................................... 23</td>
</tr>
<tr>
<td>Results ....................................................................................................................................... 24</td>
</tr>
<tr>
<td>Pre- post questionnaires: quantitative changes and challenges ........................................... 24</td>
</tr>
<tr>
<td>Parent Questionnaire Results ................................................................................................. 24</td>
</tr>
<tr>
<td>Worker Questionnaire Results ................................................................................................. 25</td>
</tr>
<tr>
<td>Teenager Questionnaires ......................................................................................................... 26</td>
</tr>
<tr>
<td>Interviews and online surveys: qualitative observations ....................................................... 28</td>
</tr>
<tr>
<td>Reported Program Philosophy ................................................................................................. 29</td>
</tr>
<tr>
<td>Teamwork and Clinician and Mentor Roles ............................................................................. 31</td>
</tr>
</tbody>
</table>
Osiris Group Member Online Survey Responses .................................................................32
Department of Social Services Referral Sources and Online Survey Responses ............40
Client and activity tracking database ..................................................................................41
Informal Narrative Summary of Osiris Data – Prepared by Philip Decter, LICSW ..........42
Conclusion ..........................................................................................................................44
Pilot Implementation of evaluation: successes and challenges ........................................44
Family Conditions ..........................................................................................................44
Resources in the Community ............................................................................................44
Confidence in Benefits of Service Process ......................................................................44
The Online Successful Case Method Survey ....................................................................45
Recommendations ............................................................................................................46
Installation of client tracking database for future program delivery and documentation ..46
Training and support for administration of standardized measures of outcome and process 46
Value of online surveys with referral agencies and clients to assess satisfaction with services ........................................................................................................................................46
Reference List ....................................................................................................................47
<table>
<thead>
<tr>
<th>TABLE OF TABLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1. Approach to Answering Evaluation Questions about Family Outcomes ........................................16</td>
</tr>
<tr>
<td>Table 2. Approach to Answering Analyses Questions about Children’s Outcomes .....................................16</td>
</tr>
<tr>
<td>Table 3. Approach to Answering Analyses Questions about Outcomes for Youth/Teens ..........................16</td>
</tr>
<tr>
<td>Table 4. Approach to Answering Analyses Questions about Observations by Clinicians and Mentors ..........................................................16</td>
</tr>
<tr>
<td>Table 5. Approach to Answering Analyses Questions about Observations of the Service Process ..................17</td>
</tr>
<tr>
<td>Table 6. Outcomes and Source of Measures ................................................................................................19</td>
</tr>
</tbody>
</table>
TABLE OF FIGURES

Figure 1. Osiris Group Family Stabilization Program Logic Model .............................................18
Figure 2. Osiris Group Data Elements for Tracking Activity with Clients ..................................41
EXECUTIVE SUMMARY

In the spring of 2006 the founder and CEO of the Osiris Group, Inc. (OG), Larry Higginbottom, approached Simmons School of Social Work (SSSW) faculty about conducting an evaluation of the Family Stabilization and Support Program of Osiris Group, Inc. For more than 5 years the Osiris Group, Inc. has pilot-tested and operated the Family Stabilization and Support Program (FSSP) with funds from the Massachusetts Child and Family Services (MCFS; formerly Massachusetts Department of Social Services – MDSS) and other funding sources including private insurance and health centers.

Observations and interviews with staff and administrators revealed that Osiris Group Family Stabilization Program is uniquely organized as a family of independent professional consultants and clinicians reporting to an executive administrator who guided their assignments, time and financial reporting, and priorities. Each clinician and mentor works as an independent sole proprietor to achieve common social work and clinical treatment goals depending on the family conditions and client needs.

The primary purpose of this study is to pilot-test a mixed-method evaluation of the effectiveness of the Osiris Group Family Stabilization Program model to improve family functioning and behaviors of referred parents, children and youth; and to assess the strengths and challenges of implementing ongoing program evaluation of OG programs. This information will be used to develop a greater awareness of the strengths and weakness of the model in an effort to learn about the best ways to support Black and Latino families who are at risk of an out of home placement.

The primary evaluation questions are:

- How effective are Osiris Group clinicians and mentors at reducing risk of placement for children and youth in families referred by DSS?
- How effective are Osiris Group clinicians and mentors at increasing parenting skills?
- How effective are Osiris Group clinicians and mentors at improving child and youth social skills and school outcomes for children and youth at risk for behavior problems?
- How effective are Osiris Group clinicians and mentors at improving family interaction with other community resources and providers?
- What are the challenges and success of integrating program evaluation activities with ongoing clinical and mentoring work of OG members and administration?

A total of 47 parents completed the demographic questionnaire (See attachment tables). A majority of parents were female (96%), between the ages of 26 and 41 years (71%), African American (55%) or Hispanic/Latina (21%). A majority of parents were single (51%) or divorced (28%). Two-thirds of the parents were born in the U.S. (64%), and most parents’ noted their primary language as English (87%). Nearly half of all parent respondents were Roman Catholic (45%) or Protestant (45%). Approximately one-third of parents were employed (34%). A quarter of parents were high school graduates (23%), and nearly half of parents had some college (28%), and 17% had a college degree.
A total of 22 OG members responded to the demographic questionnaire (see attachment tables). Half of OG staff were between the ages of 23 and 41 years (55%). Males and females were nearly equally divided (46% to 55%), and more than two-thirds of OG staff were African American (68%). Two-thirds of OG staff are married (64%). The majority of OG staff use English as their primary language (82%), and were born in the U.S. (77%). Two-thirds of OG staff are Protestant (64%). A majority of OG staff have college degrees (45%) or advanced degrees (36%). Nearly half of the OG staff reported their primary role at OG as clinician (48%), and over a third were mentors (38%). On average OG staff were carrying 7.6 cases at the time they completed the questionnaire, had an average of 2 years with OG, and had an average of 14 years experience working with children, youth and families.

For the most part, OG staff characteristics reflected the parent population at the time of the questionnaire was completed. There was no difference in age groups, country of birth, and primary language. There were more female parents than female OG staff (96% to 55% respectively). Parents and OG staff were similar in racial/ethnic characteristics. Slightly more OG staff were married, in the Protestant religion, and higher education levels. More OG staff were married than parent respondents (64% to 13% respectively).

This evaluation study found evidence of the benefits of the Osiris Group Family Stabilization model for involved families. Parents reported reduced self-reported symptoms of depression and sadness at or near the end of services compared to earlier in the service. Parents also reported a lower frequency of anxiety and worry at the post assessment than during the pre-assessment period. Self-reported frequency of conflicts with others were also lower at or near the end of the service period than reported at the beginning of services. In addition, parents reported improved and positive relationships with their clinician – a key indicator and predictor of successful behavior change according to other studies of the benefits of family services.

Child welfare specialists and researchers have identified isolation from community assets as a key factor that keeps family conflict from improving, and has been associated with increased family violence. Parents and Osiris Group members tracked referrals to and use of community resources during service delivery. Parents reported being referred most often to family counseling/therapy, after-school recreation programs, youth mentoring/tutoring, and teen community services. The majority of family members referred to community resources reported making contact with the referred sources.

The analysis also supports evidence for the prerequisites of improved family functioning, namely the confidence of mentors and clinicians to resolve conflict and exact change in the way the family communicates with members and helpers. Nearly all of the clinicians and mentors expressed confidence in their ability to help their clients reduce conflict and improve family relationships. A majority of clinicians and mentors also observed that family members and helpers were working on mutually agreed upon goals, on the importance of the goals being worked on during service delivery, and that both family members and helpers are confident that the work being done is useful. Furthermore, a majority of clinicians and mentors expressed appreciation of their clients’ struggles and believed there existed mutual trust in each other to accomplish real change for the good.
Clinicians and mentors were also largely in agreement with families on the steps that needed to be taken would reduce conflict and improve communication, conditions that led to the current problem situation for families. By the end of the service delivery period, mentors and clinicians reported that family members were able to discuss their beliefs and feelings without constraint, and family members were able to agree on what is important.

Osiris Group members referred family members most often to after-school and recreation programs, youth serving organizations in the community, family counseling, and educational programs within the community. Families were also referred to food resources, parent training programs, and other teen-focused resources in the neighborhood.

Osiris Group mentors and clinicians have adapted an objective risk assessment tool for youth whereby they are now documenting behaviors and conditions including school issues, conduct problems, eating disorders, substance abuse, violence and suicide risk. These assessments, if used during the service period, provides clinicians and mentors with objective data on current and changed conditions of youth in the families they serve. This data also provides objective evidence of the serious risks to youth in the population served by different insurance companies and the Massachusetts State health plan, Mass Health.

The online survey of clinicians and mentors provided evidence for the severity of conditions in which the current families are living, and the risk of placement for the children and young teens. Mentors and clinicians describe poor communication and emotional reactivity due to deep social and emotional losses, as major contributing factors to family conflict at the time of entry into the services of Osiris Group. They also describe the attitudes and behaviors of parents and teens that contribute to successful change during service delivery. The most frequent characteristic mentioned by clinicians and mentors is the willingness of family members to accept the work that is required to change – not all families are willing to do what it takes to change. Other conditions and factors in families that contribute to positive changes include: a willingness to care and listen to each other, taking time to communicate, hopefulness, and support for positive relationship between family and helpers.

The Massachusetts Department of Child and Family (DCF) workers who responded to the survey confirmed the positive view of Osiris Group clinicians and mentors. They reported that the service model used by Osiris Group workers works best with families in very complex situations, who are mostly African American and have teenagers. Because the referred families have many needs, Osiris Group uses a hands-on approach, making time to help address the families many needs and limited resources. DCF workers reported being “very satisfied” with the work, and planned to refer new families to the Osiris Group program in the future.

**BACKGROUND AND SIGNIFICANCE**

In the spring of 2006 the founder and CEO of the Osiris Group, Inc., Larry Higginbottom, approached Simmons School of Social Work (SSSW) faculty about conducting an evaluation of the Family Stabilization and Support Program of Osiris Group, Inc. For more than 5 years the Osiris Group, Inc. has piloted-tested and operated the Family Stabilization and Support Program.
(FSSP) with funds from the DCF; formerly Massachusetts Department of Social Services –DSS) and other funding sources including private insurance and health centers.

During the formative development of the FSSP, Osiris Group administration and staff have observed positive changes in families, children and youth participating in the program; and the rapid growth in demand from public and private sources of referrals have supported this anecdotal evidence of effectiveness. Until now, no formal or systematic documentation has been collected and used to objectively assess the anecdotal observations of successes and challenges. The openness of Osiris Group, Inc. (OG) administration and staff to collaborate on a pilot evaluation plan with Simmons School of Social Work is a positive strength usually reserved for more mature organizations and programs.

As discussions with senior faculty and leaders at SSSW continued through the fall and spring of 2007, informal meetings and different evaluation plans were shared and discussed. Formal meetings between faculty at SSSW and OG administrators and staff through 2007. An evaluation plan was formally approved in the fall of 2008. During 2006 and 2007 interviews were conducted with the CEO, DSS and selected staff of OG.

David S. Robinson and three doctoral students (Rebecca Mirick, Philip Decter, and Jonghyun Lee) continued to refine the evaluation plan in a course during the spring of 2008, creating measures and procedures to collect data at OG, beginning in late spring through December 2008. Background materials were collected, measures and data collection procedures were finalized by late spring of 2008. The scope of the evaluation plan was limited to the period beginning in the spring of 2007 (for activity tracking and analysis), and in the period of mid-May 2008 through November 2008 (for pre-post questionnaires and online surveys of OG staff and MCFS referral sources).

FAMILY STABILIZATION AND SUPPORT PROGRAMS

Observations and interviews with staff and administrators revealed that Osiris Group Family Stabilization Program is uniquely organized as a family of independent professional consultants and clinicians reporting to an executive administrator who guided their assignments, time and financial reporting, and priorities. Each clinician and mentor works as an independent sole proprietor to achieve common social work and clinical treatment goals depending on the family conditions and client needs.

The Family Stabilization service approach of Massachusetts assessed during the period of this evaluation was initially guided by the staff of the Department of Social Services (now Department of Children and Families – MDCF) as a contract with external providers for follow-up services after a serious report of child maltreatment or neglect (Massachusetts State Legislature). Families were referred to the Osiris Group Family Stabilization program after efforts to remedy the problems or conditions of the report to DCF appeared to be intractable and efforts by DCF were exhausted. Referrals from Boston and surrounding communities were documented by staff and administrators during the study period. Assignments of families to clinicians and mentors were made through the administrators, and DCF provided paperwork on prior work with the family and the initial reported problem.
In general, family stabilization services are administered by Family Stabilization Teams (FST)\(^1\). Family stabilization services typically include intensive in-home clinical and support services. These services are provided during an episode of psychiatric or acute emotional disturbance or crisis of a parent or child, an out of home treatment episode, or an out of home foster care placement (Osiris Group, Inc., 2003). FST services may also be accessed when a child or children in a family are at risk of an out of home placement.

The Osiris Group model as described in agency literature and available on the OG website (http://www.osirisgroup.org/) is comprised of teams consisting of a mental health clinician and a mentor (a counselor or clinician with experience in child welfare services in the community). The team is led by the clinician, but the clinician and mentor work closely together to help families acknowledge and make use of their strengths, identify and create relationships formal and informal social supports, and learn new skills of communication and ways of interacting in the home and the community (Higginbottom).

**BRIEF LITERATURE REVIEW OF FAMILY STABILIZATION SERVICES FOR AFRICAN AMERICAN FAMILIES**

The strengths-based values expressed in collaborative family-provider treatment models or “wraparound services” are often unmistakably clear, but the ways in which these services are carried out are often less so (Walker and Schutte). The value base that shapes wraparound programs is family-driven, based on an empowerment model, individualized, culturally competent, and community-based (Walker and Schutte). Practice guidelines, or tasks that clinicians and family members of wraparound teams actually do in the day to day to avoid out of home placement, are often vague. This lack of clarity may impact program effectiveness because information about best practices often does not exist. This often means that strategies for and information about supporting families does not exist for individuals who wish to do this work. Without this information, these practices cannot be evaluated or replicated. In other words, there is a lack of research about the theories that describe how wraparound services produce positive outcomes.

Walker and Schutte’s (2004) report highlighted the importance of family stabilization team process and structure. They found that highly structured team planning and goal setting, clear and timely feedback from all team members, member accountability, a process for information

---

\(^1\) Family stabilization services are defined by Massachusetts Budget Recommendation: FAMILY STABILIZATION AND PRESERVATION SERVICES 4800-0018 For family stabilization services and family unification services for non-placement families and for families whose children are expected to return home following placement, including, but not limited to, school and community-based young parent programs, parent and home health aides, education and counseling services, shelter services, substance abuse treatment, and respite care; provided, that the department shall pursue the establishment of public-private partnership agreements to fund family stabilization and family unification services from sources other than the commonwealth; and provided further, that the commissioner of social services may transfer a total amount not to exceed 15 per cent of the funds appropriated herein to items 4800-0031 and 4800-0041

Osiris Group Family Stabilization Program Evaluation Report
sharing between team members, generating and deciding on strategies and next steps, team cohesiveness, team efficacy, and equitable decision making produces positive outcomes.

These collaborative planning teams are widely used in the context of juvenile justice, child welfare and child mental health to support family systems as they negotiate involvement with these systems. The quality of interpersonal relationships between providers, family members and community members and the cohesiveness of the team are key to the success of this type of treatment model.

According to the authors’ report, little information exists about practical guidelines for family stabilization work. Unfortunately, the authors added to this lack of clear guidelines by failing to provide specific information how to facilitate multicultural wraparound teams whose members hail from a variety of places and different walks of life. If team members do not know how to be part of an effective and supportive team, the family stabilization process may be derailed. Information about how to mange an effective team is incredibly important to this type of work. The proposed evaluation will provide this information.

In 2004, Chafouleas and Witcomb (2004) published an evaluation of the Placement Prevention Program (PPP). The PPP is a collaborative, community-based program that focuses on the prevention of out of home placements for children. The PPP staff works with families to increase prosocial behaviors, with the goals of promoting school success, positive family interactions, and helping students avoid court involvement. The ultimate goal of the PPP is to reduce, divert, or provide alternatives to out of home placement (Chafouleas and Whitcomb). One of the underlying beliefs of PPP staff is that that collaboration between family systems and community agencies acts as a protection for and promotes resiliency in children. The PPP is based in western New York State and is a collaborative effort between DSS, the Youth Bureau, the Office of Mental Health, and the Probation Department.

The PPP is individualized for each student and program components include crisis intervention, counseling, intensive supervision, mentoring, and preventive programming. The PPP staff offer recreational and educational activities for students, parent support and education, housing assistance, escort services, and community linkages. Research shows that programs that offer mentoring, group education for parents and children, and social/ recreational activities often support the awareness and development of increased prosocial behaviors in parents and children (Barron-McKeagney, Woody, and D'Souza).

Work with families that are involved with DSS is often time and labor intensive. Involved families typically perform better when agencies are well-resourced, make use of flexible spending and a mix of concrete and clinical services (Barth et al.). Like the Osiris Group, the PPP staff use flexible time and financial arrangements to promote family and team connection.

The PPP evaluation team investigated the number of PPP cases, client demographics (by school, grade, gender, special education), reasons for referral, case status at the end of the school year, student progress (student attendance records, behavior, academic achievement), and problem severity from the beginning to the end of one school year (Chafouleas & Witcomb, 2004). The findings revealed that of the 98 students who participated in the program, nearly 80% of the students remained in the home, 22% achieved success and no longer required program
services, 57.1% continued to access the program services and only 3% were placed outside of the home. Students in the program demonstrated some improvement in school. Teachers and parents reported reduced problem severity. Parents benefited most from linkages with community resources. The evaluation team found the collaborative PPP model to be effective.

According to the findings, the PPP program had a positive impact. The report, however, did not provide information about race and ethnicity and the possible effects of race, socioeconomics, family structure or other contextual factors on the lives, beliefs, and behaviors of the participating families. The PPP seems holistic and comprehensive, but the impact of culture, history and possible racial oppression in the lives of many DSS involved families cannot be denied. This awareness and consideration may have strengthened their study findings and analysis.

A 2001 study highlighted the strength of inter-agency collaboration as a protection against family disruption (Walton). In this study, family preservation service (FPS) workers were paired with child protective service (CPS) workers to investigate the possible impact of this partnership on out of home placements, family satisfaction and worker job satisfaction. An FPS is synonymous with an FST. This study was conducted to assess the effects of FPS and CPS partnerships on child placement. Often, findings about the effects of FPS services, with or without the existence of CPS partnerships, are mixed, possibly overrated and plagued by poor research designs, limited measures of child and family functioning, and small samples (Walton, 2001).

The racial composition of the 125 families that participated in this study of Utah residents was 90% white and 7% Latino. The most common referring issue was physical abuse. Walton used a post-test only experimental design. Experimental families (n = 65) worked with CPS and FPS workers as a team and control families (n = 60) worked only with CPS workers. Findings revealed that there was no significant difference between the groups regarding the number of children maintained in the home. For children who were removed, however, those in the experimental group remained out of the home for a shorter period of time than did those in the control group. Members of the experimental group were more likely to make use of community based services, were more satisfied with the workers and services received, and were more likely to view their workers as more competent than were CPS only families (Walton, 2001). These feelings supported family unity and efficacy.

Partnered CPS and FPS workers, or those workers collaborating with experimental group families, generally enjoyed working as a team, learning from one another, and expressed enhanced morale. Because experimental group CPS workers’ case loads were decreased due to the FPS model, they expressed higher job satisfaction, an increased ability to follow-through with helping families to access resources. Most importantly, CPS workers developed a strengths-based view of families. This perspective shift helped to support family satisfaction and positive family functioning because workers expressed a strong belief in families and their ability to be successful. Interagency relationships that are positive, collaborative and supportive benefit parents, children, and agency staff.

The Walston (2001) study boasted a large sample size, but the researchers provided no information about cultural competence, awareness, or the potential impact of culture on the
lives of families. In addition, the study was conducted in a non-urban and predominantly white setting. The proposed Osiris Group evaluation will take place in a highly urban and predominantly black and Latino setting on the east coast region of the United States. These differences may yield different findings. Lastly, the sample of families came only from child protective service referrals. None of the involved families, unlike Osiris Group families, were referred from hospitals, schools or other agencies.

A research study conducted in Dallas, Texas in 2005 focused on the number of child abuse or neglect reports filed after a parent or parents participated in a parent aide home visiting program (Harder). Families who were identified as at risk for child maltreatment, but were without any previous involvement with CPS, and families who were known to CPS due to substantiated reports of abuse and neglect were included in the study. Data was collected from 1993-1999 and involved 246 predominantly female-headed households (96% female). Most of the sample of parents, over 80%, reported experiencing physical abuse as children. Nearly 50% of parents reported experiencing sexual abuse during childhood. Many of the families included in the study struggled with financial, housing, education, employment, health care, domestic violence, and substance abuse issues. Many of the parents reported feelings of social isolation and presented with difficulties with the task of parenting. Mothers who experience high levels of stress and who are inadequately supported by natural and community based social supports often feel negatively about their parenting role (Crnic et al.). This feeling, in turn, negatively affects their relationships with and the behaviors of and emotional health of their children.

Parent aide services were provided through the Parent Aide Program at the Child Abuse Prevention (CAP) Center in Dallas. CAP receives all its referrals from the local child protective services (CPS) agency. All of the families included children who were under the age of 12 and these younger children were the identified victims. The mean age of children in the study was 4.3.

Parent aides were recruited from the community through television and print media and received 10 hours of training. The aides were instructed to visit families at least once per week, although visits typically fell short of that. The researcher did not provide reasons for this shortcoming. Parent aides reported to and were supervised by CPS workers. Sixty-seven percent of the parent aides were white, 23% were black, and 10% were Hispanic. Of the identified families, 45% were black, 35% were white and 18% were Hispanic.

Study findings revealed that 46 of the 246 families in the sample completed the parent aide program, which typically lasted for about 5.5 months. These “completers” had fewer substantiated reports of child maltreatment to CPS of child maltreatment than did those parents who refused to participate in the program (n = 112) and those who dropped out of the program (n = 88).

This study and its findings provided important information about the type of agency contact that may support parents as they struggle to care for their young children while managing a myriad of life stressors. Consistent, home-based support that focuses on social and environmental stressors may prevent future maltreatment for parents at risk of maltreating their children and for parents who have maltreated their children. However, the researcher shared that parent aides struggled with engaging with parents and children. This fact was
reflected in the high number of parent drop outs and refusers. In other words, 200 of the 246 subjects did not complete or refused to participate in the program.

This difficulty with participation, engagement, completion could have been due to many factors. One possible factor was the lack of focus on cultural issues, racial and cultural oppression, and the lack of racial or cultural match between family members and their assigned parent aides. Another possible factor is that parenting skills are often best acknowledged and changed, if necessary, when parents participate in psychoeducational parenting groups. These groups offer a sense of community, support and concrete learning (Barth et al, 2005). These Parents were not offered parenting groups. The researcher did not provide any information about the factors that helped the completers to complete the program. This data could have added to the relevant literature about promoting family-worker connection and engagement and could have provided the parent aides with strategies to use in the future. One last factor that may have contributed to the low participation and completion rate was that children included in the study were typically younger than five years of age. Parents of young children may be less able or interested in participating in such a program.

**METHODS**

**PURPOSE OF EVALUATION**

The primary purpose of this study is to pilot-test a mixed-method evaluation of the effectiveness of the Osiris Group Family Stabilization Program model to improve family functioning and behaviors of referred parents, children and youth; and to assess the strengths and challenges of implementing ongoing program evaluation of OG programs. This information will be used to develop a greater awareness of the strengths and weakness of the model in an effort to learn about the best ways to support Black and Latino families who are at risk of an out of home placement.

**EVALUATION QUESTIONS**

The primary evaluation questions are:

- How effective are Osiris Group clinicians and mentors at reducing risk of placement for children and youth in families referred by DSS?
- How effective are Osiris Group clinicians and mentors at increasing parenting skills?
- How effective are Osiris Group clinicians and mentors at improving child and youth social skills and school outcomes for children and youth at risk for behavior problems?
- How effective are Osiris Group clinicians and mentors at improving family interaction with other community resources and providers?
- What are the challenges and success of integrating program evaluation activities with ongoing clinical and mentoring work of OG members and administration?
Based on the logic model the analysis questions of interest to the Osiris Group Family Stabilization and Support Program will be assessed using data collection methods agreed to by the clinicians, mentors and Osiris Group leaders. The tables below present the analyses questions and the procedures used to answer the questions.

Table 1. Approach to Answering Evaluation Questions about Family Outcomes

<table>
<thead>
<tr>
<th>Analyses Questions</th>
<th>Source(s)</th>
<th>Data Collection Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does parent-youth/child communication improve?</td>
<td>Parent, OG member</td>
<td>questionnaires</td>
</tr>
<tr>
<td>Do family members reduce their court involvement?</td>
<td>Parent, OG member</td>
<td>questionnaires</td>
</tr>
<tr>
<td>Has violence within family decreased?</td>
<td>Parent, OG member</td>
<td>questionnaires</td>
</tr>
<tr>
<td>Have parents increased their monitoring of child/youth behaviors?</td>
<td>Parent, OG member</td>
<td>questionnaires</td>
</tr>
<tr>
<td>Has aggression among family members reduced?</td>
<td>Parent, OG member</td>
<td>questionnaires</td>
</tr>
<tr>
<td>Have family members increased use of community resources?</td>
<td>Parent, OG member</td>
<td>questionnaires</td>
</tr>
<tr>
<td>Have family members’ anxiety and depression been reduced?</td>
<td>Parent, OG member</td>
<td>questionnaires</td>
</tr>
</tbody>
</table>

Table 2. Approach to Answering Analyses Questions about Children’s Outcomes

<table>
<thead>
<tr>
<th>Analyses Questions</th>
<th>Source(s)</th>
<th>Data Collection Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do young children feel safer?</td>
<td>Parent, OG member</td>
<td>questionnaires</td>
</tr>
<tr>
<td>Are children less aggressive?</td>
<td>Parent, OG member</td>
<td>questionnaires</td>
</tr>
<tr>
<td>Do children increase their positive attitudes and school performance?</td>
<td>Parent, OG member</td>
<td>questionnaires</td>
</tr>
<tr>
<td>Do children demonstrate healthy behaviors?</td>
<td>Parent, OG member</td>
<td>questionnaires</td>
</tr>
</tbody>
</table>

Table 3. Approach to Answering Analyses Questions about Outcomes for Youth/Teens

<table>
<thead>
<tr>
<th>Analyses Questions</th>
<th>Source(s)</th>
<th>Data Collection Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do youth feel safer?</td>
<td>Teen, OG member</td>
<td>questionnaires</td>
</tr>
<tr>
<td>Are youth less aggressive?</td>
<td>Teen, OG member</td>
<td>questionnaires</td>
</tr>
<tr>
<td>Do youth improve their attitudes and school performance?</td>
<td>Teen, OG member</td>
<td>questionnaires</td>
</tr>
<tr>
<td>Do youth increase their healthy behaviors?</td>
<td>Teen, OG member</td>
<td>questionnaires</td>
</tr>
</tbody>
</table>

Table 4. Approach to Answering Analyses Questions about Observations by Clinicians and
Mentors

<table>
<thead>
<tr>
<th>Analyses Questions</th>
<th>Source(s)</th>
<th>Data Collection Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>How are the relationships with clinicians perceived by family members?</td>
<td>Parent</td>
<td>questionnaires</td>
</tr>
<tr>
<td>How do the DSS referral sources view Osiris Group services?</td>
<td>DSS referral supervisor</td>
<td>questionnaires</td>
</tr>
</tbody>
</table>

Table 5. Approach to Answering Analyses Questions about Observations of the Service Process

<table>
<thead>
<tr>
<th>Analyses Questions</th>
<th>Source(s)</th>
<th>Data Collection Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the characteristics of families and youth served by the Osiris Group clinicians and mentors?</td>
<td>Parent, youth</td>
<td>questionnaire</td>
</tr>
<tr>
<td>What kinds of services do family members receive?</td>
<td>Parent, OG member</td>
<td>questionnaire</td>
</tr>
<tr>
<td>What kinds of family problems do clinicians and mentors encounter?</td>
<td>OG member</td>
<td>questionnaire</td>
</tr>
<tr>
<td>How do youth and family members perceive their relationship with mentors?</td>
<td>Parent, youth</td>
<td>questionnaire</td>
</tr>
<tr>
<td>What kinds of family problems are encountered by clinicians and mentors?</td>
<td>OG member</td>
<td>interviews, online questionnaire</td>
</tr>
<tr>
<td>What are some examples of successful family work?</td>
<td>OG member</td>
<td>interviews, online questionnaire</td>
</tr>
<tr>
<td>What kinds of things did clinicians and mentors do to help families become more successful?</td>
<td>OG member</td>
<td>interviews, online questionnaire</td>
</tr>
<tr>
<td>What kinds of challenges are clinicians and mentors working to resolve?</td>
<td>OG member</td>
<td>interviews, online questionnaire</td>
</tr>
<tr>
<td>How often do clinicians and mentors observe success in family work?</td>
<td>OG member</td>
<td>interviews, online questionnaire</td>
</tr>
<tr>
<td>What role does culture and ethnicity play in work with families?</td>
<td>OG member</td>
<td>interviews, online questionnaire</td>
</tr>
</tbody>
</table>

EVALUATION DESIGN: PILOTING A MIXED METHODS APPROACH

Based on the Figure 1 concepts and constructs, the evaluators constructed evaluation methods and procedures that would answer the key evaluation questions emerging from the discussions with Osiris Group members about the process and outcomes of this program. Figure 1 presents the major process and outcome evaluation constructs of the OG FSSP. After presenting the logic model to staff at a formal presentation of the evaluation plan, and after agreement on the
evaluation approach, the evaluators provided follow-up training on the administration of the forms and evaluation questionnaires designed to collect process and outcome information.

**Figure 1. Osiris Group Family Stabilization Program Logic Model**

Measures for processes and outcomes were developed with the following assumptions and guidelines in mind:

- OG staff and administrators will want to incorporate measures that are similar to standardized measures required by insurance companies and Massachusetts Behavioral Health Partnership (http://www.masspartnership.com/);
- Introduce standardized measures that have been tested in child welfare programs that focus on families in crisis;
- Use measures that have been researched with African American and Latino families;
- As much as possible, use positively worded items from existing instruments;
- To the extent possible use existing forms to assess processes and activities with families (activity tracking forms, opening and closing forms);
- Develop separate questionnaires for parents (and children), teenagers, and OG workers with a linking family-worker-teenager identification code to allow for analysis of changes.
over time, multiple perspectives for some constructs (violence, court/police involvement, and relationship quality);

- Utilize online questionnaire methods for perceptions of what makes OG work successfully, and referral perceptions (satisfaction with OG services).

**MEASURES**

The measures selected were reviewed by the lead evaluator and graduate students and then adapted to the study requirements and guidelines. Table 6 below presents the major outcome constructs and the source of the procedures and instruments developed to assess them.

**Table 6. Outcomes and Source of Measures**

<table>
<thead>
<tr>
<th>Process and Conditional Outcomes</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client and Worker Relationship</td>
<td><a href="https://niatx.net/PDF/PIPractice/FormsTemplates/Working_Alliance_Surveys.pdf">https://niatx.net/PDF/PIPractice/FormsTemplates/Working_Alliance_Surveys.pdf</a></td>
</tr>
<tr>
<td>Family Communication</td>
<td>Family Functioning Style Scale: This 26-item scale was originally devised by Dunst, C.J., Trivette, C.M., &amp; Deal, A.G. in 1988 (see <em>Enabling and empowering families principles and guidelines for practice</em>. Cambridge, MA: Brookline Books). Questions have been modified from the original source.</td>
</tr>
<tr>
<td>Number of 51-A filed &amp; Police involvement</td>
<td>Project Developed</td>
</tr>
<tr>
<td>Utilization of community resources</td>
<td>Project Developed</td>
</tr>
<tr>
<td>Positive parent-youth/child communication;</td>
<td>Global rating (e.g. 7-point scale from very positive = 7 to very negative = 1) after family meeting and again after 8 weeks.</td>
</tr>
</tbody>
</table>
Parent/Guardian Outcomes | Source
--- | ---
--Decreased family court involvement; | One question no. of court-related sessions after family meeting and 8 weeks. (Source: Clinician. For Parent/guardian, and adolescent)
--Decreased family violence; | Source: Parent, Adolescent, Child from TOP
--Monitoring youth/child behavior; | Source: Clinician. Global rating after family meeting and 8 weeks
--Reduced aggression among family members; | Source: Parent, Adolescent, Child from TOP; items from CDC Measures of Violent Behaviors; from CDC Domestic Violence Screening Compendium.
--Positive use of community resources | Source: Parent – one question with list of resources (e.g., FACES, Head Start Parent Interviews) after family meeting and at 8 weeks

Youth/Teen Outcomes | Source
--- | ---
--Safety; | No. 51-A filed from referral to family meeting and again at 8 weeks
--Reduced aggression; | Adolescent TOP
--Improved attitudes and school performance; | Items from TOP and David’s items sent via email
--Healthy behaviors | Adolescent TOP items

Young & School-Age Children outcomes | Source
--- | ---
--Safety; | No. 51-A Filed from referral to family meeting and again at 8 weeks
--Reduced aggression; | Child TOP (source: parent)
--Positive school attitudes and performance; | Child TOP (and David’s items sent via email)
--Healthy behaviors | Child TOP after family meeting and at 8 weeks

SAMPLES

The primary sources of data come from parents, teenagers and OG workers (clinicians and mentors) for changes in problem areas. Massachusetts Department of Social Service referring


3 TOP completed after family meeting and again at 8 weeks.
staff were recruited through the CEO, who contacted each DSS staff in person to tell them of
the opportunity to provide feedback via an online survey. Osiris Group workers were recruited
during several meetings at the OG offices in Roxbury in which the principal evaluator and
graduate students met with all staff at a general staff meeting, and at two subsequent meetings
with supervisors and CEO. During that meeting the draft instruments were presented and
comments were solicited. The evaluators revised the questionnaires to adapt them to the
comments made by OG staff members and supervisors.

Demographic information was collected for parents during their second or third visit to an OG
member. Demographic information of the Osiris Group staff members was collected during the
fall 2008.

Parents were not recruited into the study by OG clinicians and mentors until the second or third
visit with the family – usually within a week of referral. Informed consent forms were provided
and explained to parents and teens (Teen Assent Form). If parent and teen agreed to volunteer
to participate, they signed form and were provided a copy. The signed form was stored at the
OG offices.

**DEMOGRAPHIC CHARACTERISTICS OF PARENTS**

A total of 47 parents completed the demographic questionnaire (See attachment tables). A
majority of parents were female (96%), between ages of 26 and 41 years (71%), African
American (55%) or Hispanic/Latina (21%). A majority of parents were single (51%) or divorced
(28%). Two-thirds of the parents were born in the U.S. (64%), and most parents’ noted their
primary language as English (87%). Nearly half of all parent respondents were Roman Catholic
(45%) or Protestant (45%). Approximately one-third of parents were employed (34%). A
quarter of parents were high school graduates (23%), and nearly half of parents had some
college (28%), and 17% had a college degree.

**DEMOGRAPHIC CHARACTERISTICS OF OSIRIS GROUP CLINICIANS AND MENTORS**

A total of 22 OG members responded to the demographic questionnaire (see attachment
tables). Half of OG staff were between the ages of 23 and 41 years (55%). Males and females
were nearly equally divided (46% to 55%), and more than two-thirds of OG staff were African
American (68%). Two-thirds of OG staff are married (64%). The majority of OG staff use English
as their primary language (82%), and were born in the U.S. (77%). Two-thirds of OG staff are
Protestant (64%). A majority of OG staff have college degrees (45%) or advanced degrees
(36%). Nearly half of the OG staff reported their primary role at OG as clinician (48%), and over
a third were mentors (38%). On average OG staff were carrying 7.6 cases at the time they
completed the questionnaire, had an average of 2 years with OG, and had an average of 14
years experience working with children, youth and families.

**SIMILAR DEMOGRAPHIC AND CULTURAL CHARACTERISTICS OF OG STAFF AND PARENTS**

For the most part, OG staff characteristics reflected the parent population at the time of the
questionnaire was completed. There was no difference in age groups, country of birth, and
primary language. There were more female parents than female OG staff (96% to 55% respectively). Parents and OG staff were similar in racial/ethnic characteristics. Slightly more OG staff were married, in the Protestant religion, and higher education levels. More OG staff were married than parent respondents (64% to 13% respectively).

**ANALYSIS**

**ONLINE SURVEYS OF OSIRIS GROUP MEMBERS**

The Osiris staff was emailed instructions to complete an online survey asking for details about successful cases and unsuccessful cases. Seventeen Osiris staff members replied; 7 clinicians and 7 mentors (four staff members did not identify their role). The staff members ranged in age from 29 to 56. They speak a number of languages including English, Spanish, French, Portuguese and Creole. The survey asked several questions about a successful case that they had worked on and factors that contributed to that success. Workers identified a number of their own actions that made the case successful. Workers identified a number of their partner’s actions that made the case successful. Osiris staff identified things that DSS or other larger helping systems did to contribute to the case being successful. Osiris staff identified things the children or youth did to contribute to the case being successful. Osiris staff identified things the parents or guardians did to contribute to the case being successful. When the Osiris staff wrote about a successful case in their work, they identified a number of specific ways that the family changed. Osiris staff identified what they think most gets in the way of cases being successful. Osiris staff identified what they think most gets in the way for them with unsuccessful cases. Osiris staff identified what they think most gets in the way for their partner with unsuccessful cases. Osiris staff identified what they think most gets in the way for parents or guardians with unsuccessful cases.

**ONLINE SURVEYS OF DSS REFERRAL SOURCES**

The director of The Osiris Group identified DSS workers who refer to The Osiris Group. They were emailed a survey that asked about referral patterns, reasons for referrals, satisfaction with The Osiris Group, outcomes for families, challenges and strengths of working with The Osiris Group, future referral plans and Five DSS workers responded.

**OSIRIS GROUP ACTIVITY DATABASE**

In order to begin to analyze the data, I took the Osiris activities from June-Dec 2007 and selected all the activities that appeared **10 or more times**. From that group I totaled both the **total amount of times** (units) these specific activities appeared, and created a **mean** for the total time spent in each activity.
This created a listing of 80 discrete activities and is available on the “Overview” sheet of the attached excel workbook. While this step to only select activities that appeared 10 or more times was helpful, it still left a great deal of different kinds of activities Osiris employees engage in.

In order to make further sense of this, I went through the 80 activities and assigned them a new “primary” code. If they contained direct contact with family member I coded them FAM, if they appeared to be more focused on case management I coded them CM, and if they were related to “no-shows” for visits I coded them NS. There also were some activity codes I was unfamiliar with and so I coded those unknown (UK). Each of these separated categories is listed on it’s own separate worksheet in the excel file.

Once I separated these out again, I thought some new “secondary” codes might be helpful, and these appear on the individual “Family” or “Case Management” worksheets, as well as the “Family Activity Details” worksheet.

**PARENT, TEEN AND OSIRIS GROUP MEMBER QUESTIONNAIRES**

All questionnaires were entered into a Microsoft Excel database separately into a parent/child, teenager and OG member spreadsheet. After all data was entered, the databases were imported into Version 16.01 of SPSS for cleaning and analysis. Unique ID numbers were use to link parent and worker questionnaires. Frequencies, and descriptive statistics were calculated for each item in the questionnaire, and total scores were calculated for scaled constructs. Composite variables were created for standardized scales embedded in the questionnaire. Pre-questionnaire values were compared to post-questionnaire values whenever appropriate. The small number of post-questionnaires prevented us from using inferential statistics. As a pilot of evaluation implementation, we compared differences where appropriate without statistical tests of significance, and preferred observations of practical significance whenever meaningful.(Houle and Stump).

Analyses of the parent questionnaires includes 46 complete pre-questionnaires out of (53 questionnaires returned). Seven questionnaires were not completed and could not be included in the analysis. Only 7 post-questionnaires were returned. The small number of post-questionnaires precludes any statistical significance testing of pre- and post-differences. Differences are reported without inferential statistics.

Analyses of the OG staff questionnaire includes a total of 49 pre-questionnaires and 9 post-questionnaires. No statistical tests for differences were calculated due to the small number of useable post-questionnaires, although differences will be reported.

Analyses of the teen questionnaire includes a total of 29 completed questionnaires – 26 pre-questionnaires and 3 post-questionnaires. No statistical tests for differences were calculated due to the small number of useable questionnaires, although differences will be reported.
RESULTS

This section presents the actual results from the quantitative pre- and post-questionnaires, qualitative interviews and online surveys of OG staff and DSS referral sources, and activity database documented by OG staff as they work with families.

PRE- POST QUESTIONNAIRES: QUANTITATIVE CHANGES AND CHALLENGES

PARENT QUESTIONNAIRE RESULTS

CLINICIAN PARENT RELATIONSHIP

Parents rated the quality of their relationship with their clinician higher overall at the post-questionnaire than the pre-questionnaire for 11 of 12 items on the questionnaire. A composite score created of the 10 positively worded items calculated at the pre-questionnaire and at the post-questionnaire resulted in higher post-questionnaire score than at the pre-questionnaire rating (means = 58.4 at pre- and 69.0 at post-). Clinician – parent relationships were mostly rated high at both the pre- and post-questionnaire periods.

PARENT SADNESS AND DEPRESSION

Parents rated the frequency of their sad and depressed feelings lower at the post-questionnaire time than at the pre-questionnaire administration on all 9 items. A composite score created from the 9 items calculated at the pre- and post-questionnaire administration resulted in a lower sadness and depression at the post-questionnaire than at the pre-questionnaire (higher score means lower frequency of sadness and depressive symptoms; mean = 35.8 at pre- and 44.9 at the post-).

AGGRESSIVE AND VIOLENT THOUGHTS AND BEHAVIORS

While aggression and violence were rated lower in 2 of the 4 items on the post- than on the pre-questionnaire, the differences were very small. The composite score of all 4 items was not different at pre- and post-questionnaire administration. The composite score had an internal consistency alpha score of less than .7 and is not a reliable measure of violent thoughts and behaviors. The ratings by parents were all skewed at the extreme rating of the scale.

ANXIETY AND WORRISOME THOUGHTS

Parent ratings of anxious and worrisome thoughts and feelings were rated lower at the post-than at the pre-questionnaire on 3 of the 3 items asking about anxiety and worry. A composite score calculated from all three items was lower at the post- than at the pre-questionnaire (a higher score indicates lower anxiety; means = 15.0 at pre- and 16.4 at post-).
CONFLICT IN RELATIONSHIPS

Parents rated the frequency of conflicts with others over the past two weeks lower at the post-than at the pre-questionnaire administration on all 4 items. A composite score was not created for these items due to low internal consistency (below .7 alpha).

Parents who responded to the pre- and post-questionnaire reported improved and positive relationships with their clinician, decreased levels of depression, aggression, anxiety, and conflict in their relationships at the post-questionnaire period. While the low number of questionnaires at the post-questionnaire period prevents any inferential statistical tests, the change observed is in the direction posited by the program theory.

USE OF COMMUNITY RESOURCES

Parents reported on referrals by the OG team to community resources and whether they had made contact with the resource. The 4 most frequent categories of resources parents were referred to were “family counseling or therapy” (18 parents), “after school recreation programs” (12 parents), “mentoring/tutoring” (9), and “youth, teen or other community services” (8). The majority of parents who were referred reported making contact with the community resource to which they were referred.

WORKER QUESTIONNAIRE RESULTS

WORKER/PARENT RELATIONSHIP

Osiris Group clinicians and mentors reported on their perception of their relationship with the parents they work with. Nearly all clinicians and mentors reported that they are confident in their ability to help their clients (98%), and that they are working toward mutually agreed upon goals (83%). A majority of clinicians and mentors reported that there is agreement between the worker and client on what is important for them to work on, and both feel confident about the usefulness of what each is doing (77%). Three-quarters of the Osiris Group workers reported that they appreciate their clients as persons, there is mutual trust between the client and worker, and that the worker and client have a good understanding of the kinds of changes that would be good for clients (75%). Nearly 73% of workers reported that there is agreement with their clients on the steps to be taken to improve the family situation.

FAMILY COMMUNICATION

Clinicians and mentors reported on their perceptions of the quality of family communication. Nearly half of Osiris Group workers (48%) observed that family members can discuss their beliefs without feeling constrained “sometimes” or “often.” Just under half of workers also observed that family members “sometimes” or “often” can generally agree on what is important (46%). Nearly half of clinicians and mentors stated that family members insult each other when angry (45%), and family members pile things up without talking or dealing with them (42%) “sometimes” or “often.”

LEGAL AND LARGER SYSTEM INVOLVEMENT
Osiris Group clinicians and mentors were asked about the frequency of contacts with public child welfare agencies (DSS/DCF) and police due to child maltreatment or disturbances involving risk of violence/actual violence within the family. At the pre-questionnaire time period, nearly all of the OG staff (92%, n=44) reported that no “51-A’s” (child maltreatment report) were filed; three families were reported once; and, one family was reported twice. A majority of the reports that were filed were reported by “professionals in the family’s community (68%). At the post-questionnaire period there were no 51-A reports filed.

At the pre-questionnaire, during the past four weeks of completion of the questionnaire, the police were called in to respond to 6 families at their home. At the post-questionnaire time, police were called in to 4 family homes. Most reports to police were made by professionals in the community or other family members.

REFERRAL TO AND USE OF COMMUNITY RESOURCES

Clinicians referred family members to a wide range of community organizations and services. Most often family members were referred to after school and recreation programs (31%), youth-serving organizations in the community (26.5%), family counseling or therapy (24.5%), and educational resources like early childhood programs and vocational supports in the community (10.2%). Family members were also referred to food assistance resources (10.2%), parent training programs (8.2%), and other teen-focused community programs (8.2%). Family members were referred least often to disability related services and domestic violence response programs (0%). Infrequently, family members were referred to housing assistance, income assistance, and DCF (6.1%). Family members did not all attend the programs they were referred to – on average about 8% of all families referred for community services attended the services and programs to which they were referred. This percent is consistent with published accounts of self-reported distressed adults who seek mental health community services (8% to 9%).

TEENAGER QUESTIONNAIRES

TEENAGER DEMOGRAPHICS

The average of teens completing the teen questionnaire were 14.8 years, and ranged in age from 12 to 18 years. Three-fifths of the teens were male (58%) and two-fifths were female (42%). A majority of teens were born in the U.S. (87%), and spoke English at home (90%); while half of the teens spoke English and Spanish at home (45%); and three teens speak only Spanish. A majority of teens describe themselves as Hispanic/Latina/o (58%) and two-fifths describe themselves as African American (39%). White, non-Hispanic, Cape Verdean, Haitian Creole, and Cambodian make up about 19% of the teens. About half of the teens are in grades 1st – 8th (55%), and 42% are in grades 9th – 11th. Nearly all teens identify themselves as belonging to Protestant Christian (72%) or 28% Roman Catholic religions.

---

TEEN EXPERIENCES AND RISKY BEHAVIORS

Teenagers responded to questions about their feelings, thoughts and behaviors related to school, conduct, violence, substance abuse, eating problems, and suicide risk.

MENTOR-TEEN RELATIONSHIPS

A majority of teens report positive relations overall with their mentor. Nearly all teens are in agreement with their mentor about what work they need to do together (94%); are confident that their mentor’s ability to help them (97%); believe that their mentor likes them (97%), are working toward mutually agreed upon goals (94%); feels appreciated by his/her mentor (94%); trusts his/her mentor (90%); and, believe that the way he/she and mentor are working on problems is correct (90%). Teens are slightly less in agreement that their mentor gives them new ways of looking at their problem (65%), and that they have the same ideas about what the teens problems are (71%).

SCHOOL ISSUES

Most teens say that they have not missed school (90%), have been acknowledge for their performance at school (83%), and have not been criticized at school (90%). Less than two-thirds of teens say that they have been excited about school work (61%).

CONDUCT PROBLEMS

Nearly all of the teens report that they have not run away in the past two weeks (90%), have not been in trouble with the police (97%), and all teens have not stolen or shoplifted (100%).

EATING PROBLEMS

A majority of teens report that they have not thought that they were too fat (90%), and have not purged after eating (97%). One-fourth of teens say that they have gone on an eating binge in the past two weeks (25%).

SUBSTANCE ABUSE PROBLEMS

All of the teens report that they have not spent more time drinking or using drugs than they intended (100%); and have not spent much time thinking about a drink or getting high (100%). Nearly all report that they have not neglected school or work responsibilities because of using drugs or alcohol (97%); and that they have not used drugs or alcohol to relieve uncomfortable feelings (97%).

VIOLENCE PROBLEMS

No teens report physically hurting an animal or person in the past two weeks, nor seriously hurt someone (100%). A majority of teens say they have not had a desire to seriously hurt someone (90%); and have not had thoughts of killing someone (94%). A majority of teens say that they have not been too shy in the past two weeks (87%).
SUICIDE RISK

A majority of teens say that they have not thought of hurting themselves, nor killing themselves, nor wishing to be dead in the past two weeks (90%).

The results of the teen questionnaire frequencies is presented as descriptive information for Osiris Group staff, and serves only as a benchmark for further evaluation work later, if feasible. A comparison of pre- and post-questionnaire results for teens was not conducted due to the low number of post-questionnaires that could be matched to pre-questionnaires (n=3).

INTERVIEWS AND ONLINE SURVEYS: QUALITATIVE OBSERVATIONS

Observations and interviews with staff and administrators revealed that Osiris Group Family Stabilization Program was uniquely organized as a family of independent professional consultants and clinicians reporting to an executive administrator who guided their assignments, time and financial reporting, and priorities. Each clinician and mentor works as an independent sole proprietor to achieve common social work and clinical treatment goals depending on the family conditions and client needs.

The Family Stabilization model during the period of this evaluation was originally developed by the Department of Social Services (now Department of Children and Families – DCF) as a contract for follow-up services after a serious report of child maltreatment or neglect (Massachusetts State Legislature). The Osiris Group adapted the DCF policy into the Family Stabilization approach described in this report. Families were referred to the Osiris Group Family Stabilization program after efforts to remedy the problems or conditions of the report to DCF appeared to be intractable and efforts by DCF were exhausted. Referrals from Boston and surrounding communities were reported by staff and administrators during the study period. Assignments of families to clinicians and mentors were made through the administrators, and DCF provided paperwork on prior work with the family and the initial reported problem.

Family stabilization services are administered by Family Stabilization Teams (FST)\(^5\). Family stabilization services typically include intensive in-home clinical and support services. These services are provided during an episode of psychiatric or acute emotional disturbance or crisis of a parent or child, an out of home treatment episode, or an out of home foster care placement (Osiris Group, Inc., 2003). FST services may also be accessed when a child or children in a family are at risk of an out of home placement.

\(^5\) Family stabilization services are defined by Massachusetts Budget Recommendation: FAMILY STABILIZATION AND PRESERVATION SERVICES 4800-0018. For family stabilization services and family unification services for non-placement families and for families whose children are expected to return home following placement, including, but not limited to, school and community-based young parent programs, parent and home health aides, education and counseling services, shelter services, substance abuse treatment, and respite care; provided, that the department shall pursue the establishment of public-private partnership agreements to fund family stabilization and family unification services from sources other than the commonwealth; and provided further, that the commissioner of social services may transfer a total amount not to exceed 15 per cent of the funds appropriated herein to items 4800-0031 and 4800-0041.
Osiris Group teams consist of a mental health clinician and a mentor. The team is led by the clinician, but the clinician and mentor work closely together to help families acknowledge and make use of their strengths, identify and create relationships formal and informal social supports, and learn new skills of communication and ways of interacting in the home and the community.

**REPORTED PROGRAM PHILOSOPHY**

The program director described his approach to the Osiris Group approach in this way (author’s emphases, based on interview with Director of Osiris Group, June 20, 2009):

“Our model has a teaching focus. There is a team of therapist and mentor to teach families the skill sets they lack. These include: communication, tolerance, discipline, challenging the old culture that most urban people with southern Baptist backgrounds bring to their kids. Communication means both language and physical. The old culture involves harsh, degrading, insulting, bullying approaches to teaching kids, and it involves corporal punishment. Teaching is time consuming and tedious, not a quick fix. It is going to be a slow process. Most models have a quick fix: bring in more services – it feels like you got something done. The teaching model is slow. You need to help folks to give up what they have mastered, the ways they cope and see the world. You are asking them to strip down and to rebuild, which is a frightening thing for a lot of urban parents.”

This program approach comes from a deeply held conviction by the Osiris Group Director, and is based on a personal history as he describes:

“In other words, you need to rethink the culture of the home, to develop a new skill set. This new skill set does not mean you are ‘less than.’ The biggest challenge is getting parents to believe this does not take away from their authority. We ask: What do you want your child to be? Then give them the skills. I vowed never to do to my daughter what was done to me. I talked to my Dad, who was born in 1930, about punishments used on the 14 kids in his family growing up. His father had a rope soaked in vinegar – if you can imagine. Go back a few generations to slavery. It all came out of slavery.”

The Director lists the major elements of this cultural-historical teaching approach which are linked to social work values, best practices in parent education (Saulnier), and self-reflection (Fleck-Henderson):

- Get parents to realize it is a new game; the rules have changed, no one told them and they have to adapt;
- The culture does not prepare kids for the world of adulthood;
- We teach skills for negotiating with adults;
- Our kids are not our property - we help parents hear the kids messages;
- We need to learn to hear and welcome the exchange with our children and guide it;
- They need thinking skills and verbal skills;
• What works when kids are 6 or 7 won’t work when they are 12 or 14;
• If child feels leadership is unfair, cruel, they won’t take it – without cooperation a parent cannot lead;
• Without equal justice, kids sense that it is not fair, and they rebel;
• Parents have to acknowledge that the current way is not working and that they are not happy with the way things are going at home;
• The family culture has to change; when parents acknowledge that things are not working and they are not happy with it, then they can express their uncertainty of what to do next;
• We are there to teach the new skills, to model, support and reinforce cooperation and leadership.

These conditions are achieved through the use of different direct and indirect services. Direct services include home visiting, mentoring for parents and children, parental coaching, family therapy, outings and recreational activities, 24 hour on-call services, crisis management, mental health assessment and individual therapy. Support or indirect services include legal, school, and medical advocacy, housing assistance, career planning and job search, linkage to informal and formal community supports, transportation, referral services and respite services.

The Osiris Group program model also includes education about housekeeping, household financial management, the effects of environmental trauma and domestic violence on behavior and cognition, problem-solving, communication, and socialization so that family members may capitalize on skills they already possess and learn new skills. The stated purpose of the Osiris Group staff members is to help families to acknowledge their unique family culture and identify ways in which it may be supportive of and detract from a healthy and productive present and future. Osiris Group clinicians and mentors are urged to create relationships with families and other services providers to maintaining family unity and stability.

Osiris Group staff members typically collaborate with families for 90 days, although services may be extended in some cases. Osiris Group teams visit families frequently, often more than one time per week. Schedules are flexible and open, depending on the needs of each family. Team members use financial resources in a variety of creative ways in their work to finance recreational outings and other activities that build a sense of connection, responsibility and future. Many Osiris Group services are financed through billing insurance carriers and some referring agencies.

Another major aspect of the Osiris Group program model is that it is designed specifically with the strengths and needs Black and Latino families in mind. The Osiris Group approach states that the psychological, emotional, and spiritual needs of Black and Latino families can be best served by practitioners who reflect the same demographic, ethnicity, culture and values, and who are culturally competent, dynamic, ethnically diverse, family centered and inclusive (Osiris Group, Inc., 2003). The purpose of this focused work is to help families acknowledge the
possible effects of culture and family history, racial oppression, and poverty on the ways in which they view the world, view themselves, and interact with others within and outside of the family. Clinicians, during their work with families, are urged to address these issues head-on to support awareness, self-actualization, and success.

The Osiris Group literature states that the desired outcomes of the direct and indirect services are to:

- increase feelings of social support;
- create and develop relationships and community connections;
- help parents to become more aware and critical of current parenting skills and to develop and experiment with new ones;
- help families develop new problem-solving strategies that lead to feelings of efficacy and hope, and;
- to help families be critical of current ways of relating in an effort to develop healthier interactions.

The Osiris Group method expects staff, family members and community agencies to collaborate to identify families’ strengths and needs as individuals and as a family system in an effort to build upon those strengths and address those needs. The Osiris Group’s mission rests on a strong belief that collaboration with families and communities supports children’s safety in the home.

**TEAMWORK AND CLINICIAN AND MENTOR ROLES**

According to the Director:

Each team has a mentor and clinician. The mentor goes three times a week; the clinician two times, spread out over the week. They are available 24/7 by cell phone. We can coach when needed. We can teach and apply, seeing follow up of what happened earlier in the week. We are there for 90 days, which is not enough. After the first two weeks, there is a family meeting to address the culture in the home. People have to hear each other without interrupting, actually hear and sit with what each member says. I want the kid to understand what the parent is feeling if she is frightened when he has been out late, and the parent to feel what the kid is feeling. You (family members) have the power to begin to change – that is the message. You are the agent for change, not us. That is critical. Our job is to point it out and let you see how this culture is toxic and to help you practice new skills.”

The skills of clinicians and mentors to work with parents and kids in ways that reinforce the values and philosophy of the program is pivotal according to the Director. Clinicians and mentors display cooperation and model communication for the family, for parents, for children and teens. The training of clinicians and mentors to be successful in the 90 days of involvement is unique, according to the Director.

“Training focuses on responding in the moment, especially to violent or angry behaviors. Shock will not do. We need to learn how to teach. We create internal focus groups to learn to challenge and teach in the moment. We use our history and theirs, for instance, about hitting
and denigrating. Acknowledge that this was our own experience and it did not help us, ask about the parents’ experience – did it work well for you? Is it working now? What are the alternatives? The goal is to confront behaviors lovingly without shaming. This takes practice, which is what the training is for. Be clear that we are not questioning the parent’s authority, only whether this is working well. I can see after 6 months or a year if a staff person will work out. Few choose to leave, but I let some go. Also, we train for running family meetings. How to help people see things from another’s point of view.”

The key components of teamwork among the Osiris Group staff include:

- During the 90 day period meet at least 2 times per week with parents at a time convenient to the parents;
- Staff provide support in unique ways including accompanying parent or kids to local services, coach and model good conflict resolution skills, setting limits and boundaries, and personal development for each member of the family;
- Assign mentors to work with children and teens through active involvement in community life with primary purpose to build positive relationships – activities that do not rely on more traditional talk therapy, but walks in the park, out for an ice cream, trips to movies, dinners and sporting events;
- Osiris Group staff reside within the communities that they serve and are known as involved citizens of their communities;

**OSIRIS GROUP MEMBER ONLINE SURVEY RESPONSES**

The Osiris staff responded to an online survey asking for details about successful cases and unsuccessful cases. Seventeen Osiris staff members replied; 7 clinicians and 7 mentors (four staff members did not identify their role). The staff members ranged in age from 29 to 56. They speak a number of languages including English, Spanish, French, Portuguese and Creole. The online questionnaire asked questions about a successful case that Osiris Group clinicians and mentors had worked on, and factors that contributed to that success to learn how Osiris Group clinicians and mentors identified features of the families and the factors that made a contribution to successful case practice.

**FAMILY CASES: RESPONDING TO CRISIS AND TRAUMA**

The clinicians and mentors described families in extreme crisis, facing great challenges in their encounters outside and inside the family. Several families were encountering severe financial problems that then created difficulties in communication among family members.

*One case in particular comes to mind. It was one of the first few cases that were assigned to me. This family was in crisis; they had just recently lost a family member to violence, (mother*

---

6 We used SurveyMonkey (www.SurveyMonkey.com), an online survey tool designed to aid researchers to conveniently collect questionnaire data from respondents with access to computers connected to the internet. This survey included 30 questions and a copy is attached to this report in the appendix.
lost her second oldest son). They were DSS involved. The mother was severely depressed and in crisis. The children were not following direction and not doing well in school. Towards the middle of the casework, the Mother finds out she expecting another child. It took four months, however, and when we terminated services, the mother and her children were thriving, communication with each other, and the children's grades had improved. The family was receiving therapy to address their loss. The mother was looking into returning to school.

Sometimes families were struggling to express their support and love for each other because they lacked the knowledge and skills to communicate about uncomfortable feelings of sadness, shame, and disappointment.

The primary client was a 13 year old boy who had a lot of communication difficulties with his mother. He was one of three boys and his mother, being a single mother depended a lot on him for the upkeep of the home and the care of his younger siblings. The boy felt that he could not confide in his mother. He had a huge secret that he believed his mother would disapprove of. Through several meetings that I had with the boy, he revealed that he identified himself as being gay. The client felt that his mother’s cultural and religious background would diminish their already unstable relationship. My partner and I steadily led both my client and his mother to openly speak of his sexuality. At first the mother was very reluctant of believing her son, however she was able to cope with his decision and since her acceptance and refortification of her love for him, the mother and son were able to build a trusting relationship through the one truth that they will always be family. Mom was connected to several parent support groups that revolved around gay and lesbian children. Her son was also connected to a teenage gay and lesbian group.

Osiris Group clinicians and mentors describe families with deeply felt losses through urban violence. These traumatic family experiences are believed to create serious communication challenges for family members, whose emotional conditions are often fragile, unexpressed, and painfully adding to the stress of daily functioning.

There is one particular case I worked on that I felt was successful. When we started our work with the family, mom wasn't motivated, the kids were not listening and not doing well in school. The primary stressor was the death of the second oldest child. He was murdered and the family had not processed that death in a healthy manner. When the case closed, mom was motivated, on her meds, and interactions with her children had improved tremendously. The oldest child turned her grades around and her attitude towards mom. All of the family members were in counseling. DSS was happy with the improvements and was thinking about closing the family [case].

The family descriptions provided by Osiris Group clinicians and mentors included situations in which conditions were not always in such turmoil, and family members could remember better more successful times. At the time of Osiris Group referral, the emotional challenges of growing children stretched the adaptive capacity of parents, and spilled out into school and community life.

A single mother faces a number of hard situations with her seven year old son who is diagnosed with bipolar with some level of learning disability. She became involved with DSS following a
51A filed by her son’s school following her pulling her son by the top of his coat because the boy refused to leave the area as directed by mom. The family was referred to Osiris for family stabilization services. Originally, mom seemed interested and yet embarrassed about the services. She would talk about how she has worked in the social service field, and that as a nursing student she also provides parenting classes as part of her clinical.

The youths from these urban families are often victims of frequent disruptions in their care outside of their families, and Osiris Group clinicians and mentors recalled examples of work with angry, displaced, and emotionally scarred youth in foster care.

The young man had been in and out of foster care, residential care and group homes. This young man had been pretty much abandoned by his family and turned over to the state. His defiance and anger was never properly addressed; he was not a bad kid, he was just a kid in a lot of pain he was very introverted, a loner who seemed to be on a self-destructive path. Did not care about the next day.

Sometimes these youth are faced with extraordinary life decisions that place them at odds with the very people who are supposed to care and protect them. The emotional consequences of these decisions are never fully processed until they can be retold to caring and supportive clinicians and mentors with the knowledge and experience to help young people (and parents) to acknowledge the pain and the unfairness of the choices they had to make.

My very first case was with a young woman who had been sexually assaulted by her father and was having a lot of trouble at school and home. She was being put in a tough position by being asked to testify against her father while living in her mother’s home. Her mother was urging her not to testify because she wanted him to get out of jail and come home. I found very quickly that the young woman was suffering from depression and very low self-esteem. She was having unprotected sex with a lot of different young men and was getting into a lot of fights with other young women. She had little to no self-value and was not taking care of herself emotionally, mentally or physically (and neither was anyone else).

The Osiris clinicians and mentors reported situations in which youth were separated from their families through traumatic circumstances, but were connected with resources and services in time to respond and heal painful emotions. Even with serious emotional pain, these reports provide some evidence that timely intervention with caring and responsive clinical resources, family members can overcome extraordinary odds to grow more healthy over time.

Yes, this client was a 16 year girl, who have experienced a great deal of trauma which affected her ability to make positive health decision and the client was removed her home. After six months of working with this client along with an Osiris Mentor, the client was returned back to her parents, client's grades increased and the communication between client and family has also greatly improved.

The descriptions of family trauma and emotional or behavioral problems reported by Osiris Group clinicians and mentors is typical of organizations working in urban settings in the United States.
SUCCESSFUL CASES

The survey asked several questions about a successful case that they had worked on and factors that contributed to that success. When asked what contributed most to that success, there were numerous answers. One of the most common answers, given by six of the workers, was willingness on the part of the family to do the work. Other common answers included caring & listening (4), time (3), hope and encouragement offered to the families (3) and relationship building (3). Other workers identified the high frequency of visits (2), consistency (2), meeting the client where he/she is (2), trusting relationship (2), workers doing what they said they would (2) and not judging the client (2). Factors that were mentioned by just one worker include positive & open communication, modeling consistent behaviors, working with family that wants services, having the team on mom’s side, helping kids get what they want, confronting issues, nurturing the client, the worker being able to connect with the client, offering a positive male influence, offering a new point of view, working collaboratively with the family, advocating for the family, and the worker having patience, empathy and experience.

Workers identified a number of their own actions that made the case successful. The most commonly given answer was empowerment of clients (5) and listening to the client (4). Other frequent answers were developing trust (3), being present and available to their clients (3), relationship building (2), validation of clients (2) helping clients get resources (2) and follow-through (2) & “doing what you say you are going to do” (2). Other answers included giving control to the client (1), helping client recognize their own positive characteristics (1), being direct (1), love (1), confronting issues with clients (1), using positive criticism (1), helping clients with bad decisions (1), mediating with family members (1), working with the entire family (1), advocating for clients (1), staying in constant contact with the client (1) and letting clients know that services are voluntary (1).

Workers identified a number of their partner’s actions that made the case successful. The most frequently given responses referred to the teamwork between clinicians and mentors. Four respondents referred to the good communication between team members and another respondent mentioned good teamwork between team members. Another response acknowledged the partner being “open to suggestions”. Other responses included reference to how the team member worked with the family, such as being there for parent (1), connecting the family to resources (2), doing intensive social grooming with the family (1), offering parent time to focus on herself (1), supporting the parent (1) and good communication with client (1). There were also some responses that referred to how the team member worked, such as being available to clients (1), working hard with the parent (1) and following through (1).

Osiris staff identified things that DSS or other larger helping systems did to contribute to the case being successful. There were fewer responses given for this question. Two respondents were either not sure or said “nothing”. Overall, a number of Osiris team members identified the supporting agencies, such as DSS, offering resources (6) and working collaboratively with the Osiris team as two important contributions to the case being successful. Other helpful actions on their part included supporting the team (1), offering support (2), offering structure (1), going along with the Osiris team’s recommendations (1), appreciating the Osiris team (1), trusting the Osiris team (1), offering goals (1) and referring the family to the Osiris Group (1).
Osiris staff identified things the children or youth did to contribute to the case being successful. The most common answers related to their readiness to do the work and their engagement with the work, such as that the youth were “ready to work” and engaged in services (3), that they were “open to change” and that they kept appointments with their Osiris worker (2). Other actions that were identified included improving school performance (1), supporting a parent (1), having a more positive self-image (1), changing behavior (1), trusting the Osiris worker (1), being honest (1), enjoying working with Osiris staff (1), listening (1), cooperating with services (1), working hard (1), making difficult changes (1), taking chances (1), attending family meetings (1), using advice (1), believing in services (1) and being open (1).

Osiris staff identified things the parents or guardians did to contribute to the case being successful. As with the youth, many of these answers centered around the parent’s engagement with the services and willingness to do the work, such as being open to either the work or the worker (6), listening to the Osiris worker (3), believing in the services being offered (1), participating in the services (1), cooperating with the services and being engaged in the work (1). Other ideas that were identified by the Osiris staff included parents taking responsibility for their part of the issues (1), parents not giving up (1), parents having humility (1), parents being open to new ideas (2), parents trusting the Osiris team (1), parents allowing the Osiris team to participate in important events (1), parents being open to feedback & criticism (1), parents doing good self-care (1) and parents using different communication with their children (1).

When the Osiris staff wrote about a successful case in their work, they identified a number of specific ways that the family changed. The most common answers were better communication in the family (6) and the kids having better grades in school (4). There were a number of concrete changes identified, such as kids went to school clean (1), medications were given to the child (1), the bills were paid (1), child involved in more activities (1), the parent got child support (1), the mother filed a restraining order against the child’s father (1) the mother enrolled in college (1), and the mom got a CNA certificate (1), as well as some changes in how the family functioned, such as the family being more involved (1), the family being relieved that a difficult issue was addressed (1), the family is a stronger family unit (2), the family does more activities together (1), the family understands each other better (2), the son disclosed his sexual identity to the mom and she accepted it (1), “mom is in control of the discipline” and “the family is less dysfunctional” (1).

Some changes focused on an increase in connection to outside services, including a comment that the family has continued with outside services (3) and more specific identification of services including, the child is enrolled in a therapeutic afterschool program (1), the family is on section 8 housing list (1), the family has been connected to DMH (1) and all the members of the family were in counseling (1).

There were also some individual changes that were highlighted, such as “mom motivated to take meds” (1), “child has better attitude towards parent” (1) the client is more responsible (1), the client is empowered (1), mom followed medical advice (1), the children try to respect parents more (1), fewer behavior problems in school (1), the child got his/her first job (1), the client learned life skills (1), the child gained self worth (1), the client takes more responsibility
(2), the client is in a relationship (1), the child is happier (1), the client is able to trust (1), the child graduated from high school (1), client working full time (1) and the client attends community college (1). Only a couple of Osiris staff members mentioned the child’s placement at the end of the case. Two respondents said that the child was returned to the mother and one said that the child was not with the parents.

Forty-one percent of Osiris staff reported that success like this happens in 51-75% of their cases. Thirty percent of the Osiris staff thought that success happened more frequently, in 76 to 100% of their cases while 18% thought it happened less often, in only 26-50% of their cases.

**UNSUCCESSFUL CASES**

Osiris staff identified what they think most gets in the way of cases being successful. There were many different answers that were given to this question, but several that were raised by more than one respondent included issues around the family not being interested or willing to do the work, such as the parents not following-through (2), the family being unwilling to change (3) or participate in services (3), family not ready to deal with root problem (1), adolescents not keeping appointments (1), clients not being open to hearing the truth (1), families not being in a place to accept services (1), families believing there is nothing wrong with their family (1), clients feeling forced to participate in services (1), clients wanting case closed ASAP (1), parents in denial (1) child being hard to reach (1) or treat (1), and families not being open to listening to service providers (1).

The respondents also identified issues around the parenting in families, such as parents see child as the problem (1), parents thinking they should be their children’s friends (1) or that they should give in to their children (1), parents thinking their kids should just follow the rules, no matter what (1), parents don’t take responsibility for child’s behavior (1).

The respondents also identified issues in the family dynamics, such as neither family member being able to compromise (2), family members blaming each other (1), families having too many crises (1), having multiple problems for all family members (1), families not recognizing the importance of consistency (1), family members with severe unaddressed mental health disorders (1), inability of clients to take responsibility (2) and mental illness in the family (1), Issues around the structure of the services were also identified, such as the lack of time to do long-term work (1), families regressing when the case closes (1) and the services being hard to access (1).

Osiris staff identified what they think most gets in the way for them with unsuccessful cases. Some of these answers were similar to the answers to the previous question. There were issues identified around whether the families were ready to do work, such as parents not taking responsibility (1), families being stuck (1), parents not participating (1), clients missing appointments (1) or simply “parents” and issues in the families, such as there being too much trauma (1), parental mental illness (1), parents not being motivated (1) and clients missing appointments (1). Issues around the structure of the work were also identified here, such as there being limited time (1) and resources (1) available.
Osiris staff also identified some issues that are unique to the service provider, such as the difficulty drawing the line between being and ally and a mandated reporter—sometimes the service provider must file a 51-A (1). Other respondents identified issues that made families difficult to work with for the individual service provider, such as the service provider having a lack of tolerance for deception (1) or for others’ half-efforts (1). Other barriers that were identified by respondents were poor self-care (1) and fatigue (1). One respondent reported that “all cases are successful”.

Osiris staff identified what they think most gets in the way for their partner with unsuccessful cases. Fewer barriers were identified in response to this question. Many of the answers were similar to the previous questions, such as families not being ready to do work, parents (1) client’s being inconsistent (1), unwilling to change (1), not participating (1) or no showing (2). Issues with the structure of the work were also identified, such as Taking setbacks personally (1), attachment to children (11), limited time (1) and resources (1).

Self care was also identified as a barrier (1). One new barrier which had not been identified before was the issue of the service provider working harder than the client (1). As with the previous question, one respondent reported that “all cases are successful”.

Osiris staff identified what they think most gets in the way for parents or guardians with unsuccessful cases. Issues of families not being ready to do the work were identified here as well, such as not being ready for change (1) and lack of participation (1). A number of the factors identified here were negative characteristics of families and parents, such as being overwhelmed (1), being lazy (1), pessimism (1), lack of confidence (1), parents not taking responsibility for their part (3), not wanting to hear the truth (1), wanting a quick fix (1). Other limitations in the family were identified, such as lack of education (1), lack of time (1), single parenting (1), fear of the system (1), parents’ beliefs re: what’s wrong (1), parents’ low cognitive ability (1), parents’ loyalty to their family of origin (1), issues with strangers in their home teaching them how to parent (1) and a desire to parent differently than they were parented (1).

Other issues were also identified, such as a culture of blaming others (1), parental insecurities (1), parents’ limited knowledge (1), parents’ belief system (1), social issues (1), people’s response to parents (1) and issues around getting rid of old habits (1).

The Osiris staff identified what they think most gets in the way for children or youth with unsuccessful cases. Issues around parenting were identified, such as parents (1), parents don’t push them to succeed (1), parents don’t show interest (1), not trusting the system (1) and lack of support (1).

Other issues around the child were identified, such as feeling empty (1), feeling they have nothing to loose (1), feeling nothing matters (1), feeling frustration that people aren’t listening (1), economics (1), peer pressure (1), society (1) substance use (1), no sense of direction (1), lack of understanding (1), anger (2), denial (1), cockiness/bravado (2), pessimism (1), having communication issues (1), having trust issues (1), being inexperienced (1) and ignorant (1).

Osiris staff identified what they think most gets in the way for DSS or larger helping systems with unsuccessful cases. Systemic issues were identified, such as Non-compliance of families...
(1), having too many cases (11), being overwhelmed (1), DSS having a poor reputation (1), bureaucracy (2), there being too much red tape to access services (1), time (1), doing only crisis work (1) and limiting the amount of money to be spent on each family (1).

Issues around their relationship with the families were also identified, such as DSS not seeing “behind the scenes” in families (1), families seeing DSS as the problem and not trusting them (2). Other issues that were identified included a desire to see minimal success in a family (1), wanting to keep services longer than necessary (1), inconsistency (1), laziness (1), burnout (1) and a lack of involvement (1).

Osiris staff identified what they think are the outcomes of unsuccessful cases. The most common outcome of unsuccessful cases was identified as children being placed (3) or re-referral to FSS or other services (3). Other outcomes that were identified included families fail when Osiris closes the case (1), re-entry into the system (1), long-term services (1), family will connect with resources (1), focus on safety of children (1), family will struggle (1), family will regress (1) or family will reach a “stalemate” (1). Several respondents suggested that some of these families will do well (2) and be successful (2). Another respondent suggested that while the service plan satisfied and the family builds relationship, significant work is hard.

RACIAL & CULTURAL ISSUES

Osiris staff identifies how they discuss racial or cultural issues with their clients. A large number of respondents reported that they discuss these issues openly (6) and honestly (3) with clients. Other ways that were identified include in an educational and/or historical fashion (1), identifying that every family has its own culture (1), being understanding (1), being respectful of their opinion (1), acknowledging their feelings (1), being sensitive (1) and developing trust first (1).

Several clinicians reported ways that they incorporated this conversations in the clinical work, such as by stressing that race or culture is not a crutch for poor behavior (1), showing families a broader perspective (1), redirecting if racial bias interferes with forward movement (1). One respondent reported that he/she only had these conversations “as needed” (1) and another reported that race/ethnicity was a non-issue (1) with families.

Osiris staff identified how they think these conversations contribute to the success of their cases. Overall, the feeling was that these conversations had a positive impact on the work with families. Several respondents just gave that information (2) while others gave examples of the impact of these conversations, such as making clients not feel judged (1), clients don’t need to explain things (1), clients feel empowered (1), it generates dialogue that helps the family process their thinking (1), they are key to getting parents unstuck and children heard (1), parents are less defensive (1), kids are more receptive to a team that understands them (1), it is more acceptable to tackle the culture of the home than the parenting skills (1), clinicians are seen as a positive example (1), clinicians are seen as partners (1), they open parents to better way of living their lives (2), honesty goes a long way (1), successfully (1), teamwork (1), understanding (1), helps build relationship with team (1) and they help families voice feelings (1). One respondent disagreed and said that “conversations about race have little to do with outcomes” while three respondents reported that the outcome of these conversations “vary”.

Osiris Group Family Stabilization Program Evaluation Report
DEPARTMENT OF SOCIAL SERVICES REFERRAL SOURCES AND ONLINE SURVEY RESPONSES

The DSS workers have been referring families to The Osiris Group for up to two to three years. Two workers have been referring for less than one year, two for one to two years and one for two to three years. Two workers had referred one family, one had referred two families, one had referred three families and one had referred five or more families.

When the DSS workers were asked how they decide whom to refer to The Osiris Group, they responded by saying, “model & family needs”, “Families with the most complex situations are referred”, African-American or multicultural families”, “Usually with teenagers”, “The family needs a high level of hands on work”, the “Family is willing to engage in services” and “depending on the family situation and cultural values”.

The DSS workers were very satisfied with the services that The Osiris Group provided. However, not all the families referred experienced a positive outcome. One person responded that 26-50% of families had a positive outcome. Two people responded that 51-76% of families had a positive outcome and two people responded that more than 76% of families had a positive outcome. All of the respondents said that they will refer to The Osiris Group in the future and will recommend The Osiris Group to other workers or agencies.

When asked about the strengths of The Osiris Group, participants responded by saying they were “very flexible”, had “exceptional clinicians and mentors”, had a “team approach”, “ability to form strong relationships with families”, “treatment is very focused and goal oriented”, “connection with other community resources”, “staff doesn’t give up on a family”, “communication is usually excellent”, “time and effort put into a case”, “their [clinicians’ & mentors’] willingness to go above and beyond to accomplish goals” and “flexibility of clinicians and mentors”. Respondents offered fewer challenges around working with The Osiris Group. These challenges included the price of the services and the issue that DSS is reluctant to pay for them because the “price is too high”, room for improvement on their documentation, and “contact with the second mentor to get updates on the child’s progress”. One respondent reported that there have been few challenges but whenever she/he has brought up a concern, it has been addressed immediately. Another respondent left this section blank and one reported “none at this time”.

When asked if they would like to share anything else about their experiences with The Osiris Group, the respondents answered “Osiris is the best agency I have worked with”, “I wish DSS would recognize the high quality work and be willing to use Osiris services more” and “I have had a great experience working with Osiris Group. I wish they accepted more types of insurances to have them continue to work with the families.”

Overall, the DSS workers who replied were positive about their experiences with The Osiris Group, would recommend them to other workers and agencies and were planning to continue to refer to them.
CLIENT AND ACTIVITY TRACKING DATABASE

During evaluation planning the evaluator and CEO discussed the need to track activities of clinicians and mentors and time spent during activities with clients and families. All active Osiris Group forms in use were reviewed. The graphic below presents the major data elements discussed during evaluation planning stage.

**Figure 2. Osiris Group Data Elements for Tracking Activity with Clients**

Figure 1 presents the major data elements required to track activity and time information and link to client and service providers. Evaluators examined a sample of tracking forms during the 2007 year of service delivery to identify the number of activity codes used by service providers, and to suggest a simplified approach that would serve Osiris Group members and administrators, while allowing contract billing. The following section presents a special report provided by Philip Decter, a doctoral student in the Simmons evaluation course, who took on the assignment to analyze the activity codes collected in 2007.
In order to make further sense of this, I went through the 80 activities and assigned them a new “primary” code. If they contained direct contact with family member I coded them FAM, if they appeared to be more focused on case management I coded them CM, and if they were related to “no-shows” for visits I coded them NS. There also were some activity codes I was unfamiliar with and so I coded those unknown (UK). Each of these separated categories is listed on it’s own separate worksheet in the excel file.

Once I separated these out again, I thought some new “secondary” codes might be helpful, and these appear on the individual “Family” or “Case Management” worksheets, as well as the “Family Activity Details” worksheet.

**Snapshot analysis:**

The vast majority of activities Osiris employees engage in are related to work with families. Over 6100 separate activities with families occurred during the recoded period to 2000 case management activities. This represents almost 70% of the total activities during this time period.

<table>
<thead>
<tr>
<th>Total Osiris Activities</th>
<th>Family Work</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>8870</td>
<td>6167</td>
<td>69.5%</td>
</tr>
</tbody>
</table>

Of these 6000+ activities with families, almost half appear to be direct, face to face contact with families (2607, see “Family Contact Details” worksheet). About one third are phone contacts, and the rest various other kinds of activities related to work with families, such as entertainment activities. Of note are how few school contacts are reported. With this kind of service one would expect many more academic contacts, although the lack of them may be due to reporting errors (see below for recommendations).

<table>
<thead>
<tr>
<th>Type of Activity</th>
<th>Number of Units</th>
<th>Percentage of Total Family Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic</td>
<td>326 Units</td>
<td>5.2%</td>
</tr>
<tr>
<td>Entertainment</td>
<td>1079 Units</td>
<td>17.4%</td>
</tr>
<tr>
<td>Direct Meetings</td>
<td>2607 Units</td>
<td>42.2%</td>
</tr>
<tr>
<td>Phone Contacts</td>
<td>2108 Units</td>
<td>34.1%</td>
</tr>
<tr>
<td>Unknown</td>
<td>47</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>
Family Work Total: 6167 Units

Based on this, I believe the data supports the notion that Osiris employees spend most of their time focused on work with families, and most of that in direct contact with families. When the total amount of “Direct Meeting” time is compared to the whole 8870 units however, it accounts for only 29% of their total activities, a number that should perhaps be higher.

Problems in sorting the data this way: There are a great deal of “holes” in this data. Sorting the data as I did leaves out all activities that were not repeated more than 10 times. While in the particular that likely sorts out activities that were not very relevant, in the aggregate we might be losing important data.

Additionally, as I went through the activity codes and recoded them, it is possible I mis-labeled something that was more case management as a direct family contact, or vice versa. Some of the activity codes (i.e., “shopping and meals”) are not entirely clear as to their purpose. Similarly, some activity codes are also very similar (“home visit” vs. “family session”) or could be overlapping (“school visit” vs. “collateral contact”).

Recommendations for future data collection:

Going forward, I would strongly recommend a more simple, straightforward initial coding of the activities, something along the lines of what I tried to do here:

- Family Contact
- Case Management
- No Shows

From those primary codes, more detailed secondary codes for activities could be developed, such as phone, in person, entertainment, academic support, etc.

Next steps with this data:

It might be useful to review this data with Osiris staff to see if the new primary and secondary codes I assigned to their activities seem likely to be accurate. It might also be useful for Osiris staff to review the kinds of activities this data says they are doing most with families to see if that resonates with their own experiences. I would be curious – is this what they think they are doing? Is it what they want to be doing? In particular, as mentioned above, I also would be interested to know why they think the school contacts are so low – because they don’t see it as a priority (unlikely) or because of data collection errors.7

---

7 Written memorandum from Philip Decter, May 2008.
CONCLUSION

PILOT IMPLEMENTATION OF EVALUATION: SUCCESSES AND CHALLENGES

FAMILY CONDITIONS

This evaluation study found evidence of the benefits of the Osiris Group Family Stabilization model for involved families. Parents reported reduced self-reported symptoms of depression and sadness at or near the end of services compared to earlier in the service. Parents also reported a lower frequency of anxiety and worry at the post assessment than during the pre-assessment period. Self-reported frequency of conflicts with others were also lower at or near the end of the service period than reported at the beginning of services. In addition, parents reported improved and positive relationships with their clinician – a key indicator and predictor of successful behavior change according to other studies of the benefits of family services.

RESOURCES IN THE COMMUNITY

Child welfare specialists and researchers have identified isolation from community assets as a key factor that keeps family conflict from improving, and has been associated with increased family violence. Parents and Osiris Group members tracked referrals to and use of community resources during service delivery. Parents reported being referred most often to family counseling/therapy, after-school recreation programs, youth mentoring/tutoring, and teen community services. The majority of family members referred to community resources reported making contact with the referred sources.

CONFIDENCE IN BENEFITS OF SERVICE PROCESS

The analysis also supports evidence for the prerequisites of improved family functioning, namely the confidence of mentors and clinicians to resolve conflict and exact change in the way the family communicates with members and helpers. Nearly all of the clinicians and mentors expressed confidence in their ability to help their clients reduce conflict and improve family relationships. A majority of clinicians and mentors also observed that family members and helpers were working on mutually agreed upon goals, on the importance of the goals being worked on during service delivery, and that both family members and helpers are confident that the work being done is useful. Furthermore, a majority of clinicians and mentors expressed appreciation of their clients’ struggles and believed there existed mutual trust in each other to accomplish real change for the good.

Clinicians and mentors also were largely in agreement with families on the steps that needed to be taken would reduce conflict and improve communication, conditions that led to the current
problem situation for families. By the end of the service delivery period, mentors and clinicians reported that family members were able to discuss their beliefs and feelings without constraint, and family members were able to agree on what is important.

Osiris Group members referred family members most often to after-school and recreation programs, youth serving organizations in the community, family counseling, and educational programs within the community. Families were also referred to food resources, parent training programs, and other teen-focused resources in the neighborhood.

Osiris Group mentors and clinicians have adapted an objective risk assessment tool for youth whereby they are now documenting behaviors and conditions including school issues, conduct problems, eating disorders, substance abuse, violence and suicide risk. These assessments, if used during the service period provides clinicians and mentors with objective data on current and changed conditions of youth in the families they serve. This data also provides objective evidence of the serious risks to youth in the population served by different insurance companies and the Massachusetts State health plan, Mass Health.

**THE ONLINE SUCCESSFUL CASE METHOD SURVEY**

The online survey of clinicians and mentors provided evidence for the severity of conditions in which the current families are living, and the risk of placement for the children and young teens. Mentors and clinicians describe poor communication and emotional reactivity due to deep social and emotional losses, as major contributing factors to family conflict at the time of entry into the services of Osiris Group. They also describe the attitudes and behaviors of parents and teens that contribute to successful change during service delivery. The most frequent characteristic mentioned by clinicians and mentors is the willingness of family members to accept the work that is required to change – not all families are willing to do what it takes to change. Other conditions and factors in families that contribute to positive changes include: a willingness to care and listen to each other, taking time to communicate, hopefulness, and support for positive relationship between family and helpers.

The DCF workers who responded to the survey confirmed the positive view of Osiris Group clinicians and mentors. They reported that the service model used by Osiris Group workers works best with families in very complex situations, who are mostly African American and have teenagers. Because the referred families have many needs, Osiris Group uses a hands-on approach, making time to help address the families many needs and limited resources. DCF workers reported being “very satisfied” with the work, and planned to refer new families to the Osiris Group program in the future.
RECOMMENDATIONS

Three recommendations are made based on this evaluation: (1) implementation of a client tracking database using remote data entry; (2) benefits of using standardized assessment and tracking instruments; and (3) using online surveys of referral agencies and clients to assess satisfaction with services.

INSTALLATION OF CLIENT TRACKING DATABASE FOR FUTURE PROGRAM DELIVERY AND DOCUMENTATION

The special report on the database suggests that a streamlined coding system would help make the service tracking more efficient. Osiris Group administrators should consider implementing a database that workers can access and use to track client services remotely from home or in the field, making client and worker tracking more useful, accurate and efficient. Work on this has already begun, and after an initial period of testing and training, workers and administrators should have reports available to use in improving service and marketing the program to other insurance companies.

TRAINING AND SUPPORT FOR ADMINISTRATION OF STANDARDIZED MEASURES OF OUTCOME AND PROCESS

Increasingly insurance companies will insist on some form of standardized assessment at the beginning and end of service to objectively document client changes. Whatever tools are used, workers and administrators should become familiar with the tools and how to use them for improving service. The hardest part of this transition will be to incorporate the standardized assessment into ongoing clinical and mentor service delivery in a consistent way so that the data is complete and useful. Training on administration of the tools should be repeated during the year, and advanced training on using the data from the tools should be offered as well.

VALUE OF ONLINE SURVEYS WITH REFERRAL AGENCIES AND CLIENTS TO ASSESS SATISFACTION WITH SERVICES

While conducting satisfaction surveys within the health community has become more frequent, social service agencies have been slower to adopt the practice. With internet access more prevalent through schools and public libraries, many more opportunities now exist to survey referring providers and parents about their experience of Osiris Group services. Using client satisfaction questionnaires to document both inefficiencies and successful work can be helpful in building common understanding within Osiris Group workers and administrators about the effectiveness of the Family Stabilization and Support Program, and other therapeutic programs offered by Osiris Group in the future.


Fleck-Henderson, A. Interview with Osiris Group Director. 6-20-2006. 2006. Ref Type: Personal Communication


Houle, T. T. and Stump, D. A. Statistical Significance Versus Clinical Significance. Seminars in Cardiothoracic and Vascular Anesthesia, 12[1], 5-6. 2008. Ref Type: Journal (Full)


