Father as Resources in Families Involved in the Child Welfare System

Marsha Kline Pruett, Carolyn Pape Cowan, Philip A. Cowan, and Kyle Pruett

Marsha Kline Pruett, Ph.D., M.S.L., is the Maconda Brown O’Connor Professor at Smith College School for Social Work. She has written extensively for academic and lay audiences, coedited two books, coauthored Your Divorce Advisor: A Lawyer and a Psychologist Guide You Through the Legal and Emotional Landscape of Divorce, and has written a new book with her husband on coparenting (forthcoming). She was awarded the Association of Family and Conciliation Courts’ Stanley Cohen Award for Distinguished Research.

Carolyn Pape Cowan is a professor emerita of psychology at the University of California, Berkeley, and codirector with Philip Cowan of three longitudinal preventive intervention projects: Becoming a Family, Schoolchildren and Their Families, and Supporting Father Involvement. With Phil Cowan, she coauthored When Partners Become Parents: The Big Life Change for Couples, which has been translated into six languages.

Philip A. Cowan is a professor emeritus of psychology at the University of California, Berkeley, where he served as director of the clinical psychology program and then the Institute of Human Development. He is the author of Piaget With Feeling; coauthor of When Partners Become Parents: The Big Life Change for Couples; and coeditor of four books and monographs, including Family Transitions and The Family Context of Parenting in Children’s Adaptation to Elementary School.

Kyle Pruett, M.D., is a clinical professor of child psychiatry and nursing at the Yale Child Study Center, the award-winning author of Fatherneed, and the principal investigator for the Effects of Primary Paternal Care on Child Development longitudinal study. He was also recently awarded a Lifetime Teaching Award by the Yale University School of Medicine. He is a former president of the Zero to Three: National Center for Infants, Toddlers and Their Families, and serves on the board of trustees of Sesame Workshop.

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The ongoing presence and prevalence of child abuse and neglect in our society poses major challenges for the lawmakers and policymakers charged with keeping children safe and the mental health professionals charged with treating them when they are not. As public awareness of the problem has grown, reports of child maltreatment have increased exponentially: From 1976 to 1993 the number of reported child maltreatment instances increased 347% (U.S. House of Representatives Committee on Ways and Means, 1996), stressing the child welfare system’s capacity to respond in a timely and effective...
manner. To respond to this surge in abuse, program developers and policymakers began speaking about the need to generate community and neighborhood supports to strengthen parenting, family relationships, and communities (Schere, 1998). A general consensus formed that the “it takes a village” approach is necessary for success.

This paper describes an opportunity to identify and use fathers as family and community resources. Until recently, fathers were rarely recognized as positive resources for reducing risks and strengthening protective factors for children at risk of abuse and neglect, and consequently they were rarely included in social welfare programs aimed at protecting children. Even as positive father involvement became accepted as a proven resource in the life of families over the past 2 decades (Pruett, 2000; Rohnner & Veneziano, 2001), there was little to no indication about the effectiveness of fatherhood programs for high-risk families (Cowan, Cowan, Pruett, & Pruett, 2007) and little acceptance of such programs for families involved in child protective services. A program emphasis evolved that focused on family-centered, community-based, culturally competent, and outcome-oriented care (McCrosky & Meezan, 1998; Wynn, Costello, Halpern, & Richman, 1994), but it was not clear what role fathers played in the equation. Instances of child abuse and domestic violence in many families (Campbell, 1994) led to a wariness and distrust of paternal engagement and a continued focus on only mothers and their children.

The California Department of Social Services, Office of Child Abuse Prevention, initiated and funded The Supporting Father Involvement study in collaboration with a team of four academic specialists in prevention programs and evaluation research and five California family resource centers. The study was designed to evaluate the effects of a theoretically driven, group-based model program on parents and their young children in low-income, at-risk families who were not involved in the child welfare system.

Supporting Father Involvement is the first father-involvement preventive program designed specifically for such families and evaluated with a randomized clinical trial design.

This paper reports on a study in progress. Based on a successful randomized clinical trial of two father-involvement interventions (Cowan, Cowan, Pruett, Pruett, & Wong, 2009) with the first 540 primarily low-income families, the Office of Child Abuse Prevention requested that the Supporting Father Involvement study be modified and extended to conduct a new test of its effectiveness for families that have been involved with the child welfare system because of reported child abuse or neglect. What follows is a brief outline of the intervention approach and the early results, followed by issues involved in adapting the intervention for higher-risk families.

Completed Phases of the Supporting Father Involvement Study

The intervention model targeted five domains of family life identified as risk or protective factors for adults’ and children’s well-being (Cowan & Cowan, 2000):

1. Family members’ mental health and well-being
2. Quality of the relationship between the parents as partners and coparents (among cohabiting, married, separated, or divorced parents)
3. Quality of the parent-child relationship
4. Three-generational transmission of expectations and behavior patterns (grandparents to parents to children)
5. Balance of life stresses and social supports in the family’s relationships with peers, schools, work, and other social systems
The program was predicated on the belief that reducing symptoms of parents’ distress would affect the quality of their relationships as a couple, with the child, and with their kin. Along with helping parents use support resources more effectively, it was hypothesized that the program would reduce the probability of family violence, child abuse, and neglect.

Supporting Father Involvement (described in detail elsewhere — see Cowan, Cowan, Prue, Prue, & Wong, 2009; Prue, Cowan, Cowan, & Prue, 2009) entails two types of interventions to which participants were randomly assigned: a fathers-only group and a couples group, each lasting 32 hours over 16 weeks and co-led by a clinically trained male-female team. Organizational change efforts aimed at increasing father friendliness at the family resource centers were also implemented. Families who participated in the groups for fathers or couples were compared with parents in a control group, who attended a 3-hour information session about the importance of fathers to children’s development and well-being. All intervention and control group families received ongoing case management for referrals to other services as needed.

Phase I included only biological fathers and mothers committed to coparenting at least one child from birth to age 7 (N = 276 families); two thirds of the participants were Mexican American, 75% were married, and 66% were low-income, defined as below twice the federal poverty level (Pruett et al., 2009). Phase II, with new participants, expanded program criteria to include African American families, a youngest child up to 11 years, and any self- and mother-identified father figure (e.g., uncle, long-term boyfriend, etc.). This phase included 312 families with comparable demographics and descriptive characteristics at baseline to families in Phase I. In both phases, families with an open case in the child welfare system were excluded from the study and referred to other services.

In all three conditions (information-only control group, fathers groups, couples groups), parents were assessed using a large variety of self-report instruments targeting the five domains of family life described previously, administered orally prior to the intervention (baseline), and 2 months (post-test) and 11 months (follow-up) after the intervention ended.

Results demonstrate the program’s effectiveness in reducing risk factors and increasing protective factors associated with child abuse and neglect. Compared to participants in the control group, parents in the couples groups showed increased father involvement, couple satisfaction maintained over time, and decreased personal and parenting distress. Moreover, children whose parents participated in the fathers and couples groups had no increases in problem behavior (e.g., aggression, hyperactivity, or depression), while control group children did. Parents in the fathers groups made fewer gains but showed more significant positive effects on father involvement than did control group families. The intervention effects held across ethnic group membership, income level, and marital status. Agencies housing the Supporting Father Involvement study showed improvement in father-inclusive policies, procedures, and services (for details on the sample, intervention, and findings, see Cowan, Cowan, Prue, Prue,
& Wong, 2009). Results of Phase II were consistent with those in Phase I, with some intervention effects emerging even more strongly.

**A Planning Phase**

Based on these positive results obtained with more than 500 families, Phase IV will examine the impact of Supporting Father Involvement on families who are at even higher risk for child abuse or neglect, including those with open cases in the child welfare system. The study is currently being adapted for families who voluntarily choose to participate in it concurrently or after involvement in the child welfare system.

**Phase IV: Adaptation of the Study to Families in the Child Welfare System**

The clinical research team and the staff of five family resource centers are working closely with child protective services agencies, developing appropriate screening procedures for inclusion, adapting curricula and assessment materials, designing additional staff training, and putting procedures in place to ensure the safety of all participants. Various groups are now being conducted with mixed referrals of families from both the child welfare system and the broader community.

**Staffing**

Staff at each site will continue to consist of a project director, two clinically trained group leaders (each at approximately 20 hours per week), two case managers, and one data coordinator. The clinician/researchers will continue to be actively involved, leading group phone consultations for each staff group, analyzing the data, and conducting semiannual all-site training meetings. Phase IV will also include ongoing consultation by an expert in domestic violence and child abuse issues, in order to guide the development team and to consult with all site staff as the program expands to include families whose risk for subsequent abuse or neglect is higher than it was for families in the earlier program phases.

**Recruitment and Collaboration With Child Welfare Services**

Previously, recruitment occurred through community channels, including local agency referrals, newspaper and radio advertisements, staff appearances at community events, and eventually, word of mouth. In the newest phase, community-based recruitment will continue, but many families will be referred by child welfare workers. This new referral source requires a different level of collaboration with county liaisons and caseworkers from the state agency. Phone and face-to-face meetings have provided opportunities to introduce county child welfare agencies to the program and address a number of unresolved questions.

First, criteria were established for exclusion of families. While accepting higher-risk families into the study, provisions had to be established to ensure that ongoing family violence did not contraindicate working with both parents together in a group. In addition, families whose children have been removed and who are not approaching or beginning reunification will be excluded. Second, it was felt that child welfare workers needed a better understanding of the necessity for the program to remain a controlled study while determining if it is effective for child welfare system families. Because some representatives of the child welfare system objected to a no-treatment or very low-dose treatment option in the study (the information-only control group used in the initial phase), a delayed treatment condition was adopted as a comparison group. In this condition, families will be randomly assigned, to the intervention or to services already available in the community, with an offer to participate in a Supporting Father Involvement group 7 months after the initial referral and baseline assessment. This option
will allow service provision to all families, while allowing a comparison of the effectiveness of the Supporting Father Involvement intervention with each county's "treatment-as-usual" options.

Other criteria for inclusion remain the same as those in earlier phases: Both parents must agree to participate; at least one child must be 7 years or younger; the father or father figure can be any male coparenting figure (not necessarily the biological father); and neither parent has mental illness, substance abuse, or violence problems severe enough to compromise his or her daily functioning as parent or partner, or call into question his or her ability to parent the child adequately and participate in a family program that will be safe for all participants. Typically, when a biological father is involved to any extent in the child's life, he is the one who participates with the mother. When a father figure who has been involved with the biological mother participates instead, they are encouraged to coparent together while accepting the possibility of the biological father's involvement to remain or be resumed in the child's life. Typically, this male figure is a family member or psychological parent to the child by virtue of being involved with the mother for some time, in contrast with the biological father who has been unavailable.

In regard to the inclusion of child welfare services, the eligibility criteria include those families in which 1) calls to child welfare services have been made but not substantiated; 2) calls to child welfare services have been made, investigated, and deemed suitable for community treatment; 3) the family is completing other mandated treatments and accepts an additional, voluntary referral to Supporting Father Involvement; and 4) reunified families have begun unsupervised visits. Referrals will be handled case by case, first evaluated by the child welfare worker, then assessed by Supporting Father Involvement program staff using the project's own assessment tool for suitability. Families with open cases will be individually evaluated to ascertain that father involvement is indicated, considering the type of violence and abuse that led to child welfare involvement, with the child's and parents' safety the primary consideration.

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A memorandum of understanding with each county allows some flexibility for decisions across agencies that have diverse populations, operating structures, and policies. The key point is active, ongoing consultation and collaboration on the plan between child welfare workers and staff of Supporting Father Involvement.

One challenge in accepting child welfare service referrals is defining roles for case managers from both the child welfare system and the Supporting Father Involvement study, and setting a communication structure that will guide the types of information to be communicated between the two workers. The primary concern involves coordination between agencies when there is an open case. In this circumstance, the child welfare worker will retain major responsibility for monitoring the family's case plan and follow-up. Supporting Father Involvement will function in ways that are similar to those of community agencies to which child welfare workers currently refer their families: The Supporting Father Involvement case manager will focus on making sure that participants complete
study assessments and attend the ongoing intervention groups.

**Adaptation of Screening Procedures**

Supporting Father Involvement has had a screening instrument in place to determine whether a family was suitable for participation. An interview process was developed that screens for levels of alcohol and drug abuse, domestic violence, and impairment in parental health and mental health, including suicide risk — all self-reported. For families referred by child welfare workers, several elements have been added to the former screen. First, a comprehensive definition of domestic violence was added:

*A pattern of abuse and coercive behaviors, including physical, sexual, and psychological abuse as well as economic coercion used against an intimate partner. The abuse often involves the use of a combination of tactics aimed at establishing control of one partner over another.*

Similarly, an expanded definition of child abuse that includes physical and psychological or emotional abuse or injury (California Department of Social Services Regulations, 2005) was explicated.

Next, a careful assessment of any incidents is conducted with individual partners, with a detailed protocol for responding to various scenarios that could arise from parents’ responses during the screening process.

Additional domestic violence considerations have been included in the assessment process, such as:

- Is there a level of entitlement to be violent or to be boss?

Additional considerations regarding child abuse and neglect have been included. The parent is asked:

- As far as you know, have there been any instances in which:
  - your child has been disciplined physically?
  - your child has been touched sexually by an adult?
  - your child has been left alone for long periods or not taken care of?
- Do you think that children are supposed to meet parents’ needs?
- Do you think that children *belong* to their parents?

**Adaptation of Assessment and Evaluation Procedures**

To be more relevant to child welfare families, evaluation in the next phase will continue longitudinal assessments (baseline, 2 months after groups end, and follow-up at 1 year after post-assessments). New instruments have been added to the evaluation materials to determine any self-reported changes in levels of abuse, neglect, or family violence. Another addition is a videotaped assessment of each parent interacting with his or her youngest child at baseline and the follow-up (done in earlier program phases only at follow-up) and videotaped discussions of a current conflict between mother and father pairs. Notably, county welfare data about past or current involvement of participants in the child welfare system will be collected to learn whether the interventions are making a difference to participants’ involvement in the system after their involvement in Supporting Father Involvement.
Curriculum Changes

The Supporting Father Involvement curriculum involves 32 hours of attendance in groups meeting for 11 to 16 weeks. Meetings include an open-ended check-in, plus a discussion focus at each meeting on one of the five aspects of family life outlined above: the well-being of each individual adult, the couple/coparenting relationship, parent-child relationships, intergenerational family patterns, and life stresses and social support outside the nuclear family. Two meetings are devoted to each aspect of family life. A brief didactic piece is combined with a choice of activities, allowing for consistency across groups and room for individualizing to fit the learning objectives to a particular group’s needs.

After extensive consultation about the curriculum, along with a literature search on interventions pertaining to child abuse and domestic violence, it became clear that the existing curriculum aptly included major risk and protective factors associated with child abuse and neglect. Information on parenting stress and many other relevant aspects of family relationships that affect or indirectly lead to abuse and neglect had previously been integrated into the curriculum. Specific materials on child abuse, neglect, and domestic violence were then developed and integrated into the curriculum. Relevant content includes signs and symptoms of each type of abuse and violence; statistics of incidence, prevalence, and known correlates of abuse or family violence; effects of abuse or violence on children; and additional sources and resources.

Advanced Training

Before fully launching this new program phase, 11 staff members participated in didactic and interactive 3-day trainings on child abuse, domestic violence, and patterns of individual and couple behavior to observe and follow in assessments, case management contacts, and ongoing groups. Group leaders will also focus on group management considerations in groups consisting of families who are and are not involved in the child welfare system. The groups will aid for a mix of families from the community and the child welfare system. The goal is to include mostly families involved in the child welfare system, because the purpose of this phase is to assess the intervention’s effectiveness with this population. Group leader feedback from initial groups was that many of the original study families’ psychological and social difficulties were severe enough that they had difficulty offering support and advice to other families in similar situations.

Many of the original study families’ psychological and social difficulties were severe enough that they had difficulty offering support and advice to other families in similar situations. Enrolling some higher functioning families in a group with those experiencing more severe symptoms and problems provided the needier families with insights, ideas, and a vision of how changes could positively affect them and their children. Mixing groups in this way will require keeping a careful eye on group dynamics to ascertain that all couples feel supported, a sense of belonging in the group, and that there is ample opportunity for their own issues to be heard and considered by the leaders and the group. Although regular telephone consultation will continue with all group leaders, achieving this group atmosphere will fall largely to the skill of the leaders, reinforcing the emphasis on using highly skilled, clinically experienced facilitators.
Additional Safety and Clinical Considerations

A licensed clinician will consult 5 hours per week with the sites, as needed, regarding clinical emergencies (e.g., safety and reporting issues), and participate in staff trainings. While the university-based clinician-researcher teams have considerable expertise, a person dedicated to immediate responsiveness to the sites, and who is experienced in working with families of color and with child welfare populations will provide another means of protection for the families and quality assurance for the program.

Whenever questions arise, internet listservs for research staff and teams from all sites allow collaborative discussions of concerns regarding individual families from their acceptance into the program to the final assessment 18 months later. In addition, a safety net of communication between program staff and child welfare agencies enables swift contact and follow-through as necessary for the safety of any child or family.

Practice and Policy Implications

A careful consideration of the behaviors and attitudes revealed in the groups during the most recent project phases suggests some policy implications that were not as clear in the initial phases of the study. Many fatherhood involvement programs are reluctant to raise domestic violence and abuse issues in parenting groups for fear it will discourage fathers’ participation (Williams, Boggess, & Carter, 2001). Yet such groups led by skilled practitioners (Doherty, Kouneski, & Erickson, 1996) can be instrumental in improving fathers’ (and mothers’) interpersonal skills, offering mutual aid, encouraging confrontation of denial and aggressive behavior, setting positive norms for individual and group change, and maximizing social rewards for change (Bennette & Williams, 1999). The experiences of Supporting Father Involvement group leaders thus far have borne this out. Parents raise issues of abuse and violence cautiously but openly, and, when encouraged, are willing to examine their own and their family’s behavioral patterns that reinforce the abuse or neglect.

As more groups are conducted in the newest phase, we expect to gain additional insights about how parents are struggling to eradicate old patterns that have become ingrained. Because change often does not take place without sufficient time and encouragement, the curriculum will be held to a 32-hour standard, although child welfare workers initially doubted whether disorganized families could sustain their involvement over that period. So far, they have been able to do so, though often with much difficulty and the help of case managers to maximize their continued involvement. In fact, many families have clamored for more when the intervention is completed, and Supporting Father Involvement has devised ways for them to be involved through the family resource centers and periodic events specific to the program.

Supporting Father Involvement, with its inclusion of training for case managers and clinicians and its work with organizations on their father-friendly policies and practices, attempts to address institutional and intrafamilial barriers to including fathers as positive resources in the lives of their children, especially in high-risk families. As noted elsewhere (Cowan, Cowan,
Pruett, & Pruett, 2009), barriers stem from stereotypes within child protective services that favor mothers as children's primary parents. Government programs often consider fathers as sources of financial rather than emotional support, and research and intervention programs continue to include mothers far more often than they do fathers, and most important for this paper, family service agencies primarily address mothers. Initially, the host agency's physical facilities were mother-oriented in terms of pictures on walls, magazines, hours open, and staff composition. Case files often had only mothers' names, even when they were married to children's fathers. It was as if no one in the agency expected fathers to be around for long. It is not clear, however, which expectation affects which in the circularity that has become "further proof" of fathers' relative disposability in child welfare situations.

Overcoming Barriers to Father Involvement in Child Welfare

Low income fathers from both White and non-White ethnic groups can be recruited to participate in relatively long (32-hour) intervention and they may even plead for additional time as the groups draw to a close. Keys to the success of the project include a proactive staff of both males and females willing to show up at community events, shopping centers, and soccer games at times that fathers are likely to be there; case managers and group leaders who make extra efforts to stay in touch when one or both partners miss groups; and skilled group leaders guided by a curriculum that does not tell men what to do, but raises topics that relate to both men's and women's day-to-day experiences.

Programs can address both parents together as coparents whenever it is possible to do so safely. This means focusing on neither parent to the exclusion of the other. In fact, in light of the power of married and unmarried mothers to influence fathers' access to their children (see Pruett, Arthur, & Ebling, 2007; Williams et al., 2001), and the powerful influence of fathers on children's cognitive, emotional, and social development, parents must be helped to work together for the interests of their children. The ongoing vigor of the relationship between partners as potential coparents must be respected and acknowledged if the relationship is to become more functional as a tool for healthy familial change and development.

Research-based interventions must be developed and supported. Research combined with intervention has a role that is yet unrealized to its fullest potential. Williams et al. (2001) call on researchers to explore the usefulness of groups to better understand the intersection of domestic violence and fatherhood. They point out how little is known about how fathering themes influence effective parenting and the reduction of violence among men who are batterers and abusers. Parenting and violence may be affected simultaneously or sequentially; the causative agents for any change in this regard remain questions for future research. In addition, little is known about how programs like Supporting Father Involvement can augment men's motivation to actively parent their children and become more effective fathers and partners in the process. Similarly, it will be the challenge for father involvement programs to articulate just how they are able to effect positive change in cooperative parenting relationships in families faced with histories of violence, abuse, and multiple stressors. Initial experience with adaptation of the Supporting Father Involvement intervention has shown that parents do change for the better with intervention; similarly, some men who batter also change their ways (Gondolf, 1998). Not yet known is whether men who change from abusers to nurturers increase their children's well-being (Williams et al., 2001), and what scars remain. It also remains as a research agenda to understand which fathers and mothers are able to change into more lovingly involved parents, and in what ways.
Supporting Father Involvement intervenes with families before a child in the family is 7 years old. Early intervention has been touted as a key to stemming abuse and neglect (Shonkoff & Phillips, 2000; Zero to Three Policy Center, 2007). Mother-based program efforts must now include fathers if we are to capitalize on the transition to parenthood (Cowan & Cowan, 2000) as a sensitive “touchpoint” (Brazelton, 1994) in which fathers and mothers may be more open to intervention than at later periods of life.

Turnover and burnout in social services is high, and child abuse workers face stress and discouragement on a daily basis. Among the lessons learned from this program thus far is that social workers and community-based care providers reported that their own lives improved as a result of participation in this program. Their reports on couple relationships, relationships with fathers and with children, and optimism about the possibility for change are from a staff that has stayed with the program over its 6-year longevity. The key has been in the systems of communication and support through phone conferences, listservs, enforced weekly staff meetings, semiannual cross-site 2-day meetings, and open access to the researchers.

Just as research interventions can help determine how parental collaborations are developed, strengthened, and supported, future work must also elucidate how agency collaborations, such as those between universities and family resource centers in Supporting Father Involvement or between the program and the child welfare workers and supervisors, support healthy parenting, coparenting, and child development, especially in an era of shrinking resources.

Conclusions

In this father involvement study, hundreds of Mexican American, African American, and European American fathers who say they are eager to become involved with their children also reported that they are uncertain how to do that. Supporting Father Involvement has been learning how best to provide them with the skills and supports that enable them to draw on their motivation to be involved parents and partners.

While child abuse and parenting programs have been implemented widely through large and small initiatives, program effects have been modest and inconsistent, and research has rarely incorporated random assignment or reliable outcome measures (McCrosky & Meezan, 1998). Ten years after McCrosky and Meezan’s review, too few programs target the whole family, are systematically evaluated, or take a primary prevention tack by focusing on the early years of parenting, despite evidence of the rocky start to family life that so many families experience (Cowan & Cowan, 2000; Gottman & Gottman, 2007) — even those not facing chronic and severe life stressors. Without the synthesis of these ingredients, society will continue to engage in two simultaneous uphill battles: reducing child abuse and neglect and positively involving at-risk fathers in the lives of their children. It is time to marshal our fullest knowledge base and resources to protect children and strengthen families, despite the many complexities we face in doing so.

References


