

Abstract

Family Functioning and Social Capital of Families Participating in Intensive In-Home Services: A North Carolina Study

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April 2010

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Family functioning and social capital are two important realities for families receiving Intensive In-Home Services in North Carolina. Intensive In-Home Services provide a time limited treatment approach for families who have a child or adolescent with a clinical diagnosis such as ADHD, Anti-Social Disorders, Anxiety Disorders, or Mood Disorders; and having difficulty functioning with life domains such as the home, school, and community. This study seeks to determine if there is a relationship between social capital and family functioning. Participants (n=7) were the legal guardians of children and adolescents currently receiving Intensive In-Home Services within North Carolina. It was hypothesized that higher perceptions of social capital would be related to higher family functioning scores. Six of the seven participants' scores revealed a pattern between social capital and family functioning supporting the hypothesis suggesting that lower social capital scores would be associated with lower family functioning scores and higher social capital scores positively associated with higher family functioning. However, one participant had a high social capital score, but a low family functioning score. This may be an implication of other psychosocial factors to consider such as SES, employment status, area of residence, or age. The small size requires precaution in making generalizations and future studies with larger sample sizes will be needed.

Family Functioning and Social Capital of Families Participating in Intensive In-Home Services:
A North Carolina Study

A Thesis

Presented To

The Department of Child Development and Family Relations

East Carolina University

In Partial Fulfillment

of the Requirements for the Degree

Master of Science

Child Development and Family Relations

by

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April, 2010

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ACKNOWLEDGEMENTS

First, I would like to thank God for giving me the passion, strength, and desire to address such an important area of research relating to children and families. I would also like to thank all those who have inspired me to develop, organize, edit, and learn during the process of completing this thesis. A special thanks to my committee members: Dr. Sandra Triebenbacher, Dr. Sarah Williams, and Dr. Martha Early for your invaluable support; the IRB Committee at East Carolina University; and my family (Daddy, Boss, Marque, and Clarence), and friends who provided encouragement, prayers, and blessings during this time. Another special thanks to Dr. Bernice Dodor who provided support and feedback on the process of doing a thesis and understanding the importance of staying positive and tenacious no matter what. Plus, I would like to thank Dr. Cynthia Johnson, Department Chair of Child Development and Family Relations, for your final review of my thesis and your words of wisdom during the process of reaching this point. Many thanks to Ethan, the Rivers Building computer lab assistant, for your tireless effort and patience while helping me with my page numbers was amazing and definitely on time! A special acknowledgement goes also to Grandma Etta Mae Pollard who inspired me during her final days here on Earth as I prepared to submit my thesis. Finally, I would like to dedicate the completion of my thesis to my Mother. I know you are looking down on me and proud of this accomplishment. Growing up I recognize the importance of people in the way you lived your life as you gave to others. For that reason, I celebrate your life by continuing to do the same via research and real life.

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INTRODUCTION

Families are arguably the most important social institution in our highly diverse world. In most situations regarding social work keeping families together is essential. Building family sufficiency, stability, and safety in order to reunite families or deter out of home placement for children and adolescents requires active listening and coordinating supports that will meet both basic and complex needs within their environment. However, understanding the demands and stressors of each family unit is a must; while acknowledging that perceptions, symbols, meanings, and beliefs surrounding who is considered “a support” may vary.

Intensive In-Home Services have also been called family preservation services, home-based services, family-centered services, family-based services, or intensive family services. This service model is designed to increase family strengths and ability to grow together, increase support for families, reunite child and youth in out of home placements, and prevent out of home placements (Burns, Barbara, Hoagwood, Kimberly & Mrazek, 1999). Intensive In-Home Services are provided in over thirty-five states across the United States, but qualifications and how to provide services is defined by each individual state. Intensive In-Home Services can be funded by the following systems: mental health, juvenile justice, and child welfare (Bazelton Center, 1999). Intensive In-Home within North Carolina is an enhanced service that utilizes a team approach to address identified needs of needs of children and adolescents who may have serious and chronic symptoms of an emotional, behavioral, and/or substance use disorder. Eligible are children and adolescents who are unable to remain in tact with their family without intensive interventions. The Intensive In-Home Service model is a time-limited, intensive family intervention based on clinical needs of children and youth. It is provided through the Mental Health System of North Carolina by private provider agencies. Funding sources for the service

model include the following: third party Insurance, Medicaid, Health Choice, or state funded support by the local management entities. Intensive In-Home Services is funded by primarily by Medicaid in North Carolina. Participation eligibility involves the presence of a diagnosable mental, behavioral, or emotional disturbance as defined by the American Psychiatric Association (2000) within the Diagnostic Statistical Manual. There is also documentation that these children or adolescents have presenting needs and symptoms that have caused poor functioning in the home, school, or community setting. Individual children and youth must be clinically diagnosed with an Axis I or Axis II diagnosis that includes a mental or substance abuse diagnosis (or both), but can not be predominately developmentally associated in North Carolina.

Services can be provided in the home, school, community, homeless shelters, libraries, or out of home placement facilities (for children and youth transitioning back home). Emphasis is placed on direct contact with youth and families (at least sixty percent of contact time) in the home setting. The service also involves a team approach (Licensed/Provisionally Licensed Professional Team Leader and two Associate Professionals) and is a community-based approach that is delivered primarily in the home. Services include the following: diffusing crisis by a first responder (Intensive In-Home Team Members), intervening to reduce likelihood of a crisis occurring, linking to community services and resources, monitoring and managing presenting psychiatric and/or addictions, providing self-help and living skills for youth, working with caregivers in implementation of home-based supports, and providing other rehabilitative supports to prevent out of home placement for the youth. The team approach involves structured, face-to-face, and indirect scheduled therapeutic interventions that are available 24 hours a day, 7 days a week 365 days a year. Interventions may include the following components: assessments, behavior management, parent mentoring, medication management,

household management, crisis management, intensive case management, skills training (youth, parent, and family), individual therapy, family therapy, substance abuse intervention, and rehabilitative supports. Services are individualized and tailored to the individual family's needs in relation to the child or youth's clinical concerns or anti-social behaviors. The average length of services is three to five months. Services should be based on an evidenced based or best practices with a system of care service delivery approach (Division of Medical Assistance Enhanced Mental Health and Substance Abuse Services Clinical Coverage Policy 8A, 2010)

Intensive In-Home Services are about keeping the family together and providing treatment and support. It also considered a treatment model that can be provided in the most normative environment for youth and families that is cost efficient. The Surgeon General Report (2000) suggested the effectiveness of home-based services that provide very intensive services within the homes of children and youth with serious emotional disturbances. Federal initiatives such as President Bush's Freedom Commission (2001) stressed the importance of increasing community based services and treatment for people with mental health, substance abuse, or developmental disorders. This service was especially pertinent to children and youth assessed and identified with serious emotional disorders traditionally placed in group homes, youth development centers (training school), detention, or residential treatment facilities. Currently, North Carolina promotes a system of care approach that values the following: family centeredness, building on the strengths of the family, increasing community supports for the family, engaging systems connected to the family, having child and family team meetings, using evidence base, best, or promising practices, and the importance of cultural and linguistic competence when working with youth and families. Services should address the wellness of individuals and the family as a unit from a holistic perspective that encompasses all life domains.

They also involve working in collaboration and integration within the community to increase the accessibility of a full range of supports and services.

It is vital to identify ways to empower families (particularly parents and caregivers) to increase positive outcomes for youth and families within their natural environment. One way to promote empowerment within families is to acknowledge their talents, abilities, and solutions; while also recognizing their needs. Team members within Intensive In-Home Services are responsible for helping families connect to social supports; particularly informal ones (immediate family members, extended family members, pastors, neighbors, peers, community leaders, or other unpaid support).

Families are dynamic and can be connected to several life domains such as home, school, job, and community. They also have times when they may go through change that can cause both eustress (positive stress) and distress (negative stress) that may disrupt their structure and balance. Families may need people around to assist them in navigating stressors and changes that result in crisis. As a result, this research presents a literature review discussing the relationship between social capital and family functioning. It also provides a working definition for social capital; while presenting three theoretical social capital concepts based on the work of Robert Putnam, Pierre Bourdieu, and James Coleman. Emphasis will be placed on Coleman's theoretical perspective of social capital.

Literature Review

Defining Social Capital

Social capital has become an influential factor when studying families. James Coleman's theoretical work (1988) on school participation in Chicago, is credited as being the foundation that inspired the work of Putnam (1993) relating to democratic institutions in America. This was considered to be an expanded view of Bourdieu's (1983) work on social capital in European sociological theatre (Woolcock, 1998). Social capital, according to sociologist James Coleman at the University of Chicago, refers to the quality and depth of relationships between people in a family or in a community (Coleman, 1988). Coleman (1988) notes, "The social capital of the family is the relation between children and parents (and, when families include other members, relationships with them as well" (p. 384). He adds that the social capital of the community "resides in the functional community, the actual social relationships that exist among parents, in the closure exhibited by the structure of relations, and in the parent's relations with the institutions of the community" (p. 387).

Social capital emphasizes the ability of the family to work toward a child's well-being and the ability of the community to work toward a common good. A strong sense of community, common values, shared trust, and a willingness to intervene in problem behaviors of youth are essential in creating a positive atmosphere for children to develop and achieve is also associated with Coleman's view of social capital.

The concept of social capital is abstract. For years scholars have struggled with identifying a universal definition to appropriately capture the meaning of social capital. Social capital is about recognizing assets of supports relating to trust, civic involvement, social engagement, and reciprocity. Trust is the belief that an individual, group, or organization can be

relied upon to act in a consistent, fair, rational, and expected manner-criteria that are shaped by the individual or family's own values and beliefs. Civic involvement is the participation in activities that directly or indirectly contribute to a community's well-being. These include solitary activities such as voting or newspaper readership, as well as interactive activities, e.g. joining organizations that have civic improvement agendas. Social engagement refers to the interactions that foster connections among community members or organizations. These connections included not only the organized group (family) that characterize many types of civic involvement, but also informal connections that have no organized or specific purpose, e.g. knowing one's neighbors or socializing with them. Reciprocity refers to the expectation of a return on one's investment-the faith that an action or good deed will be returned in some form in the future. Individuals, of course, may have access to resources outside the immediate family (Kreuter, Lezin, and Koplán, 1997).

Theoretical Concepts of Social Capital

Since social capital lacks a unified definition, the thoughts of Putnam, Bourdieu, and Coleman are often applied. All three theorists believe that social capital is a resource, but present a different paradigm about the meaning of resource. According to Coleman, social capital refers to resources available to individuals and families to achieve social mobility, for Putnam it is seen as an endowment for civil society and important for economic growth and establishing democratic institutions, and for Bourdieu it is about how power and inequalities are reproduced in social networks. Once again, the purpose of this research paper is not to dispute these varied perspectives, but to use Coleman's view in reference to discussing families receiving Intensive In-Home Services in efforts to recognize whether it has an affect on family functioning.

Bourdieu's View of Social Capital

Bourdieu's approach to social capital relates to an interest in understanding how subordinate groups might seek to raise their socio-economic status by the deployment of or investment in different kinds of capital beyond the economic (Bourdieu, 1997). These different capitals may include social capital, such as the operation of social networks or group membership, and cultural capital as well as economic capital. Thus, Bourdieu's work raises the possibility that families lacking in economic capital may be able to use other capitals to achieve their educational aims and goals. His interest is in how those with financial capital can convert it into educational qualifications and then back again. This theorist laid the foundation for understanding social capital in Europe.

Putnam's View of Social Capital

Putnam's later work has developed this theoretical framework. Not only has he developed the concept of trust to an emphasis on reciprocity (Putnam, 2000) but he has also expanded his definition of social capital and in particular to emphasize a tension between 'bridging' and 'bonding' forms of social capital. Thus bonding social capital builds strong ties but may lead to separation of a group. In order for a group to foster social inclusion groups need to build bridging social capital which builds connections between heterogeneous groups.

Coleman's View of Social Capital

Coleman (1988,a) saw social capital as inherent in the structure of family relationships, particularly inter-generationally. He was concerned with explaining how children's educational achievement is driven by parental investment, which then radiates out to the community in the form of the generational passing-on of cohesive social and moral norms of trust and co-operation, and sanction, and producing economic efficiency.

Coleman's empirical work focused on the link between school and attainment and particularly the success of Catholic high schools in offering benefits to pupils from less-advantaged backgrounds (Coleman 1988, 1990). Coleman felt social capital included the set of resources that inhere in family relations and in community social organization that were useful for the cognitive or social development of a child or young person (Coleman, 1994). Coleman's definition (1988, 1990) is based on social relations between individuals from a reciprocity point of view. Coleman's findings suggest that economic disadvantage can be compensated by a strong form of social capital in the form of family norms, values and networks, as well as a broader set of community values and networks which promote particular educational goals (Coleman, 1988b). In short, Coleman believed that families were the foundation of social capital.

According to Coleman, social capital is defined by its function. He also believed it involved several entities that primarily related to structure and the actors involved in the process. Social capital is meant to be productive; which in turns increases achievement of certain ends that in its absence would not be possible. Coleman felt that all social relations and structures facilitate some form of social capital (Coleman, 1988).

Attachment Theory and Social Capital

Attachment theory, according to Bowlby (1988), suggests that that secure attachment provides the opportunity for positive bonds and security within a larger system. In the family, children form bonds with their parents; particularly the mother. Attachment early in life encourages a sense of security and self-esteem that promotes lasting, loving relationships in adult life. According to Bowlby (1988), the ability to achieve mature adult relationships results from a series of complex cyclical processes of attachment, loss, and reattachment. Emphasis is on the

existence of networks that supply the resources to which families can become empowered in order to increase positive family functioning, wellness, and receive knowledge and access to supports. Here, attachment starts within the family (intrapersonal) and permeates throughout systems within the natural environment such as school and community (interpersonal). Strong attachments within the family can lay the foundation for how individuals connect with others or attach themselves. Healthy attachments could enhance social capital, whereas unhealthy attachments could do the opposite.

Family Wellness and Social Capital

Family life sets the tone for understanding and defining a child's first encounter of social capital. Family life is the first symbol of social capital. Supporting youth in their home means renewing the social supports that are often strain, disempowered, or lacking. This in turn may require other social capital institutions to help the family. Intensive In-Home Services seek to work with the whole family in the context of the identified youth suffering from mental health and/or substance abuse disorders.

Family resources are the key to helping them thrive within their environment. Meeting basic needs is the foundation to building on family's health in all life domains (spiritual, biological, emotional, mental, cognitive, social, and educational). Families and people with high quality social networks/social capital appear to suffer less illness and live longer than people with poor networks. Several longitudinal studies in the US, Japan and Scandinavia have shown that the quality of people's social networks measured at an earlier point in time predicts morbidity and mortality in later years (Putnam, 2000). People who have poor networks are between two and five times more likely to die, compared with individuals match on income, education etc) who have high quality family and social networks (Berkman and Glass, 2000).

There is a considerable body of research which claims that good social networks improve mental health and more specifically, that they reduce anxiety and depression, and buffer or reduce the impact of adverse life events and experiences (like divorce and unemployment) on mental health (Pearlin and Schooler, 1978; Thoits, 1983).

Family Functioning and Social Capital

Positive functioning is critical to family management and stability. According to Mathambo and Gibbs (2008), functional families love, rear and protect children and buffer them from negative effects. They also believed that such families have sufficient material and social resources to care for children, possess the motivation to ensure that children are nurtured and protected, and are part of a community of people who provide one another with mutual assistance. Mathambo and Gibbs also contend that family environments are especially important for young children because multiple risks can affect the cognitive, motor and social-emotional development of children. Yet, the quality of parenting, assisted by intervention when needed, can ameliorate such impacts. Hence, for the sake of this literature review, criteria mentioned by Mathambo and Gibbs adopted to set boundaries for defining what is a functional family.

Belsey (2005) contends that the family has always had productive, reproductive and protective functions. Belsey also notes that families provide food and shelter, share domestic labour, distribute family goods and resources, socialize their young, make decisions regarding access to health and educational opportunities, and transfer cultural and moral traditions from one generation to the next (Belsey, 2005). Winter (2000) suggests important linkages between family life and social capital. Here, family life, the development of self-esteem, and trust appears to be associated with the generation of social capital in civil society. Yet, when family

life is characterized by 'familism' (the elevation of family and kinship ties above other social types of obligation), social capital within civil society is limited (Winter, 2000).

Coleman (1988a) observed the factors of family life that appeared related to social capital. He measured social capital of the family through the strength of their relations between parent and child. He believed that a lot of this was based on the physical presence of adults in the family and on the attention given by adults to the child. Hence, Coleman felt the ratio of parents to children in the household and the extent of the family network had a major effect upon the likelihood of a child dropping out of high school (Coleman, 1988a). For example, a single parent with five children was more likely to witness one of those children dropping out of high school than a two-parent family with two children. He also found that there was no connection to dropping out of school based on parents' personal experiences; while finding that mother's expectation that their child would go to college was associated with the likelihood of the child dropping out of high school (Coleman, 1988).

Coleman measured social capital in relation to family functioning based on networks (objective factor) and norms (subjective factor). Networks in Coleman's eyes were connected to the parent-child ratios. He contended, 'the most prominent element of structural deficiency in modern families is the single-parent family,' suggesting that family structure is the key to a child's success and overall stability within the family (Coleman, 1988b).

To highlight the strength of norms regarding cooperation within the family, Coleman measured the quality of parent-child interactions. This was based on the frequency of discussions with parents about personal matters-not norms associated with trust and reciprocity between parent and child (Coleman, 1988a). Coleman believed that there must be a positive

attachment between children and parents. Otherwise, there would be a lack of social capital in families if the parent was only physically present (Coleman, 1988).

Coleman presented relevant information on social capital and families by discussing the following: variations in the relationship between family life and social capital based on levels of social capital within families varying due to different factors, identifying parent-child ratios as vital in explaining variation in levels of social capital within families, and by emphasizing the recognition of family values. However, it is important to appreciate the plight of the modern family. Families are different. Their constructions are not merely based on the nuclear approach. Some are extended and involve fictive kinship. In short, families are emerging and may require additional help to maintain a state of balance and positive functioning. This is not to excuse or undermine the works of Coleman, but to recognize that many families; particularly African American families receiving Intensive In-Home services are headed up by a single parent (usually the mother) with multiple children involved that experience multiple needs. Yet, strengths of such families are evident that is supersaturated with resilience, strength, courage, wisdom, and hope that can not be denied.

In order for any model to be effective and culturally correct, there must be fluidity in theory. Fluidity in theory basically means that the model can be adaptive to diverse cultures, structures, and contexts of families. Coleman's view is acknowledged, but this study will stress the emphasis of adapting Coleman's approach as it relates to the relevance of the families. Here, families will not be made to fit a model, but Coleman's model will be adjusted to fit the families. Since this is the case, core beliefs and standards of Coleman will be adapted when deemed necessary due to the dominant demographics that appear to associate with children, youth, and families who receive Intensive In-Home Services.

Besides, family functioning can be buffeted with the appropriate protective factors and supports. Goddard notes that social capital can be viewed as both an individual (family members) and collective (family as a unit) resource that provides personal, as well as communal benefits (Goddard, 2003). For example, Goddard (2003) found positive correlations between school achievement and social capital in his study of urban elementary schools in the United States. Fullan, Watson, and Leithwood (2003) also contended that social capital was a determinant of children's school success. They argued that family social capital revealed itself in the following ways:

- reciprocal obligations and expectations of one another held by family members (the obligation a child feels to work hard at school is reciprocated by parental obligations to provide a happy, secure environment);
- the potential for information available in social relations (family knowledge of who to contact for assistance or advice);
- the existence of effective norms and sanctions that encourage some forms of behavior and discourage others (family norms and expectations about appropriate behavior at school); and
- the habits and dispositions evident in family members' individual and collective responses to problems (families can model self-efficacy when faced with difficult issues).

Based on such implications, professionals within Intensive In-Home services should strongly consider social capital within the family itself that are based on informal supports (immediate family members, extended family members, community leaders, pastors, neighbors, and peers) before connecting families to more formal supports (paid individuals that support the family).

Sanders (2003) implies that as a change of both structure and function of families and neighborhoods, many children are growing up without the social capital necessary for healthy development. She also believes that with better support and connections for youth and families within their communities and through the sharing of knowledge and resources, guidance and values, social capital can be enhanced and benefit youth; particularly in school settings (Sanders, 2003).

Although the meaning of social capital is not universal, it is important to recognize its role in family functioning in relation to a youth's mental health status. It is also equally important to appreciate the different theoretical thoughts (Coleman, Putnam, and Bourdieu's) and concepts that have given scholars an opportunity to take a further look at the meaning of social capital. However, families set the tone for the way youth are affected by social capital. Therefore, it is highly important that professionals understand the associations and constructions of families as collective units and individuals members when defining what social capital is and who consist of social capital agents (people that help to provide support and resources) as a interesting phenomena. As Ainsworth (2002) suggests children who grow up in environments possessing high levels of social capital are more likely to be exposed to helpful social networks and adults who provide positive resources. Alternatively, children living in areas with low levels of social capital can be disadvantaged by small social networks or networks can also be applied to families. It is believe the same can be said for families. Families living in environments possessing high levels of social capital are more likely meet their basic needs and improve their stability, independence, and functioning capacity. However, families living in areas with low levels of social capital may be limited in their ability to meet basic needs that can deplete their functioning capacity; while cause an increase in family stressors, mental, and emotional needs.

Consequently, efforts must be centered upon building social capital (resources and supports) that will afford families the opportunities to move forward and make progress despite their demographics (social economic status, structure, number of children in the household, educational level, and etc...). Families define themselves as well as meaning of support. Listening to them is important. Validating their concerns is critical. Recognizing their resilience, strengths, talents, abilities, resources, and supports is invaluable to the wellbeing and overall functioning ultimately. As a result, this study will address the question below:

1. Is there a relationship between perceived levels of social support and functioning levels of families receiving Intensive In-Home Services?

Hypothesis

Hypothesis one: Parents having higher levels of social capital will report higher levels of family functioning. It is perceived that participants believing they have support will see their families as being highly supported to navigate through life situations as well as having positive attachments with their families both inside and outside the home.

METHODS

Population

Participants were parents or grandparents with one child that had been authorized to receive Intensive In-Home Services in Eastern North Carolina. Participants and their families had been participating within Intensive In-Home for a minimum of one month and a maximum of eleven months. All participants were actively involved with Intensive In-Home Services which included the following: Child and Family Team Meetings (meetings to discuss both progress and needs of children, adolescents, and families based on functioning capacity and pro-social behavioral outcomes of the child such as staying on task, accepting no for an answer, improved cognitive skills, impulse control, and positive social skills), family skill building, parenting skill building, linkage to community supports, case management, individual and family therapy, and skill building for individual children and adolescents. Four agencies were contacted in Eastern North Carolina based on their endorsement (legal and clinical approval to provide Intensive In-Home Services in North Carolina) and were provided with information to share with families. One agency reported that no parents were interested; while two other agencies were not able to gather potential families together to present information within the time frame allowed for the study. As a result, one agency provided seven participants; which are all were represented in the study.

Sample

A convenience sample was utilized in this study because the principle investigator strategically recruited families currently receiving Intensive In-Home Services. All participants were selected based on the sole criteria of having a child or adolescent receiving Intensive In-Home Services because a child or adolescent under their guardianship met the medical criteria

based on a clinical diagnosis within the mental health system in North Carolina. Each family represented had been involved in Intensive In-Home Services for at one month with the longest one being involved for eleven. Participants were given an opportunity to participate in the study based on informed consent. Each participant had a child or adolescent who met medical necessity based on a clinical diagnosis within mental health in North Carolina. None of the families represented had a child or adolescent diagnosed with a substance abuse disorder. Participants were the legal guardians of children or adolescents diagnosed with one of the following: Attention Deficit Hyperactivity Disorder (ADHD), Anti-social Disorders (Conduct Disorder, Oppositional Defiant Disorder, or Conduct Disorder), or Mood Disorder. Participation was voluntary and nonparticipation did not adversely affect any services to which they were legally entitled.

A total number of seven (n=7) families were involved in the study. All participants were female and included six mothers and one grandmother of children or adolescents, 5-17, receiving Intensive In-Home Services within North Carolina. The ethnicity of the sample was predominantly African American (n=6) and Caucasian (n=1).

Out of the seven responders, only one was married, a grandmother who had legally adopted her grandson. Two of the responders admitted they had a boyfriend living in the home; while the remaining participants provided no information on having a significant other at the time. One family had a father who was currently serving time in prison.

Only one of the participants was employed full-time. Another participant was a weekly volunteer in the community. One participant had an associate's degree; while two had completed at least high school; while the others had some high school, but did not complete it or have a General Education Diploma (GED). Two participants had access to a car for

transportation purposes; while other participants used the public transit bus, family members, and other supports to navigate from one place to another.

The purpose of the research was to determine the relationship between social capital (independent variable) and family functioning (dependent variable) in families receiving Intensive In-Home Services within North Carolina. No attempts were made to change or alter behaviors. All children and adolescents in the families were receiving Medicaid as their method of insurance to pay for Intensive In-Home Services at the time.

All participants lived in the following Eastern counties within North Carolina: Hyde (n=5), Beaufort (n=1), and Pitt (n=1). Most of the participants (n=5) resided in Hyde County, a rural area within North Carolina. The others resided in Beaufort County (n=1) and Pitt county (n=1) respectively. According to the North Carolina Rural Economic Development Center (2008), Hyde County had a total population of 5,181 compared to Pitt County; which had a total of 156,081. Beaufort County had a total population of 46,035. The report also states that physicians per population in Hyde County is 1.9 compared to 43.4 in Pitt County and 13.6 in Beaufort County. Table 1 provides details about sample demographics.

Table 1: Demographic Characteristics of Study Participants

	<i>n</i>	<i>Percent %</i>
<i>Gender</i>		
<i>Male</i>	0	0.0%
<i>Female</i>	7	100.0%
<i>Race/Ethnicity</i>		
<i>White</i>	1	14.3%
<i>African American</i>	6	85.7%
<i>Age</i>		
<i>20-30</i>	1	14.3%
<i>31-40</i>	2	28.6%
<i>41-50</i>	3	42.9%
<i>51-60</i>	1	14.3%
<i>County of Residence</i>		
<i>Beaufort</i>	1	14.3%
<i>Pitt</i>	1	14.3%
<i>Hyde</i>	5	71.4%
<i>Marital Status</i>		
<i>Married</i>	1	14.3%
<i>Single</i>	0	0.0%
<i>Divorce</i>	1	14.3%
<i>Never Married</i>	5	71.4%
	7	100%

Procedures

Participants completed the informed consent form and two written surveys within their homes. Participants were first given the Family Functioning Scale (Tavitian, Lubiner, Green, Grebstein, & Velicer, 1987 in Fischer & Corcoran, 1994) to complete, followed by the Social Capital Survey created by the principal investigator. The principal investigator provided a review of the informed consent document was also physically available to answer questions that participants had regarding the any questions either within the Functioning Family Scale or the Social Capital Survey. Four participants completed the Family Functioning Scale and Social Capital Survey on their own; while the principal investigator read both the Family Functioning Scale and Social Capital Survey to one participant. Another mother completed the Social Capital Survey, but had the principal investigator read the Family Functioning Scale. One mother asked if her older daughter could assist her in reading both the Family Functioning Scale and Social Capital Scale.

Instruments

Family Functioning Scale

The Family Functioning Scale (Tavitian, Lubiner, Green, Grebstein, & Velicer, 1987 in Fischer & Corcoran, 1994) consisted of forty questions and was used to measure dimensions of family functioning relating to the following: positive family affect, family communication, family conflict, family worries, and family rituals/supports. The scale is a questionnaire about family life that allowed participants to circle the number from one to seven that best expressed how they say their family at the present time. Participants were required to rank their families on a 7-point scale (Never =1, Almost Never = 2, Rarely = 3, Sometimes = 4, Frequently =5, Almost always = 6, and Always= 7). Higher scores are indicative of healthier family functioning. The highest score that one could obtain was 280. The Family Functioning Scale has a reported internal consistency

with alphas that range from .90 for the positive family affect subscale to .74 for the conflicts subscale. According to past research (Fischer & Corcoran, 1994), the Family Functioning Scale has good concurrent validity. Sample items include, “My family accepts me as I am,” “People in my family listen when I speak,” and “When things are going wrong in my family, someone gets blamed.” Such validity is demonstrated by correlations with the FACES III measure of family functioning. The scale successfully discriminated between two clinical groups and a group of “normals.” The scale also predicted individualization among late adolescents, suggesting good predictive validity. The most reliable subscales, positive family affect, were highly correlated with social desirability, suggesting a need to caution in interpreting that subscale. The scale has been used primarily with Caucasian families.

The Social Capital Survey was developed by the researcher and survey items were created based on previous literature surrounding social capital related to Coleman’s view, consideration family life domains (home, school, and community), civil engagement participation, and supportive factors discussed in previous research for family functioning and positive outcomes. The scale consisted of fifteen questions relating to social support, civic engagement, and perceptions of resources such as transportation, obtaining support for homelessness, and recognizing types of supports (informal or formal supports) for meeting basic needs in the natural environment. The survey also allowed participants to quantify their support based on a 5-five point scale (Never =1, Hardly Ever =2, Sometimes =3, Most of the Time =4, and Always =5). The maximum score on the scale is 75. The higher the score revealed a higher social capital score. Lower scores suggest that the participant’ believes they have poor or limited social capital within the natural environment.

The scale involved fifteen questions relating to social support, civic engagement, and perceptions of resources such as transportation, obtaining support for homelessness, and recognizing types of supports (informal or formal supports) for meeting basic needs in the

natural environment. The survey also allowed participants to quantify their support based on a 5-five point scale (Never =1, Hardly Ever =2, Sometimes =3, Most of the Time =4, and Always =5), allowing participants to provide appropriate responses based on their perception of support, access to it, and current trust and involvement of the family. The maximum score on the scale is 75. Implications of higher scores suggest higher perceptions of social capital. Lower scores suggest that the participant' believes they have poor or limited social capital within the natural environment. The Social Capital Survey was developed for this specific research study. Therefore, reliability and validity have not yet been assessed.

RESULTS

The data sample included a total of seven female participants. While the small sample size hinders in-depth statistical analysis, a pattern emerged from participant responses. Generalizing the findings is not recommended. Yet, survey results (n=6) demonstrated a positive relationship between social capital and family functioning.

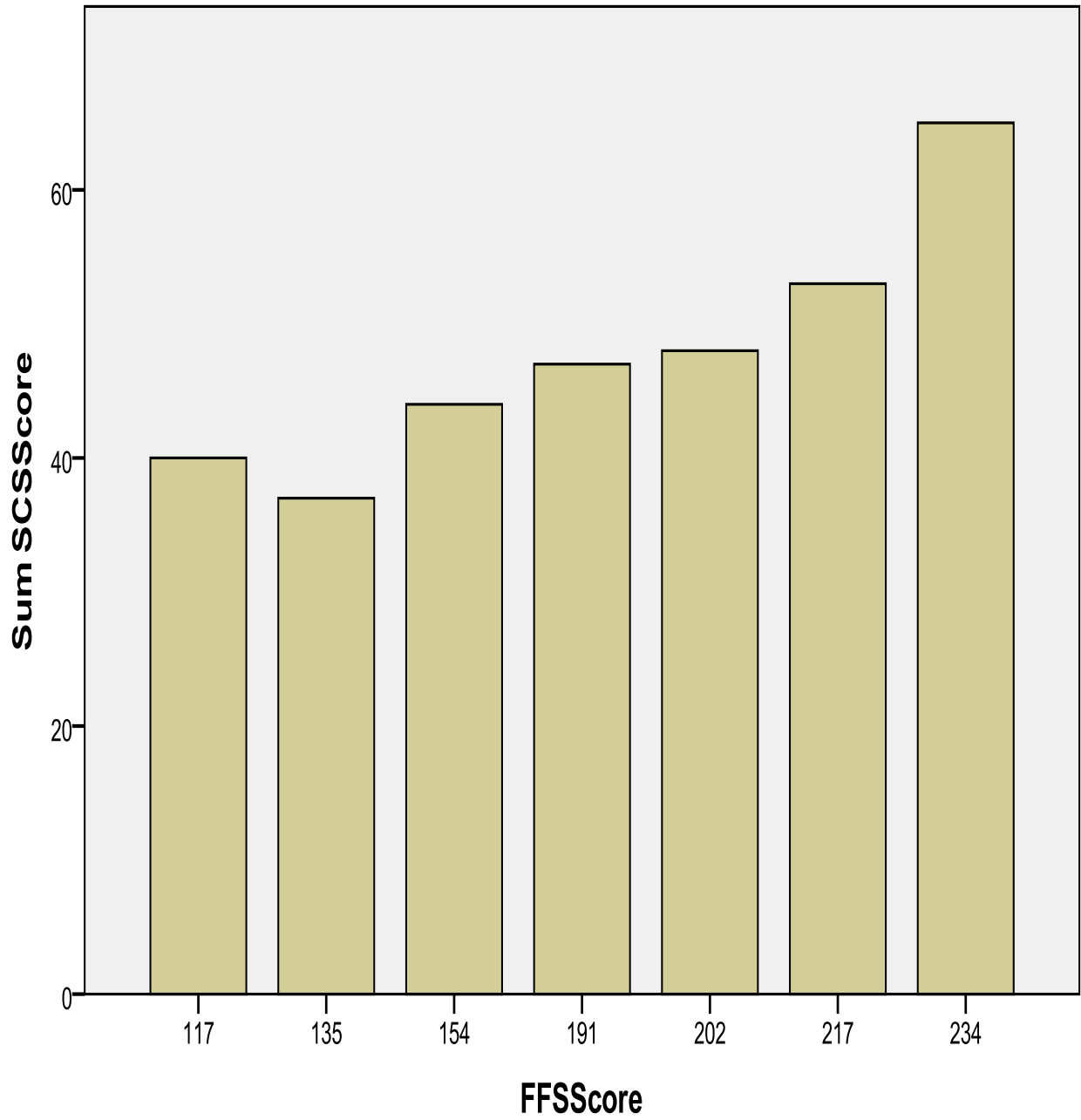
Overall, participants (n=6) showed that family functioning was affected by social capital. Social capital and family functioning produced a strong positive correlation ($r=.899$) to each other as indicated by Table 2. The hypothesis was supported regarding the relationship between social capital and family functioning, but a larger sample size is needed to further support this idea.

These numbers may indicate that overall families within Intensive In-Home are qualifying for services because of family functioning needs as well as linkage to more community supports that will help them maximize their optimal development and strengths. However, the small number of participants may not reflect the general population receiving Intensive In-Home once again. The hypothesis presented in the paper was supported by the data. Participants with a low social capital score (SCScore) (n=5) also had a lower family functioning score (FFSScore). Higher social capital had a positive relationship with higher family functioning scale scores with the exception of one participant that had a higher social capital scale score, but a low family functioning scale (Figure 1).

Findings indicate a pattern that should be further researched with more participants in order to formulate a generalization about families receiving Intensive In-Home Services within North Carolina. The pattern presented in this study according to Figure 1 suggests that perceptions of

family functioning were perceived in accordance with perceptions of social capital. It also showed that the participant with the highest Family Functioning Scale Score of 234 also had the highest Social Capital Survey Scale score of 65. Conversely, the participants with the two lowest Family Functioning Scale Scores of 117 and 135 also had the lowest Social Capital Survey Scores of 40 and 37.

Participants' Social Capital and Family Functioning Scores



SCSS = Social Capital Scale Score

FFS = Family Functioning Scale Score

Table 2: Social Capital and Family Functioning Correlations

	<i>FFS Score</i>	<i>SCS Score</i>
<i>Family FFS Score Pearson Correlation</i>	1	.899**
<i>Sig. (2-tailed)</i>		.006
<i>Sum of Squares and Cross-products</i>	1. 11545.714	2192.143
<i>Covariance</i>	1924.286	365.357
<i>N</i>	7	7
<i>SCS Score</i>	.899**	1
<i>Sig. (2-tailed)</i>	.006	
<i>Sum of Squares and Cross-products</i>	2192.143	515.429
<i>Covariance</i>	365.357	85.905
<i>N</i>	7	7

** .Correlation is significant at the 0.01 level (2-tailed).

Discussion

The purpose of this study was to explore the relationship between family functioning and social capital of families receiving Intensive In-Home Services within North Carolina. The Family Functioning Scale was used to assess family function as perceived by the parent or legal guardian of children and youth receiving Intensive In-Home Services. The Social Capital Survey was a survey instrument designed to assess the caretaker's perception of the family's social supports, civil engagement, trust, and reciprocity in relationships within the home and community. Most of the respondents were African American women who were unmarried and living in a rural area within North Carolina.

The results of this study expand on the concept of social capital as it relates to family functioning and positive attachments with supports. It also expands on the idea of understanding a caretaker's perception of supports and resources that can help them to reach family goals and positive outcomes such as meeting basic and functional needs in the home setting. Most of the participants lived in a rural area with limited supports and access to community resources due to location. The participant's children or adolescent were receiving Medicaid as indicated previously to fund the therapeutic services for the family. Currently, children and adolescents who fall 200% within the poverty line are eligible for Medicaid Insurance benefits. Yet, the study is a start for helping professionals understand the importance of recognizing the family member's perception of how they are doing and what they need to reach their optimal development within and outside the family from a collective and individual perspective by understanding the association between family functioning and social capital that is revealed in the pattern found within the study. What accounted for one participant having more social capital despite family functioning could be related to other variables such as age, employment,

age of other children, or educational level. As a result, more research should be done that considers other variables besides the ones presented in the study.

Bowlby (1988) believed in his attachment theory that strong attachments within the family can lay the foundation for how individuals connect to others and attach themselves. Perceptions of the participants may be indicators of their attachments within the home, school, and community. It may also provide insight about attachments within family system as a result of the caretaker's view of social capital.

These findings also expand on the concept of social capital based on Coleman's perspective in the context of family functioning and positive attachments in order to produce outcomes (1988). Coleman saw social capital as inherent in the structure of family relationships, particularly inter-generationally as stated previously. He believed social capital included the set of resources that inhere in family relations and in community social organization that were useful for the cognitive or social development of a child or young person. Based on the patterns identified regarding social capital and family functioning, Coleman's views hold true to the need for families to lay the foundation for social capital (family values, norms, beliefs, and culture) in order to help increase family functioning; especially when their physical resources are limited. Coleman's findings also suggest that economic disadvantage can be compensated by a strong form of social capital in the form of family norms, values and networks, as well as a broader set of community values and networks which promote particular educational goals.

This research examines and adds insight into understanding a caretaker's perception of supports and resources that can help them to reach family goals and positive outcomes such as meeting basic and functional needs in the home setting. Most of the participants lived areas; particularly Hyde County that is limited in supports and access to community resources due to

location. The participant's children or adolescent were receiving Medicaid as indicated previously to fund the therapeutic services for the family. Currently, children and adolescents who fall 200% within the poverty line are eligible for Medicaid Insurance benefits.

The patterns found in this study are a starting point for helping professionals understand the importance of recognizing the family member's perception of how they are doing and what they need to reach their optimal development within and outside the family from a collective and individual perspective. What accounted for one participant having more social capital despite family functioning could be related to other variables such as age, employment, age of other children, or educational level. As a result, more research should be done that considers other variables besides the ones presented in the study within the natural environments of families receiving Intensive In-Home Service.

Coleman believed that structure in the family was the key to a child's society citing the nuclear family as the family type most likely to increase overall success. Nevertheless, most of the participants in this research were single. As a result, one should consider the diversity in today's family and its implications when applying Coleman's view. In addition, this research enables both researchers and practitioners to view both social capital and family functioning from the lens of individual participants, which may be heavily influenced by life experiences.

Social networks in Coleman's eyes were connected to the parent-child ratios. He contended, 'the most prominent element of structural deficiency in modern families is the single-parent family,' suggesting that family structure is the key to a child's success and overall stability within the family. We can not discount Coleman's perspective, but we must recognize strengths in all types of family; especially minority populations.

Availability of resources also appeared to have a major influence on perception of social capital. For example, most of the participants living in Hyde or other small towns reported lower scores of social capital; while the parent in Pitt County reported the highest. Possible reasons for may be linked to the lack of economic capital available in the smaller areas (Hyde and Beaufort County) compared to Pitt County, which has substantially more community and economic resources , including a major university. Jobs could also be another influence in the area, as well as people. For example, professional support is often limited in areas such as Hyde County which in turn may cause disparity gaps within ethnicities and among people within the residences of participants in the study; particularly Hyde County. Yet, findings indicate a pattern that warrant further research with more participants in order to formulate a generalization about families receiving Intensive In-Home Services within North Carolina.

Limitations of Study

The limitations presented within the study include a small sample size with a lack of ethnic diversity. As a result, the opportunity to generalize results beyond the findings is limited. While the study sample was predominantly African-American, the study sample mirrors populations currently served by state and federally funded behavioral health services.

Additional limitations to consider relate to having only legal guardians of children or adolescents within Intensive In-Home Services completing the survey. Since support and functioning appeared to be based on perceptions of the participants, it may be important to examine the perceptions of the children and adolescents in efforts to compare with adult caregiver perceptions. This is suggested because within Intensive In-Home Services, professionals work with families as a unit, as well as parents and children and adolescents individually. And finally, the language and word usage of the Family Functioning Scale, used to

measure perceptions of family functioning, was normal for Caucasians and may not be culturally sensitive to other ethnic groups. The current study sample was primarily African-American and potentially the working of some items on the scale may not have captured aspects of family functioning perceived as particularly relevant to this ethnic group. Children and adolescent receiving Intensive In-Home Services under the guardianship of participants in the study were not given the Family Functioning Scale or Social Capital Survey to complete.

Implications for Further Research

More research should be done to compare the perceptions of the legal guardians and children or adolescents receiving Intensive In-Home Service since children and adolescents were not included in this study. Nevertheless, this study provides a starting point for researchers and professionals to recognize the vitality of family function and social capital. It also provides a glimpse to two focus areas that should be emphasized during the treatment process of Intensive In-Home Services. Despite the small sample size, it is clear that perception of family functioning can be directly related to social capital overall. Nevertheless, as stated previously, generalizations do not accurately be made due to the small number of participants, but clearly the study gives one an idea of how important it is for family functioning and social capital to be considered during the course of providing therapeutic interventions and supports for families receiving Intensive In-Home Services within North Carolina.

Conclusion

Social capital is gaining more recognition within the area of families in behavioral health. It is believe that connecting families to social supports within their natural environment is one of the major keys of promoting positive outcomes with children, adolescents, and their families who receive Intensive In-Home Services. Three frameworks give us a view of the meaning of social capital, but Coleman's perspective is ultimately utilized in this study to formulate a working measure of the meaning of social capital. Still, social capital continues to be an abstract that is based on the perceptions of individuals as witnessed within the study. Family functioning is another perception that seems to be based on the construction of the individual as well. Still, it is important that professionals within Intensive In-Home Services understand the dynamics of family functioning and social capital in order to increase family stability, safety, access to supports, and preservation to deter out of home placements or disconnections within and outside family.

Family functioning and social capital are two important aspects to consider for families receiving Intensive In-Home Services in North Carolina. Findings suggested a pattern between social capital and family functioning that supported the hypothesis of this research with lower social capital scores relating to lower family functioning scores and social capital scores relating to higher family functioning scores.

Based on the results of this study, there are patterns of relationships between family functioning and social capital. Once again, one must be careful not to generalize families within Intensive In-Home due to limited data. Wherefore, much research is needed in order to build upon these findings.

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APPENDICES

Appendix A: IRB Approval Form



University and Medical Center Institutional Review Board
 East Carolina University, 600 Moyer Boulevard
 1L-09 Brody Medical Sciences Bldg. • Greenville, NC 27834
 Office 252-744-2914 • Fax 252-744-2284 • www.ecu.edu/irb
 Chair and Director of Biomedical IRB: L. Wiley Nifong, MD
 Chair and Director of Behavioral and Social Science IRB: Susan L. McCammon, PhD

TO: Laketa Sutton
 Child Development & Family Relations

FROM: UMCIRB

DATE: February 25, 2010

RE: Expedited Category Research Study

TITLE: "Family Functioning and Social Capital of Families Participating in Intensive In-Home Services: A North Carolina Study"

UMCIRB #10-0110

This research study has undergone review and approval using expedited review on February 22, 2010. This research study is eligible for review under an expedited categories 6 and 7. The Chairperson (or designee) deemed this **unfunded study no more than minimal risk** requiring a continuing review in **twelve (12) months**. Changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must submit a continuing review/closure application to the UMCIRB prior to the date of study expiration. The investigator must adhere to all reporting requirements for this study.

The above referenced research study has been given approval for the period of **February 22, 2010 to February 21, 2011**. The approval includes the following items:

- Internal Processing Form
- Informed consent document

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

The UMCIRB applies 45 CFR 46, Subparts A-D, to all research reviewed by the UMCIRB regardless of the funding source. 21 CFR 50 and 21 CFR 56 are applied to all research studies under the Food and Drug Administration regulation. The UMCIRB follows applicable International Conference on Harmonisation Good Clinical Practice guidelines.

Electronic copy: Triebenbacher
 Epley

**Appendix B:
Informed Consent to Participate in Research**

Title of Research Study: Family Functioning and Social Capital of Families Participating in Intensive In-Home Services: A North Carolina Study

Principal Investigator: Laketa Sutton

Institution/Department or Division: East Carolina University, College of Human Ecology,
Child Development and Family Relations

Address: 133 Rivers West, Greenville, NC 27858

Telephone #: (252) 328-1336 or (919) 539-0438

Researchers at East Carolina University (ECU) study problems in society, health problems, environmental problems, behavior problems and the human condition. Our goal is to try to find ways to improve the lives of you and others. To do this, we need the help of people who are willing to take part in research.

Laketa Sutton, Graduate Student within the Department of Child Development and Family Relations at East Carolina University, will be the Principle Investigator in this study. She will be assisted in this research by Dr. Sandy Triebenbacher, a Professor in the Department of Child Development and Family Relations who is her academic advisor. Others who will assist in this research are Dr. Sarah Williams, a Professor in the College of Education at East Carolina University and Dr. Martha Early, LCSW, LCAS, who is an Assistant Professor, Department of Family and Community Medicine at Eastern Virginia Medical School. Dr. Williams And Dr. Early serve as Committee Members and assistants for this research when deemed appropriate.

You may have questions that this form does not answer. If you do, feel free to ask the person explaining the study, as you go along. You may have questions later and you should ask those questions, as you think of them. There is no time limit for asking questions about this research. You can contact the Principle Investigator Laketa Sutton at lrs1219@ecu.edu or via telephone at 919-539-0438 if you have any questions or concerns during the process of this research or to receive a copy of the results once the research is completed.

You do not have to take part in this research. Take your time and think about the information that is provided. If you want, have a friend or family member go over this form with you before you decide. It is up to you. If you choose to be in the study, then you should sign the form when you are comfortable that you understand the information provided. If you do not want to take part in the study, you should not sign this form. That decision is yours and it is okay to decide not to volunteer.

Why is this research being done?

The purpose of this research is to examine the relationship between family functioning and social capital (social support) of families participating in Intensive In-Home Services within North Carolina. This research is designed to determine whether building family supports can help to improve their overall interaction and wellbeing in their natural environment such as the home. By doing this research, we hope to learn how families define their social support within their natural environment. Another thing we hope to learn is if there is a relationship between social support and functioning levels of families participating in Intensive In-Home Services within North Carolina. This research is also being conducted to make providers of Intensive In-Home Services and the community aware of supports that can help to promote positive family functioning and wellness that builds upon the strengths, social supports, and meanings families attach to such supports that are known as social capital.

Why am I being invited to take part in this research?

You are being invited to take part in this research because your child and family are currently participating in Intensive In-Home Services. If you volunteer to take part in this research, you will be one of about eight people to do so nationally at East Carolina University.

Are there reasons I should not take part in this research?

At this time, a person could be excluded from volunteering from this research study if they are not currently participating with their children and family within Intensive In-Home Services in North Carolina.

What other choices do I have if I do not take part in this research?

You have the choice of not taking part in this research study.

Where is the research going to take place and how long will it last?

The research procedures will be conducted at the Mendenhall Student Center Building at East Carolina University. You will need to come to this site only one time during the study. The total amount of times you will need to volunteer for this study is one time. You will need to come to the Mendenhall Student Center Building at East Carolina University for a focus group. During this focus group session, you will be given an opportunity to complete a social capital survey and family functioning scale. The focus group session will take about three to four hours, but will include lunch during the process. The total amount of time you will be asked to volunteer for this study is two times over the next five weeks.

What will I be asked to do?

You are being asked to do the following: complete a Social Capital Survey, complete the Family Functioning Scale, and participate in a focus group. The Social Capital Survey and Family Functioning Scale will be administered the same day of the focus group. During this time, the Principal Investigator, Advisor, and Committee Members will be administering these tools. During the focus group, the moderator will be the Principal Investigator. The questions asked during the focus group will be the following:

1. What does it mean to receive support for your family?
 - How do you define “support” in relation to your family?
 - What would be a “support” that would be relevant to your family’s needs?
 - The term “support” is used a lot, and that word means different things to different people. When you think of the word *support* in relation to your family what does it mean to you?
2. When was the last time you received support for your family? What was the purpose of this support? Can you also share the source of support?
3. What should people working with Intensive In-Home Services with your family need to know when it comes to identifying support that will empower or assist your family?
4. Do you believe having support helps your family function better at home? Explain your answer by giving examples?
5. What are the main reasons why you need support for your family at this time?
6. What could professionals delivering Intensive In-Home Services do to help your family gain support in the community?
7. What type of support do you need to manage your family as a parent? What do you need as a single parent to help support your family?
8. When you hear the term “positive family functioning,” what does it mean to you?
9. Given your answer in that last question, do you believe your family has enough natural supports in place already to increase positive family functioning? Explain your answer.

During the time of the focus group, your answers will be recorded manually and also taped. Photographs will not be taken during the focus group. The total duration of time for the focus group and to complete the Social Capital Survey and Family Functioning Scale will be between three to four hours. This will time frame will also include lunch. All information will be kept in a secure place. Furthermore, you will be asked to refrain from putting your name on both the survey and family functioning scale. You will have the opportunity to agree to opt in or out of these procedures. For example, if you do not feel comfortable answering a focus group question or participating in the focus group, that is your choice.

The Social Capital Survey will inquire about the sources of support and participation in your community that exist for your family in various life domains (home, school, job, extended family members, friends, and community). The Family Functioning Scale includes questions about your family’s stability and overall ability to interact, cope, adjust, and sustain stability within the natural environment (home, school, and community). Focus group questions listed will ask about how your family defines support and how that support helps with day to day functions for individual members of your family and the family as a whole. Completing

the Social Capital Survey should take about thirty minutes. Completing the Family Functioning Scale should take about an hour. The focus group discussion should take between one to two hours.

What possible harms or discomforts might I experience if I take part in the research?

There are always risks (the chance of harm) when taking part in research. It has been determined that the risks associated with this research are no more than what you would experience in a normal life. However, some people react to things differently so it is important for you to tell us as quickly as possible if you experience any negative feelings, or feel sick. Also, you may be concerned about the potential for embarrassment, risk of concern for impact on services you are participating in, and the perception that may occur with speaking honestly if your opinions appear negative regarding Intensive In-Home Services.

Are there any reasons you might take me out of the research?

During the study, information about this research may become available that would be important to you. This includes information that, once learned, might cause you to change your mind about wanting to be in the study. We will tell you as soon as we can.

There may be reasons we will need to take you out of the study, even if you want to stay in. We may find that you are not or cannot come for your study visits as scheduled. If this is found to be true, we will need to take you out of the study.

What are the possible benefits I may experience from taking part in this research?

We do not know if you will get any benefits by taking part in this study. However, you and your family may learn some ideas about additional ways to increase social capital and improve family functioning in your home. Your participation in the research may provide key information about effective ways to engage and support families while they are participating in Intensive In-Home Services within North Carolina. This research might help us learn more about There may be no personal benefit from your participation but the information gained by doing this research may help others in the future. Plus, this research could be beneficial to other families, clinical professionals, policy makers, researchers, child psychiatrists, licensed professionals, policy makers, and community members when implementing appropriate social support measures and community resources for families.

Will I be paid for taking part in this research?

We will not be able to pay you for the time you volunteer while being in this study. However, lunch and childcare will be provided for participating in the focus group and study. Also, support in getting transportation will be provided when deemed appropriate. If transportation is

needed, please make sure you contact the Principal Investigator to make preparation for supporting you in this area two weeks in advance before the focus group session takes place.

What will it cost me to take part in this research?

It will not cost you any money to be part of the research. The sponsor of this research will pay the costs of: providing lunch during the focus group session.

Who will know that I took part in this research and learn personal information about me?

To do this research, ECU and the people and organizations listed below may know that you took part in this research and may see information about you that is normally kept private. With your permission, these people may use your private information to do this research:

- Any agency of the federal, state, or local government that regulates human research. This includes the Department of Health and Human Services (DHHS), North Carolina Department of Health, and the Office for Human Research Protections, Substance Abuse and Mental Health Services Administration (SAMHSA), and National Institution of Mental Health (NIMH)
- The University & Medical Center Institutional Review Board (UMCIRB) and its staff, who have responsibility for overseeing your welfare during this research, and other ECU staff who oversee this research.
- The private provider where your family is participating in Intensive In-Home Services.

Please note that any information provided that suggest abuse, neglect, or exploitation of children or youth will be reported to appropriate parties such as Child Welfare.

How will you keep the information you collect about me secure? How long will you keep it?

Please do not put your name anywhere on the questionnaires. This is important so your answers remain anonymous. This will also allow the results of the questionnaire to be kept confidential because there will be no identifying information attached to the questionnaires. All information will be kept in a secured area. The duration of time for keeping information collected is indefinite.

What if I decide I do not want to continue in this research?

If you decide you no longer want to be in this research after it has already started, you may stop at any time. You will not be penalized or criticized for stopping. You will not lose any benefits that you should normally receive.

What if I get sick or hurt while I am in this research?

This study does not involve any risk greater than what you experience in everyday life. Therefore, we do not expect you to become sick or hurt as a result of being part of this research. However, people respond differently to things and sometimes accidents do happen. Therefore, if you need emergency care call 911 for help. If possible, take a copy of this consent form with you when you go.

Call the principal investigator as soon as you can. She needs to know that you are hurt or ill. Call Laketa Sutton (Principal Investigator) at (919) 539-0438 or Dr. Sandy Triebenbacher (Advisor) at (252) 328-1336.

If you believe you have been hurt or if you get sick because of something that is done during the study, you should call the Principal Investigator. There are procedures in place to help provide care for you. Costs associated with this care will be billed in the ordinary manner, to you or your insurance company. However, some insurance companies will not pay bills that are related to research costs. You should check with your insurance about this. Costs that result from research-related harm may also not qualify for payments through Medicare, or Medicaid. You should talk to the Principal Investigator about this, if you have concerns.

Who should I contact if I have questions?

Please contact the researcher, Laketa Sutton at lrs1219@ecu.edu. You may also contact Dr. Sandy Triebenbacher, research advisor at TRIEBENBACHERS@ecu.edu or research committee members, Dr. Sarah Williams (WILLIAMSSAR@ecu.edu) or Dr. Martha Early (EARLYMT@EVMS.EDU) that will also serve as subinvestigators. Also, you contact the Principal Investigator at 252-328-1336 during the day and 919-539-0438 during the evening.

If you have questions about your rights as someone taking part in research, you may call the UMCIRB Office at phone number 252-744-2914 (days, 8:00 am-5:00 pm). If you would like to report a complaint or concern about this research study, you may call the Director of UMCIRB Office, at 252-744-1971.

Is there anything else I should know?

At this present time, it is determined that all information given is adequate for the understanding of the purpose and your rights as a potential volunteer for this study.

I have decided I want to take part in this research. What should I do now?

The person obtaining informed consent will ask you to read the following and if you agree, you should sign this form:

- I have read (or had read to me) all of the above information.
- I have had an opportunity to ask questions about things in this research I did not understand and have received satisfactory answers.
- I understand that I can stop taking part in this study at any time.
- By signing this informed consent form, I am not giving up any of my rights.
- I have been given a copy of this consent document, and it is mine to keep.

Participant's Name (PRINT)

Signature

Date

Person Obtaining Informed Consent: I have conducted the initial informed consent process. I have orally reviewed the contents of the consent document with the person who has signed above, and answered all of the person's questions about the research.

Person Obtaining Consent (PRINT)

Signature

Date

Principal Investigator (PRINT)

Signature

Date

(If other than person obtaining informed consent)

**Appendix C:
Social Capital Survey**

**Appendix C:
Social Capital Survey**

The purpose of this survey is to look at the relationship between support and family functioning. Please answer on a scale from one to five (One-Never, Two-Hardly Ever, Three-Sometimes, 4-Most of the time, and 5-Always). This survey is anonymous. All surveys will be kept in a safe and secure place.

Statement	1-Never	2-Hardly Ever	3-Sometimes	4-Most the time	5-Always
My family has contact with family and friends.					
My family has financial and emotional sources of support during times of a crisis or need.					
My family can ask for help from people in the community.					
My family participates in family events.					
My family participates in school events.					
My family participates in religious activities such as attending church, being apart of church programs, or other faith based events.					
My family volunteers in the community.					
My family can access funds by asking supports in the community.					
My family has ease getting access to transportation.					
My family would ask family for help if they were homeless.					
My family would ask family, friends, neighbors, the church, or other informal supports if we					

needed food, housing, or other basic needs support.					
My family would ask family serving systems such as the following: Department of Social Services if we needed food, housing, or other basic needs support.					
Overall, my family feels we have enough support from those around us such as friends, families, and professional agencies such as DSS.					
Overall, my family believes we can trust our supports (formal or informal).					
Overall, my family offers support to others when they are in need.					

Appendix D: Family Functioning Scale

FFS

This is a questionnaire about family life, which includes a variety of statements that describe families. Please rate how each statement describes your family at the present time. Use the following seven-point scale:

Never	Almost never	Rarely	Some- times	Frequently	Almost always	Always
1	2	3	4	5	6	7

For each statement, please circle the number that best expresses how you see your current family. Do not spend too much time on any one statement. If you read a statement that is too difficult for you to answer, please give your first reaction. Remember that there are no right or wrong answers, so please answer as honestly as you can. All of your responses will remain confidential.

Kindly rate each statement. Thank you for your cooperation.

- | | |
|---|---------------|
| 1. Birthdays are important events in my family. | 1 2 3 4 5 6 7 |
| 2. The children in my family fight with each other. | 1 2 3 4 5 6 7 |
| 3. People in my family have to be reminded when they are asked to do something. | 1 2 3 4 5 6 7 |
| 4. People in my family do not care enough about what I need. | 1 2 3 4 5 6 7 |
| 5. Our family spends holidays together. | 1 2 3 4 5 6 7 |
| 6. Members of my family argue about money. | 1 2 3 4 5 6 7 |
| 7. My family accepts me as I am. | 1 2 3 4 5 6 7 |
| 8. When someone in my family is angry, I feel worried. | 1 2 3 4 5 6 7 |
| 9. People in my family listen when I speak. | 1 2 3 4 5 6 7 |
| 10. I worry when I disagree with the opinions of other family members. | 1 2 3 4 5 6 7 |
| 11. I feel respected by my family. | 1 2 3 4 5 6 7 |
| 12. We pay attention to traditions in my family. | 1 2 3 4 5 6 7 |

13. When things are not going well in my family I feel sick. 1 2 3 4 5 6 7
14. Our family celebrates special events, such as anniversaries and graduations. 1 2 3 4 5 6 7
15. People in my family hit each other. 1 2 3 4 5 6 7
16. When I have questions about personal relationships, I talk with family members. 1 2 3 4 5 6 7
17. I let my family know when I am sad. 1 2 3 4 5 6 7
18. The mood of one family member can spread to everyone in the house. 1 2 3 4 5 6 7
19. I let family members know when I am upset. 1 2 3 4 5 6 7
20. People in my family yell at each other. 1 2 3 4 5 6 7
21. My family sees me as a hopeless case. 1 2 3 4 5 6 7
22. It is hard for me to forget painful events that have happened in my family. 1 2 3 4 5 6 7
23. People in my family use my things without asking. 1 2 3 4 5 6 7
24. In my family we talk about what is right and wrong with regard to sex. 1 2 3 4 5 6 7
25. Family members are critical of each other's eating habits. 1 2 3 4 5 6 7
26. When things are going wrong in my family, someone gets blamed. 1 2 3 4 5 6 7
27. In my family we talk about the physical changes that go along with growing up. 1 2 3 4 5 6 7
28. I tell people in my family when I am angry with them. 1 2 3 4 5 6 7
29. Family members eat at least one meal a day together. 1 2 3 4 5 6 7
30. Family reunions are important to us. 1 2 3 4 5 6 7

31. I have trouble sleeping when I think about family problems. 1 2 3 4 5 6 7
32. We are interested in the history of our family. 1 2 3 4 5 6 7
33. I feel loved by my family. 1 2 3 4 5 6 7
34. When things are not going well in my family it affects my appetite. 1 2 3 4 5 6 7
35. I let my family know when I feel afraid. 1 2 3 4 5 6 7
36. People in my family are not interested in what I do. 1 2 3 4 5 6 7
37. It is important to know the mood of certain family members. 1 2 3 4 5 6 7
38. I feel like a stranger in my own house. 1 2 3 4 5 6 7
39. We are friendly with other families. 1 2 3 4 5 6 7
40. People in my family discuss their problems with me. 1 2 3 4 5 6 7