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The good coach: implementation and sustainment factors that affect coaching as evidence-based intervention fidelity support

Lara M. Gunderson, Cathleen E. Willging, Elise M. Trott Jaramillo, Amy E. Green, Danielle L. Fettes, Debra B. Hecht and Gregory A. Aarons

Abstract

Purpose – Evidence-based interventions (EBIs) for human services unfold within complicated social and organizational circumstances and are influenced by the attitudes and behaviors of diverse stakeholders situated within these environments. Coaching is commonly regarded as an effective strategy to support service providers in delivering EBIs and attaining high levels of fidelity over time. The purpose of this paper is to address a lacuna in research examining the factors influencing coaching, an important EBI support component.

Design/methodology/approach – The authors use the Exploration, Preparation, Implementation, and Sustainment framework to consider inner- and outer-context factors that affect coaching over time. This case study of coaching draws from a larger qualitative data set from three iterative investigations of implementation and sustainment of a home visitation program, SafeCare®. SafeCare is an EBI designed to reduce child neglect.

Findings – The authors elaborate on six major categories of findings derived from an iterative data coding and analysis process: perceptions of “good” and “bad” coaches by system sustainment status; coach as peer; in-house coaching capacity; intervention developer requirements vs other outer-context needs; outer-context support; and inner-context support.

Practical implications – Coaching is considered a key component for effective implementation of EBIs in public-sector systems, yet is under-studied. Understanding inner- and outer-context factors illuminates the ways they affect the capacity of coaches to support service delivery.

Originality/value – This paper demonstrates that coaching can accomplish more than provision of EBI fidelity support. Stakeholders characterized coaches as operating as boundary spanners who link inner and outer contexts to enable EBI implementation and sustainment.

Keywords Coaching, Consulting, Implementation science, Child neglect, Evidence-based intervention, Home visitation

Paper type Research paper

1. Introduction

Implementation of evidence-based interventions (EBIs) – health or human service interventions supported by rigorous scientific research – represents an increasingly accepted strategy for improving the wellbeing of families at risk for child maltreatment (Novins et al., 2013). However, it has long been known that the implementation of EBIs within day-to-day service delivery milieus is often inconsistent and ineffective, underscoring the challenges of transferring science to service (Horwitz et al., 2010; Novins et al., 2013). Researchers consider the implementation of innovative human service technologies, such as EBIs, to be more complicated than other types of technology, because they are delivered by individuals and organizations within complex,
multi-layered social contexts (Aarons et al., 2011; Fixsen et al., 2009). In this paper, we consider how systematic “consultation,” or “coaching,” can assist providers and organizations in implementing and sustaining EBIs.

Our case study of coaching, defined here as ongoing support, or technical assistance, from a specialist to improve EBI implementation after training (Beidas et al., 2013; Duda and Barrett, 2013; Kucharczyk et al., 2012), draws from a larger qualitative data set documenting implementation and sustainment of a home visitation program, SafeCare®, an EBI to reduce child neglect (Chaffin, Hecht, Bard, Silovsky and Beasley, 2012; Gershater-Molko et al., 2003; Whitaker et al., 2012). Interviews and focus groups were conducted with government administrators and staff of community-based organizations (CBOs) contracted to deliver SafeCare in 11 United States human service (e.g. child welfare) systems. We examine how stakeholder perceptions and experiences of coaching changed during different phases of implementation, describe the significance of these changes, and discuss factors influencing coaching support.

Studies show that while training alone (i.e. “one-shot workshops”) is unlikely to result in practice change, let alone fidelity to an EBI (Odom, 2009), there are strategies to improve adherence to EBIs that range from didactic methods (Perepletchikova et al., 2007) to systematic review of care such as audit and feedback (Foy et al., 2005; Ivers et al., 2012) to observations performed in vivo or through recordings or one-way mirrors (Forgatch et al., 2005; Sheidow et al., 2008). Such strategies vary in effectiveness (Forgatch et al., 2005; Ivers et al., 2012). Studies of audit and feedback suggest limited evidence on reliability and how to best employ this approach, although intensive feedback appears to enhance effectiveness (Jamtvedt et al., 2006; Foy et al., 2005). Observation can better assess fidelity than self-report; continuous supervision, role plays, and periodic booster trainings may also reduce deviation from intervention protocols (Perepletchikova et al., 2007). Although potentially more costly, labor intensive, and intrusive to practitioner and client than other strategies, observation as part of fidelity monitoring can contribute to greater adherence to and positive outcomes for home visitation interventions (Forgatch et al., 2005; Weiss et al., 2006).

Coaching is an implementation strategy that may involve in vivo observation, intensive feedback, and other methods described above to support use of and fidelity to EBIs, including SafeCare (Chaffin, Bard, Bigfoot and Maher, 2012). Researchers point to the critical role that coaching can play in implementing and sustaining EBIs with fidelity by ensuring ongoing support after initial training (Duda and Barrett, 2013; Edmunds et al., 2013; Fixsen et al., 2009). Coaches supply implementation support, for example, with therapists delivering cognitive-behavioral therapy to youth (Beidas et al., 2013), by the National Professional Development Center on Autism Spectrum Disorders for improved EBI provision to students with autism (Kucharczyk et al., 2012), and for preschool teachers to promote school readiness for at risk students with the Children’s School Success Project (Odom, 2009; Odom et al., 2010). Recognized characteristics of effective coaches include abilities to negotiate diverse stakeholder needs in hierarchically structured organizations and service systems (Duda and Barrett, 2013), and to cultivate the attitudes and behaviors among frontline workers that are most likely to result in successful implementation (Kucharczyk et al., 2012). Adequately trained and supported coaches can build trust, develop productive relationships, and create accountability for EBI implementation outcomes (Duda and Barrett, 2013).

Although researchers suggest that coaching improves fidelity to EBIs, the specific strategies and interactions by which coaching contributes to desired outcomes is unclear (Beidas et al., 2013). EBIs are only as good as the support systems in place to ensure their integration into practice (Odom, 2009), and more research is needed to shed light on the nuances of implementing these systems (Fixsen et al., 2005, 2009). Our study offers a unique opportunity to examine coaching as a support system by exploring the situated perspectives of multiple stakeholders implementing the same EBI in varied service systems.

1.1 Conceptual framework

Several frameworks define implementation as a complicated process involving a series of stages and factors at multiple levels, i.e., system, organization, provider, and client (Aarons et al., 2011;
Damschroder et al., 2009; Meyers et al., 2012). The Exploration, Preparation, Implementation, and sustainment (EPIS) model (Figure 1), developed for public service settings (e.g. child welfare, mental health care, substance abuse treatment), segments processes of instantiating an intervention into four phases: exploration (consideration of new innovations, evidence, and “fit” within service systems), preparation (planning for implementation), implementation (training and provision), and sustainment (maintaining with fidelity).

The EPIS model applies the analytic categories of “inner context” and “outer context” to illuminate the factors that can impact implementation and effectiveness of coaching across phases. Inner-context factors related to coaching include organizational-level variables, such as CBO leadership, organizational culture and climate, job demands, and workforce retention, as well as provider-level factors, such as disposition toward EBIs, work stress, and job autonomy (Novins et al., 2013). Outer-context factors are pertinent to the system level of the broader environment in which organizations operate (Aarons et al., 2011; Damschroder et al., 2009). A primary outer-context variable that may shape coaching is leadership in government-administered human service systems, which may determine the nature of contracts forged with CBOs to finance and facilitate EBI implementation, scopes of work embedded within contracts, allocation of training, coaching, or other support systems, and interorganizational relationships involving the sharing of resources (e.g. training and coaching) among CBOs.

Through this case study on the instantiation of a single EBI, we found that coaches play an important role in implementation because their activities span inner and outer contexts, influencing how system-level ideas and processes concerning EBI fidelity are translated and operationalized locally. Coaches are answerable to both frontline workers and CBO management in the inner context, and government administrators in the outer context. The present study elaborates on the range of inner- and outer-context factors that can impinge on coaching and its effectiveness over time, adding to our understanding of how coaching can support implementation and sustainment of EBIs more broadly within human service systems.

2. Methodology

2.1 Study context

This examination of coaching processes utilizes secondary analysis of qualitative data collected during three iterative mixed-method studies of SafeCare implementation and sustainment in one state-operated and ten county-operated human service systems in two states (Aarons, Fettes, Hurlburt, Palinkas, Gunderson, Willging and Chaffin, 2014; Aarons et al., 2009, 2012; Green et al., 2016; Willging et al., 2015). In most systems, state or county government agencies contracted with CBOs to deliver SafeCare, specifying both staffing and reporting requirements. SafeCare addresses vulnerabilities in families at risk or reported for child maltreatment by
enhancing the parenting skills of primary caregivers. The contracts required CBOs to deliver three SafeCare modules on child health, home safety, and parent-child or parent-infant interaction. Staff called “home visitors,” typically case managers responsible for working directly with families, took part in a one-week training to administer the modules to caregivers through explanation, assigned homework, role play, and hands-on demonstrations.

Coaching is a key feature of SafeCare and other EBIs to ensure the intervention is delivered in the way research has found to be effective (McHugh and Barlow, 2010). Coaching for SafeCare is modeled on tenets of effective supervision and a developmental consultation approach (Stoltenberg, 2005; Stoltenberg and Delworth, 1987), and is required by the National SafeCare Training and Research Center (NSTRC), the entity that developed SafeCare. Coaches are the “support and fidelity monitoring system” for home visitors (Aarons et al., 2009). As per the NSTRC’s coaching manual, coaching is a “collaborative process” through which coaches help home visitors refine skills as they learn how to provide parenting feedback to families. Previous research on SafeCare found that in vivo coaching for fidelity monitoring can function as quality control, and enhance working alliances between home visitors and clients (Chaffin, Hecht, Bard, Silovsky and Beasley, 2012).

In all study systems, a subset of home visitors was trained to become coaches and tasked with accompanying other home visitors to see clients monthly, using a checklist to document adherence to each module’s core components. Thus, coaches were responsible for assessing fidelity and offering technical support. Each system designated a “lead coach” who communicated with the NSTRC, taught and certified coaches and home visitors in SafeCare, and provided implementation oversight. Coaches carried caseloads as home visitors and therefore also received coaching. In several systems, coaches convened as a group and with a lead coach for continued support. Some CBOs relied on personnel from other CBOs to coach home visitors. During the preparation and implementation phases, the NSTRC also made their trainers and coaches available to home visitors. These “external trainers and coaches” trained and certified home visitors locally, and helped CBO administrators select trainees to become internal coaches and trainers. Table I describes these roles.

### 2.2 Sample

For more than ten years, we conducted individual semi-structured interviews (n=166), small group interviews with an average of three participants (n=13), and focus groups with an average of six participants (n=80) with a range of stakeholders in all 11 service systems. System-level

<table>
<thead>
<tr>
<th>Table I</th>
<th>Job roles</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Personnel</td>
</tr>
<tr>
<td>CBO administrators</td>
<td>Executive directors, area directors, program managers</td>
</tr>
<tr>
<td>CBO supervisors</td>
<td>Team leader, frontline supervisor, clinical supervisor</td>
</tr>
<tr>
<td>SafeCare trainers or lead coaches</td>
<td>Persons trained and certified to train others in delivering the EBI. In the preparation phase, trainers were employed by the intervention developers rather than within the service systems</td>
</tr>
<tr>
<td>SafeCare coaches</td>
<td>Individuals trained and certified to coach others in delivering the EBI. Coaches are frontline supervisors or other direct service staff. In the preparation phase, intervention developer coaches were employed to start and scale-up the EBI until local coaches became certified</td>
</tr>
<tr>
<td>SafeCare home visitors</td>
<td>Direct in-home service staff trained in the EBI</td>
</tr>
</tbody>
</table>

Oversee the general operations of CBOs, but are not directly involved in the day-to-day implementation of the EBI; provide administrative support to the agency and the EBI

Responsible for general clinical and workplace management of home visitor teams. Some supervisors additionally serve multiple EBI-related roles as trainers and coaches

Train home visitors in EBI practices during a 5-day workshop. Trainers or local lead coaches also coach home visitors after initial training. A minority of coaches are certified as trainers

Conduct monthly shadowing visits of each home visitor to monitor model fidelity and provide supportive coaching. The coaches serve as expert guides for home visitors for asking questions related to the EBI provision to clients

Home visitors provide in-home EBI services to families
stakeholders involved in planning and managing services included government administrators (e.g., directors of child welfare agencies), CBO administrators (e.g., executive directors and program managers), and funders (e.g., directors of funding agencies). Stakeholders at the frontline were clinical supervisors of home visitation staff, SafeCare coaches, and home visitors. As shown in Table I, coaches were distinct from clinical supervisors, who oversaw the cases and overall wellbeing of families, but were usually not SafeCare trained and certified. However, four systems had individuals who performed the roles of both supervisor and coach. Most participants were women, particularly the frontline workers, as is common in helping professions (Willging et al., 2017). Participants generally reflected the cultural demographics of workers and the service populations in their respective systems. Ages ranged widely, and most held at least a Bachelor’s degree, with Master’s degrees more common among supervisors and higher-level administrators.

For this analysis, we classified systems by sustainment status as suggested by Stirman and colleagues (2012): “full” (n = 7); “partial” (n = 1); and “non-” (n = 3). In full-sustainment systems, core implementation elements of SafeCare, i.e., ongoing delivery of modules, monthly coaching, and weekly team meetings, were maintained after initial implementation support had been withdrawn, and adequate capacity existed to maintain these elements. Partial sustainment described systems meeting only some elements after withdrawal of initial implementation guidance (e.g., service delivery continued but the system did not conduct model-required coaching). In non-sustaining systems, the EBI was no longer being provided by the system.

2.3 Data collection and analysis

Data were collected at three time points: Time 1 (T1; preparation/implementation phase; 2006-2008), Time 2 (T2; implementation phase; 2009-2011), and Time 3 (T3; sustainment phase; 2012-2014). Data were collected in at least one system each year across all three time periods. Individual systems began implementation at different times or had divergent trajectories of implementation; the bulk of data collection occurred in T3 when systems had been implementing the EBI for a minimum of two years. During T3, all coaching needs were being addressed by local stakeholders. Several stakeholders with long tenures in their positions were interviewed multiple times across time periods.

Interview and focus group guides in T1, T2, and T3 examined inner- and outer-context factors related to the preparation, implementation, and sustainment phases of SafeCare in each system, including the role of coaches and the influence of coaching on implementation and sustainment. Separate guides were developed for system and organizational stakeholders. Questions in T1 guides related to decision making to implement the EBI and first impressions of the EBI; T2 questions concerned impressions of training, coaching, and impacts of EBI implementation on systems, CBOs, and staff; and T3 questions centered on the role of leadership and collaboration in EBI implementation and sustainment, and experiences delivering and coaching the EBI. The University of California, San Diego Institutional Review Board approved the research design, sampling method, and consent procedures.

All interviews and focus groups were digitally recorded, professionally transcribed, and checked for accuracy by at least one author. We used NVivo 10 qualitative data analysis software (QSR International, 2012) for data management and to support iterative review and analysis. First, transcripts for each study in our database were coded by research assistants to condense the data into analyzable units. Codes were assigned segments of text ranging from a phrase to several paragraphs based a priori on the topic areas and questions making up the interview guides (Patton, 2015). For the secondary analysis, we re-reviewed and recoded the transcripts for content specific to coaches and coaching. As part of this secondary analysis, we created additional codes based on key sensitizing concepts from the implementation literature, including coaching or consultation, (clinical) supervision, and support. These concepts provided “a general sense of reference” for the secondary analysis and supplied descriptive data based in the actual words of research participants, which enabled us to examine their salience and meaning for different types of stakeholders over time (Patton, 2015, p. 545). We then used open and focused coding to locate new issues related to coaching in the transcripts (e.g., trainers, implementation support, scheduling coach visits) and to determine which issues emerged frequently or
represented particular concerns of the stakeholders (Corbin and Strauss, 2008). By comparing and contrasting codes in both the primary and secondary analyses of the data, we grouped codes with similar content into broad categories of the findings linked to segments of text in our database (Corbin and Strauss, 2008; Glaser and Strauss, 1967). Within this database, we also incorporated detailed memos describing and linking codes to the larger categories, which, in turn, illuminated the role of coaches in implementing and sustaining the EBI and how different types of stakeholders perceived and experienced coaching. Finally, accuracy checks of the findings and assistance with interpreting data were provided by persons involved in organizing and implementing the coach role in study systems (Patton, 2015).

3. Results

The six major categories of findings are described below in a format that tells the story of SafeCare implementation across important EPIS phases, and in a way that underscores their connectedness: perceptions of “good” and “bad” coaches by system sustainment status; coach as peer; in-house coaching capacity; intervention developer requirements vs other outer-context needs; outer-context support; and inner-context support. Table II organizes results by sustainment status and EPIS phase to highlight how inner- and outer-context factors influenced coaching over time.

Table II Coaching summary by sustainment status and EPIS phase

<table>
<thead>
<tr>
<th>System</th>
<th>Preparation (data from T1)</th>
<th>Implementation (data from T2 and T3)</th>
<th>Sustainment (data from T2 and T3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully sustaining</td>
<td>Inner: CBO administrators, home visitors, and some supervisors learn about implementation and the coach role. Some external trainers are characterized by CBO staff as difficult, to the point of threatening EBI continuation. Some home visitors express confusion about the coach’s advisory (vs supervisory) role. Some CBO staff are unhappy with not having an in-house coach.</td>
<td>Inner: CBO administrators make changes to better support coaches (e.g., mandatory consultation) and increase staff buy-in. Staff opinions of coaches improve but remain mixed. Scheduling challenges around coaching visits abound. Tensions exist between coaches and clinical supervisors regarding the coach role. Coaches depend on a lead coach for support.</td>
<td>Inner: coaches are generally integrated and valued throughout systems as part of quality assurance. Coaches maintain that it is awkward to coach peers and some supervisors remain confused about coaching role. Coaches continue to rely on lead coach.</td>
</tr>
<tr>
<td>(n = 7)</td>
<td>Outer: systems initiate EBI with external coaching and transition to their local team post-certification.</td>
<td>Outer: communication issues with coaches and about coaching begin to resolve. Challenges of integrating coaching and the EBI into systems remain. Some systems expand coaching capacity as program grows.</td>
<td>Outer: government administrators appreciate coaches as providing built-in accountability, allowing them to focus on other work. Funding for coaching and ongoing trainings is a universal concern. Turnover in leadership requires some coaches to act as “boundary spanners” due to the lack of consistent coaching. Home visitors are not implementing the EBI with full fidelity.</td>
</tr>
<tr>
<td>Partial sustaining</td>
<td>Inner: CBO administrators, home visitors, and some supervisors learn about implementation and the coach role. There is discomfort at all levels with the idea of having a peer “coach” the other providers. Outer: external trainers are not well received.</td>
<td>Inner: as with sustaining and non-sustaining systems, coaches claim discomfort coaching peers.</td>
<td>Inner: due to the lack of consistent coaching, home visitors are not implementing the EBI with full fidelity.</td>
</tr>
<tr>
<td>(n = 1)</td>
<td>Outer: the system loses one coach, leaving only the primary lead coach who refuses to travel to coach home visitors who are not nearby, leaving these more remote CBO staff without consistent coaching.</td>
<td>Outer: systems insufficiently or inappropriately support coach or EBI due to financial and/or organizational issues. EBI implementation is negatively impacted by insufficient access to coaches.</td>
<td>Outer: little support from government administrators in sharing resources after the loss of one coach.</td>
</tr>
<tr>
<td>Non-sustaining</td>
<td>Inner: stakeholders learn about the implementation and the coach role. Staff express some resistance to the EBI. Outer: some systems do not have local coaches and rely on external coaches. Multiple turnovers of lead coach position result in sporadic coaching in two systems.</td>
<td>Outer: systems insufficiently or inappropriately support coach or EBI due to financial and/or organizational issues. EBI implementation is negatively impacted by insufficient access to coaches.</td>
<td>Outer: the EBI is no longer being implemented. CBO administrators note that adding the EBI to staff’s existing responsibilities posed challenges.</td>
</tr>
<tr>
<td>(n = 3)</td>
<td></td>
<td>Inner: coaching is inconsistent due to turnover and perception among home visitors that external coaching is unhelpful.</td>
<td></td>
</tr>
</tbody>
</table>
3.1 Perceptions of “good” and “bad” coaches by system sustainment status

Several characteristics of a “good” coach were identified during implementation by stakeholders in sustaining and partial-sustaining systems. Inner-context stakeholders deemed coaches effective when they validated and encouraged the work of home visitors and helped them advance their skills, often by modeling correct techniques: “They’re able to guide the staff in a way that supervisors aren’t,” stated one CBO administrator. Home visitors added that feedback was detailed and framed in a positive light. Stakeholders concurred that good coaches were “available,” “accessible,” and skilled at building “rapport” with clients and home visitors, paralleling techniques taught to home visitors in training, and as designed by the intervention developers. Describing her/his coach, a home visitor said, “[S/he] builds on [your] strengths so much and gets a twist on things you still have to work on.” Home visitors and supervisors, especially at the onset of implementation, also valued coaches for offering useful suggestions not covered in EBI materials, such as information about autism and domestic violence resources. Supervisors in sustaining systems clarified that good coaches possessed excellent organizational skills and kept track of complex schedules and great quantities of paperwork.

Coaches in sustaining and partial-sustaining systems referred to themselves as “problem-solvers,” “mentors,” and “helpers.” In contrast, government and CBO administrators commonly characterized the coaches as the “experts” charged with learning and teaching the EBI. This difference in understanding of the coaches’ role between inner- and outer-context stakeholders reflected the range of roles and responsibilities of participants. Home visitors and supervisors in the inner context depended on the coaches’ more quotidian technical support, while government administrators in the outer context emphasized the broader structure of implementation accountability that they perceived coaches as providing.

Stakeholders across systems shared similar understandings of characteristics associated with a “bad” coach. While home visitors were trained to think of coaches as peers, a bad coach was perceived as overly directive and a face of authority. They described bad coaches as making critical remarks, or correcting them in the presence of clients. One home visitor in a sustaining system shared, “I was taught that [coaches] are supposed to help us and to teach us and to support us, but I get criticized […] And in front of the clients, that’s even worse.” Another added that the occurrence of such scenarios causes clients to think, “This case manager doesn’t know how.” On the other hand, two home visitors agreed that while their coach was “energetic” about SafeCare, “[S/he] just displayed some really bad boundaries with my client.” A bad coach was also described as not available for or late to home visits, or as taking calls on their cell phone in the presence of clients. Bad coaches reportedly did not provide much if any feedback, leaving home visitors insecure about their fidelity ratings and their implementation ability and competence. A supervisor observed that when the coaches were “absent,” or not reachable by phone or in the office, the home visitors were unhappy with them.

Home visitors in non-sustaining systems experienced inconsistent and infrequent coaching, often due to turnover, a lack of in-house coaches to provide in-person support (see Section 3.3 below), and/or poor placement of individuals in coach and lead coach positions. The CBO administrators in one non-sustaining system recalled the home visitors feeling as though an external trainer/coach had demeaned them in a way that impacted implementation negatively. Sustaining and partial-sustaining systems reported similar descriptions but overcame this conflict through assiduous effort to complete the EBI training and with the help of other external trainers provided by the intervention developers. As shown in Table II, reports of bad coaching diminished over time as home visitors, coaches, and supervisors grew more comfortable with the EBI and as administrators learned what qualities make for a good coach.

3.2 Coach as peer

The EBI’s coaching manual defined coaching as the “support and monitoring system” for home visitors delivering SafeCare, but initial trainers during the preparation phase in the 11 systems emphasized coaches as complementary “peers,” engendering some confusion and discomfort among both coaches and home visitors. While coaches were trained to provide encouraging feedback, they were also charged with reviewing and addressing implementation fidelity,
heightening anxieties among home visitors that coaches would judge their work performance negatively. One coach in a partial-sustaining system explained:

We started [implementing the EBI] at the same time. I don’t know more than they do. They don’t know more than I do. I don’t feel like that’s a good or fair position to put somebody in […] We’re like equal coworkers so to be critiqued by your coworker is not a natural or comfortable situation.

Stakeholders in sustaining systems expressed similar perspectives. For example, one home visitor stated during implementation, “I’m sure a part of it is evaluating.” In a second system, two supervisors confessed to calling coaches “monitors” among themselves and said that they only use the term “coach” when in conversation with home visitors. A CBO administrator described coaching during implementation as “a role that’s a little bit confusing because the person is seen monitoring the work of their peers and yet they’re not in a supervisory position.” Stakeholders in non-sustaining systems did not reach an EPIS phase to comment extensively on coaches as peers.

This lack of clarity and consistency regarding the coaches’ supportive vs supervisory role was also commonly expressed by outer-context stakeholders. Some government administrators who lacked familiarity with the EBI treated, used, or talked about coaches as monitors. Government administrators who were not part of the exploration and preparation phases even sought to leverage the coach role to monitor the CBO home visitors and their billable hours. The coaches’ supervisors in one system reportedly called a meeting and explained to government administrators that coaches were not “supervisors or watchdogs.” One government administrator even wanted to become a coach specifically to monitor staff fidelity to the EBI. In these cases, outer-context stakeholders misunderstood or sought to recast the coaches’ supportive role in the inner context.

For their part, coaches were concerned with not looking like “bad guys” and consciously endeavored to frame comments to home visitors positively; those who had to coach supervisors especially expressed discomfort. Many felt more comfortable coaching home visitors from outside their training cohort. Confusion about the coach role was most ubiquitous during the preparation and implementation phases and more confined to new hires in the sustainment phase as stakeholders grew accustomed to coaching as part of service delivery and quality assurance.

3.3 In-house coaching capacity

Over the EPIS phases, it became clear in sustaining and partial-sustaining systems that home visitors benefitted from having their coaches housed within their own workplaces, rather than in another, possibly geographically distant, CBO. One home visitor remarked, “I do go to my coach when [s/he’s] there, but do I call to ask [her/him] something? No, I don’t. I call [the lead coach] or when I see the other coaches in the office, I ask them.” A lead coach in one system noted that, early in implementation, “turf wars” for referrals surfaced because coaches were only based in a single CBO, leaving some home visitors to believe that those with in-house coaches were favored within the system. According to this individual, tensions were reduced among CBO staff once coaches were finally housed in multiple CBOs.

Similarly, a government administrator in another system with geographically dispersed coaches wondered if the system had enough coaches while entering the sustainment phase and planned to ask the intervention developers for help. The participants in a focus group of coaches in this system agreed that it was harder to coach geographically dispersed home visitors, “We don’t really have that closeness with their management over there. We don’t have that much communication.” A government administrator in another sustaining system claimed that system stakeholders would not have agreed to do SafeCare without a local lead coach.

A minority of staff appreciated the opportunity to interact with coaches outside their CBOs, or to travel to new localities to perform coaching. For example, one home visitor said s/he liked having a coach from another CBO because the coach provided her/him with fresh ideas.

3.4 Intervention developer requirements vs other outer-context needs

Although government and CBO administrators were generally supportive of coaching, challenges in maintaining coaching capacity arose over time in many systems. In these cases, coaches were affected by the unintended consequences of policies, procedures, and funding
arrangements originating in the outer context. For example, one CBO administrator instituted mandatory consultation times as some home visitors were not “eager” to schedule them. Government administrators in another system established a rule that home visitors must arrange coaching visits by the 15th of each month, to ameliorate rampant scheduling challenges. Coaches in this system said that, because they had to report those home visitors who did not schedule on time, resentment ensued among those who missed deadlines, undermining what was meant to be a supportive relationship. Home visitors also felt unfairly blamed for scheduling issues reportedly resulting from a reduction in coaching hours, which they believed were decreased by government administrators for financial reasons. Coaching became less consistent because of decreased hours, and coach participation in trainings for new home visitors was limited to save money, both of which fed into contradictory messages about the value accorded to coaching. The coaches believed that they no longer bonded as before with home visitors, nor were they privy to how training information was presented, hindering their ability to help home visitors.

In one system, the inability to maintain coaching in compliance with EBI requirements contributed to SafeCare’s failure to progress beyond implementation. Here, CBO administrators had trouble reconciling and integrating outer-context reporting requirements prescribed by the funder, local government, and intervention developer. The inability to efficiently report and bill for coaching reportedly led to fewer clients, and therefore lower levels of – and often unproductive – coaching. The failure to resolve the compliance issues around coaching contributed to CBO administrators deciding not to sustain the program.

3.5 Outer-context support

Administrators in the outer context affected the level of support for coaches in critical ways. For example, coaches wanted administrators to watch out for the danger of allocating large caseloads to home visitors that threatened fidelity. A coach during the sustainment phase asserted that, “If [home visitors] have any more than eight to ten cases I don’t feel that SafeCare is implemented in the way that it could be.” When asked about what was needed to sustain, one home visitor responded that they were dependent on “consultant and supervisor availability.” Finally, one lead coach asked to have her/his job requirements clarified and written down after experiencing greater and expanded responsibilities beyond what s/he perceived was appropriate.

Gaps in leadership in some systems caused by outer-context turnover during sustainment necessitated that coaches act as intermediaries between outer and inner contexts. Coaches said that they had to communicate between the CBO home visitors and the government administrators to facilitate continued sustainment. Home visitors and other stakeholders in some systems considered their coaches to be liaisons to administrators, often underscoring the pressures placed on them to span inner and outer contexts. One coach explained:

Sometimes I feel like we’re that middleman where we don’t have enough say sometimes to do certain things, and then sometimes they ask us for too much to do. So, it’s like we’re in that middle situation where we’re not their managers or their bosses but then sometimes they ask us questions that are for them.

Coaches benefited from having access to a coordinator dedicated to the SafeCare program, who simultaneously functioned as their lead coach; such individuals usually came from a supervisory administrative level. Coaches throughout implementation and sustainment phases characterized lead coaches as “key” to their ability to do their jobs. Government and CBO administrators also emphasized the importance of the lead coach during both phases, and some talked of having to replace an individual who was poorly performing in this position with a more “appropriate” person for effective implementation to progress. Lead coaches with multiple responsibilities (e.g. supervision, home visiting) commented in the sustainment phase that ideally, they would be exclusively coordinating the program in their vicinity. After multiple turnovers in the lead coach position, a CBO administrator in what became a non-sustaining system suggested that the organization should have specifically recruited for, rather than assigned existing staff to, the role.
3.6 Inner-context support

In addition to outer-context support, coaches were affected by the level of support they received within the inner context. A CBO administrator described having to communicate sternly to staff during implementation that their CBO was committed to EBIs:

[We had] a direct conversation, “We’ve gotta move forward.” You know, “We’ve gotta get on board. What do we need to do?” And so we changed how we were meeting with the consultant [coach]. We invited him to meetings. We changed our entire interactions [...].

The CBO administration concentrated on changes that would explicitly support the coach, and thus EBI implementation.

Supervisors in the inner-context were particularly positioned to help or hinder coaches, according to lead coaches, coaches, and home visitors. Generally, supervisors were not trained in the EBI because administrators in both inner and outer contexts reasoned that supervisors could do their full-time administrative jobs without needing costly EBI-specific training. While some supervisors were trained with the intention of becoming coaches or attended portions of trainings when there was time or money for them to do so, most supervisors claimed that they did not have time to learn the model and that was a reason they valued the coaches. However, one coach underscored that it was the leadership of supervisors in the inner context that reinforced the coach role by helping home visitors understand and buy-into the implementation:

It makes a difference when you have a supervisor who understands, and who lets you know that, “This is what you have to do.” So, you have that support from the supervisor versus someone who just really doesn’t care. Then guess what? Your staff are not going to care either and they’re not going to do it and then that’s going to be my struggle.

Supervisors with a firm understanding of implementation processes greatly valued their coaches and how much the coaches helped them do their jobs better. Illustrating this point, one supervisor said that her/his peers were better able to oversee administrative procedures and could trust the coach to handle the EBI end of things.

However, supervisors also observed that coaches sometimes became tangled in a web of varied CBO policies and procedures when helping home visitors overcome implementation challenges. For example, there were instances when a coach suggested a solution that clashed with a CBO’s existing policies (e.g. no home visitations with families after dark). Supervisors in the sustainment phase were especially careful to keep issues of SafeCare implementation separate from their other work with home visitors. One observed, “Mixed messages can happen, that’s why I never speak about SafeCare. I immediately refer them back to their coach.” Coaches in a sustaining system elsewhere also recognized this overlay, with one explaining, “It’s because [our CBO has its] own set of rules. The other visitors may not follow the same guidelines so sometimes we get caught up in their management.” In these cases, coaches, particularly those not working in-house, struggled to adhere to outer-context requirements while managing inner-context realities. Over time, in sustaining systems, some home visitors became supervisors, drawing from their previous role, knowledge, and expertise to support the EBI. Lack of buy-in among supervisors reduced support for coaches in the inner context of systems unable to sustain.

4. Discussion

This qualitative research benefited from a series of interrelated studies that made it possible to longitudinally investigate a multitude of factors affecting coaching, a core support component of SafeCare and other EBIs (McHugh and Barlow, 2010). Our findings clarify factors helping and hindering coaching support for EBI implementation and sustainment in complex human service systems. The findings suggest that coaches perceived as successful were those who effectively navigated and negotiated shifting inner and outer contexts throughout the implementation phase and into the sustainment phase.

In sustaining systems, coaches enabled both implementation and fidelity, despite changing procedures, paperwork, and personnel. Coaches helped home visitors incorporate these changes and provided a source of constructive feedback and solutions to everyday challenges.
However, our study also indicates that coaching can affect much more than intervention fidelity, as the efforts of coaches had implications beyond their defined role. Throughout the implementation and sustainment phases, for example, coaches were vital in communicating the intervention’s importance to home visitors, a notable aspect of organizational climate for EBI implementation (Aarons, Ehrhart, Farahnak and Sklar, 2014). In prior research, coaching also contributed to staff support for SafeCare and reduced staff turnover in child welfare systems (Aarons et al., 2012).

Our findings suggest a strong connection between home visitors’ positive evaluations of their coaches and the ability of these coaches to communicate constructively with them. In fact, the coaches perceived as “good” were practicing the principles of the EBI itself, such as inviting the home visitor to instruct the coach on his/her preferences (e.g., if s/he preferred the coach to model EBI techniques, participate, or simply observe), using specific vs general praise, and giving rationales for criticism. By operationalizing the same techniques that home visitors were to use with clients, coaches engaged in favorable consultation practices, a finding resonating with other implementation research (Beidas et al., 2013; Stoltenberg, 2005).

However, coaches in our study felt constrained in cultivating communicative and trusting relationships with home visitors by outer-context factors, such as when funding for their work hours was cut and they were unable to participate with home visitors in trainings. Home visitors also reported being less able to form trusting and supportive relationships with coaches who were not based within their daily workspace. Coaches, in turn, perceived that home visitors who received coaching remotely or did not have coaches nearby did not receive adequate assistance and demonstrated lower levels of EBI fidelity. This inner-context situation was an unintentional result of outer-context decisions about how to apportion limited funding, and perhaps the desire to control training and coaching integrity by locating coaches in one or a few organizations.

For their part, coaches depended on lead coaches and supervisors for support. Supervisors who understood the intervention and the intended role of coaches greatly influenced home visitor buy-in. In contrast, supervisors not on board with, or knowledgeable about, the EBI were not considered useful to home visitors, and in the worst cases, negatively influenced home visitor relationships with coaches and the EBI itself. This was problematic when home visitors received inconsistent messages about whether coaches were considered peers or monitors. In several systems, supervisors and government administrators, especially those unfamiliar with the EBI, sometimes treated, used, or talked about coaches as having only a fidelity monitoring function in a way that reinforced frontline anxieties about coaching. The negative effects of such misperceptions are consistent with scholarly understandings of the dimensions of effective implementation leadership (Aarons et al., 2015).

We recommend that the insecurities and initial turnover that affected home visitors can be diminished by government and CBO administrators proactively clarifying the coach role with the initial trainers during the preparation phase, and priming trainees to understand and embrace support from coaches (Aarons, Ehrhart and Farahnak, 2014). Furthermore, rather than rely on trial and error to hire coaches, greater knowledge of the role of coaching in the EBI during the preparation phase, and the characteristics of a good coach, will enable system and CBO administrators to recruit and select individuals for critical implementation positions who will support the EBI throughout the sustainment phase (Ehrhart et al., 2014; Schein, 2010) and increase fidelity. Additionally, recruitment, selection, and hiring of individuals with desirable characteristics to support implementation signify to employees the importance of the EBI (Ehrhart et al., 2014). This is in keeping with an implementation climate that communicates to employees what is expected, supported, and rewarded in organizations (Jacobs et al., 2014). Knowledgeable leaders can tailor the coach position to their implementation environments and balance it with other job assignments (e.g., supervisory functions) to prevent added responsibilities from presenting scheduling challenges like those that negatively affected the coaches in our study.

Our findings suggest that when leaders lacked knowledge of the appropriate role for coaches and expected them to act as monitors, coaches and their supervisors could resist such
outer-context pressures by explaining to administrators that coaches were meant to serve in a supportive capacity. In situations like these, coaches and supervisors intersect with stakeholders differently positioned within system hierarchies (Duda and Barrett, 2013), thereby spanning inner and outer contexts. Coaches were often conceptualized by other stakeholders in this spanning capacity as communication liaisons. While having a liaison between inner and outer contexts was valuable for other system stakeholders, our study results suggest that the boundary-spanning position puts coaches at risk of being asked to fulfill duties above and beyond their intended role, such as reporting beyond fidelity assurance for the EBI. We suggest that turnover in leadership positions, funding issues, and changing relationships between CBOs and government contracting entities – common characteristics of human service systems – risk exacerbating this issue, and may compromise the implementation support coaches can provide to frontline workers. Consequently, we recommend that CBO managers be prepared to support and protect coaches as built-in quality assurance for EBI delivery by buffering them against additional demands. Furthermore, government administrators must ensure that contracted CBOs and coaches have the tools they need to best assess and augment coaching in their systems. This includes anticipating and proactively addressing funding changes, strategically applying resources for ongoing implementation, and directing sufficient provisions for enough coaches throughout the system (Willging et al., 2017; Aarons, Ehrhart and Farahnak, 2014).

This case study further demonstrates the importance of understanding the interaction between inner- and outer-context factors by illuminating the ways that they affect the capacity of coaches to support EBI implementation and sustainment. This builds on previous research that found evidence of outer-context decisions impacting inner-context processes (Willging, 2015, 2017). Our findings indicate that the effect of coaching on implementation depends largely on a coach’s ability to navigate, and help others navigate, dynamic service delivery environments; indeed, the context may be the primary mediator to consider for an EBI to progress to the sustainment phase (Dopson et al., 2008). In these environments, support components for EBIs, including coaching, work together and are limited in their ability to function independently to influence implementation (Fixsen et al., 2009; Wandersman et al., 2012). Leaders of CBOs and government agencies must be willing to collaborate to make organizational changes that strengthen the integration of coaching processes throughout EPIS phases (Aarons et al., 2011; Green et al., 2016). Ultimately, our study indicates that concepts of “good” and “bad” coaches relate to how well the coach role is integrated within CBOs, among home visitors, and within systems.

The confluence of multiple “embedding mechanisms” may create a strategic climate that promotes EBI use (Schein, 2010). Primary embedding mechanisms are strategies that leaders at multiple levels (e.g. system, CBO, and team or workgroup) can use to develop such climates. Examples include what leaders focus on regularly, how leaders react to crises, how they allocate resources and rewards, how they teach or role model, and how they recruit staff (Aarons, Ehrhart, Farahnak and Sklar, 2014). We contend that climates in which leaders at the system and organizational levels recognize the importance of coaching are likely to be conducive to EBI provision. Leaders demonstrate coaching support by conveying this importance to others, problem solving when coaching issues arise, capitalizing coaching appropriately, teaching others about, acknowledging, and rewarding coaches for their services, and being purposeful when selecting coaches.

For home visitors, stories about important events and people associated with the emergence and maintenance of coach roles may also inspire stakeholders to take coaching seriously, and perhaps to become coaches themselves. Stories that we were privy to throughout this investigation are themselves secondary embedding mechanisms that bolster support among system stakeholders for coaching as a crucial implementation quality control measure.

Other secondary embedding mechanisms concern how leaders design systems, organizations, and teams to support EBIs, including the development of reimbursement structures to compensate for coaching services, the sharing of coaching resources across CBOs, or how coaching-home visitation teams may be configured for fidelity monitoring and quality improvement purposes. This type of design can include formal statements highlighting the value of both the EBI and its support systems, i.e., coaching. Here, we recommend that government and CBO administrators clearly document descriptions of the coach position in service contracts and agency policies and procedures to maintain institutional
memory that upholds the integrity of the coach role. This recommendation is consistent with implementation approaches that address the need for job redesign as part of comprehensive implementation strategies (Glisson and Schoenwald, 2005). Moreover, such actions will help mitigate the risk of coaches being blamed as “bad,” when, in fact, contextual factors may be culpable. Blaming the coach damages the support mechanism in place for the implementation. Documenting coach roles early may also ameliorate challenges related to turnover in government positions that led to new hires attempting to co-opt coaches as monitors. In our case study, communicating role expectations to all stakeholders may have diffused resentment among home visitors toward coaches when financial decisions led to issues with scheduling and inconsistent guidance.

Second, detailed agreements to fund ongoing training and coaching will help maintain the quality of coaching processes. Coaches who, for financial reasons, were reduced in training and billable coaching hours expressed concerns about having more distant relationships with home visitors and a limited ability to support them. A CBO in a non-sustaining system that was challenged to efficiently bill and report according to funder and government requirements may have sustained the implementation had they streamlined agreements first between the three entities.

Third, measuring and documenting processes and outcomes can create a climate for EBIs in systems and organizations (Aarons et al., 2011). Delineating reporting processes and consistent language agreed on by system stakeholders may ease communication challenges for coaches working across CBOs with different policies (Duda and Barrett, 2013), while simply describing coaches as peer support during training may generate confusion when coaches must rate the integrity of the implementation and provide guidance to home visitors. Adopting clearly articulated processes would also support coaches who become entangled in the different CBO policies and procedures when trying to solve implementation challenges.

5. Limitations

Although the systems where this research occurred were varied, the study took place in only two US states, thus limiting generalizability. Additionally, the study included participants from each non-sustaining system, but not all stakeholder groups were represented in later phases, as we could only access government and/or CBO administrators; coaches and home visitors no longer occupied the same positions related to the EBI. We also recognize that while our categorization of systems by sustainment status may allow us to suggest characteristics common to successful and less successful implementation environments, they may not fully capture the nuanced differences in implementation across systems. We are also limited in our capacity to compare across the categorizations, as the inclusion of only one partial-sustaining system limits understanding of the degree to which the elements of SafeCare were in play.

Whereas this case study emphasized the perceptions of coaching among different service delivery stakeholders, and we examined the SafeCare coach training manual, future research might include the clients who receive the intervention. Moreover, we contend that favorable components, characteristics, and procedures are dependent on local contextual factors. Nevertheless, this study benefits from 11 natural settings that enable us to examine in-depth the circumstances in which coaching occurs over time.

6. Conclusion

This paper elaborated outer- and inner-context factors affecting coaching in EBI implementation and sustainment. Our findings indicate that successful coaching involves trusting relationships and open communication, not only between coaches and home visitors, but also between coaches, outer-context stakeholders, and CBO administrators. Inner-context factors that facilitated EBI sustainment included CBO administrators enacting changes to better support coaches, use of in-house coaches, and buy-in among supervisors and home visitors. Outer-context factors facilitating sustainment included continued funding from government administrators, an understanding of the scope of work for coaches, and collaborating with CBO administrators to incorporate coaching and trainings into contracts.
Leaders in both outer and inner contexts can use embedding mechanisms to support coaching. In the present study, coaching can be considered an embedding mechanism signaling the importance of maintaining fidelity support as a critical part of EBI implementation. Where sites attained full sustainment, coaching and fidelity support were judged by the system and CBO leaders as critical to high-quality service delivery. Coaching, then, might be a valuable addition to other parenting interventions (e.g. Positive Parenting Program or Triple P) that may not emphasize this type of ongoing fidelity support at the level required by SafeCare (Chaffin, Hecht, Bard, Silovsky and Beasley, 2012; Seng et al., 2006; Funderburk et al., 2015). We recommend further institutionalizing the coach role through job redesign, clarification of coach requirements in job descriptions and performance evaluations, and recruitment for favorable coaching characteristics. Colocation of coaches in the offices of home visitors might also prove advantageous. Circulating stories about the positive role of coaching and coaches will likely reinforce coaching as a critical support system among stakeholders at multiple levels of a service system.

A clear contribution of this study is the identification of a common understanding of coaches as boundary spanners linking inner and outer contexts and facilitating communication to support implementation. However, while it may be valuable for coaches to span inner and outer contexts, doing so may also compromise the integrity of their specific role within EBI implementation and sustainment. Coaching supports EBI implementation and sustainment. Consequently, inner- and outer-context stakeholders must devote further attention to support coaching to improve fidelity and client outcomes in public-sector service systems.

References


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Pursuing the adoption pathway: the lived experiences of people living with HIV

Tam Cane, Vasso Vydellingum and Wendy Knibb

Abstract

Purpose – The purpose of this paper is to examine the experiences that people with HIV faced as they navigated through the intricate processes of trying to access adoption services in the south of England. It proposes the need to pay more attention to people living with HIV (PLWHIV) able to adopt children. The study aims to develop an increased focus on PLWHIV able to adopt.

Design/methodology/approach – The paper is an exploratory study using an interpretative phenomenological analysis (IPA) approach. Open-ended interviews were conducted with seven participants including individuals and couples. Interviews were transcribed and analysed using IPA’s cross-case and ideographic analysis.

Findings – The paper provides empirical insights about the challenges that PLWHIV experienced with social workers. Positive experiences were in the minority. Lack of information, inadequate support, stigma and discrimination, cultural insensitivity and disempowerment were frequently reported. The paper suggests that greater understanding and better education for social workers would improve access to adoption by people with HIV.

Research limitations/implications – Given the chosen approach and small sample size, results may not be generalisable.

Practical implications – This study increases knowledge, promotes positive attitudes and improved support for PLWHIV who are stable and able to offer permanency to adoptive children.

Originality/value – This paper provides new ideas in an area that is scarcely researched. It identifies the need to undertake further studies to understand how social workers assess PLWHIV and what can be done to provide adequate support.

Keywords HIV, Adoption, Discrimination, Social work, Interpretative phenomenology, People living with HIV

Paper type Research paper

Introduction

Since 2012, the UK Government has emphasised the importance of improving efficiency in adoption processes and improving the value and quality of children’s lives with their adoptive families. The Children Act (1989) made it clear that adoption is a serious decision made from assessments and evidence used to ensure that the child’s welfare will be safeguarded. The current discourse on adoption suggests that prospective adopters should not be rejected at the point of initial enquiry purely due to their background or health issues. There is a need to reduce barriers and discrimination that prevent potentially good, caring adoptive parents from adopting.

Thus, people living with HIV (PLWHIV) should be considered equally where health matters are concerned and with regard to their rights to achieve parenthood. However, Paiva et al. (2003) showed that in a sample of 250 HIV-positive men between the reproductive age of 17 and 74 years, 92 per cent of them were on antiretroviral treatment, stable and well. All participants were asked if they had a desire to have children. Out of 250 men, 43 per cent (107 men) wanted children. Of these 107 men, 26 per cent wanted a baby, yet 4 per cent had a desire to adopt. On the contrary, 52 per cent of the 250 men had expressed no desire to have children due to fear of horizontal transmission and professional or societal stigma, only 4 per cent (5) opted for adoption. Many studies suggest that some PLWHIV do not feel encouraged by professionals to...
adopt children. Structural barriers within adoption systems, lack of information or support, ignorance, stigma and discrimination associated with HIV all acted as barriers for PLWHIV seeking to adopt children (Chipwe Cane, 2017; Underhill et al., 2016).

Nattabi et al. (2012) noted that many PLWHIV felt stigmatised by health and social care workers who criticised them for wanting children. Due to judgemental attitudes and lack of information, the needs of PLWHIV have not been fully addressed. Moreover, anxieties around the prevalence of HIV may increase concerns by health and social care professionals of whether parents with HIV could provide stability to children because HIV has been seen to contribute to children experiencing stigma, discrimination and psychological burden. Because of concerns that parental chronic health conditions tend to affect children’s quality of life Gardino et al. (2010) concluded that ongoing discrimination often existed in the adoption process, resulting in many PLWHIV being unfairly disadvantaged. However, if social barriers are removed, this may create opportunities for PLWHIV to adopt (Underhill et al., 2016). This paper, therefore, reports from an exploratory study on the experiences of PLWHIV on their journey to becoming adoptive parents through the adoption system in the south of England. In the next section, we present an overview of the screening and adoption processes in the UK.

The process of adoption

Adoption processes in the UK are outlined in the Adoption Agencies Regulations 2005 (amended 2011), Adoption Statutory Guidance (2013), the Adoption National Minimum Standards (2014) (Department of Education, 2014), and other relevant legislation, regulations and guidance. The assessment process of adoptive parents involves stages 1 and 2. The pre-stage process, however, encourages those interested in adoption to approach adoption gateways for information and guidance. Issues around infertility, fertility treatment, age, bereavement and loss are explored in order to assess eligibility. Through adoption information sessions or a social work home visit, prospective adopters may express an interest to adopt. This stage is criticised for its subjective nature because applications that are not deemed viable can be rejected (Gardino et al., 2010; Moodley et al., 2014). Thus, the extent to which HIV is accepted is unclear.

The first stage is the screening stage that runs for two months and involves adoption social workers gathering information about prospective adopters, undertaking an evaluation of background investigations with many agencies, such as conducting police checks and health checks, as well as reference enquiries. Ultimately, social workers provide adoption preparation training, assess parenting capacity, parenting skills and provide prospective adopters with information about available children. Stage 2 involves an allocated social worker processing assessments, Adoption Panel scrutiny and the Adoption Agency Decision-maker who makes the final decision as to whether or not prospective adopters are suitable to adopt. Upon successful stage 2 assessments, potential adopters are approved; consequently, matching of adoptive parents to children requiring families begins. Gerrand and Nathane-Taulela (2015) and Underhill et al. (2016), however, report that adoption assessments can be complex where HIV management is concerned. They suggest that social and structural complexities lead to HIV-positive applicants withdrawing from adoption assessments to avoid either medical screening, further HIV testing, invasive assessments or discriminatory and unacceptable attitudes portrayed by professionals. Their studies advocate for adoption structures that are sensitive to HIV.

Literature review

Despite the extensive literature on adoption and in particular by minority groups, there is a dearth of studies dealing specifically with PLWHIV trying for adoption. Specifically concerning PLWHIV, this review presents the literature under three main themes: the right to adopt, health considerations of potential adopters, and ethical dimensions.

The right to adopt

The rights to adoption for PLWHIV seeking to achieve parenthood lie in the Human Rights Act (1998) asserting the right of all individuals to have a family. Indeed, this right should be considered in line with
the Paramountcy Principle. This principle states that the child’s welfare is paramount. Thus, adoptive parents should be best suited to meet the needs of that child. The literature on PLWHIV and adoption is limited, although legislation continues to discourage discrimination against health matters such as HIV. There is evidence to suggest that some PLWHIV feel discouragement by professionals from adopting children. Moodley et al. (2014) report a lack of sufficient information about adoption and that this prevented PLWHIV from receiving adequate support.

Health consideration of potential adopters

The assessment process requires applicants to demonstrate that they are physically, emotionally, and psychologically healthy enough to commit to bringing up a child. The Department of Health (2003) requires assessors and agencies to be satisfied that prospective adopters will continue to enjoy good health when they take up adoptive parenting responsibilities. Undertaking full medical checks and looking at adoptive parents’ medical histories are part of the screening process and decisions about adoptive parents’ health suitability carry a good deal of weight in the adoption process. Although the adoption minimum standards (Department of Education, 2014) clearly states that mild chronic conditions are unlikely to affect the adoption process, it also emphasises that serious health issues may impact on adoption chances if illnesses prevent children from being offered a full range of opportunities that promote their development (Douglas and Philpot, 2003).

Uncertainty about HIV-related mental health illness and its impact on parenting capacity may result in professionals feeling reluctant to accept people at risk of these issues. This disadvantages many PLWHIV and potential adopters may become subject to extensive scrutiny beyond the ordinary process and may become marginalised when seeking adoption because of professional anxieties and a lack of current HIV-related knowledge by health and social care workers (Gardino et al., 2010). Contextually, in a population of PLWHIV, about 25-40 per cent may have fertility difficulties (Kushnir and Lewis, 2012), and some are likely to apply for adoption. Therefore, adoption systems need to demonstrate a sensitive approach towards those PLWHIV entering the adoption system. Thus, the adoption minimum standards suggest that it is the duty of local authorities to welcome, value and support prospective adopters, and assess them on their ability to meet the unique needs of a child and any ethical questions about HIV and adoption need to be considered (Department of Education, 2014).

Ethical dimensions

The National Institute for Clinical Excellence (NICE, 2013) guidelines for HIV treatments acknowledge that there is a need to promote the rights of PLWHIV to have children. Health risks for adopted children are minimal as there are no risks for vertical transmission of HIV. While PLWHIV are likely to offer relatively risk-free home environments, some may need adoption counselling, emotional preparation for adoption, post-adoption advice and guidance on long-term disease management. Thus, the provision of adoptive parenthood requires balancing adoption rights, moral, welfare and best interests obligations to ensure long-term stability for prospective adoptive parents without making unjustified judgements (Clifford and Burke, 2004).

How this study fits with existing literature

Despite the rights of PLWHIV to adopt and adoption policy guidelines that promote inclusive adoption assessment procedures, there are limited empirical studies in the UK exploring the experiences of PLWHIV going through adoption. A qualitative study by Underhill et al. (2016) with 77 professionals and service providers assessing PLWHIV for adoption concluded that structural barriers, lack of awareness and stigma could be factors prohibiting PLWHIV from adopting. However, it is not clear from the perspective of PLWHIV what obstacles they faced when going through the adoption processes. This exploratory study was designed to highlight the experiences that prospective adoptive parents living with HIV face, when seeking to adopt a child through the UK adoption systems. This study will add to adoption research by providing insight into the experiences of PLWHIV who have accessed adoption. It will also strengthen overall published literature around HIV prevention.
The study

This study was an original study that examined the experiences of PLWHIV who went through the adoption process for child adoption, using an exploratory interpretative phenomenological analysis (IPA) approach. The thesis supporting this study is framed within the view that HIV is now a long-term condition and that those seeking to adopt should be allowed to experience an adoptive experience without feeling marginalised. The study, therefore, was interested in illuminating the lived experience of PLWHIV through the adoption process. The study only focuses on access to formal UK adoption services in England, and does not consider international arrangements as they vary by country.

The research question

Main question

RQ1. How do PLWHIV perceive their experiences through the process of applying to become an adoptive parent?

Subsidiary question

RQ1a. What are the challenges and joys faced by PLWHIV going through adoption assessments?

Theoretical framework

Risk and resilience theory and IPA

Risk and resilience theory (Masten and Powell, 2003,) provides a theoretical framework for understanding how PLWHIV who wish to have children identify risks of transmission and process these to prevent horizontal and vertical transmission. Resiliency is a process of active adaptation when responding to, or surviving threats, adversity or risk factors. In this study, adversity is associated with the loss of ability to have a child due to threats of HIV transmission. The process of resilience calls for one to feel that they can cope with the process of challenging threatening life events (Masten and Powell, 2003). The risk and resilience framework helps identify internal resilience and informal sources of support from social networks that increase resilience among PLWHIV (van Eeden-Moorefield, 2008). Attributes that connected to psychological theories closely relate to the IPA framework (Smith, 2004) supporting analysis that draws on psychological processes.

Method

Study design

This research followed the IPA (Smith, 2004). Through exploration, we sought to understand in detail, participants’ personal inner worlds as they tried to make sense of their adoption experiences. We explored associated feelings by looking in-depth into participants’ narratives (Smith and Osborn, 2007). IPA is underpinned by hermeneutics phenomenology elucidating that individual experiences are influenced by social, cultural, historical elements, language and emotions encountered while going through life events and how people make sense of those experiences (Eatough and Smith, 2006). Thus, we wanted to identify how participants felt and what they thought about going through adoption while living with HIV.

Double hermeneutic meaning-making occurred (Smith, 2004), helping us capture how participants made sense of their personal and social world. Thus, meaning was constructed from the interpretative interaction between the main investigator (TC) and participants through a reflexive in-depth process of understanding how participants made sense of their lifeworlds. The researchers had previous experience of working with PLWHIV as a social worker (TC) and a health visitor (VV) in the wider communities. Thus, the researchers’ knowledge and awareness of issues around HIV and health and social care issues were important in understanding and interpreting participants’ experiences. This enabled an investigation of
personal accounts to be conducted with clarity and with trustworthiness ensured. Thus, IPA was adequate because it allowed joint reflections between all researchers using analytic account (Smith and Osborn, 2007).

**Recruitment and sampling**

Ethical approval from the University of Surrey ethics committee was received as it was part of a doctoral research project. The lead researcher (TC) also received an honorary research status from the Terrence Higgins Trust (a charitable organisation supporting PLWHIV), which acted as the hub for recruitment. This promoted the legitimacy and confidence about the research and its intentions. Recruiting from HIV charities sought to render neutrality, promote anonymity, reduce anxieties about adoption applications that were underway and to facilitate data accessibility with the use of private HIV online forums and support groups. This also enabled identifying eligible participants before they were invited to participate (van Eeden-Moorefield, 2008). Thus, purposive sampling techniques were utilised to recruit those willing to participate (Smith and Osborn, 2007; Brocki and Wearden, 2007). Chain-referrals enabled accessing hard-to-reach individuals. The study recruited PLWHIV who were in their reproductive age and either in a sero-discordant or sero-concordant relationship, and who had accessed or were in the process of accessing adoption services in England.

**Participants**

The study used an acceptable sample size for IPA as recommended by Smith (2007). IPA supports small sample sizes to facilitate in-depth dynamic, reflective interpretative analysis of the rich data that emerges from interviews (Brocki and Wearden, 2007). Out of 18 respondents who expressed interest in the research, 6 participants had only attempted fertility treatment (and of these, 4 had explored adoption but not commenced the process), 1 participant became unwell and withdrew, and 4 participants dropped out.

Due to attrition and eligibility, the study subsequently relied on five semi-structured interviews involving seven participants in total. These participants comprised two heterosexual white couples with HIV-sero-discordant status (both these couples were working class); one heterosexual couple with HIV-sero-concordant status (both HIV positive, middle class); and two individual men whose sexual orientation was homosexual (one participant working class and the other a middle-class man with a senior management job in the education sector). Of these, only one single man was unsuccessful in adopting a child. The sample was homogeneous in that all participants were experiencing HIV-related infertility and they had sought child adoption services in England. All participants were above the reproductive age and within the required age to adopt a child. The sample size allowed a close exploration of the participants’ lifeworlds, thus keeping the research very close to individuals’ personal experiences and perceptions, in a better and much more attentive fashion than a larger sample would have allowed (Smith and Osborn, 2007; Flowers et al., 2011). The demographics of participants are shown in Table I.

**Table I** Summary of participants

<table>
<thead>
<tr>
<th>Participant pseudonyms</th>
<th>Demographic</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gary (white)</td>
<td>Single homosexual man (+)</td>
<td>Adoption applications were unsuccessful</td>
</tr>
<tr>
<td>Hillary (white)</td>
<td>Heterosexual couple (male +)</td>
<td>Successfully adopted two children after four failed attempts with different Local Authorities</td>
</tr>
<tr>
<td>Marius (white)</td>
<td>Single homosexual man (+)</td>
<td>Successfully adopted one child having been rejected by three Local Authorities. Adopted a child through a voluntary adoption agency</td>
</tr>
<tr>
<td>Alan (white)</td>
<td>Heterosexual couple (male +)</td>
<td>Rejected by one Local Authority. Successfully adopted two children through an alternative Local Authority and two separate occasions</td>
</tr>
<tr>
<td>Jenny (white)</td>
<td>Heterosexual couple (male +)</td>
<td>Successfully adopted one child through a Local Authority on a second attempt</td>
</tr>
<tr>
<td>Dean (white)</td>
<td>Heterosexual couple (both +)</td>
<td></td>
</tr>
<tr>
<td>Gabriella (white)</td>
<td>Heterosexual couple (both +)</td>
<td></td>
</tr>
<tr>
<td>Bred (White)</td>
<td>Heterosexual couple (both +)</td>
<td></td>
</tr>
</tbody>
</table>

*Note:* + denotes HIV positive
Data collection

Face-to-face interviews were conducted by the main investigator (TC) at a venue that was comfortable for participants, for example, at their home or in a private meeting room at a charity, the Terrence Higgins Trust offices. Interviews lasted between 45 minutes and 90 minutes depending on the complexity of participants’ narratives. A loosely structured interview schedule guided the interviews with participants. All participants provided consent to audio-record interviews and supported the study. Couples were interviewed together.

Data analysis

All interviews were transcribed, and following IPA’s analytic process, interviews were first transcribed, then read and re-read making free-text writing. Interview transcripts were individually and rigorously analysed within an ideographic case analysis to create themes and clusters but also to maintain individuality (Smith and Osborn, 2007). In each case analysis, themes were determined. They were recorded to reflect original words that were relayed by participants. This was useful for interpretation. A cross-case analysis was further undertaken for divergence and convergence of themes to create a shared understanding of a holistic analysis of each ideographic case and noting individual differences. Through mapping of themes in a cross-case analysis, master themes were created. These reflected a shared understanding arising from the experiences of participants as a group. Through monthly meetings between the three researchers (TC, VV and WK), analysing and making connections between collective superordinate themes, sub-themes emerged, with the restructuring of themes necessary until final themes provided holistic sense-making (Flowers et al., 2011; Brocki and Wearden, 2007). Final themes to report upon were agreed after detailed checks and a process of an inter-rater reliability examination (VV and WK).

Four themes were identified and these are presented below with anonymity of all participants protected. All names used here are pseudonyms:

1. Barriers: knocking on doors with no answer.
2. Hopelessness: “You are actually being judged, not assessed for adoption”.
3. Difficult staff: social workers’ lack of knowledge and sense of fear.
4. Unbridled joy: the reality of becoming an adoptive parent.

The themes describe the uniqueness of the lived experiences of PLWHIV trying to access adoption services. The first theme starts off with the initial experiences of hitting your head against a brick wall and being faced with such incredible reactions that adoption would be futile due to their diagnosis. A state of hopelessness ensues in the second theme illustrating how participants felt negatively judged for being HIV positive rather than being assessed for being an adoptive parent. These reactions were further complicated by social workers’ lack of knowledge and understanding of PLWHIV. Finally, the last theme highlights the sheer joy and exultation of those who succeeded in becoming adoptive parents.

Findings

Barriers: knocking on doors with no answer. Participants engaged and endured through what appeared to be adoption procedures that were complex to break through. A number of sub-themes were identified such as inaccessible services, stigma, and discrimination. Thus, the theme “Barriers: Knocking on doors with no answer” reflects the battle to achieve a social status of parenthood.

For Gary, commencing the process of applying to become an adoptive parent was difficult due to the lack of information and resources:

No one gave me information. The process is not an easy one. It is not as easy as ABC. You don’t know where to start, you don’t know who to go to, and you don’t know who to contact or talk to. When I saw the advert from XXX, I decided to contact them. I spoke to a man. He did not give me any other advice. I called again, and another person gave me the details of another team. They referred me to an open event, but when I went there, they were not very helpful. (Gary)
Gary identified challenges centred on access to information. His experience alludes to the lack of information, support and guidance as barriers to instigating the adoption process. Others like Hillary and Gabrielle report making enquiries but receiving no response:

Right from the beginning, I rang XXX and XXX Local Authority, and I could not get hold of them. I sent emails explaining my situation asking to make an application to adopt, but no one returned my emails. They were a terrible adoption service. They did not return my emails or my telephone calls. (Hillary)

The social worker asked us if we wanted some help with understanding adoption and how it works. She said she would give us information about adoption preparatory training programmes, but no one got back to us. It was very unpleasant; they could have communicated better. (Gabrielle)

Poor responses from agencies and lack of communication about various methods that facilitate the adoption process contributed to additional barriers preventing participants from accessing or navigating through adoption services. The lack of communication by adoption staff/teams was associated with incompetence:

They just didn’t communicate. I think it’s just a lack of competence; it’s not just my experience, it’s people from XXX, and from work who say it. It becomes a joke. It should actually not be a joke; it’s quite serious […] I can’t understand why. (Alan)

Poor communication was associated with insensitive practice and lack of competence around interpersonal skills. It would appear that better relational skills were anticipated.

Additionally, others thought that challenges around access to adoption were associated with HIV disclosure. For example:

I told them everything. I disclosed everything about our circumstances. We thought it is better to be upfront from the beginning. But, no, I was not very impressed. They never got back to me […] It was an appalling adoption service. In this day and age, you would not think that there is still such negative attitudes about HIV. (Hillary)

They asked about my health. I said, be my guest. I told them about my HIV and my mental health. After that, no one got back to me. (Gary)

The above excerpts represent a willingness to be open and transparent about one’s sero-status when seeking to adopt. Hillary and Gary thought that, by disclosing that they were HIV positive from the beginning, they would be respected for being open and honest, thus enhancing their chances to be considered. However, from their perspective, when they disclosed, they were not offered further opportunities to access information, advice or support. Thus, disclosure resulted in a state of being stigmatised and a feeling of hopelessness.

Hopelessness: “You are actually being judged, not assessed for adoption”. HIV disclosure was considered a prerequisite in the adoption process but a difficult thing to undertake, with participants showing a level of fear. Fear of disclosure was associated with internalised stigma, anxieties and doubts about possible discriminatory practices. The central thread within this theme is the notion that, following disclosure, participants were being constantly judged for being HIV positive and not being adequately assessed for their competency for parenthood. Common experiences are typified below:

I was really nervous. I was concerned about stigma because we came across this with social services. We had heard people talk about this in the support group. I was concerned about stigma. Actually, very quickly it became quite apparent they were not interested. There was nothing I could have done, but I just had to continue trying. (Alan)

It is not easy to disclose. When you disclose you hope to be treated fairly with the illness. From the beginning, each time we emailed or telephoned a local authority, we told them about the HIV. It’s better than doing it at a later stage. At least they will know that fact from the beginning […] When you disclose, it seems they think you are not fit to look after a child or something. (Hillary)

Worry about reliving negative attitudes and HIV-related social stigma are evident here and these influenced disclosures with hope to be accepted in the system. However, fear of professional prejudice reportedly became a reality that was interpreted as a lack of interest.
The adoption assessment process was perceived as unnatural and biased because decisions were made following a short interview process:

This woman who had met me for only 90 minutes, judged aspects of my life. Because I spent a lot of time with my grandfather and had regular contact with my father, she [...] said that there had been no emotional connection between us. They say you are being assessed, but you are actually being judged. I think they are making judgements about you, from there and that point on. I think any adopter feels that. That’s how it is. (Alan)

Alan suggests that adoption assessments may involve prejudices and subjective judgements. Sometimes, the interviewing process involved a construction of misconceptions that resulted in unfavourable conclusions that undermine the life experience of a prospective adopter and ultimately one’s adoption assessment. For Gary, judgemental attitudes commenced at the initial contact with adoption teams:

You ring for the first time, you go for the information evening, and you have your initial meeting with the social worker. You talk about HIV. From that point, you are being judged. I said that’s fine, but you are making a judgement on HIV, not on anything else. I said you are in no position to make that judgement. That is your own ignorance. (Gary)

Gary rationalises that focusing on HIV could result in prejudice and missing a holistic and true picture of potential adopters’ capabilities. For Hillary, social work training does not appear to eliminate prejudice:

I have been shocked by the attitude and prejudices that social workers have against HIV-positive people. It’s appalling, it really is. No matter how much training you do as social workers, people still have prejudices and feelings. You know, people with HIV will always feel this. (Hillary)

It seems those applying for adoption felt that social workers were making a judgement about their HIV and not their ability to adopt, to parent children, or their ability to provide a safe and loving environment for a child. Participants were vague about whether social workers were certain that HIV had an impact on their ability to adopt or parent children. They wanted social workers to appreciate their strengths as individuals:

I have the knowledge. I have the know-how. I want to change things for the better. I am a very placid person. I am in control of the situation. I am a fighter. The discrimination I am going through is just not good. It is the children who suffer at the end of the day. (Gary)

Further negative views were reported about sexual orientation:

The agency that I first approached this year was like because you are a [...] (sigh [...] deep breaths) single gay male, we don’t think you have the emotional intelligence or the network to adopt a child. They forget who you are. (Alan)

The above demonstrates stereotypical judgements based on sexual orientation and heterosexism. Alan was trying to adopt as a single homosexual male and a middle-class professional with a stable job. He refers to his professional status, as a head teacher when he pronounced a concern around how social workers may forget “who you are”. It appears that premature judgements and multiple discrimination (HIV and/or sexual orientation) were perceived as the cause to decline an application to become an adoptive parent. HIV and homosexuality, for Alan, resulted in double stigma and double discrimination. Participants felt a sense of misjudgement, helplessness, and being undervalued due to a lack of knowledge of HIV.

Difficult staff: social workers’ lack of knowledge and sense of fear. Some participants reported that social workers attempted to sway them from the adoption process:

When we told them about the HIV, they did not say directly we could not adopt, they said to me, yes, you can adopt, but it will not be very easy, so you need to contact us. That was it. I contacted them, but they never responded. (Hillary)

The excerpt above depicts discouragement and what was construed as indirect discrimination from pursuing adoption. Paradoxically, disclosure was seen as a barrier as opposed to a gateway for trust and opportunity:

I was really offended by the letter they wrote to me when they looked at my application. The key issues in the letter were: you might not live longer to have a child; basically, that’s what it was saying. I was
like, how can you say that. You have not contacted my HIV consultant or my GP. How can you say that? I was absolutely angry. (Alan)

Alan’s experiences depict negative stereotypes and judgements arising from social workers, seemingly created before any formal investigations, or health assessments were undertaken to confirm any diagnosis and prognosis.

Hillary felt a sense of forced helplessness:

It felt like no one was seeing him as an individual. They didn’t even see us as a couple, and my status [negative] didn’t matter but his HIV status. They didn’t take into account why we applied for adoption in the first place, all they could see is HIV. Because of the disclosure, they simply think there is no need for further medical checks and not even to consult me, yet we could have taken a chance to have our own baby if we wanted to. It’s just wrong. (Hillary and Marius)

The absence of consultation with medical professionals, usually dominant within the realms of inter-professional working within the adoption process, suggests a level of bias and judgemental practices that are potentially associated with discriminatory practice. From the above excerpts, disclosure may not prevent gatekeeping, stigmatising attitudes or resistance to accept PLWHIV within the adoption system for sero-discordant couples.

It was apparent that a lack of professional experience came in the way of sensitive practice. A typical example is drawn from Gabriella and Bred:

Especially at the hands of a newly qualified staff, a twenty-five-year old social worker who was himself new to adoption services, whose only qualifications were basic level, it becomes very difficult to change the mind-set of young people who may not have experience with HIV and with no real life experience of snubbing (humiliation or degradation). (Gabriella and Bred)

From this, a relationship between inexperience and incompetence is suggested. There is an inference that, for social workers to understand discrimination, they need to go through experiences of being humiliated in their personal life.

It appears that risk aversion was associated with discriminating against with fear of making mistakes, as illustrated below:

What I was told was that they sat on the fence and they would not advise one way or the other. I think this is generally true for doctors, but maybe I’m wrong. They are very risk averse are they not? They will not put anything in black and white unless they are sure they can back it up. (Alan)

I think they were just over-cautious, that is the problem, and this leads to many people feeling prejudiced against especially when they are not clear of the ins and outs of HIV. (Hillary and Marius)

Moreover, over-cautiousness or inconclusive decisions by social workers led to some participants feeling discriminated against:

Social Services rang me up, and they said, based on their medical advisor, we are not clear on what your life prognosis is. Therefore, we are finding it very difficult to decide whether we should go forward or not. I could not accept that the medical advisor for the panel could not make the decision one way or the other. They just sat on the fence. In the end, I could not go through with the adoption. (Alan)

Furthermore, when Hillary and Marius expressed an interest in adopting a child, their interest was declined. Hillary and Marius noted a disparity between the views of health professionals acting for adoption systems and those of specialist HIV consultants. A typical example is drawn from Hillary:

They refused to accept our request for an assessment, and they did not give us the reason for this. When we challenged them, they said, this has nothing to do with HIV. I was like, why are you saying you are concerned about whether adoptive children may be affected long term by Marius’ health [HIV+]? if it has nothing to do with HIV (laugh)? You know what I mean (emphasis). (Hillary and Marius)

These suggest that the disparities between specialist HIV opinions and adoption medical advisors are likely to heighten anxieties and uncertainties regarding the adoption process because of potential discrimination that occurs due to inconsistency and the absence of a shared understanding or fear of moral hazards (placing children for adoption with those morally seen as unsuitable). This relates to HIV-related cautionary practice and reductionism by disconnecting HIV from the body of PLWHIV, even though the reality is that the body and the HIV are inseparable.
When faced with stigma and discrimination that prevented them from accessing adoption services, some participants started looking for adoption services outside their geographical location of residence. A typical representation of this experience is suggested here:

When I started the process, they told me they could not continue with my assessment. I was thinking I have spent 6 months already. So now, I have to do it all over again. So I started the process all over again with another agency. I had to fight my way through it again, they assessed me in the end. (Alan)

Frustration and despair associated with repeated efforts of contacting adoption services, undergoing screening procedures and being rejected are noted in the above extract. Although this maximised hope and chances to adopt, social workers were seen as powerful agents:

The trouble is that if you want to adopt, the power is in the social workers’ hands. (Hillary)

In that regard, Gary felt, if one fails to fight for what they believe in, that would only be an instrument for prolonged pain and suffering:

Adoption is a process that ummh (silence) that is not inclusive. It does not welcome people in circumstances such as mine. They say that’s what they want to do, but it doesn’t. The pain I experienced through HIV, the mental health, the anguish and traumas I experienced were too much for me. It was like putting the iron on the fire to sort of reshape and make it a shape you want to make it.

I am a fighter, so I will continue fighting until I have a child. (Gary)

Recounting historical traumas, for Gary, reaffirmed resilience, recreating self-identity, social identity and a sense of control over HIV-related marginalisation. To regain a sense of purpose, fighting was associated with challenging and making formal complaints about negative adoption decisions:

We have told them [Local Authority] a few times that we don’t think that is right that they ignore us on and after we disclosed HIV. We had to challenge them. (Hillary and Marius)

Challenging discrimination implied seeking fair consideration and to be heard.

Unbridled joy: the reality of becoming an adoptive parent. This section explores feelings that relate to participants who had successfully adopted children. Participants articulated the difference between adoptive parenting and biological parenting. Alan found it “abstract” to be an approved adoptive parent when his adoptive son was not yet physically placed in his care. The matching was already completed and the adoption order agreed, but Alan was waiting for the transition plan to commence:

It is funny really. I think it is hard for adoption to be real when it is like this. You are not pregnant. It is part of child development is it not? When a woman is pregnant and having a baby, it is true that there is a physical presence that you don’t have. It is, it is really weird because, you don’t have, and there is nothing physical. There are no scans, so it becomes abstract again. You get all these moments, all these pikes and spikes of concrete, kind of, wow, this is really happening and all of a sudden aww, nothing, nothing is really happening, you know (frustration, helplessness). (Alan)

The absence of carrying a pregnancy and experiencing labour implied that adoption is unnatural given the absence of the physical closeness with the foetus that is embodied during pregnancy. However, waiting for the adopted child to be placed in his care was emotionally challenging:

It is emotionally challenging because, this whole issue of being a single parent anyway, and you think what that entails really. My anxieties are around his disability. He needs a routine. He has already had a number of foster carers. With another change of parents and coming to a new house, he will find it difficult to express his emotions. For me, it is the whole idea of getting him settled, he may be challenging, but I don’t know. The exciting bit is building that relationship. That is the bit that you want isn’t it? (Alan)

Alan’s account represents mixed feelings associated with the evolution of adoptive families. The desire to form positive relationships with his child; to ensure emotional and behavioural development is framed, but fear of how the child’s development would turn out was linked with the child’s unstable foster care arrangements and pre-existing childhood experiences. The successes of adopting as a gay man were celebrated:

The joy is quite immense despite difficulties; it is absolute because gay men have fought for it, haven’t they? All the generations, they have fought for equal rights in terms of homosexuality; and age of consent. There are a lot of things that have gone on. (Alan)
Alan rationalises the ideological difficulties linked to homosexual parenthood but celebrates the benefits of fair treatment without prejudice within the adoption system.

Hillary and Marius, as well as Jenny and Dean, were successful heterosexual adopters. Their children had already been placed in their care, and they had reportedly settled well with them. Their excerpts reflect their perceptions and experiences after adoption:

The children have attached to us, and we are really, really lucky. We were hugely lucky that they had one attachment with the foster carer. It was good attachment, but they can easily attach to us. We have been really lucky with how the girls have settled and how the process went. We did not have any issues really. (Hillary and Marius)

They are now our children you know. Although we adopted both of them, they have a strong attachment with each other and us. The whole problem with HIV and my cancer is that it prevented me from having my own children but that no longer matters really. They are both our own. (Jenny and Dean)

The above extracts suggest that adoption provides opportunities to create positive attachments with non-biological children, who become ones’ own with a personal sense of conquering infertility-facilitated power and control within a new life of adoptive parenthood. In that, the assessment process needed to be good enough:

Even though you are looking after someone else’s child, at the end of the day, we knew we had to have a good assessment. It was all worth it because the girls are such a joy. The day the social workers brought them to us, we sat there, and we were so happy, and we thought what do we do to make them so happy? (Hillary and Marius)

For Hillary and Marius, a thorough and sensitive assessment may facilitate positive experiences and success, and furthermore generate satisfaction and happiness for the adoptive child. The claim that it is “someone else’s child at the end of the day”, suggests that the embodiment of infertility is permanent and remembered even when adoption is successful. Ultimately, adoption is seen as a commitment:

No disrespect to birth parents at all but you know, the commitment and dedication is quite a lot. I think it is because of the fight against challenges involved […] There is an understanding that people like me who have gone for adoption, I think […] it is quite a powerful thing when you think about it. That is a lot to be in a thankful position. It is very good. (Alan)

The above excerpt depicts that successfully adopting children provides liberation and a real sense of accomplishment.

In summary, the four themes presented paint a picture of strife and huge emotional struggles for PLWHIV on their journey for adoption, filled with stigma and discrimination and, for some, immense joy on being successful. Adoption can be associated with various experiences, but possible.

Discussion

Our findings expand on what we know of PLWHIV struggling with the systems that control the process of adoption; the experiences highlight their reactions and responses that are linked to infertility and health-related loss. Participants in our study were feeling ready to adopt. Their resilience allowed them to fight through various challenges and tensions associated with the desire to achieve adoptive parenthood while living with HIV, an illness that they did not find readily accepted within the adoption system.

Congruent with other studies, stigma and discrimination persist within interventions available for PLWHIV to achieve parenthood (Peak et al., 2012). Unique to this study are findings whereby the disclosure of HIV status during various stages of adoption assessments could result in PLWHIV feeling that they are being denied adoption services, assessments and that they are receiving little support.

Achieving parenthood is dependent on practitioners and decision makers’ subjective assessments and creates inconsistency around how adoption assessments are undertaken. This study suggests that differences in adoption practice within different agencies may result in some PLWHIV approaching different agencies and being subjected to high levels of scrutiny but
receiving every consideration and assessment outcomes. From participants’ perspectives, the adoption assessment is underpinned by complex procedures and legitimate power located within a social, procedural, political and organisational context that may create uncertainty and powerlessness (Underhill et al., 2016). Thus, in many ways, the challenges and stressors PLWHIV experienced would be similar to other prospective adopters. However, PLWHIV continue to be vulnerable to organisational stigma, which could result in oppression and discrimination. Therefore, sensitive strength-based assessments are necessary towards producing positive experiences and outcomes that remain grounded in best interests principles.

Professional insensitivity was associated with frustration, discrimination and was less supported. Nevertheless, positive experiences demonstrate that social workers can provide sensitive adoption services to PLWHIV. While this provides reassurance about the nature of some adoption services, there is a need for universal practice regarding how PLWHIV are assessed. While practices associated with power structures and gatekeeping may be grounded within subjective professional assessments, these may be difficult to combat (Underhill et al., 2016). If adoption social workers acknowledge the structural complexities within which social work practice is placed, then they will be able to share empathy and tolerance in their practice.

Limitations
This is a small qualitative study in a very important subject that has received very little attention from researchers. The findings and implications have strong relevance for the setting in which the study was conducted. Because of the ideographic nature of this IPA study, the findings cannot be generalised to the wider population. However, these results provide particular and detailed individual experiences that allowed the research to become closely connected to aspects of their shared experiences and humanity (Smith, 2004). The study, therefore, provides an understanding of how PLWHIV have lived through and experienced the adoption process in some parts of the UK.

Implications for practice
Based on the literature supporting this study, PLWHIV have a right to parent and a right to adopt. On the other hand, adoption serves to protect vulnerable children. Thus, in regards to best interests principles, this study calls for accessible adoption services. Enhancing awareness of the modern definition of HIV will promote anti-discriminatory and anti-oppressive practices. A framework of transparency in adoption assessments for PLWHIV and multi-disciplinary training will raise awareness and remove barriers that sometimes prevent PLWHIV from successfully adopting children. Figure 1 shows a framework that will help adoption social workers to understand the HIV context with an open mind and a non-discriminatory approach. This framework will support standard government and organisational procedures for assessing prospective adopters. It promotes inclusive practice, best interests principles and parenting suitability, all of which remain pertinent and form the “foundation” for assessments.

We also recommend the framework developed by the lead author in this paper, Chipawe Cane (2017). Her framework for understanding intersectional stigmas associated with PLWHIV seeking to adopt helps adoption social workers to illuminate intersecting factors affecting PLWHIV at micro, meso, and macro levels as they come through adoption systems. Chipawe Cane’s framework encourages social workers to strengthen their approach when working with PLWHIV by applying social work values, principles, rights and cultural competence, as this promotes sensitive practices and creates increased opportunities for those seeking to adopt.

Conclusion
The study provides valuable insight into the experiences of PLWHIV trying to adopt children, demonstrating successful adoptive experiences and practical challenges. Based on PLWHIV’s experiences, this study suggests that there are inconsistencies in adoption practices, which may
lead to various experiences. These inconsistencies stem from attitudes and unchanged historic views and perceptions about HIV. The research emphasises the need for continuous efforts around inclusive practices and empowering PLWHIV to adopt children if they are considered competent to do so, in the same manner as prospective adopters in the wider population.

**Implications of the research for policy and practice**

The need to sensitively assess PLWHIV needs to be included in existing adoption assessment frameworks. This will directly promote inclusivity.

**References**


Further reading


About the authors

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Help Me Grow Utah and the impact on family protective factors development

Karen D. Hill and Brian J. Hill

Abstract

Purpose – The purpose of this paper is to examine the development of family protective factors in participants of Help Me Grow Utah (HMGU), a community-based system that promotes child development, seeks early detection of developmental delays, and links families to services.

Design/methodology/approach – In this paper, standard quasi-experimental survey design was utilized. HMGU and control group participants completed the FRIENDS Protective Factors Survey, which was slightly modified into a retrospective pre-test and post-test format to address previous survey concerns of response-shift bias, self-serving assessments, and family maturation. Participants were asked to respond to ten questions at present and then again from the perspective of two years previous.

Findings – Participants in HMGU had statistically significant increases in protective factor scores in all but one subscale, with dramatic increases in two subscale questions on knowledge of parenting and child development. Control group scores statistically increased in four subscales, albeit at lower rates than HMGU participants. Interestingly, control group scores on two subscale questions relating to child maltreatment risk were significantly lower on post-tests as compared to their retrospective pre-test scores.

Research limitations/implications – Participants in HMGU clearly increased in the development of protective factors. Replication of this study is recommended and the need for a control group in protective factor studies is imperative.

Practical implications – Findings from this study suggest that child services focused on enhancing knowledge of parenting and child development might also expect to improve protective factors. One-on-one care coordination with families seems particularly effective. The findings might also benefit other social programs as they utilize retrospective pre-test, post-test, and control groups in their evaluations.

Originality/value – HMGU is the first affiliate to utilize retrospective pre-test/post-test methodology, which can overcome confounding results attributable to response-shift bias. Also, the use of a control group affords inclusion of natural maturation in considering findings.

Keywords Child maltreatment, FRIENDS National Center for Community-based Child Abuse Prevention, Help Me Grow, Protective factors, Response-shift bias, Retrospective pre-test

Paper type Research paper

Background

Scientific research provides much evidence that the foundation for an individual’s intellectual, emotional, social, and moral development is primarily developed during early childhood (Brazelton and Greenspan, 2000; National Scientific Council on the Developing Child, 2010; Shonkoff, 2009; Thompson, 2001). Optimal child development is more likely to occur in resilient families (Patterson, 2002a, b; Walsh, 2015) that exhibit conditions or attributes that mitigate or eliminate risk, termed “protective factors.” Social scientists observe that when protective factors are present and robust in a family, the occurrence of child abuse and neglect are likely reduced (Brown et al., 1998), family resilience is strong (Benzies and Mychasiuk, 2009), and optimal child development is likely to occur (Weissberg et al., 2003). Parents who exhibit resilience, have a network of support, and have a working knowledge of parenting and child development offer their child the best opportunity for optimal development and the best chance to avoid maltreatment (Horton, 2003). In contrast, development can be negatively impacted when caregivers fail to provide a healthy home environment or expose a child to adverse experiences.

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Adverse childhood experiences have been linked with over 20 long-term chronic health and relationship problems such as alcoholism, depression, intimate partner violence, unintended pregnancies, illicit drug use, and poor academic achievement (Felitti et al., 1998; Child Trends Data Bank, 2014; Longitudinal Study on Child Abuse and Neglect, n.d.; National Data Archive on Child Abuse and Neglect, 1996-2014). Various social programs and systems throughout the country seek to assist families in developing protective factors to enhance child development and reduce child maltreatment (Haggerty et al., 2013). One such system is Help Me Grow (HMG). This study examines the impact of one HMG affiliate, Help Me Grow Utah (HMGU), on the development of protective factors.

Historically, social programs sought to reduce child maltreatment after an incident occurred and to reduce the likelihood of recurrence. In 2003, the US Department of Health and Human Services (DHHS) launched a Child Abuse Prevention Initiative and the field of child maltreatment shifted from a sole focus on intervention to the development of a framework focused on prevention and greater visibility (Thomas et al., 2001). The new framework sought to maximize potential, capitalize on the strengths of parents and communities to promote well-being, and strengthen protective factors (Stagner and Lansing, 2009; Paxson and Haskins, 2009). The DHHS also recognizes that future innovation and development and further evaluation will inform practices to increase well-being across the life-span (Haggerty et al., 2013).

The development of protective factors within this framework originated from a large body of research on family resilience and coping in the face of high risk (Patterson, 2002a, b; Walsh, 2015). Through the years, extensive lists of protective factors were identified (Luthar, 2006; Thomas et al., 2001; Benzies and Mychasiuk, 2009). As part of a two-year study starting in 2001, the Center for the Study of Social Policy (CSSP) initiated a literature review and dialogue sessions with over 300 participants to help define protective factors and discover what was known about building them. From this work, the Strengthening Families Protective Factors Framework™ initiative was formulated and protective factors for families were distilled into the following categories (www.cssp.org/reform/strengthening-families/resources/body/LiteratureReview.pdf).

- Parental resilience: managing both general life and parenting stress and functioning well when faced with stressors, challenges, or adversity; the outcome is positive change and growth.
- Social connections: having healthy, sustained relationships with people, institutions, the community, or a force greater than oneself.
- Knowledge of parenting and child development: understanding the unique aspects of child development; implementing developmentally and contextually appropriate best parenting practices.
- Concrete support in times of need: identifying, seeking, accessing, advocating for, and receiving needed adult, child, and family services; receiving a quality of service designed to preserve parents’ dignity and promote healthy development, and social and emotional competence of children.
- Social and emotional competence of children: providing an environment and experiences that enable the child to form close and secure adult and peer relationships, and to experience, regulate, and express emotions.

**HMG**

HMG is an innovative community-based system that promotes child development, seeks early detection of developmental delays, and links families to services. It does not provide direct services to families but seeks to improve access to services in order to facilitate healthy child development (Help Me Grow National Center, n.d., 2013). The HMG model calls for each affiliate to offer a single point of access (generally a call center) and a care coordinator for each family. The care coordinator links families with appropriate resources within the HMG inventory of services and then follows-through with the family, offering additional services as needed. In addition, HMG seeks to educate and train health care professionals, childcare providers, and parents concerning early detection of developmental delays and strategies for optimal child development (Dworkin, 2006).
The services, education, and training offered by HMG facilitate many of the components utilized in building protective factors (Help Me Grow National Center, 2013).

The creation of HMG began in 1998 by concerned child health professionals in Connecticut who responded to social science research findings that early detection of at-risk children provided the best chance for optimal outcomes (Chamberlin, 1992) and families dealing with multiple challenges were often overwhelmed and unable to identify and negotiate the process to contact and connect with needed services (King et al., 2001; Sloper and Berestofd, 2006). Consequently, families were at risk of receiving inadequate or incomplete services (Halfon et al., 2007). Through the demonstrated success of the program in Connecticut, funding was secured to replicate HMG systems in ten additional states over three years as well as establish a national center. HMGU was among the early adopters, beginning with a pilot program in one county in 2010 and expanding statewide in 2015. In early 2017, a total of 28 states offered or were in the process of implementing the HMG system, which generally serves families with children ages 0-8 (Help Me Grow National Center, n.d.).

Early efforts were made by HMGU to measure the development of protective factors in the families they served and to evaluate system effectiveness. The findings, however, resulted in confounding results (B. Leavitt, personal communication, February 15, 2015). Traditional pre- and post-surveys failed to reflect what HMGU staff heard from their clients. Consequently, HMGU initiated this specific research project that utilizes a retrospective pre-test and post-test (RPT) questionnaire to more closely examine the impact on families engaged with their services and the development of family protective factors.

Protective factors research

In past years, numerous instruments were designed to measure an individual protective factor (The Institute for Education Research and Public Service at the University of Kansas, 2008). The FRIENDS National Resource Center for Community-based Child Abuse Prevention (a service of the US DHHS), however, collaborated with many other experts to design and extensively field test a survey instrument to assess multiple protective factors to prevent child abuse and neglect. Field testing included administering the protective factor survey instrument to nearly 300 individual participants from 15 agencies over two timeframes (The Institute for Education Research and Public Service at the University Kansas, 2008). Individual participants completed the surveys; however, the instrument was not intended for assessment, placement, or diagnostic purposes for an individual or for a family; rather, collective survey responses are intended to provide agencies with feedback on continuous improvement and evaluation of their programs and services.

Around the same time in 2007, the CSSP launched the Strengthening Families initiative, which is primarily guided by their slightly modified Protective Factors Framework (Center for the Study of Social Policy, 2014). The CSSP initiative aimed to develop self-assessment tools for providers that lead to program best practices supporting families and children and has also been used to measure change in families (Harnar and Tarr, 2013).

Help Me Grow National, its affiliates, and the CSSP use protective factors survey results to support claims that accessing community-based resources through HMG enhances family protective factors (Harnar and Tarr, 2013; Hughes et al., 2012). According to the HMG National Center, these survey reports included multiple limitations including small response rates, small sample sizes, a lack of random sampling, incomplete administration of the surveys, missing data, possible biases, and the absence of control groups (P. Dworkin, personal communication, February 11, 2016). This study initiated by HMGU sought to mediate some of these limitations. A retrospective pre-test and a post-test (Colosi and Dunifon, 2006) were used to address issues related to response-shift bias (Howard, 1980) and self-serving assessments (Epley and Dunning, 2000) problematic in former research on HMG.

Methods

Standard quasi-experimental survey design was utilized for this study. To address response-shift bias as well as family maturation, RPT questionnaires were used for both HMGU participants and
a control group. HMGU participants were determined from the program client database and a comparable panel of families was purchased from Qualtrics. The primary research instrument was the FRIENDS Protective Factors Survey (The Institute for Education Research and Public Service at the University of Kansas, 2008). The analysis plan included descriptive statistics and paired sample t-tests between pre- and post-test scores and independent sample t-tests between the HMGU group and the control group on each of the protective factor subscales and individual items as recommended by FRIENDS.

The FRIENDS National Resource Center for Community-based Child Abuse Prevention (a service of the US DHHS) survey instrument was chosen for this project because it was developed and tested using standard measurement processes including checks for validity and reliability (The Institute for Education Research and Public Service at the University of Kansas, 2008). The FRIENDS programs and systems include “nurturing and attachment” in the list of protective factors. The CSSP, however, considers nurturing and attachment as an implicit component of the five protective factors and does not include it separately (Browne, 2014). Table I compares the protective factors used by each organization.

### Participants

HMGU participants were English speakers, had a program start date between January 1, 2013, and May 28, 2015, completed at least one developmental questionnaire for a child, and were connected to at least one community resource. E-mails were sent to 125 randomly chosen qualifying HMGU clients inviting them to participate. A $20 gift card was offered to the first 60 respondents.

The control panel was purchased from Qualtrics, a privately held data collection software company headquartered in Provo, Utah and Seattle, Washington. Most samples come from traditional, actively managed market research panels that maintain a wide variety of personal profiles including psycho-demographics. Criteria for this study were submitted to Qualtrics and qualifying respondents were sent an e-mail invitation informing them that the survey is for research purposes only, how long the survey will take, and what incentives are available. Details about the contents of the survey are not revealed to avoid self-selection bias. Incentives may include cash, airline miles, gift cards, redeemable points, sweepstakes entrance, or vouchers. Participant histories are monitored to avoid over contact of panel members.

The control panel for this study consisted of 60 families in Salt Lake and Utah Counties with at least one child age two to five during the period under investigation. To reduce hurried strategic response, control group panelists with response times less than half the average were eliminated from consideration. As the Utah population (and in particular Utah County) has a high rate of members of The Church of Jesus Christ of Latter-day Saints who hold strong family values, religious affiliation was included in the questionnaire and as a control in the analysis.

Table II details the demographic comparison between HMGU participants and the control group. The two groups are similar, but not identical. Using independent sample t-tests to compare the pre-tests of both groups among the protective factor variables, three variables had means statistically different, $p < 0.05$. In the nurturing and attachment subscale, the item I don’t know

### Table I  Protective factors comparison

<table>
<thead>
<tr>
<th>CSSP protective factors</th>
<th>FRIENDS Protective Factor Survey</th>
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<tr>
<td>Parental resilience</td>
<td>Family functioning/resilience</td>
</tr>
<tr>
<td>Social connections</td>
<td>Social support</td>
</tr>
<tr>
<td>Knowledge of parenting/child development</td>
<td>(Subset questions developed)</td>
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<tr>
<td>Concrete support in times of need</td>
<td>Concrete support</td>
</tr>
<tr>
<td>Social and emotional competence of children</td>
<td>(Not included)</td>
</tr>
<tr>
<td>(Not included)</td>
<td>Nurturing and attachment</td>
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what to do as a parent, and the item When I discipline my child, I lose control were slightly higher for the control group than HMGU participants. Logically, HMGU participants would perceive a deficit in these areas and therefore seek the resources available through HMGU.

Instrumentation

The FRIENDS Protective Factors Survey was utilized in this HMGU study. Participants were asked to score 20 questions about their family using a seven-point frequency or agreement scale. The survey questions addressed family functioning/resiliency, social support, concrete support, nurturing and attachment and child development/knowledge of parenting, and were drawn from the Protective Factors Survey developed by the FRIENDS National Resource Center. Subscales were calculated by averaging the items in each subscale, so the range of scores was 1-7 for all subscales and individual items. Cronbach’s $\alpha$ coefficients were family functioning/resiliency, $\alpha = 0.89$, social support, $\alpha = 0.89$, concrete support, $\alpha = 0.76$, and nurturing and attachment, $\alpha = 0.81$. The child development and knowledge of parenting subscale consisted of five questions, which were each scored separately. The FRIENDS Protective Factors Manual recommended no calculation of a subscale score because of the nature of the items.

In order to minimize the effects of both response-shift bias and self-serving assessment in this study, RPT survey methods were used. HMGU survey participants were asked to respond to the questions while thinking of their family at the time before they were involved with HMG and then immediately mark a response to the same question according to how they felt at present, after being involved with HMG. The control panel was asked to do a similar retrospective pre- and post-survey although their questions were altered to mark the scale while thinking back about two years ago and then again at present.

Surveys were carefully scored using the Protective Factors Survey User Manual instructions (The Protective Factors Survey User Manual, 2008). T-test analyses were conducted with $p < 0.05$ being considered statistically significant. The percentage changes in RPT scores were calculated for each subscale and each question in the child development and knowledge of parenting section for both participant groups.

Findings

Data analyses revealed the differences between HMGU participants and a control group for protective factors change. RPT scores on protective factors subscales and items demonstrated some changes over time for both groups. These results are presented in Table III. No statistically significant differences were found associated with religious affiliation or other demographic variables.

Findings from independent t-tests comparing the change in scores between HMGU participants and the control panel showed significant differences ($p < 0.05$) in several areas. Larger positive changes in protective factor scores for HMGU participants were noted in the area of nurturing and attachment, and four of the child development/knowledge of parenting items, namely, “I don’t know what to do as a parent,” “I know how to help child my child learn,” “My child misbehaves to upset me,” and “When I discipline my child, I lose control.” Over the survey time period, control

<table>
<thead>
<tr>
<th>Table II</th>
<th>Participant demographics</th>
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<tbody>
<tr>
<td>Help Me Grow Utah participants</td>
<td>Control group</td>
</tr>
<tr>
<td>Number of respondents</td>
<td>63</td>
</tr>
<tr>
<td>Gender</td>
<td>95% female</td>
</tr>
<tr>
<td>Marital status</td>
<td>94% married</td>
</tr>
<tr>
<td>Average number of children ages 0-5</td>
<td>1.7</td>
</tr>
<tr>
<td>Religious affiliation</td>
<td>77.8% Latter-day Saint</td>
</tr>
<tr>
<td>Religious affiliation</td>
<td>22.2% other or no religion</td>
</tr>
</tbody>
</table>
group scores worsened slightly for “My child misbehaves to upset me” and “When I discipline my child, I lose control” while the scores improved significantly for the HMGU participants in those areas. The findings are fully presented in the far right column of Table III.

The HMGU participants showed statistically significant positive changes from the retrospective pre-test scores to their post-test scores in the areas of family functioning/resiliency (11 percent change), social support (11.3 percent change), nurturing and attachment (7.8 percent change), and in all five of the subset questions for child development/knowledge of parenting. The changes indicated in the subset questions were: There are many times I don’t know what to do as a parent (32.0 percent change), I know how to help my child learn (22.8 percent change), My child misbehaves just to upset me (6.0 percent change), and When I discipline my child, I lose control (reverse coded, 8.1 percent change). The only area for HMGU participants with no statistically significant change from RPT scores was concrete support. Table III presents pre-test and post-test mean and standard deviation, the change and percentage change, and paired t-test significance statistics.

The control group showed statistically significant positive changes from the retrospective pre-test scores to the post-test scores in the area of family functioning/resiliency (9.0 percent change) and social support (5.7 percent change) and in two of the five subset questions for knowledge of parenting and child development, namely I know how to help my child learn (6.1 percent change), and I praise my child when he/she behaves well (4.6 percent change). The control group pre-test and post-test mean and standard deviation, the change and percentage change, and paired t-test significance statistics are also presented in Table III.

**Discussion**

The results of this study provide several meaningful applications for HMG programs and other social program evaluators. First, participants in HMGU clearly increased their protective factor scores. Second, one way to overcome the common confounding results of response-shift bias may be with a retrospective pre-test/post-test methodology. Third, in this study, having a control group confidently relates the positive change to HMGU.

Participants in HMGU increased their protective factor scores on all but one subscale. Every item of the child development/knowledge of parenting area showed marked improvements.
These statistically significant changes ranged from 5.2 to 32 percent. The largest changes came in the areas of knowing what to do as a parent (22.8 percent) and knowing how to help children learn (32.0 percent). In 2015, nearly 88 percent of the services for children provided by HMGU were providing information about child development and parenting (Hill and Hill, 2015). Parents who voluntarily contact HMGU demonstrate an eagerness to learn better parenting skills or are anxious to seek professional help for a child; therefore, an increase in protective factor scores is not surprising. A part of HMGU’s direct mission and operation and program effectiveness is in delivering this knowledge and support to parents. The improvements in items related to potential abuse (believing a child misbehaves to upset parents and struggling with discipline while losing self-control) are also particularly noteworthy. It is gratifying to see that HMGU is impacting protective factors with direct bearing on child abuse.

During the same two-year time period as the HMGU participants, the control group showed significant positive change in several protective factor variables. They improved in family functioning and resiliency by 9.0 percent, social support by 5.7 percent, knowing how to help my child learn by 6.1 percent, and believing my child misbehaves just to upset me by 4.6 percent. Control group results indicate that a natural maturation of families occurs over time including the development of some protective factors. In comparison, HMGU participants improved with higher rates than the control group. In other words, family change can be positive over time, but social programs such as HMG can augment those natural improvements.

It is interesting to note that the protective factor of concrete support is static for both the HMGU participants and the control group over the two-year time frame. This suggests that the most reliable family support systems – family, friends, church, and community – change little over the short term. In addition, control group scores for two variables potentially linked to child maltreatment worsened slightly while HMGU participant scores improved significantly in those areas.

Evaluating social programs can be a frustrating endeavor. Qualitative and anecdotal evidence may suggest that social program objectives have been met, but quantitative pre- and post-testing often show no statistically significant change or even a drop from pre-test to post-test scoring. This study corroborates other efforts (Sibthorp et al., 2007) to overcome this response-shift bias by using an RPT to measure program success. Threats to validity of the RPT consist of insufficient participant recall, fabrication or biased responses on the pre-test, and the learning or “good subject” effect (Orne, 1962). Findings may also be challenged as non-traditional methodological logic and less rigorous or convincing analyses are employed. However, one study indicates that traditional pre-tests/post-tests and RPT show little difference in findings and a recommendation is made to gather supplemental data to strengthen RPT validity (Lamb, 2005).

Though the results of this study are not generalizable to other HMG programs, the methodologies are easy to replicate and could be used by other programs hoping to evaluate their influence on the development of family protective factors.

The results of this study strongly emphasize the need to include control groups in the evaluation of protective factors and other similar variables as it relates to social program participation. Attributing all protective factor changes to a program could be problematic without the use of a control group in order to measure the natural maturation that occurs for families. Using a control group allows confident comparisons between HMGU participants and the general population and highlights important differences. A study of protective factors and the influence of social programs on those factors is strengthened with a comparable control group in the study.

Limitations

Every research study has limitations. This study may be limited by its lack of racial diversity and marital status, its inability to be generalized beyond HMGU, and the use of an incentive for participants. Although invitations to participate in the study were based on set criteria, qualifying HMG participants self-selected and the type of issues that brought these families into the HMG system nor their socio-economic status or other risk factors were identified. Another caution may be that HMGU participants and the control group were not identical in every respect.
Some of the protective factor variable pre-test scores were statistically different. The control group had higher pre-tests on a few of these variables. Additionally, survey instruments measuring protective factor development lack a complete consensus on which protective factors to include (see Table I).

Furthermore, the results of this study represent a single trial. Duplication of this study is warranted with other HMG affiliates using this methodology as well as with other methodologies that address response-shift bias and the use of more updated protective factor surveys.

**Future research recommendations**

Future research recommendations include the use of more diverse variables that might be used to find factors influencing the growth of protective factors in participant and control group families and comparisons among a variety of social programs and their impacts on protective factors. Replication studies in other states or regions would also be desirable.

**Implications for practice**

Findings from this study suggest that child services focused on enhancing knowledge of parenting and child development might also expect to improve protective factors. One-on-one care coordination with families seems particularly effective. The findings might also benefit other social programs as they utilize retrospective pre-test, post-test, and control groups in their evaluations.

**Summary**

HMGU has an impact on important protective factors. Improvements in protective factor scores for HMGU participants demonstrate the systemic effectiveness of this program for families with young children. It appears that the program not only increases knowledge of child development and appropriate parenting skills, it also improves parenting self-efficacy. This knowledge and confidence allows parents to better cope with family difficulty and behavioral problems. Furthermore, through consistent and accurate family support, HMG becomes a trusted messenger in the cacophony of parenting advice available to families.

### Implications of the research for policy and practice

- Statistically significant positive changes from retrospective pre-test scores to their post-test scores were shown in four of five protective factor measures for HMGU participants. The largest gains were in knowing what to do and how to help children learn.
- To a lesser degree, the control group had statistically significant positive changes in two measures and two subset questions.
- In two subset questions related to child maltreatment risk, the control group scores worsened from the retrospective pre-test scores to their post-test scores while scores improved significantly for the HMGU participants on the same questions.

**References**


Further reading


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Sleeping away from home: a vehicle for adolescent delinquency?

Zachary Giano, Michael J. Merten and Brooke Tuttle

Abstract

Purpose – The purpose of this paper is to explore the relationship between persistently sleeping away from the home as a predictor of adolescent delinquency in a largely Latino sample of 91 adolescents.

Design/methodology/approach – This study employs multiple linear regressions to examine the relationship between sleeping away from the home (IV) and antisocial behavior and substance use (DVVs) with dangerous neighborhood characteristics as a moderator.

Findings – Results show that sleeping away from the home on a persistent basis is a significant predictor of antisocial behavior and substance use. Neighborhood characteristics moderated the effect of sleeping away on substance use only. One possible explanation includes opportunities for increased time with deviant peers that is created by persistently sleeping away from home. Additionally, sleeping away from the home may allow adolescents from strict households to opportunistically engage in delinquent behavior in households with less strict rules.

Originality/value – Although sleeping away is a common behavior often encouraged by parents as a part of social learning, there is evidence to suggest that it could be potentially detrimental, particularly amplified when the adolescent lives in more dangerous neighborhoods. To date, this is the first study to examine the effects of persistently sleeping away from the home on adolescent delinquency.

Keywords Adolescent, Delinquency, Antisocial, Sleep, Neighborhood, Substance

Paper type Research paper

While juvenile crime has been decreasing over the last ten years, delinquency remains a serious concern during adolescence due to its criminogenic implications for communities and individual risk trajectories that may follow across the lifespan (Trumbetta et al., 2010). Since 2007, juvenile arrests have decreased by over 50 percent; however, it is estimated that juveniles remain involved in one-fifth of violent victimizations each year. Despite the overall reduction in delinquencies, the number of juvenile arrests exceeded 850,000 in 2016 (Office of Juvenile Justice and Delinquency Prevention, 2017). It is well documented that minority adolescents are at greater risk for various types of adolescent delinquency, especially if they identify as Latino (Amey and Albrecht, 1998; Samaniego and Gonzales, 1999; Seroczynski and Jobst, 2016). Previous empirical research has also supported the importance that peers and neighborhood characteristics have on adolescent delinquency (Deutsch et al., 2012; Keijser et al., 2012), with specific emphasis on minorities such as Latino youth (Ghazarian and Roche, 2010; Jennings et al., 2010). While individual factors, peer relationships, and neighborhood characteristics are among antecedents to delinquency, the act of persistently sleeping away from home involves both relational and contextual factors and thereby warrants exploration as a pathway to delinquency.

Sleeping away from home

Although sleep has been widely studied in the past decade, few studies have investigated the effects of sleeping away from the home on adolescent health-related or psychosocial outcomes. Moncrief et al. (2014) found that routinely sleeping away from the home was associated with asthma and other mild, health-related problems for children. Behaviorally, sleepovers have been established as an antecedent to pre-marital sex for adolescents (Deaton, 2013). While the above
mentioned studies examined relationships between sleeping away from the home and negative child and adolescent health outcomes, the influence of sleeping away from home on other adolescent risk-taking behaviors, such as delinquency, has not yet been explored.

Adolescents sleeping away from their homes is not uncommon as adolescents prioritize spending time with friends. Thus, it is important to discuss the role that sleeping away from the home may play in the context of spending time with peers. From snacking habits, to friend selection, to religiosity, research suggests that peer influence is highly predictive of adolescents’ choice of free time activities (Benda and Corwyn, 1997; Lewis et al., 2012). Likewise, peer relationships have been routinely documented as contributors to delinquent behavior (Brauer and DeCoster, 2015; Haynie and Osgood, 2005; Henneberger et al., 2013; Walters, 2014). According to Vásquez and Zimmerman (2014), delinquent peers tend to spend more time with other peers than their non-delinquent counterparts. It has also been documented that deviant behavior most often happens in groups (Erickson and Jensen, 1977). In fact, regardless of delinquency, an excessive amount of time spent forming peer relationships suggests possible delinquent outcomes (Osgood et al., 1996). This implies that not only are peer relationships important stimuli in adolescent decision making, but also the length of time spent with those peers may be equally influential; although less is known about the latter in the current body of literature.

Reasons to examine time spent with peers as an antecedent to delinquency are threefold. First, peers exert influence on behavior, especially in adolescence (Brauer and DeCoster, 2015). Next, time constraints with deviant peers may attenuate this influence and act as a protective factor for deviant behavior (see Weerman et al., 2015, for positive associations of time and delinquency among peers). For example, if an adolescent has restrictions on time spent with deviant peers, negative peer influence may weaken due to the shorter window of influential opportunities. Lastly, adolescents who struggle with impulse control or have less self-control over their actions and emotions are more likely to become involved in crime due to lower inhibition (Fine et al., 2016; Meldrum and Clark, 2015; Steinberg et al., 2008). Adolescents with lower self-control may look for opportunities to spend more time with deviant peers (e.g. sleeping over at a friend’s or skipping school with friends). Erickson and Jensen (1977) note that associating with peers can increase the potential for delinquent behavior by making delinquency easier and more fulfilling; an opportunity that persistently sleeping away from the home may also enhance. In addition, delinquency may enable some adolescents to move up the social order by “proving themselves.” Meldrum and Clark (2015) examined time spent with deviant peers in a virtual setting (i.e. online gaming and other online communities) and found a positive relationship between time spent virtually to delinquent behaviors; more specifically, substance use. Meldrum and Clark (2015) further implied that future research should explore alternative scenarios that enable more time spent with peers; an important impetus for this study.

Nonetheless, some research has linked time spent with peers to positive characteristics, such as camaraderie, obtaining advice, and sources of social affirmation and support (Buhrmester, 1998). However, the majority of research highlights the negative outcomes of excessive time spent with peers during adolescence. Because of this discrepancy it is necessary to discuss potential moderating effects of environmental characteristics that could determine whether excessive time spent with peers would benefit or hinder adolescent development.

Dangerous neighborhoods

The environment in which an adolescent resides has been shown to have a large impact on that adolescent’s behavior (Hollis, 1996). Dangerous neighborhood environments increase the likelihood of mental health issues, antisocial behavior, depressive symptoms, and substance use (Anderson et al., 2015; Dunn et al., 2015; Snediker et al., 2009; Wallen, 1993). While an adolescent’s choice of peers remains an important factor in delinquent behavior as mentioned above, the neighborhoods in which those adolescents live provides the selection of those peers. Dangerous neighborhoods have been linked to higher rates of delinquent behavior by adolescents (Bohnert et al., 2009), which signals a natural link between dangerous neighborhood characteristics and increased deviant peer selection (Moor et al., 2015). Several studies have found associations between the level of danger in a neighborhood and antisocial behavior (Lei et al., 2014; Trentacosta et al., 2009).
Further, Fagan et al. (2014) showed the link between neighborhood factors and increased substance use among adolescents. Neighborhood disadvantage has also been positively associated with substance use among adolescent females (Tanner-Smith, 2012).

Because spending ample amounts of time away from the home may provide opportunities for delinquent behaviors not possible in the adolescent’s home environment, this study examines the link between persistently sleeping away from the home and adolescent delinquent behavior (substance use and antisocial behavior). Further, extant research has examined the intervening effects of neighborhood characteristics on social functioning and behavioral attributes such as internalizing and externalizing problems and individual cognition problems (Callahan et al., 2011; Levasseur et al., 2011; Prins et al., 2014). Due to the effects that neighborhoods may have on adolescent behaviors, dangerous neighborhood characteristics were included as a moderating variable in this study.

Confounding variables related to sleeping away

This study looks at delinquent behaviors via persistently sleeping away from the home and examines other possible factors as control variables. Parent-adolescent conflict has been previously linked to both substance use and antisocial behavior in prior research, making it an integral control variable in isolating the effects of sleeping away. Tarantino et al. (2015) linked parent-child conflict to female adolescent/Adult substance use, while Klahr et al. (2011) investigated the links between parent-adolescent conflict with increased rates of antisocial behavior in adolescents. Additionally, adolescent depressive symptoms have been linked to various forms of delinquency (Diamantopoulou et al., 2011; Kofler et al., 2011). Lastly, a possible rationale for consistently sleeping away from the home could come in the form of a single-parent household where parents would share joint custody of an adolescent, thereby forcing a situation in which the child sleeps in two places in a typical week on a consistent basis.

Current study and research questions

The aforementioned studies have shed light on both peer influence and neighborhood influence on delinquency, yet the possible link between persistently sleeping away from home (a situation that gives rise to peer influence and neighborhood influence) and delinquency has been neglected in the literature. Therefore, the purpose of the current study is to shed light on specific experiences which may enable adolescents (more specifically Latino youth) to spend large amounts of time away from the home, thus leading to delinquent behavior; more specifically, antisocial behavior and substance use.

The act of sleeping away from the adolescent’s primary sleeping residence on a persistent basis may be predictive of delinquency. Persistently sleeping away from the home may expose adolescents to longer durations of peer influence due to the increased amount of time a sleepover encompasses, thus opening up opportunities for behaviors not possible in the adolescent’s primary residence. The current study attempts to specifically examine the notion of persistently sleeping away from the home as a potential catalyst of adolescent delinquency as it relates to Latino youth by examining it as a direct predictor of delinquent behaviors. This study also highlights the role that dangerous neighborhoods play in this interaction as a potential moderator between persistently sleeping away and adolescent delinquency (see Figure 1). The research hypotheses for this study are twofold: First, we hypothesized that sleeping away from the home on a persistent basis leads to higher rates of adolescent delinquency above and beyond the selected control variables. Second, we hypothesized that by investigating neighborhood characteristics as a moderator, less dangerous neighborhoods will attenuate the primary link between sleeping away from the home and adolescent delinquency.

Methods

Participants

The sample for the current study consisted of 91 adolescents who participated in the Tulsa 100 Families Project (T100), a federally funded program to explore multiple community elements.
within Tulsa Oklahoma’s urban, low-income families. Participant families were interviewed and surveyed, each receiving a monetary compensation. Participants’ ages ranged from 11 to 19 years (M age = 14.47) in a highly Latino sample (n = 71; 78 percent) living in the Tulsa area. Other ethnic groups included 12 percent African American, 4 percent multi-racial, 3 percent White, and 2 percent Native American. The participants were comprised of both boys (n = 50; 55 percent) and girls (n = 41; 45 percent) and ranged from 5th to 12th grade, with the majority coming from 9th and 10th grade (20 and 19 percent, respectively).

Measures

Delinquency. The T100 project administered a survey with a variety of questions to adolescents. The Child Behavior Questionnaire was used to measure two levels of delinquency used in this study: antisocial behavior and substance use (Rothbart et al., 2001). The full questionnaire measuring antisocial behavior and substance use was a 35-question scale that used frequency responses to different behaviors (i.e. “During the past year how many times have you damaged property? Shoplift? Skip School?”). Responses ranged from 1 (“Never”) to 5 (“7 or more times”). The scale was then bifurcated into two subscales, one measuring antisocial behavior (27 questions) and substance use (8 questions). Examples of substance use included uses of alcohol, marijuana, cigarettes, and prescription drugs. Cronbach’s α’s used to measure reliability were 0.84 and 0.75 for antisocial behavior and substance use, respectively.

Sleeping away from home. Sleeping away from home was measured by a question asking the adolescent “In a typical week how many different places do you usually spend at least one night?” Possible responses to this single item question were 1 = one time, 2 = two times, 3 = three times, or 4 = four or more times. For the initial t-test this variable was dichotomous (adolescents who reported sleeping away from home two or more nights per week were compared against adolescents who only reported sleeping away once). Otherwise, the variable was left as continuous for regression purposes.

Dangerous neighborhoods. Dangerous neighborhood characteristics were measured using a 20-question scale using a 4-point Likert response (“Never” to “Many times”). Questions included experiences seen in the past year such as “I have seen gangs,” “I have seen someone pull a gun,” and “I have heard guns being shot.” Cronbach’s α for this scale was 0.85, indicating suitable reliability.

Depressive symptoms. Depressive symptoms were measured by the Child Mood & Feelings Questionnaire and included 33 questions on a three-point Likert scale (Angold et al., 1995). Depressive behavior questions included, “During the past two weeks, which statements were true […] Felt miserable or unhappy? I was very restless? I felt I was no good anymore?” and had accompanying ranged responses of 0 (“Not True”) 1 (“Sometimes”) and 2 (“True”). The measure had a Cronbach’s α of 0.92, indicating high reliability.
Parent-adolescent conflict. Parent-child conflict was measured using the Parent-Adolescent Disagreement Questionnaire which included 30 questions (i.e. “How often in the past year did you and your [parent/caregiver] disagree about […] activities with friends? alcohol? dating?”) and was assessed using a 5-point Likert scale from 0 (“never”) to 5 (“very often”). The scale had a Cronbach’s α of 0.89.

Single-parent households. To control for single-parent households a variable was added to the model and was measured by a line-item question given to the parents of the adolescents which asked “Are you married, currently living as married, separated or divorced, widowed, or never married?” Participants were then bifurcated into two groups, with the first consisting of married or currently living as married (indicating a joint parent household), and the second with the remaining categories of separated or divorced, widowed, or never married (possible implications of a joint custody situation).

Antisocial behavior. Antisocial behavior was measured by a 24-item questionnaire measured by a 5-point Likert scale that asked various questions including “How often in the past year have you picked on someone? Break a rule at home? Throw something at someone?” The Cronbach’s α was 0.83, indicating good reliability.

Gender and age. Gender was assessed by a line-item question asking “Do you classify as male or female?” Age was measured by a single item question asking “How old are you?”

Results
The association between sleeping away and adolescent delinquency was initially explored using group differences between the adolescents who reported sleeping away two or more times per week with those who did not and the associated outcomes of antisocial behavior and substance use. T-tests (an appropriate method for evaluating differences in two groups with continuous outcomes) were used to analyze significant differences with respect to the dual outcomes. Next, bivariate correlations were used to examine variable relationships and multicollinearity. To examine the link between sleeping away from the home and adolescent delinquency (substance use and antisocial behavior), several multiple linear regressions were conducted. We first entered sleeping away in Model 1 to assess the unique direct effect on both forms of delinquency. In Model 2, we entered the other control study variables to the model. Lastly, in Model 3, we entered the interaction term of sleeping away and dangerous neighborhood into the model to assess a moderating effect.

Bivariate correlations between study variables are presented in Table I. In examining the adolescent delinquency variables (antisocial behavior and substance use), Pearson’s correlations are sizeable and statistically significant (p < 0.01) between sleeping away and parent-adolescent conflict. Other notable correlations are depressive symptoms with antisocial behavior (p < 0.01). The depressive symptoms variable was also associated with parent-adolescent conflict (p < 0.05). As supported by previous literature (i.e. Weiss and Schwarz, 1996) age was highly significant and positively related to substance use (p < 0.001) while having a single parent was also significantly linked to substance use (p < 0.05).

<table>
<thead>
<tr>
<th>Table I</th>
<th>Bivariate correlations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variables</td>
<td>1</td>
</tr>
<tr>
<td>1. Age</td>
<td>–</td>
</tr>
<tr>
<td>2. Female</td>
<td>0.02</td>
</tr>
<tr>
<td>3. Single parent</td>
<td>0.11</td>
</tr>
<tr>
<td>4. Depressive symptoms</td>
<td>0.04</td>
</tr>
<tr>
<td>5. Parent-adolescent conflict</td>
<td>0.13</td>
</tr>
<tr>
<td>6. Dangerous neighborhood</td>
<td>–0.04</td>
</tr>
<tr>
<td>7. Sleeping away</td>
<td>–0.01</td>
</tr>
<tr>
<td>8. Antisocial behavior</td>
<td>–0.06</td>
</tr>
<tr>
<td>9. Substance use</td>
<td>0.38***</td>
</tr>
</tbody>
</table>

Notes: *p < 0.05; **p < 0.01; ***p < 0.001
Variable means, standard deviations, and ranges of the major variables in the study are presented in Table II. The sleeping away variable average was 1.28 (see methods for range values), with 18.4 percent of the sample identifying some level of sleeping away (sleeping two or more nights outside the primary residence in a typical week).

Mean level of adolescent delinquency by level of sleeping away is displayed in Table III. Across both delinquency outcomes significant differences were found between individuals who persistently sleep away and those who do not ($p < 0.05$).

Regression coefficients of major study variables on both adolescent delinquency outcome variables are presented in Table IV. In Model 1, we entered sleeping away as the sole predictor variable. Model 2 shows the full model including control variables. Model 3 shows the full model plus the interaction between dangerous neighborhoods and sleeping away. Broadly, results show that across both models 1 and 2 in each delinquency variable, sleeping away from the home was significantly associated with high levels of both delinquency behaviors, albeit at different levels ($p < 0.01$ for antisocial behavior and $p < 0.05$ for substance use) above and beyond the five control variables.

In looking at antisocial behavior, both models 1 and 2 were significant ($F = 11.53$, $p < 0.01$, $R^2 = 0.15$ and $F = 3.43$, $p < 0.01$, $R^2 = 0.33$, respectively). Notably, no other variables were significant predictors besides sleeping away in model 2. In the next delinquency characteristic of substance use, both models 1 and 2 were found to be significant ($F = 5.83$, $p < 0.05$, $R^2 = 0.08$ and $F = 4.62$, $p < 0.001$, $R^2 = 0.39$, respectively). Age ($β = 0.30$) was found to be the only other significant predictor in model 2 at the $p < 0.05$ level.

Model 3 across both delinquency variables included the full model plus the interaction. The interaction of sleeping away and dangerous neighborhood levels was only significant in model 3 of substance use ($β = 0.29$, $p < 0.05$). Model 3 of substance use also had individual predictors of age ($β = 0.24$, $p < 0.05$) and parent-adolescent conflict ($β = 0.38$, $p < 0.01$).

Results in Table V denote that findings from the substance use regressions ran with moderating effects of neighborhood characteristics (also see Figure 2). Participants were bifurcated into two

### Table II Sample descriptive statistics for study variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>%</th>
<th>Min-Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>45.1</td>
<td></td>
<td>45.1</td>
<td></td>
</tr>
<tr>
<td>Single parent</td>
<td>22.0</td>
<td></td>
<td>22.0</td>
<td></td>
</tr>
<tr>
<td>Latino</td>
<td>78.0</td>
<td></td>
<td>78.0</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>14.47</td>
<td>2.02</td>
<td></td>
<td>11-19</td>
</tr>
<tr>
<td>Depressive symptoms</td>
<td>1.36</td>
<td>0.28</td>
<td></td>
<td>1.00-2.36</td>
</tr>
<tr>
<td>Parent-adolescent conflict</td>
<td>1.92</td>
<td>0.63</td>
<td></td>
<td>1.07-4.10</td>
</tr>
<tr>
<td>Antisocial behavior</td>
<td>1.38</td>
<td>0.34</td>
<td></td>
<td>1.00-2.50</td>
</tr>
<tr>
<td>Substance use</td>
<td>0.94</td>
<td>0.17</td>
<td></td>
<td>0.89-1.67</td>
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<tr>
<td>Dangerous neighborhood</td>
<td>37.39</td>
<td>8.16</td>
<td></td>
<td>22-65</td>
</tr>
<tr>
<td>Sleeping away from home</td>
<td>1.28</td>
<td>0.67</td>
<td></td>
<td>1.00-4.00</td>
</tr>
</tbody>
</table>

**Note:** $n = 91$ for all variables except Sleeping Away, $n = 76$

### Table III Test and mean categories of adolescents by non-sleeping away and sleeping away patterns

<table>
<thead>
<tr>
<th></th>
<th>Non-SA</th>
<th>SA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antisocial behavior</td>
<td>1.33</td>
<td>1.57*</td>
<td>1.38</td>
</tr>
<tr>
<td>Substance use</td>
<td>0.93</td>
<td>1.04*</td>
<td>1.06</td>
</tr>
</tbody>
</table>

**Notes:** $n = 76$ for all. SA, Sleeping Away Adolescents. Significant differences between non-sleeping away and sleeping away adolescents at $^*p < 0.05$
### Table IV  Multiple linear regressions examining antisocial behavior and substance abuse with moderating neighborhood characteristics

<table>
<thead>
<tr>
<th></th>
<th>Antisocial behavior</th>
<th></th>
<th>Substance use</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Model 1</td>
<td>Model 2</td>
<td>Model 3</td>
<td>Model 1</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>SE</td>
<td>β</td>
<td>B</td>
</tr>
<tr>
<td>Sleeping away</td>
<td>0.18</td>
<td>0.05</td>
<td>0.38**</td>
<td>0.17</td>
</tr>
<tr>
<td>Dangerous neighborhood</td>
<td>0.13</td>
<td>0.09</td>
<td>0.20</td>
<td>0.12</td>
</tr>
<tr>
<td>Parent-adolescent conflict</td>
<td>0.08</td>
<td>0.07</td>
<td>0.16</td>
<td>0.09</td>
</tr>
<tr>
<td>Depressive symptoms</td>
<td>0.23</td>
<td>0.14</td>
<td>0.21</td>
<td>0.22</td>
</tr>
<tr>
<td>Gender</td>
<td>0.03</td>
<td>0.08</td>
<td>0.04</td>
<td>0.03</td>
</tr>
<tr>
<td>Age</td>
<td>-0.01</td>
<td>0.02</td>
<td>-0.04</td>
<td>-0.01</td>
</tr>
<tr>
<td>Single parent</td>
<td>-0.05</td>
<td>0.10</td>
<td>-0.07</td>
<td>-0.04</td>
</tr>
<tr>
<td>DN x SA</td>
<td>0.02</td>
<td>0.03</td>
<td>0.11</td>
<td>0.02</td>
</tr>
<tr>
<td>Adjusted R²</td>
<td>0.13</td>
<td>0.23</td>
<td>0.23</td>
<td>0.06</td>
</tr>
</tbody>
</table>

Model fit:  
- $F = 11.53^{**}$  
- $F = 3.43^{**}$  
- $F = 3.06^{**}$  
- $F = 5.83^{*}$  
- $F = 4.62^{***}$  
- $F = 5.28^{***}$

Notes: DN x SA = Dangerous Neighborhood times Sleeping Away. *p < 0.05; **p < 0.01; ***p < 0.001
groups identified by low levels of dangerous characteristics and high levels of dangerous characteristics. Participants were given a total score based on dangerous neighborhood elements (see methods for details) and were split by mean. It should be noted that a median split is often used for moderation (van Strien et al., 2011), and using this criterion would have split the data in the same exact way. Because the split fell on both the mean and median, the two groups have both 50 percent equal numbers \((n = 43)\). The results indicate that living in a better neighborhood (i.e. less dangerous characteristics) attenuated the effects of sleeping away on substance use in the model.

**Discussion**

The purpose of this study was to examine the link between sleeping away from home and two forms of adolescent delinquent behavior, substance use and antisocial behavior, as well as the influence of dangerous neighborhoods on this relationship as a moderator. Using several multiple regression models with and without moderating effects, we were able to examine these associations to investigate the effect that sleeping away has on antisocial behavior and substance use. As predicted in the first hypothesis, sleeping away from home was significantly associated with both forms of adolescent delinquency, though in slightly different ways. It was positively associated with antisocial behavior regardless of neighborhood characteristics, as well as positively associated with substance use but only in dangerous neighborhoods. As such, our second hypothesis that dangerous neighborhoods moderated these effects was significant but only in the substance use category.
Implications of findings

The finding that sleeping away from home is associated with delinquency has several meaningful implications. First, adolescence can be a very sensitive period which can lead to delinquent behavior when lacking social and familial structure (Armaline, 2005; Osgood et al., 1996). The act of sleeping away from home on a persistent basis, as opposed to occasionally sleeping away, could disrupt potential organizational routines that provide structure, thus providing a pathway for delinquent behaviors. This frequent behavior in adolescence is often overlooked; however, sleeping away from home could be detrimental to adolescent development and needs further examination.

Next, and most notably, is the link that sleeping away from the home on a consistent basis potentially has with deviant peers. Associations with deviant peers have been well documented (i.e. Lansford et al., 2014). However, the length of time spent with these deviant peers is crucial in predicting the level of influence they evoke (also noted by Weerman et al., 2015). Sleeping away provides this vehicle by which an elongated period of time can elapse with a deviant peer, thus magnifying the potential influence as opposed to a more limited time engagement. Because adolescents crave exploration and may be more likely to interact with a deviant peer in order to accomplish this (Van Ryzin and Dishion, 2014; Vásquez and Zimmerman, 2014), an adolescent may be able to escape the bounds of strict parenting/home rules in order to engage in delinquent behavior. For example, an adolescent from a household with violent movie/video game restrictions may opportunistically access those materials via sleeping away, thus increasing their risk of exposure to violence. Similarly, an adolescent from a rigid household may gain access to various substances from their peers’ less rigid households (i.e. cigarettes, alcohol, marijuana, or other substances), which could help explain why dangerous neighborhood characteristics moderated the effect of substance use. With regard to ethnicity, previous research has not indicated whether Latino households are more or less likely to have their children sleep away from the home, and these findings could potentially play a role in the nature of that relationship.

The effect of dangerous neighborhood characteristics on the link between sleeping away and adolescent delinquency also had some noteworthy interactions. The moderating effect of a dangerous neighborhood was only significant with substance use. This result differs from our original hypothesis that it would be significant in both delinquency categories. Nonetheless, the logic in this result can be appreciated. Antisocial behavior can exist in any environment without access to tangible elements (i.e. stealing from or hitting others can occur in any type of neighborhood or environment and does not require the adolescent to have access to tangible items to accomplish this). However, because dangerous neighborhoods often have higher rates of illicit substances (Freisthler et al., 2005), the effect of sleeping away on substance use is amplified under conditions of dangerous neighborhoods because substance use inherently requires access to illegal substances and paraphernalia to use. The moderating effect of neighborhood characteristics was so stark that substance use actually declined when sleeping away occurred in safer neighborhoods, although not significantly ($p > 0.05$).

Relation to other research

The current study reinforces the risk for delinquency associated with spending time with deviant peers as previously found by Meldrum and Clark (2015) who examined the link between virtual gaming with deviant peers and substance use. While their study used virtual gaming as a vehicle for spending large amounts of time with peers, ours utilizes sleepovers as a pathway to delinquency. Sleeping away at secondary households is a medium that can create opportunities for delinquent behaviors to flourish in a face-to-face environment which primary households may restrict (i.e. violent movies/games, alcohol, pornography, lengthy unsupervised amounts of time, etc.). Not surprisingly, both at-risk populations (adolescents who spent more time online in the Meldrum and Clark study and adolescents who spend more time sleeping away from the home in ours) were more likely to be engaged in delinquent behavior, especially substance use.

Osgood et al. (1996) presented a study that focused on organizational structures and routines that are linked with adolescent behavior. Their study found that unstructured peer environments are associated with more delinquent behavior. Although their current study differs in the examination of delinquent behavior, both studies are related in the way by which adolescents can configure an
environment for unstructured behavior. Previous examples in this paper presented one adolescent spending time at another adolescent’s less strict household, as also noted above. However, another scenario could present itself as both adolescents engaging in sleeping away at a third location, thus increasing the chances of unstructured socializing to which Osgood’s study references.

**Alternative explanations**

Although our study shows that sleeping away has potential pathways toward adolescent delinquency, possible alternatives exist. First, delinquent adolescents may be more likely to choose to sleep away from the home, which in turn exposes them to more delinquent behavior (a causation fallacy). The nature of these patterns has potential to be cyclical with starting points at both delinquent predispositions or sleeping away from the home on a persistent basis. Another alternative explanation is engaging with deviant individuals other than peers. Although this study controlled for single-parent households (which could explain sleeping away), adolescents may engage with other family members (siblings, step siblings, cousins, etc.) which may not be present at their primary place of sleep.

**Limitations**

Although this study has promising exploratory results, there are some limitations associated with it. The first is the obvious limitations of cross-sectional studies. A longitudinal study examining individuals who undergo long-standing sleeping away from the home can better capture an accurate picture of the potential causative links to delinquency. Next, the sample was highly Hispanic (78 percent) and relatively small (91 participants). Of those, 15 participants did not answer the sleeping away variable (only 76 out of 91).

**Conclusions**

This study offers important insights regarding the delinquent effects that persistently sleeping away from the home can have on adolescents, and notably, is underexplored in existing literature. Further, although this study found a link between persistently sleeping away from the home and adolescent delinquency (especially in dangerous neighborhoods), it is still unclear why these adolescents choose to spend nights away from their primary residence. Future studies should explore this phenomenon using qualitative and mixed-method designs to understand the motivation for sleeping away from home and how the experience shapes adolescent decision making and behavior. Lastly, and contextually, future investigation should consider the question of why adolescents choose to sleep away, and to whose residence are they sleeping at. While our study provided the necessary quantitative foundational evidence to study this phenomenon, a mixed-methods or qualitative analysis would help shed light on these questions. Whether the reason is disruptive family structure, deviant peer relationships, or a combination with those and/or other elements, the hope of this study is to invigorate more research concerning why adolescents sleep away from their primary place of residence on a persistent basis and how sleeping away affects behavioral patterns related to delinquency.

**References**


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