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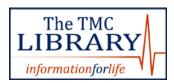
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This study evaluated a modified home-based model of family preservation services, the long-term community case management model, as operationalized by a private child welfare agency that serves as the last resort for hard-to-serve families with children at severe risk of out-of-home placement. The evaluation used a One-Group Pretest-Posttest design with a modified time-series design to determine if the intervention would produce a change over time in the composite score of each family's Child Well-Being Scales (CWBS). A comparison of the mean CWBS scores of the 208 families and subsets of these families at the pretest and various posttests showed a statistically significant decrease in the CWBS scores, indicating decreased risk factors. The longer the duration of services, the greater the statistically significant risk reduction. The results support the conclusion that the families who participate in empowerment-oriented community case management, with the option to extend service duration to resolve or ameliorate chronic family problems, have experienced effective strengthening in family functioning.

Early Intensive Family Preservation Programs

Intensive family preservation programs (IFPP) began in the late 1970's in response to the need to help families reduce the risk of removal of children from the home for abuse or neglect. The initial IFPPs operating through the 1980's and 1990's were based on the Homebuilders model which was designed to serve families with acute problems (Bagdasaryan, 2004; Forsythe, 1992). The premise of the Homebuilders model is that short-term interventions of four to eight weeks duration will help the family deal with the immediate crisis and prevent out-of-home placement (Bath & Haapala, 1993).

While the originating philosophy underlying family preservation is that families are in crisis and that crisis must be resolved if the family is to have a chance of surviving intact, in most cases families also face chronic, complex social and psychological problems which short-duration services and crisis intervention practices cannot begin to solve (Scherman, 1997; Straudt & Drake, 2002). Short-term IFPPs are not a remedy for the precipitating causes of child abuse and neglect, nor are they likely to reduce foster care caseloads (Fraser, Nelson & Rivard, 1997). MacDonald (1994) reminds us that most families served by IFPPs have pervasive emotional and behavioral problems that will usually result in child neglect becoming a chronic state. Because the seriousness of family problems are not amenable to short-term interventions, Littell (1995) questions the expectation that IFPPs will have long lasting positive effects on family functioning and lead to reductions in out-of-home placements. The 1990 New Jersey program found some benefits in family functioning but they dissipated over time, because dysfunctional families cannot stay functional over time with only short-term treatment and supports (MacDonald, 1994). Barth (1990) suggests that because of the lack of empirical evidence

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to support crisis intervention as a treatment modality, IFPPs should move from a short-term crisis-oriented model to a more long-term re-educational or re-training model.

The Family Preservation Community Case Management Model

Alternatives to the original Homebuilders model have evolved in response to more refined understanding of family needs. One such program is the New Haven Family Alliance, a community case management model, as operationalized by a private child welfare agency in Connecticut. The agency has operated for more than 16 years as the program of last resort for hard-to-serve families who have children at severe risk of out-of-home placement. The model is characterized by a focus on underlying and chronic family problems and needs as well as crisis needs, with an empowerment approach, a holistic orientation to individual, family and systemic issues, and the duration of services driven by level of need and rate of the family's progress in resolving risk factors. The model is operated as a generalist social work practice model, utilizing the diverse dimensions of the field, ranging from individual counseling to systems analysis and advocacy and community organizing.

The goals of the community case management program are to develop individualized family service plans that incorporate and integrate a continuum of care for the family across agency boundaries, to access services that are needed by the family, and to coordinate the actual delivery of specific services. At the same time, the agency actively identifies gaps in the available service system and vigorously advocates for system change. These goals reflect the agency's "child welfare reform" orientation, and correspond to what Kamerman and Kahn (1990) recommend: the establishment of locally based, comprehensive child and family-service systems that will provide for continuity of care over time and across service systems.

The Empowerment Approach

A number of studies have recommended incorporating the empowerment model into IFPPs. The community case management model employed by the agency emphasizes family empowerment. MacLeod and Nelson's (2000) meta-analysis of 56 programs designed to promote family wellness and prevent child maltreatment found that intensive family preservation programs with high levels of participant involvement, an empowerment and strengths based approach, and a component of social support had higher effect sizes than programs without those elements.

Lindsey (1994b) has recommended empowering families and placing resources directly under the control and management of parents, and encouraging independence and self-initiative. Through efforts to empower caregivers workers attempt to increase clients' self-confidence and improve problem-solving and negotiating skills (Littell et al., 1993). "Empowerment strategies recognize and build on family strengths, asking families themselves to identify and prioritize treatment goals. Family participation in setting goals, the type of goals set, and goal achievement have all been found to be related to placement prevention in several studies (Fraser, Pecora, & Haapala, 1991; Nelson & Hunter, 1994; Nelson & Lansman, 1992; Reid, Kagan, & Schlosberg, 1988; Schwartz, AuClaire, & Harris, 1991)" (Nelson, 1997, p.108). Furthermore, "enabling interventions which emphasize skill and self-esteem building and actively assist families to identify

and access community services and support on their own have been found to be more effective than simply providing concrete services" (Nelson, 1997, p. 108).

In the community case management model, the community case manager works with clients in their homes and in the community on issues that have overwhelmed client coping skills. What differentiates the community case manager model is the comprehensive client-based nature of the services which combines an Individual Family Service Plan (i.e. what the client family states are priorities) with the Case Management Service Plan which is derived from the case manager's assessment of the areas of greatest risk and strengths.

Empowerment occurs via education (teaching parenting and various family coping skills instead of merely providing direct services); bridging (networking, connecting and preparing families to maximize services); and advocacy (helping families not only to access services from other agencies, but how to secure these services on their own initiative).

The Capacity for Open-ended Duration of Services

Empowerment is a process that takes time and involves change in the attitudes and behavior of an individual. The family's problems are caused by a chronicity of problems, not an event. Patterns must be unlearned. Empowerment creates the possibility for the person to change by providing him or her with opportunities to develop a new, more positive view of him or herself. As a result of this change, the person feels that he or she has greater control or influence over situations, greater responsibility, and eventually greater power. Effectively creating empowered families typically requires a longer duration of services than the crisis intervention mode of earlier IFPPs.

The value of longer-duration services is supported by the literature. Besharov (1994) argues for long-term service for the most troubled families, those that have a host of social, economic, and familial problems and suggests that what is needed is an on-going and non-categorical approach to services with a home visitor model. He maintains that the obstacles to offering long-term service are budgetary and conceptual. Dore and Alexander (1996) suggest that the need of family members to develop relational capacity may be contraindicated for high-risk families receiving treatment only for the four to eight week period employed by most IFPP models and that a longer term model that allows for developing a helping alliance prior to initiating change appears warranted. Kirk and Griffith (2004) suggest that once a family case is closed there is a period of vulnerability for the family and that the solution might be to offer post-IFPPs services or to extend the initial treatment period for a time if the family still has unresolved issues. Nelson et al., (1990) also recommend longer-term services for young parents who might not benefit from brief assistance. Some programs have realized that families really have chronically acute problems and therefore extending service past the short durational limits is a good idea (Bagdasaryan, 2005).

While there have been few studies of family prevention models that offer intensive services and are home based that have used the time dimension or duration as an independent variable (Bath & Haapala, 1993), findings from programs that have used a longer duration model have been positive. Bagdasaryan's (2005) study of 488 families who received family preservation services in Los Angeles County found that the duration of services emerged as a key predictor of outcome such that the longer families received

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services, the greater the likelihood for a successful outcome; the duration was more significant than particular types of services. Berry's (1992) study with a sample of 407 cases found that a greater proportion of time the worker spent in the home was important and a relevant predictor of success in reducing out of home placement. On the other hand, Littell and Schuerman (2002) found that there was no clear advantage of longer or shorter treatment durations for the subgroups that they studied. Finally, Jones, Magura, and Shyne (1981) have noted that long-term cases can be a mixture of difficult and less difficult cases that may confound the assessment of the effects of the length of service.

In the New Haven model, the lengths of time cases are open vary greatly due to the chronicity of problems for most of the families. The fundamental policy of the agency, which makes this model of family preservation services unique, is that cases can and should remain open for a long period, six months to a year or longer, if necessary. The main reason for successfully closing a case is that the family/child intervention goals have been met, with outcomes generally defined as family movement from high risk to moderate or manageable risk, bringing families from a high degree of dependency to a level of lesser dependency with improved coping skills. If the family later has a need for services to prevent a family breakup, the agency assists in the provision of appropriate services.

Context of Need: Characteristics of Families

The families assessed by the study represent the demographics-driven needs and characteristics that, in part, elicited the development of the community case management model. The families were 72 percent African-American, 16 percent Hispanic, and 11 percent Caucasian, existing at the forgotten margins of society. The demographic description of these families highlights the overwhelming odds these caretakers face in responsibly parenting and assuring a promising future for their children. Most of the families were headed by a single parent. Twenty-seven percent were single, and an additional 61 percent were separated, divorced, or widowed, all essentially managing the demands of their families on their own. Only 12 percent of the caretakers were married, living together or remarried. Clients were not the youngest parents; only 8 percent were age 21 and under and 15 percent were age 25 and under. Most of the primary caretakers were in early to middle adulthood, between 26 and 40 years of age. In addition to their isolation, most of the caretakers did not have the necessary education to provide them with skills for successful parenting and employment. A total of 58 percent of caretakers had never attended high school; only nine percent had graduated from high school.

Twenty-two percent of these families had no income, and in most cases (84 percent) the family income was well below the poverty level. Only nine percent of primary caretakers were employed. Even beyond the problems of poverty, lack of education, and minority status, the primary caretakers in these families deal with serious problems in their present lives, often problems haunting them since childhood. Fifty-three percent of primary caretakers had a history of alcohol abuse, and 58 percent had abused other drugs. As children themselves, 57 percent of primary caretakers were victims of physical abuse, and 31 percent were victims of sexual abuse. Of the caretakers for whom data were available, 36 percent had physically abused their children, and one percent reported having sexually abused their children, and 64 percent had been accused of child neglect. Given the magnitude and intensity of the problems, an intervention that is

service-intensive and long-term is essential to help empower these families to improve their functioning.

The Research Methodology

The evaluation employed a One-Group Pretest-Posttest design augmented by a time-series component to examine family change in 208 cases to examine the effectiveness of the community case management model. The time-series pretest-posttest study compared the same target families before, during and after participation in the intervention. While this design is not as robust as an experimental design for this type of evaluation activity, "in some cases, evaluations may be undertaken that are 'good enough' for answering ... policy and program questions, although from a scientific standpoint, they are not the 'best' designs" (Rossi and Freeman, 1985, p. 35).

Research Hypothesis and Key Variables
The research hypothesis was that the intervention would produce a detectable, substantive increase in the outcome, defined as the functioning of at-risk families served by the agency. The indicator of effective outcome was operationalized as the change over time in the composite score of each family's Child Well-Being Scales (CWBS), an instrument developed by the Child Welfare League of America (Magura & Moses, 1986). The CWBS identifies risk factors in family functioning, and assesses family dysfunction indicated by factors ranging from psychosocial risks to more concrete problems such as lack of housing, food, and utilities. It also explores children's problems in school, including truancy, fighting, and stealing. The scale measures psychological vulnerabilities of the family caretaker that could interfere with family functioning such as depression, suicide, isolation, and interpersonal difficulties. The independent variable was the community case management service model, with agency supervision and extensive training ensuring its consistent application by individual case managers.

Data Collection Procedures and Instruments
Data from successive administrations of the Child Well-Being Scale was available on all clients through the agency's management information system and was used to test the research hypothesis to determine if family functioning improved during and after program participation.
The CWBS measures 43 separate dimensions related to the physical, social, and psychological needs of children using an anchored scale. Caseworkers rate families using descriptions of adequacy on a three to six-part scale ranging from 'adequate' to 'severely inadequate. The degree to which this set of needs is met defines a child's state of overall well-being (Magura & Moses, 1986). According to Magura and Moses (1986), test-retest reliability is satisfactory with a mean value of kappa = .65; inter-rater reliability is also moderately high; and, Cronbach's alpha is .89 for the composite CWBS.
The CWBS was designed to be completed by a service worker in direct contact with the family in their home, and enhanced by a synthesis of information on the family from multiple sources. According to Magura and Moses (1986), "the scales are designed to be completed several times during the term of a case, so that change (or lack of change) in problems over time can be determined for families...The scales are intended to

track relatively long-term changes, rather than changes from day-to-day or week-to-week" (p. 99-100).

When possible, the study sought to utilize multiple measures of the CWBS for each client family according to the following four-repetition "optimal" schedule: Baseline CWBS completed within 30 days of opening the case; with repetitions, after 6 months of client involvement in the program; after 12 months; and at case closure. The baseline measurement occurred approximately 30 days after the case opening but before intensive case management intervention services, allowing the community case manager to produce an evaluation of the family's environment that was not based on first impressions.

Although the CWBS has been used by a number of state and local child welfare agencies, the minimal research that has been conducted has produced conflicting findings concerning the efficacy of the CWBS as either a predictor or an outcome measure. Rossi (1992b) maintains that the CWBS are deficient because the caseworkers that provide treatment also rate the families and bias can play a role in scoring. Thieman & Dall (1992) report that although their study's findings showed positive results, most troubling was the finding that the CWBS "appear to lack criterion validity...they do not predict out-or-home placement either at entry into service or at the conclusion of service...the scores do not appear to identify families seriously at risk...the scales do not consistently predict aspects of family demographics that, on the basis of face validity, should be associated with risk level" (p.190). On the other hand, Gaudin et al. (1992) conclude, "The CWBSs do discriminate between externally verified neglectful and nonneglectful families. Therefore, the concurrent validity of the scales as measures of adequacy of child caring is supported" (p. 327). Clearly, more empirical research on family assessment instruments such as the CWBS should be conducted.

Target Population

The study occurred over a thirteen-month period and included those client families with two or more CWBS composite scores. Two hundred and eight (208) cases in the database met this criterion. Of these cases, 106 were closed cases with a satisfactory outcome (i.e., satisfactory progress to goals); 51 were closed cases with other outcomes (i.e., child placed, child on the run for an extended period of time, case removed due to serious incident, the family refused to participate, other reasons); and 51 were open cases that were still receiving services at the time of the evaluation. One hundred thirteen families had two CWBS scores; 69 had three scores and 26 had four scores.

The Single Group Pretest-Posttest Design, Augmented by a Time-Series Component

The use of pre- and post- measures allowed treated clients to serve as their own controls supporting the inference that any difference in scores would be the result of the intervention. However, pre-post studies may be vulnerable to competing explanations for any observed change. Major threats to internal validity can accrue from maturation, history, statistical regression, and instrumentation. In the current study, however, the threat to results from individual maturation is mitigated as a confounding factor because the unit of analysis is the family rather than the individual. Statistical regression is a threat because many clients begin treatment at a point when things are very bad in their

lives, and it is therefore common for their life circumstances to subsequently improve. However, for the more generalized regression effect, the general tendency for scores to converge toward the mean can be controlled for by using multiple post-test measures of the outcome variable. History effects (outcome confounded as the result of some unique interfering event), confounding due to endogenous change (e.g. subjects receive assistance from some unknown source), or confounding due to secular drift (long-term changes occurring at a higher level in the social structure which may impact the outcome variable) must be considered as potential rival explanations for change, but no such events were operative, at least in the case records that were reviewed and in the case study interviews that were conducted. In addition, instrumentation effects (i.e. the way the CWBS instrument is scored) may also be considered as a potential rival explanation for changes in the outcome variable.

The use of a time-series component in the design attempted to identify trends in the target problem. If marked deviations in these trends coincide with the introduction of the community case management service, then the plausibility of the hypothesis that changes in the dependent variable were caused by variation in the service (i.e. the independent variable) can be supported. The more measurement points, and the more stable the trends identified in that measurement, the stronger the inference that changes in the target problem can be attributed to the intervention. Identifying stable trends through many repeated measures enhances the internal validity of evaluations that cannot utilize control groups. To the extent that changes in the outcome measures consistently occur, a pattern of coincidences can be established that makes rival explanations unlikely.

To overcome threats to external validity (i.e. the generalizability of the findings to the larger population representative of this client group receiving this type of treatment), a comparison of multiple cases which differ in some manner can be used to determine if all cases are responding to the treatment (i.e. study replication). The study was strengthened by replication of outcomes across different clients, settings and case managers, supporting more confidence in generalizing outcomes.

Data Analysis Techniques

Initial analysis of the data detected change between the baseline pre-test measure and the second measure, taken either at the end of six months in the program or at case closure. The initial baseline measures were then compared to the final outcome measure obtained from clients, i.e. composite CWBS score from the second, third, or fourth observation period depending upon when the case was defined as closed. The analyses were performed for all subjects including those whose cases were defined as closed.

The analysis of the shifts in the trend of scores on the CWBS between the baseline and the first posttest period (time two) and all following posttest periods (times three and four) is presented as proportionate changes for composite scores, or gain scores. Because the CWBS are scored, on average, every six months, the totals of all client scores were aggregated by cohorts according to those with two, three, and four CWBS composite scores.

In order to assess the impact of other factors on the relationship between the intervention and the outcomes, a multiple regression model was used. The regression of gain scores on client demographics, indicators of principal caretakers' experience with drugs and alcohol, whether they were the perpetrator of abuse and neglect, family

composition, and other factors provides a mean for assessing if these factors distort the relationship between the intervention and the outcome. Significant negative effects of these factors indicate that the generalizability of the program to settings other than the agency may be questioned.

Results

Analysis of Pretest-Posttest Results

The following research question was asked: What are the outcomes in reduction of risk factors and improvement in functioning experienced by families who receive intensive family preservation community case management? To answer this question, CWBS scores were compared from various perspectives. The CWBS measures the presence of risk factors for family dysfunction. A high score indicates the presence of many serious risk factors. A low CWBS score represents few and/or less serious factors and is desirable to obtain.

Comparison of Mean Scores on the CWBS

The first comparison includes data on all clients in the program: both open cases (those in progress) and closed cases, either completed with satisfactory progress or otherwise interrupted. A comparison of the mean CWBS scores of these 208 families at the pretest and at the second time the scale was administered, showed a CWBS decrease from 136 to 118, a statistically significant reduction ($t(207) = 10.78$, $p < .001$). The next paired sample focuses on closed cases only and compared CWBS pretest scores with posttest scores at the first posttest--either at 6 months or at closure. Again, the CWBS mean score decreased, from 131 to 114. The difference in scores is statistically significant ($t(155) = 10.05$, $p < .001$). These results lead to the conclusion that the families who participate in community case management have experienced improvements in family functioning.

The third paired sample compares mean scores of all cases, both open and closed, at the pretest and at the final measurement point. This final measurement posttest could be the second, third, or fourth time the CWBS was administered. The data show a reduction in mean scores from 136 to 112, which is statistically significant ($t(207) = 11.57$, $p < .001$), documenting again that participants in the program improved between the pretest and last posttest. The mean reduction in scores was statistically significant in all groups, and somewhat greater in the group that had been in the case management program longer. This latter finding underscores the importance of continuity of services provided by the community case management model. The data clearly demonstrate that simply connecting families with the right social services is not sufficient to reduce risk factors for family dysfunction, and raise the question about "what else" occurs to account for the difference.

The fourth paired sample focuses only on closed cases. Like the previous comparison, it compares mean scores at the start of the case management program with final score for each family. The reduction in mean CWBS scores for closed cases (131 to 108) is similar to the reduction of all cases and is also statistically significant ($t(155) = 11.18$, $p < .001$). This comparison shows a greater decrease between first and final than between first and second scores. This trend may indicate that families who continued in

the program experienced a continual decline in the presence of risk factors for family dysfunction.

Comparison of Mean Scores By Length of Time in Program

The following tables convert outcome scores to gain scores. Gain scores document the success in the program and are the result of subtracting the baseline CWBS score from the final CWBS score. This is a mathematical transformation that makes it possible to work with positive rather than negative numbers. With scores, higher values are desirable; progress is indicated by an increase rather than a decrease in score. Table 1 is a one-way analysis of variance of all client families. Families were classified by relative length of time in the program. Cases were stratified by how long they have been enrolled in case management: "short" being up to six months, "medium" being six months to one year, and "long" being over one year. The mean differences in gain scores were positive for all three groups and increased most for those who were enrolled the longest. These results were statistically significant at $p < .001$. Moreover, the longer families spent in the case management program, the greater the rate of increase. For short duration group, the mean gain score was 17 points, for those in the program the intermediate length of time, the average gain was 26 points, and for those in the program the longest time, the gain score average was 43 points. These findings may indicate that sustained participation in community case management decreases risk factors and improves family functioning. An additional one-way analysis of variance was performed on closed cases only. Mean gain scores increased with the duration that cases were enrolled in the program. The differences in mean scores were statistically significant at $p < .05$.

Table 2 focuses on the same three groups that were identified in Table 1 but with closed cases only. This table shows the percentage of families within each group who were determined to have made satisfactory progress in the case management program. The Chi square test was used to test the significance of the differences between the families classified into different categories and a random distribution of scores. The differences were statistically significant at $p < .01$. The proportion of cases considered successful increases with the duration of time that families are enrolled in the program. In general, the longer they stay, the greater the proportion that case managers judged to have successful outcomes.

Analysis of Multiple Variables to Separate Individual Effects

Outcomes were also analyzed to determine whether an association existed between improved family functioning and demographic characteristics and life problems or difficulties experienced by the family's primary and secondary caretakers. Demographic variables included age, racial or ethnic group, income, marital status, and level of education. Life problems or difficulties included abuse of drugs and alcohol, neglect, and sexual and physical abuse.

A multiple regression model with gain scores as the dependent variable was used to detect a linear relationship between caretaker life problems, or attributes, and improvements in family functioning due to the positive effects of the community case management program. Table 3 includes data for all clients. The analysis showed a significant ($p < .05$) relationship between improvements in CWBS scores and a history of

the caretaker being a perpetrator of neglect. This finding may indicate that the one-on-one counseling offered by the case management program helped caretakers cope better with their own life problems and needs, develop skills in communication, and become more available to their children, or simply that the straightforward and concrete services that were provided improved environmental conditions enough to account for the changes.

There was also a significant (p < .05) relationship between improvements in CWBS scores and cases where the primary caretakers were victims of sexual abuse. This improvement may be considered in the light that sexual abuse leads to behavioral aberrations. As the client becomes increasingly aware of how the history of sexual abuse has affected her behaviors and feelings, she may become increasingly capable of self-awareness and therefore of changing her patterns of functioning with her family, patterns that were sequelae of past abuse, although this interpretation is a possibility rather than a definitive conclusion from the available data.

Conclusions

From the results of the CWBS analyses, a substantial picture of the effectiveness of the community case management program emerges. From the measures of families' functioning over time, risk factors demonstrate a convincing decline. The strength of these results is attested to by the results reappearing through multiple tests - four different statistical manipulations -demonstrating their viability. The gains that families make continue to progressively accrue the longer they are affiliated with the service, suggesting that what occurs is not the product of single-shot or short-term intervention such as the mere linkage with needed services, but that the positive outcomes hinge on more complex processes of service that take a long period of time.

The long duration of program involvement and the family patterns of continuing improvement also argue against the possible interpretation that attribute outcomes are due to the simple resolution of the immediate crisis at hand. The nature of life for these families is the revolving door cycle of repeated crises and dysfunction embedded pervasively across multiple areas of functioning. The longitudinality of the data and the measurement sensitivity of the instrument to multiple dimensions of family life depict both a reduction in incidence of specific crises and an improvement across numerous domains. The lack of repeated crises and the pervasiveness and embededdness in arenas of improvement argue against a more simplistic regression to the mean interpretation of outcomes.

The results indicate that, through community case management, families can retrieve themselves from high risk, high dysfunction and overwhelmed coping skills. Furthermore, families evidence an ability to both contain and reduce the incidence of family problems, and to improve their levels of healthful functioning. In an era when the incidence of family dysfunction and the ineffectuality of the existing service system for remediation have reached crisis proportions (Pelton, 1990), the results produced by this study have significant implications for future design of service delivery, funding priorities, and the value of the model's application elsewhere.

The results also suggest that the social benefits obtained from more widespread use of the community case management model should be considered. The community case management model effectively mitigates the social costs of probable out-placement,

hospitalization, incarceration or other institutional interventions which were the basis of the original referrals to the agency but which were avoided because of community case management. As a successful intervention for families who are otherwise consigned to the margins of society the model not only addresses individual and family-level issues, but also positively contributes to the fabric of whole communities and to the reversal of the damaging trends of a throwaway class which imposes deficits to society across the board.

Policy Implications

The trend from extensive support from federal and state government for family preservation services and the shift away from family preservation to removing at-risk children from their homes as quickly as possible may have come full circle with the consistently high foster care numbers. The number of children in foster care has continued to go up, from 360,000 in 1989 to 520,000 in 1996 and continuing at more than a half million today with only about half returning to their parents (Bagdasaryan, 2005; Festinger, 1996; Lindsey, 1994a; Stovall & Dozier, 1998; http://www.fosterclub.grownups/statistics.cfm).

The significance of this study's findings is that the best way to help at risk families is commit to a long-term intensive family preservation service model that empowers families and strengthens communities. Farrow (2001) has proposed a new direction in child welfare for services that keep children safe and strengthen the community and he proposes "the goals of child safety, strengthening families and assuring permanent homes for children become community-wide goals to which a host of strategies can be dedicated." (p.12). "A strong argument in favor of this approach is that it seems to avoid the polarizing debates that occur whenever 'child safety' is pitted against 'strengthening families' – which was at the crux of the backlash against family preservation. Community child welfare focuses explicitly on the desired outcomes of safety, permanence, and well-being" (Farrow, 2001, p. 12). McCroskey (2001) has also suggested that family and child outcomes as a result of family preservation should be seen in a community context, reaffirming the beliefs of early social workers in the importance of community-based service delivery. Finally, Wells and Tracy (1996) recommended retaining in child welfare services key components of IFPP such as the emphasis on family strengths and empowerment including building parents' skills and social supports, working in the family's home and helping families access a range of services.

Implications for Future Research

The model merits replication in other venues where similar populations are unserved or underserved by more traditional approaches. A clear delineation of the model's elements would enhance its availability for replication and make components readily identifiable and extractable in the process of service planning. Bitonti (2002) has recommended that future research focus on describing in detail the worker activities and therapeutic goals. A desirable design addition would be a comparative contrast to an alternative intervention model or models, either of the more typical state agency child

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welfare case management model or a more specialized family preservation model. Such a comparative study would be enhanced by a randomized control group design. Adding a cost-benefit analysis to such a study would also substantially add to the value of findings for state planning, policy and budgeting purposes.

References

Bagdasaryan, S. (2005). Evaluating family preservation services: Reframing the question of effectiveness. *Children and Youth Services Review.* 27: 615-635.

Barth, R.P. (1990). Theories guiding home-based intensive family preservation services. In J.K. Whitaker, J. Kinney, E.M. Tracy, & C. Booth (Eds.), *Reaching high risk families: Intensive family preservation.* New York: Aldine de Gruyter.

Bath, H.I., & Haapala, D.A. (1993). Intensive family preservation services with abused and neglected children: An examination of group differences. *Child Abuse & Neglect,* 17, 213-226.

Berlin, G. (1992). Choosing and measuring interventions. *Children and Youth Services Review.* 14, 99-118.

Berry, M. (1992). An evaluation of family preservation services: Fitting agency services to family needs. *Social Work, 37, 4,* 314-321.

Besharov, D.J. (1994). Looking beyond 30, 60, 90 days. *Children and Youth Services Review,* 16, 445-452.

Bitonti, C. (2002). Formative evaluations in family preservation: Lessons from Nevada. *Children and Youth Services Review*, 24 (9/10), 653-672.

Dore, M.M., & Alexander, L.B. (1996). Preserving families at risk of child abuse and neglect: The role of the helping alliance. *Child Abuse & Neglect,* 20, 349-361.

Farrow, F. (2001). The shifting policy impact of intensive family preservation services. *Discussion Paper CS-68,* Chapin Hill Center for Children.

Festinger, T. (1996). Going home and returning to foster care. *Children and Youth Services Review, 18,* 383-402.

Forsythe, P. (1992). Homebuilders and family preservation. *Children and Youth Services Review, 14,* 37-47.

Fraser, M.W., Nelson, K.E. & Rivard, J.C. (1997). Effectiveness of family preservation services. *Social Work Research,* 21 (3), 138-153.

Fraser, M.W., Pecora, P.J., & Haapala, D.A. (1991). Families *in Crisis: The Impact of Intensive Family Preservation Services*. Hawthorne, NY: Aldine de Gruyter.

Gaudin, J.M., Polansky, N.A., & Kilpatrick, A.C. (1992). The Child Well-Being Scales: A field trial. *Child Welfare, 121*(4), 319-328.

http://www.fosterclub.com/grownups/statistics.cfm

Jones, M.A., Magura, S., & Shyne, A.W. (1981). Effective practice with families in protective and preventive services: What works? *Child Welfare,* 60, 67-80.

Kamerman, S.B., & Kahn, A.J. (1990). If CPS is driving welfare - where do we go from here? *Public Welfare, 18*, 1, 9-13.

Kirk S.R., & Griffith, D.P. (2004). Intensive family preservation services: Demonstrating placement prevention using event history analysis. *Social Work Research,* V28, #1, 5-16.

Lindsey, D. (1994a). The *Welfare of Children*. New York: Oxford University Press.

Lindsey, D. (1994b). Family preservation and child protection: Striking a balance. *Children and Youth Services Review,* 16, 279-294.

Littell, J.H., & Schuerman, J.R. (2002). What works best for whom? A closer look at intensive Family Preservation Services. *Children and Youth Services Review, 24, 9/10,* 673-699.

Littell, J.H. (1995). Evidence or assertion? The outcomes of family preservation services. *Social Science Review,* 69, 338-351.

Littell, J.H., Schuerman, J.R., Rzepnicki, T.L., Howard, J., & Budde, S. (1993). Shifting objectives in family preservation programs. In E.S. Morton & R.K. Grigsby (Eds.), *Advancing family preservation practice* (pp.99-118). Newbury Park, CA: Sage Publications.

MacDonald, H. (1994). The ideology of "family preservation." *The Public Interest, 115,* 45-61.

MacLeod, J. & Nelson, G. (2000). Programs for the promotion of family wellness and the prevention of child maltreatment: A meta-analytic review. *Child Abuse & Neglect, 24 (9), 1127-1149.*

Magura, S., & Moses, B.S. (1986). *Outcome measures for child welfare services.* Washington D.C.: Child Welfare League of America.

McCroskey, J. (2001). What is family preservation and why does it matter? *Family Preservation Journal,* 5, 2, 1-24.

Nelson, K.E. (1997). Family preservation – What is it? *Children and youth services review,* 19 (1/2), 101-118.

Nelson, K.E., & Hunter, R. W. (1994). Empowering families through home-based services. In P. Nurious & L. Gutierrez (Eds.), *Education and research for empowerment.* Seattle, WA: University of Washington School of Social Work.

Nelson, K.E., & Landsman, M.J. (1992). *Alternative models of family preservation: Family-based services in context.* Springfield, IL: Charles C. Thomas.

Nelson, K.E. Landsman, M.J., & Deutelbaum, W. (1990). Three models of family centered placement prevention. *Child Welfare,* 69, 3-21.

Pelton, L. H. (1990). Resolving the crisis in child welfare. Public Welfare, 48(4), 19-25.

Reid, J.W., Kagan, R.M., & Schlosberg, S.B. (1988). Prevention of placement: Critical factors in program success. *Child Welfare,* 67, 25-37.

Rossi, P.H. (1992). Strategies for evaluation. *Children and Youth Services Review*, 14, 167-191.

Rossi, P., & Freeman, H. (1985). Evaluation research. Palo Alto, CA: Sage Publishers.

Schuerman, J.R. (1997). Best interests and family preservation in America. *Discussion paper CS-44,* Chapin Hall Center for Children.

Schwartz, I.M, AuClaire, P., & Harris, L. (1991). Family preservation services as an alternative to the out of home placement of adolescents: The Hennepin County experience. In K. Wells & D.E. Biegel (Eds.), *Family Preservation Services: Research and Evaluation.* (33-46). Newbury Park, CA: Sage Publications.

Staudt, M, & Drake, B. (2002). Intensive family preservation services: Where's the Crisis? *Children and Youth Services Review,* 24, (9/10), 777-795.

Stovall, K.C., & Dozier, M. (1998). Infants in foster care: An attachment theory perspective. *Adoption Quarterly, 2, 1,* 55-88.

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Thieman, A.A., & Dall, P. W.   (1992). Family preservation services: Problems of measurement and assessment of risk. <u>Family Relations</u>, <u>41</u>, 186-191.

Wells, K., & Tracy, E. (1996). Reorienting intensive family preservation services in relation to public child welfare practice. *Child Welfare,* 75, 667-692.

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TABLE 1: ANALYSIS OF VARIANCE FOR GAIN SCORES BY LENGTH OF PERIOD OF CLIENT INVOLVEMENT IN CCM PROGRAM
(All Cases in Program)

Analysis of Variance					
Source	d.f.	Sum of Squares	Mean Square	F Ratio	F Prob
Between Groups	2	15255.11	7627.55	9.77	.0001
Within Groups	205	159973.66	780.36		
Total	207	175228.76			

Group Differences							
Group	Count	Mean	Standard Deviation	Standard Error	Min.	Max.	95 Pct Confidence Interval for Mean
Short	113	17.14	21.53	2.03	-37	116	13.13 to 21.15
Moderate	69	25.94	34.20	4.12	-63	151	17.73 to 34.16
Long	26	43.39	33.79	6.63	-2	146	29.74 to 57.03
Total	208	23.34	33.79	2.02	-63	151	19.36 to 27.32
Fixed Effects Model			27.94	1.94			19.53 to 27.16
Random Effects Model				7.18			-7.56 to 54.25

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TABLE 2: CROSS-TABULATION OF CLIENT PROGRAM COMPLETION BY LENGTH OF PERIOD OF CLIENT INVOLVEMENT IN CCM PROGRAM (Closed Cases Only)

Period of Client Involvement -->	Short Group 1100	Moderate Group 1110	Long Group 1111	Total
Satisfactory Outcome	39 47.0%	37 72.5%	15 68.2%	91 58.3%
Less than Satisfactory Outcome	44 53%	14 27.5%	7 31.8%	65 41.7%
Total	83 53.2%	51 32.7%	22 14.1%	156 100%
$\chi^2 = 9.51$, d.f. = 2, $\alpha = .0086$				

TABLE 3: REGRESSION OF GAIN SCORES ON CLIENT INDICATORS OF LIFE PROBLEMS
(All Cases in Program)

Multiple R	0.3322
R Squared	0.1103
Adjusted R Square	0.0827
Standard Error	25.9867

Analysis of Variance

Source	Degrees of Freedom	Sum of Squares	Mean Square	F	Sig.
Regression	4	10802.5102	2700.6276	3.9991	0.0043
Residual	129	87114.6241	675.3072		

Variables in the Equation

Variable	B	SE B	Beta	T	Sig. of T
Perpetrator of Neglect	11.54	4.80	0.201	2.41	0.0175
Victim Sexual Abuse	11.26	5.04	0.186	2.23	0.0272
History Drug Abuse	-12.16	6.23	-0.224	-1.95	0.0531
History Alcohol Abuse	11.91	6.31	0.219	1.89	0.0612
Constant	14.10	4.03		3.50	0.0006