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The *Family Preservation Journal* is a refereed annual publication. The *Journal* provides a forum for practitioners, administrators, researchers and educators to present and critically review programs, policy, practice methods, and research findings in the areas of family preservation and family support. The *Journal* is intended to positively impact the type and manner of services provided to families. Research and case studies from those delivering services are encouraged.

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Provide three hard copies or one electronic copy of the manuscript; the title page only should list the author's name, affiliation, address, and telephone number. The author's name must not appear after the title page; only the title should appear on the abstract and first page of the text, include an abstract of about 100 words.

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Editorial

A Holistic View of Family Preservation Services

One of the hallmarks of family preservation services is that they are holistic and attend to multiple dimensions of family life. In that spirit, this issue of the *Family Preservation Journal* provides a holistic view of these services, by offering research from the perspective of children, parents, caseworkers, and students of social work. These articles focus on the effectiveness of services, parents' perceptions of services, and the knowledge, attitudes and behavior of child welfare caseworkers. There should be something here for everyone who serves children and their families.

This issue contains two studies of the effectiveness of family preservation services. The first, by Rofuth and Connors, uses a time-series design to examine the effect of family preservation services when the length of services can be extended for those families with chronic problems. Using empowerment-oriented case management services, families' scores on the Child Well Being scales decreased in risk factors over time. The second study of service effectiveness, by Hanssen and Epstein, uses retrospective investigation of case files to examine the particular service components that are associated with positive program outcomes. The researchers find that empowerment, education and advocacy for families were most effective in reducing unmanageable child behaviors. These two studies together demonstrate the effect that holistic services that do not focus solely on parent or child behavior can have important effects on those behaviors.

From a parent's point of view, those families receiving family preservation services are more satisfied with services than those receiving family maintenance services, according to the study by Lee and Ayon. These parents also perceived family preservation services to be most helpful in improving child discipline, emotional care of children, and help with housing, despite the fact that those families receiving family preservation services were more likely to be Spanish-only speakers and have more children. Logan's qualitative study with child welfare caseworkers demonstrates the importance of concrete supports to family success as well. These studies together point to the continuing need for family preservation and child welfare program to attend to the holistic needs of parents, especially concrete needs such as housing, transportation, financial aid, and child care.

The next two articles in this issue concern the training of, and decision making by, child welfare caseworkers, so that services to families are delivered in the most respectful, collaborative and positive ways. A training program delineated by Love and Campbell focuses on the attitudes of child welfare workers who are pursuing their masters degree in social work. When attitudes about birth parents are shifted to be more positive, birth parents are more motivated to participate in services. Meek explores how decisions are made whether to serve families in the office or in the home, and finds that these decisions are rarely thoughtful or purposeful. She provides a framework for making this decision more meaningful to program outcomes.

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Lastly, an article by Cheung and Queen discusses the lack of consistent measures on service effectiveness in human service organizations. In an attempt to fill this void, the authors present their findings from a national survey of 250 not-for-profit family service organizations in the United States. The survey yielded results relevant to client identified needs and agency effectiveness measures in serving today's families.

This issue of the Family Preservation Journal adds to the evidence-base for family services, and demonstrates how much is added to our knowledge when a variety of perspectives are sought and included in the research.

Marianne Berry
University of Kansas

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Effectiveness of Community Case Management in Family Risk Reduction

Todd Rofuth and Kathleen A. Connors

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 embededness 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

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.

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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

Learning What Works: Demonstrating Practice Effectiveness with Children and Families Through Retrospective Investigation

Daria V. Hanssen and Irwin Epstein

Intensive family preservation services (IFPS), designed to stabilize at-risk families and avert out-of-home care, have been the focus of many randomized, experimental studies. Employing a retrospective "clinical data-mining" (CDM) methodology (Epstein, 2001), this study makes use of available information extracted from client records in one IFPS agency over the course of two years. The primary goal of this descriptive and associational study was to gain a clearer understanding of IFPS service delivery and effectiveness. Interventions provided to families are delineated and assessed for their impact on improved family functioning, their impact on the reduction of family violence, as well as placement prevention. Findings confirm the use of a wide range of services consistent with IFPS program theory. Because the study employs a quasi-experimental, retrospective use of available information, clinical outcomes described cannot be causally attributed to interventions employed as with randomized controlled trials. With regard to service outcomes, findings suggest that family education, empowerment services and advocacy are most influential in placement prevention and in ameliorating unmanageable behaviors in children as well as the incidence of family violence.

Intensive family preservation services (IFPS), designed to stabilize at-risk families and avert out-of-home care, have been the focus of many randomized, experimental studies (Pecora, Whittaker, Maluccio, Barth & Plotnic 1992)**.** This study attempts to assess the overall effectiveness of family preservation, treated as a single, relatively standardized intervention, on placement prevention, as well as explore associations between IFPS interventions, presenting problems, and placement prevention. Employing a retrospective "clinical data-mining" (CDM) methodology (Epstein & Blumenthal, 2004), this study makes use of available information extracted from client records in one IFPS agency over the course of two years.

Empirically assessing the delivery of specific service components responds to the demands for greater accountability in intervention management (Rossi, 1991). Moreover, it can suggest ways in which intervention variations differentially affect child and family outcomes, as well as providing an opportunity to reconfigure practice, based on the identification of differentially effective interventions (Berry, 1997; Pecora et al., 1992; Rossi, 1991, 1992a; 1992b; Staff & Fein, 1994). Knowledge generated is intended to inform and enhance practice and program development for family support programs and family focused placement prevention programs.

Literature Review

Service Provision

The intensive family preservation services model posits a family empowerment approach, encouraging family participation in intervention, goal setting, and in developing solutions to avoid family dissolution. The operational elements of this model include: 1) a home-based approach, 2) service intensity up to 20 hours per week for no longer than 90 days, 3) round the clock worker availability for emergency visits, and 4) worker caseloads of no more than two families at any given time in order to insure intensive treatment (Wells & Biegel, 1992).

Services typically provided by IFPS programs have been described as soft, hard/concrete, and enabling services (Berry, 1995). Soft services include such activities as psychoeducation, family counseling, and individual counseling. Concrete services consist of a range of services such as, financial assistance, home repairs, transportation, and recreational activities that families generally cannot afford. Enabling services provided on behalf of families include advocacy with social services, legal and educational systems, as well assistance in negotiating access to community support services (Berry, 1995; Rossi, 1991; Wells & Biegel, 1992; Wells & Tracy, 1996).

Characteristics that distinguish IFPS from other holistic family-centered services and from the more traditional "person-centered" perspective (Farrow, 1991; Nelson, 1997; Whittaker, 1991) include: 1) establishing a service continuum with the capacity for individualized case planning, 2) promoting competence in children and families by teaching practical life skills and providing environmental supports, 3) providing services that support and strengthen Families, 4) collaborating with families and other agencies to best serve at-risk children and families, 5) intensive service provision, of short duration, to all members of the household to restore family stability and, 6) ongoing assessment of the safety and well-being of the children with consideration of placement when necessary (Brieland, 1987; Pecora, Fraser, Nelson, McCroskey & Meezan, 1995; Rossi, 1991; Whittaker, 1991; Whittaker, Kinney, Tracy & Booth, 1990).

Intensive Family Preservation Services: Intervention Research

Key studies which explore IFPS service provision include prospective descriptive intervention evaluations (Berry, 1992, 1995; Berry, Cash & Brook, 2000; Fraser, Pecora & Lewis, 1991; Kinney, Haapala & Booth, 1991; Lewis, 1991; Tjeerd ten Brink, Veerman, de Kemp & Berger, 2004), experimental studies (Feldman, 1991; Schuerman, Rzepnicki & Littell, 1994), and quantitative studies correlating services to placement and treatment outcomes (Berry, 1994, 1995; Cash & Berry,2003; Kirk & Griffith, 2004). Additionally, two meta-analytic studies explore family preservation outcome research with attention to the provision of services and interventions to specific populations (Blythe, Salley, & Jayaratne, 1994; Fraser, Nelson & Rivard, 1997).

A number of researchers have addressed the effects of intensive services on the reduction of risk behaviors relative to child behavior and family functioning (AuClaire & Schwartz, 1986; Feldman, 1991; Fraser et al, 1991; Landsman, 1985; Meezan & McCroskey, 1996; McCroskey & Meezan, 1997; Wells & Whittington, 1993). Feldman (1990) found that families referred because of a combined problem of emotional

disturbance or behavior problems and poor parenting were more likely to experience placement. In a similar vein, Fraser, Pecora and Lewis (1991) found that children who had mental health histories had a greater risk of placement than those children with no prior mental health history. Fraser, Nelson and Rivard (1997) reported that intensive home based services appeared to be moderately effective in preventing placement of children who are in early adolescence and who are referred for behavior problems such as truancy, oppositional behaviors and other delinquent acts.

Assessing the improvement in child functioning is an implicit goal of intensive family preservation programs, yet few studies focus on specifying service components to determine the impact on child and family functioning (McCroskey & Meezan, 1997). Studies focusing on family outcomes (Berry, 1992, 1995; Feldman, 1991) reported that skill building services, such as teaching child management, alone or in combination with concrete services, was generally associated with better outcomes for families. In contrast, soft services, such as individual or family counseling, were not found to be associated with improved family functioning or placement prevention (Fraser, Pecora & Lewis, 1991, Berry, Cash & Brook, 2000). In yet another study conducted by Cash and Berry (2003), it was concluded that services had minimal effect on improved family functioning outcomes when the relationship between family characteristics, services provided and child well-being were explored.

Method

The study site, Families First, is located in a small urban center, serving a suburban and rural community. The program adheres to an intensive family preservation service model (IFPS), similar to the Homebuilders model, developed in the 1970's which was designed to stabilize at-risk families and avert out-of-home care. It was theorized that out-of- home care could be prevented by the provision of a combination of counseling, psychoeducation, and concrete services to families in their homes for ten to twenty hours per week and for four to six weeks (Nelson, 1997; Rossi, 1991; Wells and Biegal, 1992). Consistent with intensive family preservation program theory, Families First is a voluntary program that subscribes to a family centered approach, in-home intensive service provision, a generic and integrated response to multiple family problems, and a time-limited service duration. The entry point for service eligibility is a child's risk of imminent placement. Treatment is based on a family's willingness to participate in intensive services, commencing when at least one family member expresses a desire to maintain the family unit. Tailored to accommodate individual family needs while building on family strengths, a continuum of hard, soft, and enabling (Berry, 1996) services are provided, including counseling, information and referral, budgeting and money management, health care, nutrition, parenting and communication skill development. Referrals originate from the Division of Social Services, Child Protective Services unit, specifically through either the mandated prevention unit; the foster care unit, the intake/investigation child protection service workers, family court, mental health services, or families themselves. Services are provided from four to eight weeks, meetings are scheduled at least four times per week for as many as fifteen hours per week in the family's home, and workers are on call to their caseload of two families, twenty-four hours per day.

Families First proved to be a prime site for this data mining research, particularly because client records contained detailed service information, which allowed for comparative intervention research with prior studies and made it possible to examine treatment fidelity.

Participants

The sample was comprised of case records for all families served by Families First during the two-year period from January 1, 2000 through December 31, 2001 resulting in 116 case records (N=116). Four of the currently employed Families First workers were also employed during the two-year period noted above. This allowed for input from practitioners and corroboration of information for potential interpretation of interventions and services.

Procedure

This study was essentially a case study of a single IFPS agency. Yin (1989) describes the case study as an "empirical inquiry that investigates a contemporary phenomenon within its real life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used" (p. 23). CDM was selected for determining the specific nature of IFPS practice and intervention patterns because it is an unobtrusive approach to gathering clinical information from existing client records (Epstein, 2001).

Materials

The extracting tool, the Inventory of Demographics and Services was designed to retrieve and record available data from client records. This inventory reflected salient program theory and concepts derived from the family preservation literature. Three tools designed for prospective analysis of IFPS interventions informed the development of this data-mining instrument: 1) Concrete Service Checklist and the Clinical Services Checklist (Fraser, Pecora & Haapala, 1991), 2) Major Techniques Checklist (Schuerman, Rzepnicki & Littell, 1994), and 3) Therapeutic Interventions and Concrete Services Inventory (Pecora, Fraser, Nelson, McCroskey & Meezan, 1995). The final Inventory of Demographics and Services resulted in 134 variable measures of which 112 were interventions and the remainder was demographic characteristics. In order to insure that each intervention was mutually exclusive and simple to understand, an exhaustive list of operational definitions was developed for all variables, utilizing the review of the literature, as well as practice knowledge. A few examples of operational definitions for interventions are: 1) Define obstacles to task achievement: identify events, relationships and behaviors that interfere with successful accomplishments of tasks, goals and/or behaviors; 2) Explore problems: work from generalized labels of problematic behavior down to specifics; break into small, manageable goals; examine why this is a problem; determine problem ownership, family goals/values in relation to problem; and 3) Generate action plan: negotiate mutual agreement on treatment methods to be used, how to measure success, consequences, timetables.

Measures

The 116 case records were analyzed for distinctive services, interventions, and demographic information through an exacting review of process notes, three and six week summaries, termination summaries, and from supplemental material in the case record, such as, hospitalization or police reports, psychological testing reports, individualized education planning reports, school incident reports, and summaries from mental health counseling and other social service agencies. Data was entered onto the Inventory of Services and Demographics and later into SPSS for data analysis.

The child at imminent risk of being placed in substitute care is referred to as the "identified child" who was in physical and/or emotional danger in terms of personal safety at home, at school, or in the community. Only one child per family was considered as the "identified child", the child most in danger of placement.

Each intervention was counted and recorded only once, despite the number of times a worker might have utilized an intervention in a single case. This decision to record service provision only once was made because services were imbedded in the case narrative, making it extremely difficult to count each dose. Types of interventions were treated as independent variables when the dependent variable was placement outcome. However, when assessing interventions relative to family problems, the family problem was treated as the independent variable while the intervention was treated as the dependent variable. To assess program fidelity, the 112 interventions identified in the case records were then combined into existing categories defined by Berry (1995, 1997, 2000) and Lewis (1991) as hard, soft, enabling, and strengths assessment services. Additional categories of service identified by Fraser et al (1997) and used in this study included: empowerment, skill building, collateral, marital and family, crisis, and concrete services. A Cronbach's Alpha was performed to determine reliability of the summated service scales, resulting in positive reliability scores ranging from .81 to .86 of the summated scales.

The data-extracting instrument was determined to be content valid through the literature review and through personal conversations with Family First practitioners who provided their interpretations of services and interventions, when necessary. Reliability of the data-gathering instrument was assessed empirically within the study itself and by comparing study findings to those in prior empirical studies (Berry, 1992; Berry, et al., 2000; Fraser, et al., 1991; Lewis, 1991). To establish intra-rater reliability of the instrument ten case records were randomly selected and coded again three months after the initial data mining. Although not an ideal method for establishing reliability, Families First would not permit any outside readers of the case files. The intra-rater reliability was computed using .80 as the cut-off point for inclusion or exclusion. A reliability coefficient of .96 to .80, was obtained for 134 of the 137 inventory variables. Reliability ratings below this standard were found in the following three service related variables: 1) providing reinforcement had a reliability coefficient of .60, 2) teaching cognitive self-control, .70, and 3) teaching self-management skills, .60. These variables were deleted in order to increase assurance of intervention distinctiveness and to avoid services being counted more than once.

Results

Cross tabulations permitted analysis of possible associations between: 1) whether a child was placed or not and presenting problems, 2) whether a child was placed or not and interventions provided, and 3) interventions provided and presenting problem. To determine if any relationship existed between the level of family violence before and after service provision, a paired samples T Test was computed based on the assessment of the level of family violence at the time of referral and discharge. A linear regression analysis was conducted to determine if any association existed between interventions and the reduction in family violence following service provision. Throughout the data analysis, $p < .05$ level of statistical significance is used for treating findings as "facts". However, given the relatively small sample size, trend level findings will be reported at $p < .07$ level, suggesting possibly important associations between IFPS interventions and outcomes.

Family Characteristics and Presenting Problems

Overview of Families: Families First served 296 children from 116 families in the two year period under investigation, with one child from each family referred to as the identified child (N=116). The mean number of children per family unit was 2.55. The age of the identified child ranged from infancy to seventeen years of age. In more than half of the families (54.5%), the child most at risk of placement was between the ages of 13 to 17, who demonstrated incorrigible behavior at home and at school, and who were receiving outpatient or inpatient mental health treatment. The child identified as being at risk of placement and most in need of services was male (61.2%) of the time. Approximately half of the 116 identified children referred to Families First were diagnosed with an emotional disturbance (53.4%) and had committed a status offense (48%). As compared to other risk factors, child abuse and neglect were not major reasons for referral. Family violence was a reason for referral in approximately 20% of all families served. Table 1 reports a more detailed list of family demographics mined from the existing data.

Placement prevention and demographics: The mean age of children who had placement prevented was 11.90 as compared to the mean age of children who experienced placement, which was 13.57. No significant age difference was found for identified children by placement outcome, $t (114) =1.45$, $p=.15$, or gender difference by placement outcome, $\chi2 (1, N=116) = .701$, $p=.403$. Children residing with birthparents and living in a blended family unit were defined as a "dual" parent family, while all other families were defined as single parent family units. A statistically significant relationship was not found to exist between family composition and placement prevention, $\chi2 (1, N=116) = 2.66$, $p=.102$; therefore, one can infer that family composition had no association to placement outcomes in this study.

Placement prevention and presenting problems: Child abuse and neglect, emotional disturbance, reunification, unmanageability resulting in a status offense, family violence, parental mental illness, and substance abuse were typical family problems which constituted a reason for referral to Families First. Overall, placement prevention was achieved for 88% of all 116 families served. Table 2 illustrates the placement prevention outcomes relative to presenting problems.

There were significant associations between the provision of IFPS services and the prevention of placement, particularly when substance abuse, parental mental illness, and unmanageability were problems.

Family Violence: Approximately 20% of all families in the sample experienced some form of family violence. Family violence was assessed by the referral source using a 4-point scale. Each category was defined as follows (per referral agent): 1) high level-often physically or verbally threatening, physically abuses others and damages property, 2) moderate level-has angry outbursts, verbally abusive, may be destructive to property, but not people, 3) low level- occasionally has verbal outbursts and, 4) no family violence. At case closure, the Families First worker provided a narrative description of family accomplishments and areas for continued improvement. This narrative was read carefully and assessed for the level of family violence utilizing the 4-point scale discussed above. A paired samples T Test was administered to assess the reduction in family violence before and after service provision for ten family characteristics. Table 3 illustrates the outcomes.

It was encouraging to find that there was a significant reduction in family violence for all families in the sample from intake to discharge when: 1) families were referred for unmanageability, domestic violence, and reunification, 2) when substance abuse was a problem for a parent/guardian; 3) the identified child was male; 4) when a child committed a status offense; and 5) when a child was emotionally disturbed. Thus, these findings are suggestive of a positive impact of IFPS on child and family functioning.

Interventions and the Reduction in Family Violence: When individual services were assessed relative to the reduction in family violence, there were no statistically significant associations. However, when services were assessed as categories of service: hard, soft, enabling, empowerment, skill building, collateral, marital and family, crisis (Berry, 1995, 1997, 2000; Lewis, 1991; Fraser et al., 1997) significant associations were found to exist between the reduction of violence and soft services, skill-building services, marital and family interventions, and empowerment services. These outcomes do not reflect the impact intervening variables may have had on the reduction of family violence. Table 4 illustrates associations between the reduction in family violence and service categories. The following section will discuss the findings relative to services and demographic characteristics.

Presenting Problems and Categories of Service

 Data "mined" from the records included length of service time, concrete, enabling, and soft or clinical interventions. Of the 112 interventions, 82% were identified as clinical or soft services, 11% of interventions were identified as enabling activities, and 7% were identified as concrete activities. Chi-square analyses listed in the following subsections suggest that associations exist between presenting family problems and a profile of interventions provided to families.

Emotional disturbance: Families with an emotionally disturbed child were more likely to receive enabling services such as helping clients to locate housing $\chi2$ (1, *N*=116) = 5.105, p = .024, and testifying and attending court hearings, $\chi2$ (1, *N*=116) = 10.590, p =.001. Soft services aimed at improving family functioning and child management skills included: encouraging the client to tell their story $\chi2$ (1, *N*=116) = 4.59, p =.032, encouraging individual ventilation $\chi2$ (1, *N*=116) = 4.32, p =.037, use of the family

process, χ2 (1, *N*=116) = 13.721, p =.000, identifying behavioral sequences for change, χ2 (1, *N*=116) = 7.39, p =.007 and developing behavioral contracts, χ2 (1, *N*=116) = 5.34, p =.035. Skill-building services provided included: teaching anger management, χ2 (1, *N*=116) = 4.45, p =.035, teaching time outs, χ2 (1, *N*=116) = 4.45, p =.035 and teaching relaxation skills, χ² (1, *N*=116) = 3.92, p =.048.

Status offenses: Children who committed a status offense accounted for 48.3% of the 116 identified children in the sample. Significant associations with placement prevention were found for this group when soft services were provided: with clarifying family roles, χ2 (1, *N*=116) =12.33, p =.000, clarifying family rules, χ2 (1, *N*=116) = 9.51, p =.002, generate action plan χ2 (1, *N*=116) = 9.20, p =.002, explores coping skills, χ2 (1, *N*=116) = 12.10, p =.001, and use of family process, χ2 (1, *N*=116) = 7.36, p =.007. The enabling service that appeared to be significantly associated with families where children had committed a status offense was the provision of information and referrals χ² (1, *N*=116) = 6.34, p =.012.

Substance abuse: Almost half (45.6%) of all parents and or caretakers were identified as experiencing substance abuse problems. As with the previous presenting problems discussed, the soft services, particularly skill building and crisis intervention services were associated with better outcomes for these families. Examining past behavior and consequences χ2 (1, *N*=116) = 4.21, p =.040, teaching parenting skills χ² (1, *N*=116) = 6.82, p =.009, teaching social skills, χ² (1, *N*=116) = 4.94, p =.026 and providing structure during a crisis, χ² (1, *N*=116) = 4.497, p =.034 all produced significant associations.

Parental mental illness: In this sample, 19.8% (n=23) of families had a parent or guardian who suffered from a mental illness. Significant associations were found relative to the enabling services, concrete services, and soft services. Teaching clients how to negotiate service systems χ2 (1, *N*=116) = 10.44, p =.001 and arranging for respite or daycare services χ2 (1, *N*=116) = 4.24, p =.039, were significantly associated with placement prevention. The provision of concrete services, including food and financial support, was found to be significantly associated with parental mental illness, χ2 (1, *N*=116) = 5.339, p =.021. Soft services which were found to be associated with this group of families included encouraging families to call during a crisis, χ2 (1, *N*=116) = 4.41, p =.036, and teaching problem solving skills, χ² (1, *N*=116) = 4.015, p =.045.

Categories of Service and Placement Prevention

Overall, the soft services were most commonly provided to families in this study, suggesting that these types of services were most significantly associated with the prevention of placement for the 116 families served by Families First. Considering the complexity and overlapping nature of family problems, a modicum of success in placement prevention has been achieved by Families First. Table 5 illustrates these findings. This table demonstrates that significant associations exist between the soft and enabling interventions and placement prevention.

Feasibility of "Clinical Data Mining" as a Research Strategy

Clinical Data mining has helped to clarify which interventions appear to be associated with placement prevention when particular family and child problems are

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present. Retrospective study of process notes, three and six week summaries, and assessments, yielded service variables and family demographics not considered in other studies of interventions. Accordingly, CDM helped enumerate a range of interventions that are often glossed over in the literature as simply "marital and family" or "enabling" services. The character of the work and of the families became vivid in the detailed notes of family problems, interventions used, and outcomes.

The findings produced comparable results to published findings using prospective measures (Fraser, Pecora & Haapla, 1991), particularly with regard to the positive association between placement prevention and enabling services, skill-building services, and empowering services. Fraser, Pecora, Haapala, and Lewis (1991) found that placement was prevented when the following interventions were provided: parenting education, child development education, self-esteem enhancement, relationship development skills, and case management. Similarly, the present retrospective study found that the soft services which focus on relationship building and
improving family dynamics, as well as those, devoted to skill building and advocacy activities were associated with placement prevention. Likewise, Feldman (1994) in an experimental study found that the soft services, particularly, child management education, relationship building skills, communication skill development, as well as advocacy activities were associated with placement prevention.

In Berry's studies of services, it was found that enabling services were associated with better family outcomes (1992) and placement prevention was associated with counseling (1995). Similarly, the present study found that couples counseling, as well as a number of other counseling interventions such as listening to the client's story and encouraging ventilation were associated with the prevention of placement. It was encouraging to find that family education, empowerment interventions, and marital and family interventions were associated with a reduction in family violence. It is to be remembered that participation in Families First is voluntary; therefore, positive outcomes might naturally be a result of family willingness to engage in intensive services.

There were limitations to utilizing CDM in this study, which must be taken into consideration: 1) each practitioner possessed their frame of reference, worldview, and style of treatment, which influenced how and what was documented in the case record; 2) this research method did not employ a control group; and 3) the sample size was small. Therefore, generalization to other programs is risky, and the ability to infer causality within the data is not realistic. In addition, CDM is time consuming, however once definitions are operationalized and the extracting tool is created, work proceeds smoothly. Use of available clinical records, although not experimental, is a very feasible method of research in evaluation of services and outcomes in social work practice, child welfare, and family preservation practice. It allows one to get "at the heart" of services and their effectiveness.

Implications for Policy Development, Research and Education

Program planners, child welfare policy-makers and practitioners must seriously consider the multi-problem nature of at-risk families and the need for representatives of child welfare, social services, and mental health to work as a team in treating the mental health problems of children and   families. Equally important is the ongoing education

needed to support the creativity and ingenuity of workers who are engaged with families whose problems may have a long history.

If the social work profession hopes to conduct more research using "clinical data mining" as well as advance the practitioner-research model toward improving service delivery, front line workers must be provided with the opportunity and education to be involved in program evaluation. There are many aspects of family preservation programs that are in need of evaluation, as they bear heavily on placement outcomes. Essential program components that need to be measured include client characteristics, program goals and objectives, improvement of child and family functioning, the presence and extent of the range of services provided to families, measurement of the knowledge and skill family members have acquired reduction in family risk factors, and identification of family strengths. However, more knowledge is needed for child welfare professionals to determine who really benefits from IFPS services. These authors did attempt a qualitative study with little success due to a very low response rate. Thus the question that remains for future analysis is-under what kind of conditions, with what kinds of families, do these interventions work?

Conclusion

For quite some time now, experts in the child welfare field have questioned the utility of placement prevention as the single outcome measure of IFPS program effectiveness (Berry, 1997; McCroskey & Meezan, 1997; Pecora, et al., 1992; Rossi, 1991). The child welfare literature has acknowledged that remaining at home is not always in the best interest of the child and that not every family can or should be preserved. To better serve children and their families, program outcomes should be defined more broadly and not limited to placement prevention. Because placement has many causes, it is important that a measurement of outcomes address the impact of services on the whole family and the individuals that are a part of that family unit.

There are many aspects of family preservation programs that are in need of evaluation, as they bear heavily on placement outcomes. Essential program components that need to be measured include client characteristics, program goals and objectives, improvement of child and family functioning, the presence and extent of the range of services provided to families, measurement of the knowledge and skill family members have acquired reduction in family risk factors, and identification of family strengths. As has already been demonstrated, "clinical data mining" is a promising method for gaining insight into program process, service and intervention technology, and the impact on child and family functioning.

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Table 1

Profile of Families (N=116)

	N	%
Single Mother	49	42.2
Biological Family	26	22.4
Blended Family	28	25.0
Other Family Type	13	10.4
Identified Child		
Male	71	61.2
Female	45	38.8
Reasons for Referral		
Unmanageability	53	45.7
Reunification	21	18.1
Neglect	16	13.8
Abuse	12	10.3
Other	3	13.4
Family Risk Factors		
Emotional disturbance	62	53.4
Unmanageability/Juvenile court involvement	56	48.3
Substance abuse	49	42.2
Domestic violence	23	19.8
Parental mental illness	23	19.8
Previously placed in care	17	14.7
Sexual abuse victim	17	14.7
Homeless	9	7.8

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Table 2

Placement Prevention by Presenting Problem (N=116)

Presenting Problem	Problem				$\chi 2$	df	p	phi
	Yes		No					
	%	n	%	n				
Child Neglect	100	14	86.3	88	2.18	1	.139	.137
Child Abuse	93.8	15	87.0	87	5.92	1	.442	.071
Emotional Disturbance	91.9	57	83.3	45	2.012	1	.156	.132
Family Violence	95.7	22	86.0	80	1.61	1	.204	.118
Parental Mental Illness	100	23	84.9	79	3.93	1	.047	.184
Reunification	81.5	22	89.9	80	1.37	1	.240	.109
Substance Abuse	77.6	38	95.5	64	8.61	1	.003	.270
Unmanageability	82.1	46	93.3	56	3.41	1	.064	.172

Table 3

Comparison of Mean Family Violence Scores by Characteristics at Intake and Discharge

Characteristic	Mean at Intake	SD	Mean at Discharge	SD	df	*t*	p
Identified Child was Male	3.04	1.10	2.49	0.15	70	4.236	.001
Single Parent	3.02	0.13	2.17	0.14	64	5.738	.001
Dual Parent	3.06	1.61	2.75	1.31	50	2.679	.01
Reunification	2.67	1.43	2.00	1.26	20	2.870	.009
Emotional Disturbance	3.03	1.23	2.42	1.11	115	6.117	.001
Status Offense Committed	3.16	0.14	2.34	0.15	55	5.440	.001
Substance Abuse	3.22	0.14	2.59	0.16	49	4.280	.001
Unmanageability	3.04	0.94	2.40	1.18	52	4.204	.001
Placement was Prevented	3.00	1.13	2.32	1.22	101	6.312	.001
All Families	3.03	1.11	2.42	1.23	115	6.117	.001

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Table 4

Reduction in Family Violence by Intervention Categories (N=116)

Intervention Category	*ß*	*Beta*	*t*	p
Crisis	-.012	-.009	-.106	.916
Hard	-.027	-.024	-.304	.761
Enabling	-.041	-.070	-.915	.362
Collateral	-.804	-.806	-1.044	.299
Skill Building	.022	.186	2.487	.014
Marital and Family	.48	.212	2.573	.011
Soft	.027	.205	.2742	.007
Empowerment	.162	.2989	4.160	.000

Table 5

Placement Prevention by Interventions (N=116)

Intervention	Intervention				χ^2	df	p	phi
	Yes		No					
	%	n	%	n				
Generate Action Plan	90.7	98	50.0	4	11.65	1	.001	.317
Teaches to Negotiate Services	96.1	49	81.5	53	5.69	1	.017	.222
Reflect and Validate Feelings	89.7	98	57.1	4	.6.65	1	.010	.240
Couples Counseling	97.6	40	82.7	62	5.54	1	.019	.219
Teaches Problem Solving	94.9	56	80.7	46	5.59	1	.019	.218
Provides Information	90.8	89	72.2	13	4.95	1	.026	.207
Discusses Progress	90.6	87	75.0	15	3.80	1	.051	.181
Solution focused Techniques	97.1	33	84.1	69	3.77	1	.052	.180

Family Preservation: The Parents' Perceptions

Cheryl D. Lee and Cecilia Ayón

This research documents the perspective of 100 parents who had an open case with the Department of Children and Family Service's (DCFS) regarding their family's well-being, reasons for referral and satisfaction with services. Two DCFS services, Family Preservation (FP) and routine Family Maintenance (FM) were examined using standardized instruments. Parents' responses regarding reasons for involvement with the system differed from DCFS administrative data. FP parents had more children, were more likely to be monolingual Spanish speakers, and perceived greater improvement in discipline and emotional care of children and housing than FM parents. FP parents reported being satisfied with services. Implications include supporting community based culturally competent FP programs.

Key Words: family preservation, child abuse and neglect, culturally relevant services

As the number of children in out-of-home placements surpasses half a million, various attempts have been made to obtain permanency for these children (AFCARS, 2005). Family Preservation (FP) programs have emerged as a vehicle for addressing the needs of the whole family in an attempt to promote family well-being and maintain children in their home. The evaluations of such programs have yielded mixed findings (Bagdasaryan, 2005; Fraser, Nelson, & Rivard, 1997; Kirk & Griffith, 2004; Lindsey, Martin, & Doh, 2000; Littell, 1995; Meezan & McCroskey, 1996; Potocky & McDonald, 1996; Unrau & Coleman, 2006). Most studies use placements outside the home as the primary outcome measure, and the results indicate equivalent findings in comparing FP to routine Family Maintenance (FM) services (Heneghan, Horwitz, & Leventhal, 1996; Meezan & McCroskey, 1996; Rubin, 1997; Schuerman, Rzepnicki, Littell, & Chak, 1993).

Researchers purport that most of the early studies on FP's success were flawed because of a lack of comparison groups and assignment of less difficult cases (Lindsay, Martin & Doh, 2002; Littell, 1995). Other researchers argue that we do great harm to children by leaving them with their dysfunctional families (Epstein, 1999; Gelles, 1993). Studies using comparison groups (Blythe & Jayaratne, 2002; Kirk & Griffith, 2004) and event history analyses (Kirk & Griffith, 2004; Unrau & Coleman, 2006) find family preservation services to be more effective than traditional child welfare services. Unrau and Coleman (2006), who used dynamic event history analysis, demonstrated that certain factors such as children's disability, family poverty, and number of children in the family affect long-term progress and recommended longer treatment and follow up booster sessions as do Kirk and Griffith (2004). Bagdasaryan (2004) studied a large sample in Los Angeles County and found that longer duration of services is a predictor of a successful outcome. Fewer studies have explored family functioning as an outcome

measure and are mainly conducted from the perspective of the agency worker (Feldman, 1990; Meezan & McCroskey, 1996).

Recently, family preservation techniques are being effectively employed in post-adoption services to ward off adoption disruption (Berry, Propp, & Martens, 2006; Atkinson & Gonet, 2007) and to diminish serious child behavior and management problems with families not yet in the child welfare system (Lewis, 2005). There is a continuing need to evaluate FP services because of the sensitivity and importance of this approach for children's welfare.

Previous studies have used case record review or instruments completed by child welfare workers to gather data. To add a different dimension to the body of research, this study looked at parents' perceptions of their families' well-being, reasons for referral, and satisfaction with services (i.e., FP or FM). Exploring the client perception has been identified as an important factor in evaluating services (Kapp & Vela, 1999). Kapp and Vela state that understanding how clients cope after the intervention and their perception of the impact of the services are important components of evaluative research.

Family Preservation and Family Maintenance Services

Family Preservation (FP) is a community-based service that provides caseworkers to families in their homes as well as an array of services such as parent education classes, drug abuse counseling, transportation, and housing assistance. FP has been characterized mostly in the literature as a crisis-oriented intervention for families for four to six weeks with multiple visits per week by a caseworker who is available 24 hours a day (Lindsey, Martin & Doh, 2002; Smith, 1995). This is not the model that exists in the Los Angeles Department of Children and Family Services (LADCFS) (Meezan & McCroskey, 1996; Soloman & Lee, 2001). Family Preservation in LA County is a home-based service offered by diverse community agencies where the totality of family and children's problems are addressed. The original request for service by DCFS is for six months, but this amount of time can be extended depending on the needs of the family. The FP in-home counselor or caseworker goes to the home one or two times a week. The primary goals of this service are to preserve and empower the family, protect children, and support healthy functioning of all family members. The DCFS worker maintains contact with the FP in-home counselor and visits the family once per month. Refer to Table 1 for a summary of the service characteristics.

Family Maintenance (FM) is the traditional case management program that offers office-based services to families that have substantiated cases of child maltreatment. FM is similar to FP in that as a result of services the family may remain intact. However, the goal of FM is different from FP as its primary focus is to protect the child from harm. Working with the other family members is secondary. Parents are helped as a means of protecting the child. The FM time frame is similar (typically 6 – 12 months) but the services are not home-based. The FM services are managed by the DCFS worker and may be completed by one or multiple agencies. The DCFS worker is responsible for visiting the child once per month.

Table 1. Family Preservation and Family Maintenance in Los Angeles

Characteristic	Family Preservation	Family Maintenance
Service Goal	Preservation of family	Children's safety
Nature of Service	Community/culturally sensitive	Case management
Services Offered (location)	In home	Various agencies
Length of Services	6-12 months	6-12 months
Frequency of Caseworker Visits	FP worker (1-2 times/week) Caseworkers (1 time/month)	Caseworker (1 time/month) Agency workers (office appointments depending on case)

Background

Child welfare policies in the U. S., such as the Adoption Assistance Child Welfare Act of 1980 (Wells & Biegel, 1991) and the Family Preservation and Support Services Act created as part of the Omnibus Budget Reconciliation Act of 1993 (Thieman & Dail, 1997) have supported permanency planning for children and looked at the child's biological family as the preferred resource for serving children's best interests. Even in the more recent Adoption and Safe Families Act of 1997, which supports reducing the amount of time children spend in foster care and severing parents' rights when case progress is not made in a year or less, biological families including kin are seen as the first line of defense in promoting children's welfare. This preference for preserving the biological family is criticized as a policy that merely saves taxpayers' money as opposed to being in the best interest of children (Epstein, 1999; Lindsey, Martin, & Doh, 2002). Placing children outside of the home is in most cases more expensive (Humphrey, Turnbull, & Turnbull III, 2006); additionally, the lack of available foster and adoptive homes for special needs children has reached a crisis level (D'Adrade & Berrick, 2006; Hanley, 2004). It has also been reported that children who spend time in foster care have a preponderance of problems including mental illness, drug and alcohol abuse, and homelessness as adults (Children's Defense Fund, 2000; Courtney, Terao, & Bost, 2004).

Since David Fanshel's classic longitudinal evaluation of the foster care system (Fanshel & Shinn, 1978), it has been documented that children are often subject to "foster care drift" where they remain in foster care for inordinate periods of time and have multiple placements. Children not only suffer from the abuse and neglect they may have experienced, but are further victimized by multiple placements in the foster care system (Courtney, Terao, & Bost, 2004). Classic research studies on attachment theory

(Ainsworth, 1978, 1993; Bowlby, 1969) explain how children develop optimally when attachments to significant people are maintained. Results from the National Survey of Child and Adolescent Well-Being (NSCAW), a longitudinal study of children who are in the foster care system, indicate that children in foster care experienced more developmental problems, especially infants (NSCAW, 2003).

Another important issue to consider regarding removal of children from families is that ethnic/racial minority children are overrepresented in the child welfare system (D'Andrade & Berrick, 2006; Derezotes, Poertner & Testa, 2005; Needell et al. 2002; Needell, Brookhard, & Lee, 2003; Pine & Drachman, 2005). African American and Latino children make up a large portion of the children in the foster care system. Furthermore, services that consider the specific needs of diverse ethnic groups are lacking. For example, in addition to possibly experiencing abuse, Latino children may have to endure long term foster care placement if parents are unable to comply with the demands of the child welfare system. This can worsen the state of crisis experienced by the child and the family as the family system is very highly valued within this culture (Baca Zinn, 1994; Cauce & Domenech-Rodriguez, 2000). There are specific needs of a Latino family that may differ from the needs of other families. For example, it is estimated that 10% of all children in the U.S. live in mixed documentation status households. Of these 30% reside in California and, of these, approximately 50% reside in the city of Los Angeles (CHCF, 2004; Kanaiaupuni, 2000). Not only do mixed status households experience special needs such as services in Spanish (or another language), economic hardships, trauma related to the migration process and discrimination/oppression experienced in this country, but they also run the risk of having their actions misinterpreted. For example, public health research has found that immigrant individuals (documented and undocumented) avoid or delay seeking medical attention due to fear of immigration consequences including deportation or penalties (Asch, Leake, & Gelberg, 1994; L.A. County Department of Health Services, 2004; Loue, Faust, & Bunce, 2000). Not seeking medical attention for children may be interpreted as neglect or not caring for the child's well-being, but in reality the family members may be acting in ways to ensure the safety of their family.

In order to examine parents' perceptions of their family's well-being, reasons for referral to DCFS, and satisfaction with services, this study was guided by the following research questions: (1) What are the demographic differences and similarities of caregivers in FP and FM cases? (2) What did FP and FM clients state as the reasons they were referred to child welfare services, and how do parents' reasons for referrals to services compare to DCFS administrative data? (3) Do FM and FP participants' well-being outcomes improve from referral to follow up? (4) Are FP and FM clients satisfied with the services received?

Method

Sampling and Data Collection

After approval for this study from the university's Institutional Review Board, LADCFS provided contact information which consisted of names, last known phone numbers and addresses, ethnicity, type of service received (FM or FP), and number of children. The cases had been closed in 1999, and this study took place in 2001, which

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meant that the cases had been closed for approximately two years. There were attempts to contact every person on this list by telephone or mail (N=1000). This was a very difficult process since many of the former clients had moved or changed telephone numbers, which is typical of clients involved in the child welfare system. Of the 700 FM cases and 300 FP cases, 125 (65 FM and 60 FP) were actually located (12.5%). Of these, 55 FM cases and 45 FP cases agreed to participate by the deadline for scheduling interviews. This sample of 100 (10% of the original population) was somewhat comparable to the larger list of potential participants on the known demographics; that is, a greater number of FP clients were ethnic/racial minorities and had more children (Solomon & Lee, 2001). Once located, participants were asked if they wished to participate in 45-minute telephone interviews in exchange for a remuneration of $20.00. The interviews were conducted in Spanish and English.

Measures

This study utilized The Parent Outcome Interview, a standardized measure used to evaluate children's and parent's well-being outcomes (Magura & Moses, 1986) and the Client Satisfaction Questionnaire (CSQ-8) (Attkinsson, 1985). FP participants were asked to reflect only on their FP in-home counselor and services, and FM clients were asked to reflect solely on their DCFS worker and services. In both groups, if the participant had multiple workers they were asked to reflect on the worker who was involved in their case for the longest period of time.

The Parent Outcome Interview (Magura & Moses, 1986) is a parent self-report measure used to determine children's and parents' well being. Ten outcome subscales from the Parent Outcome Interview were used in this study (Children's Academic Adjustment, Children's Conduct, Physical Child Care, Discipline and Emotional Care of Children, Children's Symptomatic Behavior, Parent's Coping, Housing Conditions, Economic Conditions, Overall Safety, and Overall Family Functioning). The instrument has established face, construct and convergent validity, and the average internal consistency of the subscales is alpha = .84 (Magura & Moses, 1986). In addition to the English version of this instrument a Spanish one was created by translating the instrument into Spanish and then back into English in order to increase its validity. Although the instrument administrators were native Spanish speakers with child welfare experience, there was no established reliability and validity of the Spanish version of the instrument. Participants were asked to consider two time periods - onset of services and follow-up interview. Sample questions of the outcome subscales can be found in Table 2. Change scores were calculated by subtracting the "at referral" score from the "follow up" score. Lower change scores were indicative of greater improvement of children and parents' well-being. Alphas for this sample were good ranging from .76 to .91 (See Table 2).

Table 2. Parent Outcome Interview Subscales

Subscales	Number of items	Sample Questions	Alphas for this sample
Children's Academic Adjustment	9	Were any of your children: • not enrolled in school (if of school age)? • failing any classes?	.76
Children's Conduct	9	Were any of your children: • breaking and busting things on purpose? • lying and not listening to you?	.87
Physical Child Care	8	• Were your children hungry sometimes because you had trouble preparing meals? • Were you worried about leaving your children alone when you had to go out?	.78
Discipline and Emotional Care of Children	12	• Did your children get on your nerves so much that you sometimes lost your temper with them? •Did you sometimes feel that your children were taking up too much of your time, that they kept you from doing things that you really wanted to do?	.89
Children's Symptomatic Behavior	10	Were any of your children: • anxious, afraid, or tense a lot of the time? • complaining about aches and pains a lot?	.86
Parents' Coping	9	Were you: • having any health problem that limited what you could do? • overwhelmed with work and no one to help you?	.81
Housing Conditions	10	Did you have any problems with: • overcrowding in your home, not enough space for everyone to live, sleep, and have some privacy? • unsafe or dangerous conditions that could hurt someone?	.77
Economic Conditions	7	Did you • have enough money to pay your rent? • buy food for your family?	.91
Overall Safety	5	How likely is it that children might be harmed by: • parental discipline? • behavior of others in the neighborhood?	.79
Overall Functioning	6	How severe was the stress you've experienced been because of: • family relations? • economic security?	.86

*This table was adapted and modified from Lee & Ayón (2004).

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The Client Satisfaction Questionnaire (CSQ 8) (Attkinsson, 1985) is an eight-question scale measuring client satisfaction with services rendered. It is a standardized instrument that has been translated into several languages including Spanish. Scores could range from 8-32. The higher the score the more satisfied the person is with the services. The established reliability has ranged from .86 to .94 in previous studies (Attkinsson, 1985). The reliability of this scale for this sample was excellent (alpha = .96).

The following open-ended questions were also analyzed: What was the reason for the case with DCFS? Did you agree with what your worker said was the reason for referral for the case? Participants were able to reply "yes" or "no." Their responses were dummy coded with yes as 1 and no as 0. Administrative data was used to compare the allegations as reported by workers in contrast to the reasons why the parents stated they had been referred to DCFS.

Results

The demographic characteristics of the FP and FM cases are described in Tables 3, 4, and 5. Chi-squares and t-tests were used to test Research Question 1 regarding demographic differences. The characteristics of the primary caregivers in both groups were: they were mothers (94%), 70% had no secondary caregiver, 48% were Latino, and the average age was 37.85 (SD 7.8). Educational levels were comparable ranging from less than high school (32%), high school graduates/GED (15%), to college graduates (33%). Sixty-four percent had incomes less than $20,000 when they received the services. At follow up 62% were still in this impoverished income bracket. Forty-three percent received public assistance at time of entry and two years later at follow-up.

Table 3. Demographics of Caregivers

Variables	Study Sample N = 100		Family Preservation n = 45		Family Maintenance n = 55	
	N	%	N	%	N	%
Primary Caregiver						
Mother	94	94.0	43	95.6	51	92.7
Father	1	1.0	1	2.2	0	0.0
Grandmother	1	1.0	0	0.0	1	1.8
Missing	4	4.0	1	2.2	3	5.5
Secondary Caregiver						
None	70	70.0	33	73.4	37	67.3
Father	26	26.0	10	22.2	16	29.1
Grandmother	3	3.0	1	2.2	2	3.6
Mother	1	1.0	1	2.2	0	0.0
Ethnicity of Primary Caregiver						
Latino	48	48.0	24	53.3	24	43.6
Caucasian	26	26.0	9	20.0	17	30.9
African-American	14	14.0	6	13.3	8	14.5
Pacific Islander	1	1.0	1	2.2	0	0.0
Italian	1	1.0	1	2.2	0	0.0
Missing	10	10.0	4	8.9	6	10.9
Language* Interview was Conducted in						
English	65	65.0	24	54.0	41	26.0
Spanish	35	35.0	21	46.0	14	74.0

Note: * X^2 = 4.90, p = .03

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Table 4. Education and Income Characteristics of Caregivers

Variable	Study Sample N = 100		Family Preservation n = 45		Family Maintenance n = 55		$X^2(p)$
	N	%	N	%	N	%	
Education of Primary Caregiver							
No Formal Educ.	1	1.0	1	2.2	0	0.0	
> High School	31	31.0	13	28.9	18	32.7	
High School Grad 15		15.0	4	8.9	11	20.0	
Some college/Trade School or college Graduate	39	39.0	14	31.1	25	45.5	
Missing	14	30.7	13	28.9	1	1.8	
Income as DCFS Clients							.95(.33)
Under $19,999	64	64.0	27	60.0	37	67.3	
Over $20,000	20	20.0	6	13.3	14	25.5	
Missing	16	16.0	12	26.7	4	7.3	
Income at time of Study							.11(.74)
Under $19,999	62	62.0	25	55.6	37	67.3	
Over $20,000	22	22.0	8	17.8	14	25.5	
Missing	16	16.0	12	26.7	4	7.3	
Receipt of Public Assistance as DCFS Clients							2.62(.27)
Yes	43	43.0	20	44.4	23	41.8	
No	45	45.0	14	31.1	31	54.4	
Missing	12	12.0	11	24.4	1	1.8	
Receipt of Public Assistance at time of Study							1.57(.46)
Yes	43	43.0	19	42.2	24	43.6	
No	45	44.0	15	33.3	30	52.7	
Missing	12	12.0	11	24.4	1	1.8	

Table 5. Mean Comparisons of Select Demographic Characteristics

Variable	Study Sample N = 100		Family Preservation n = 45		Family Maintenance n = 55		
	M	SD	M	SD	M	SD	t
Age of Primary Caregiver	37.85	7.80	37.47	7.68	38.14	7.96	-.40
Number of Children in Home	3.33	1.85	3.80	2.05	2.96	1.59	2.28*

Note: * p < .05

The groups differed in number of children per family with FP parents averaging four children and FM parents three children (t =2.28, df= 1, $p < .05$). More FP parents were Spanish speakers (X^2 = 4.90, $p < .05$). Thirty-five of the participants were interviewed in Spanish with twenty-one of these being former FP clients.

For Research Question 2, participants indicated they were most often referred for physical abuse (24%), followed by severe neglect (16%), and drug abuse (12%). Domestic violence was the least common reason for referral (5%) and others reported truancy and false reporting by neighbors. The administrative data revealed that approximately 40% of the cases had two or more suspected abuse allegations. The most common allegations were general neglect (41%), physical abuse (36%), and emotional abuse (31%, See Table 6).

Although many of the parents reported the reason as one of the child maltreatment categories (i.e., neglect, physical abuse, or sexual abuse), their responses did not always correspond to the allegations found in the administrative data. A comparison of the allegations as reported by the parent and reported by DCFS revealed that approximately 60% of the parents reported a different reason leading to an open case with DCFS.

The participants were asked if they agreed or disagreed with their worker regarding the reasons or cause for their referral to DCFS. Forty-five percent of the participants said they agreed with the worker. An independent means t-test revealed that FP parents were more likely to agree with the worker about the reason for referral to DCFS (FP, M = .78, SD = .42; FM, M =.53, SD = .50; t = 2.204, df = 62, p = .03).

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Table 6. Reasons for Referral – Parents' Perceptions and Administrative Data

	Parent Report N	Administrative Data* N
Physical abuse	24	36
General neglect	16	41
Severe neglect		7
Drug abuse	12	
Domestic violence	5	
Caretaker absence	1	15
Emotional abuse	1	31
Sexual abuse	3	14
Child runaway	5	
School related (truancy)	6	
Both physical & neglect	1	
Parent concerned for child (self-report)	2	
Parent illness	1	
False reporting	4	
Don't know	19	

Note: Multiple referral reasons were reported in the administrative data.

In order to test Research Question 3, multiple dependent means *t*-tests were completed to find if the families who received FP and FM services perceived that they improved from time of referral to follow up on the well-being outcomes (See Table 7.). To protect against a Type 1 error, a Bonferroni correction was completed. The Bonferroni correction lowered the alpha to a .005 level of significance. Families who received FP services indicated that they improved in the following well-being measures: Housing Conditions, Overall Safety, Discipline and Emotional Care of Children, Parent Coping, Overall Family Functioning, Children's Academic Adjustment, Children's Conduct, and Children's Symptomatic Behavior. FM recipients reported they improved on the following well-being measures: Overall Safety, Discipline and Emotional Care of Children, Parent Coping, Overall Family Functioning, Children's Academic Adjustment, Children's Conduct, and Children's Symptomatic Behavior. Both FP and FM families reported no improvement on the Economic Conditions outcome subscale, and FM families reported no improvement in the Physical Care of Children or Housing Conditions.

Table 7. Mean Comparisons of Subscales

Scale	Family Preservation n = 45				Family Maintenance n = 55			
	M	*SD*	*t*	*p*	*M*	*SD*	*t*	*p*
Physical Child Care	2.90	.006			2.41	.02		
At Referral	.79	1.52			.49	.91		
At Follow up	.21	.62			.11	.43		
Housing Conditions			-3.65	.001*			-2.68	.01
At Referral	1.97	2.35			1.16	1.45		
At Follow up	.68	1.27			.59	1.06		
Economic Conditions			.24	.96			.41	.68
At Referral	2.94	2.24			1.82	1.63		
At Follow up	3.03	2.44			1.90	1.64		
Overall Safety			-3.81	.000*			-5.31	.000*
At Referral	5.18	3.02			5.18	2.49		
At Follow up	3.53	1.61			3.81	1.48		
Children's Conduct			-3.08	.005*			-3.50	.002*
At Referral	2.41	2.27			2.75	3.43		
At Follow up	1.64	1.31			.54	.99		
Discipline/ Emotional Care			-4.97	.000*			-3.40	.002*
At Referral	2.69	2.93			.86	1.44		
At Follow up	.71	2.03			.16	.53		
Parental Functioning			-4.83	.000*			-6.36	.000*
At Referral	2.97	2.68			2.58	2.05		
At Follow up	.68	1.40			.82	1.68		

Table 7. Mean Comparisons of Subscales (Continued)

Scale	Family Preservation n = 45				Family Maintenance n = 55			
	M	*SD*	*t*	*p*	*M*	*SD*	*t*	*p*
<u>Overall Family Functioning</u>			-454	.000*			-5.42	.000*
At Referral	13.12	4.24			11.23	3.73		
At Follow up	9.67	3.56			9.18	3.42		
<u>Children's Academics</u>			-3.14	.004*			-4.29	.000*
At Referral	1.72	1.65			1.78	2.10		
At Follow up	.86	1.44			1.44	.45		
<u>Children's Symptomatic Behavior</u>			-3.51	.001*			-3.86	.000*
At Referral	2.46	2.58			2.12	2.45		
At Follow up	1.03	1.94			1.00	1.78		

Note: The Bonferroni correction lowered the alpha to a .005 level of significance; *p≤ .005Research Question 4 sought to find if differences existed in satisfaction with services between FP and FM clients (See Table 8). A *t*-test revealed that FP clients rated their satisfaction with the quality of services considerably higher than routine FM participants (*t* = 4.22, *df*=1, *p* < .001). The mean for FP was 27.10 (*SD* = 5.8). The mean for FM was 21.03 (*SD* = 8.37).

Table 8. Mean Comparisons of Client Satisfaction with Services

Variable	Study Sample N = 100		Family Preservation n = 45		Family Maintenance n = 55		
	M	SD	M	SD	M	SD	*t(p)*
Client Satisfaction Questionnaire	23.8	7.92	27.21	5.80	21.03	8.37	4.22(.000)*

Note: *p < .05

Limitations

This study looked at family preservation and routine family maintenance services from the perspective of the clients (the parents). Former clients of LADCFS may have been fearful of indicating problems with their own or their children's functioning as this may cause them to be re-reported and again come under state scrutiny. Parents were asked to reflect back on when they first started with DCFS services and retrospectively report on their problems comparing the past to the present. This is a significant limitation as their memories of problems may lack accuracy. In addition, this design does not allow for the study of causality. Only the perspective of parents is explored. Other perspectives, the children's and the workers', were not studied. As previously mentioned the Spanish version of the Parent Outcome Measure had not previously been standardized and results need to be interpreted with caution. Selection bias may also play a role in the results as it was difficult to locate many of the families on the original sampling pool list. Providing a compensation may have contributed to sampling bias. Although this study was not without limitations, it makes significant contributions to the field as it examines families' well-being from the perspective of the parent/client, and this is rare.

Discussion and Implications for Practice, Policy and Research

It is clear from the results of this study that FP cases were not the easier cases as other studies have reported (Lindsey, Martin, & Doh, 2001; Littell, 1995). This may be an artifact of LA County's large and diverse child welfare system where workers are overburdened with cases and distribute them to services that will help the families. When referring to FP services, workers are aware that a FP worker, who regularly visits the home, will share their responsibilities. In fact, these results may indicate that more complex cases are sent to FP services. For example, mothers in FP had more children and were more likely to be monolingual Spanish speakers. Therefore, FP services should continue to be supported and efforts toward allocating more funds for such programs need to be made as families are likely to benefit from receiving intense help from an FP worker as well as oversight by the DCFS worker.

Parents reported physical abuse as the primary reason their families had been referred to LADCFS. Neglect and drug abuse were the next most frequent responses followed by other responses including domestic violence, runaway children, and school-related issues. It is important to note that the referral allegations found in the administrative data varied from those reported by the parents. DCFS reports the allegations as a type of maltreatment toward children, but when parents were asked about the reasons for their case with DCFS many of them reported the actual problem they were facing rather than a type of maltreatment. If a parent responds domestic violence or drug abuse, this is an indication of a special type of help that is necessary. Although current policy views the protection of the child as a priority, by removing a child due to neglect or emotional abuse and not providing the parent with the necessary help, the child is not being protected in the long run. Family preservation programs tend to address the needs of the whole family, as these services are family-centered while maintaining children in their homes; yet, the support for such programs is scarce. It is important to consider that in order to maintain families and keep them together parents need to receive services and supports that address the needs of each family member. Child welfare workers in the

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child welfare system need to pay close attention to what the parents present as the problems and advocate for services to meet those challenges. For example, if a family member has an addiction problem then services need to be tailored to address those needs (i.e. as part of case management services, families should be referred to addiction treatment programs and support groups for families of addicts such as Al-Anon).

The findings revealed that 45% of the parents did not agree with their worker about the reason for having an open case. This may be due to the problem being viewed as something internal to the parent rather than something occurring to the child, or parents may also disagree with their worker based on cultural norms. However, parents who received FP services were more likely to agree with the worker about the reasons for receiving services. FP workers spend more time with the parents and families, which may allow them to establish better relationships with their workers (Lee & Ayón, 2004); this may facilitate their interaction with the system. Family preservation cases in LA are open for a minimum of six months. Some recent studies recommend longer-term services to be effective and even booster services after case closure (Bagdasaryan, 2005; Kirk & Griffith, 2004; Unrau & Coleman, 2006). The FP worker who is not an employee of the publicchild welfare system would be in a good position to offer services once the case is closed with child protective services; however, this would require government funding for such services which currently does not exist in many traditional child welfare service systems or budget allocations.

From the parents' perspectives, FP families improved on a majority of the family well-being or parent and child functioning scales. Similarly, FM families improved on most of the well-being measures. Most of the parents in this study reported that they and their children's functioning had improved from the time that they received FM or FP services until the time of this follow-up study (two years later). Child welfare agencies and workers are under constant criticism by the media and the professional community, but this study's sample self-reports on standardized measures that they perceived that some progress had been made for themselves and their children since they first entered the system. The participants/former-clients' responses validate the work of child welfare workers. FP clients were significantly more satisfied with the services and perceived that they had greater improvement regarding housing and discipline and emotional care of children than FM parents. This study adds to other recent research (Bagdasaryan, 2004; Berry et al., 2006; Blythe & Jayaratne, 2002; Kirk & Griffith, 2004) that illustrate that family preservation services is better suited for addressing the multifaceted needs of families compared to traditional child welfare services. As previously indicated, these services may be constantly improved by offering booster sessions after the case is closed (Kirk & Griffith, 2004; Unrau & Coleman, 2006).

Families in both groups encountered serious economic hardships, which did not improve from the time they entered the system to the time of this research study. This indicates that the child welfare system is not able to change the poverty status of their clients. FM families did not improve their housing conditions whereas FP clients indicated that their housing situation had improved. The more intense home based services where the worker is aware of the clients' living situation and needs may assist these families in obtaining subsidized housing or improving their housing conditions. FP parents reported a tendency toward greater improvement in the physical care of children than FM parents. Having a worker who regularly visits the home and is able to observe

and help modify family interactions may facilitate improved physical care. The structural systemic issue of poverty, which both groups of parents reported as a continuing problem, must be addressed. It is a societal problem that needs to be at the forefront of child/family advocacy at the state and national levels of government. Issues such as unaffordable housing, inadequate jobs and pay, and lack of access to medical care are problems that incite stress in families and foster child abuse and neglect as well as a host of other pathological behaviors.

The most significant finding in this study was that FP clients were more satisfied with their services than the FM parents. This finding is consistent with Meezan and McCroskey's (1996) study on FP in LA County. It indicates that the community-based services, which are sensitive to cultural differences, are appreciated by the clientele that these agencies serve. If clients feel good about the way they are treated, they are more likely to accept the services, make an effort to change, and seek out future assistance when needed (Solomon & Lee, 2001). The FP workers may lend a vision of an opportunity to improve family functioning (Schwartz, 1961).

The longer length of FP services and the community culturally based model in LA County may be reasons why the FP services seem to have a positive impact on these families. LADCFS acknowledges that problems that families experience, such as poverty, cultural dissonance with mainstream culture, lack of parenting skills, coping with disabilities, and substance abuse, may take significant time to heal and treat. Some families may have been able to make progress because they received services in their own homes and community and for a longer period of time. Many of the parents of the children that come to DCFS's attention have had difficulties in their own lives and families of origin. Intensive and culturally sensitive services can offer them rehabilitation as opposed to having children permanently removed. However, some cases exist where removing a child is necessary because of the egregious treatment by the parents. In these cases, placements outside the homes would be considered positive outcomes as opposed to leaving the children with their families. Educating child welfare workers to appropriately assess and treat their cases, providing them with manageable caseloads, and giving them adequate supervision, assessment tools, resources, and support will help foster the practice of preserving families while at the same time protecting vulnerable children.

Future studies will want to gain multiple perspectives of family preservation services. Particularly enlightening would be data collected from older children whose families receive these services. Longitudinal research is needed to enhance objectivity in reporting family and child functioning. It is recommended that social work researchers develop instruments that can be used across cultures in multiple languages. Larger studies from this location and others will continue to shed light on family preservation as a practice that protects children by preserving the family and helping each family member improve their functioning.

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Relationships, Income Support and Decision Making:
A Qualitative Synopsis

Angie Logan and Kevin Meir

This qualitative study of one midwestern state's child protective services addresses whether an income support measure for poor biological caregivers reduces the length of time that their children spend in foster care. The overall findings suggest that workers do value the worker-family relationship. However, some view the immediate worker-client relationship as secondary to the inclusion of extended familial supports particularly as related to sustained more long-term outcome achievement. Most workers additionally agree that client involvement during all phases of the reunification process is critical.

In 2005, one midwestern state's child protective services agency administrative staff expressed an interest in conducting a qualitative study to determine whether an income support measure for poor biological caregivers would reduce the length of time that their children spend in foster care. This particular qualitative inquiry was initiated as a means to elicit insight regarding the caseworker–client relationship, discretionary decision-making, income support, and biological family reunification. The state's child protective agency administrators were asked to select key stakeholders for inclusion in the focus group from both Economic and Employment Support Services (EES) and Child Protective Services (CPS) administrative, supervisory, and front-line staff while simultaneously identifying key foster care subcontractor staff members from a foster care agency in the state.

Poverty/Child Neglect Connection

Poverty-related neglect substantiations account for nearly 60% of the entire foster care population (CWLA, 2000). When children are outplaced into foster care, their parents often lose Temporary Assistance to Needy Families (TANF) cash in addition to medical card benefits. Consequently, the loss of these supports results in extended length of stay in foster care for children. Therefore, if public assistance policy were construed in concert with child welfare policy all parents would be given the opportunity to reunify with their biological children. "Vagueness of statutes enlarge judicial discretion while increasing the likelihood of failures of due process and false findings of child abuse" (Huxtable, 1994, p.60). Since states receive their Temporary Assistance to Needy Families (TANF) funding via block grants, they have the authority to determine how their TANF dollars get spent. Therefore, it would be a viable option, according to the state's child protective services agency administrators, to pilot an income support measure by utilizing a portion of their block grant budget. However, federal Adoption and Safe Families Act (1997) permanency timeline legislation would still need to be amended to include a standardized TANF waiver, which would extend monthly payments throughout the standard fifteen month outplacement period.

Empirically Identified Factors in Reunification

The following factors serve to reinforce timely reunification: the caseworker-client relationship, discretionary decision-making, and income support. Numerous child welfare scholars have indicated that a link exists between the caseworker-client relationship and sustained long-term outcomes (Littell & Schuerman, 2000; Littell & Alexander, 2004; Caliso & Milner, 1992; Coleman & Collins, 1997; Stein, 2003; Smith & Donovan, 2004; Safran, Crocker, McMain, & Murray, 1990; Gaudin, 1993; Morrison-Dore, 1996; Horvath & Greenberg, 1989; Berry, Charlson & Dawson, 2003). The caseworker-client engagement process in the volatile involuntary child welfare arena is difficult to cultivate when families are experiencing pervasive levels of poverty. An empowerment-based theoretical approach to working with these families would support the notion that their participation to work toward reunification is contingent upon adequate access to income, healthcare, childcare, employment, transportation, housing, and education.

Although this particular qualitative inquiry includes caseworkers as participants as opposed to parents as participants, it is imperative to briefly provide a context citing parents' views of the working relationship as described in the child welfare literature. Chapman, Gibbons, Barth and McCrae (2003) found that parents receiving child welfare services cited four overall key factors contributing to the success of the worker-client relationship: frequent contact, continuity of care by the same worker throughout the entire treatment process, implementing relevant services in a swift manner, and ensuring that service provision will assist in sustaining successful outcomes.

According to Cash (2001), parents are more likely to participate in services when more task-oriented approaches are utilized as a means to reduce heightened levels of family stress. Coleman and Collins' (1997) qualitative inquiry further lamented that parents prefer working with friendly yet frank workers who "listen, support, and teach" while providing individually tailored services and supports. Morrison-Dore's (1996) comprehensive review of the working alliance literature suggested that relationships with involuntary child welfare clients could be cultivated fairly quickly if workers would consistently adhere and subscribe to using an empathy-driven empowerment-based approach.

Outcomes in child welfare are in part, contingent upon the quality of the caseworker-client relationship (Berry & Dawson, 2003; Littell & Alexander, 2004; Morrison-Dore, 1996). Morrison-Dore (1996) refers to Safran, Crocker, McMain, and Murray's (1990) work on the warning signs of alliance rupture, while noting that the caseworker-client relationship could in fact be monitored and tracked by specifically identifying (1) negative statements regarding the caseworker or services rendered by the caseworker; (2) conflicting responses from clients regarding previously agreed upon goals, (3) failure to maintain appointments, (4) refusal to follow through on agreed upon tasks between scheduled appointments, and (5) overly compliant reactions to agreed upon objectives.

Petras, Massat, and Lehr-Essex (2002) developed the ENGAGE Model for caseworkers serving children and their families involved in the child welfare system. The premise of their conceptual model conforms to Bowlby's (1969) notions regarding

attachment theory, which implicitly acknowledges the inherent bond between children and their biological parents. Petras et al., (2002) further illustrate that child welfare system involvement serves to perpetuate despair and hopelessness. Therefore, they recommend that caseworkers work toward educating parents about the adversarial nature of the child welfare system while simultaneously culminating the restoration of hope and the development of supportive community partnerships.

"Given the time limitations in child welfare legislation and managed care, it is especially important to determine methods of quick engagement and treatment compliance for neglectful families" (Dawson & Berry, 2002, p. 305). Littell and Schuerman (2003) in conjunction with Gaudin (1993) and Berry (2003) further illustrate that relationships and services need to be individually tailored to suit the immediate and complex needs of families involved the child welfare system in an effort to promote more sustained long-term changes.

Berry, Charlson, and Dawson (2003) stated that "The two most recent family policy directives [Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) 1996 and Adoption and Safe Families Act (ASFA) 1997] are: limits on the length and amount of financial assistance to families in poverty and limits on the amount of time that families can receive child welfare services. Given that families who neglect their children are those typically most in need of (i) continuing financial assistance, and (ii) services of a longer duration, the outlook for these families under current practice directives is poor" (p. 21). Concurring with the findings of other child welfare scholars, Waldfogel (2004) states that increases in poverty in the state of Illinois are associated with increases in child maltreatment rates. Courtney (1999) additionally indicated that as a nation, we must begin to assess the ramifications of poverty instead of consistently focusing on individual family deficits as a means to more adequately address and prevent child maltreatment. Courtney (1991), in earlier work, also noted that it is a common phenomenon for biological caregivers to become involved in the child welfare system while unemployed.

According to Gaudin (1993), poor caregivers substantiated for child neglect have ongoing restricted access to the adequate resources necessary to remedy their allegations. "Poverty is a confounding factor in defining neglect"(Gaudin, 1993, p. 4). Paxon and Waldfogel's (2002) work further illustrated that poor parents receiving TANF, consistently more often than not, were reported, alleged and substantiated for poverty-related neglect. "We still find that poverty, working single mothers, and unemployed parents are significantly related to the number of victims of maltreatment" (Paxon & Waldfogel, 2002, p. 458).

Child well-being outcomes, with respect to child maltreatment, are relative to the economic conditions of individual states (Waldfogel, 2004; Ozawa et al; 2004). Brandon (2000) also previously found that that prior to welfare reform, states with higher Aid to Families with Dependent Children (AFDC) cash payments had lower foster care caseloads. Wells and Guo (2003) also indicated that consistent receipt of welfare as opposed to income earned from work is associated with swift reunification. In sum, the child welfare system is utilizing the foster care system as an ineffective means to address the overall wellbeing of poor children.

Income Support

Too many poor children are residing in foster care because TANF public policy is not construed in concert with child welfare policy. Waldfogel and Paxon's (2002) research illustrated that 40% of families receiving TANF in Illinois had their children removed from the home. The authors also concluded based on their findings, that lower welfare payments were associated with higher foster care caseloads. Wells and Guo (2003) study found that consistent receipt of TANF during child outplacement resulted in reduced number of days spent in out of home care. Currently, foster care "maintenance payments" paid to foster parents during child outplacement come from uncapped Title IV-E funds which cost states millions of dollars, whereas TANF child payments to biological parents typically range from $140.00-$202.00 per month (Kansas Social and Rehabilitative Services Economic and Employment Services Manual, 2004). One midwestern state's child protective services agency 2003 Fact Sheet indicated that 88.4 million dollars were spent on preserving 3,046 foster care families while only 9.3 million dollars were spent on more front-end family preservation services for 2,570 families. At the present time, several states provide a 45-180 day TANF extension to poor families during outplacement, however, this is a discretionary decision that presently rests in the hands of individual caseworkers. Several Child Protective Service (CPS) workers in one state noted during an informal focus group interview, that they were completely unaware of the discretionary 180-day waiver extension option for poor families even though it is clearly outlined in that state's 2004 Economic and Employment Support Services (EES) Manual.

Discretionary TANF waivers are only authorized and extended to poor families during the outplacement period if their caseworker is aware of the 180 day policy. Child abuse and neglect substantiation and removal criteria consume the bulk of the research literature regarding caseworker decision-making. Therefore, it is necessary to refer instead to the literature on income support immediately following child outplacement to ascertain reunification outcomes as related to discretionary caseworker decision-making. Smith and Donovan's (2003) qualitative research findings suggest that " Decision making time frames established by the federal Adoption and Safe Families Act (ASFA; U.S. Public Law 105-89) underscore the need for child welfare caseworkers to use efficient and effective practices, especially when families are working toward reunification" (p. 541).

Child welfare scholars Kortenkamp et al(2004); Harris and Courtney (2003); and Wells and Guo (1999) suggest that there are six key characteristics that predict longer lengths of stay for children living in out-of-home placements: family race (African American); child gender (male); female-headed single parent households; neglect substantiations; pervasive poverty conditions; and child and maternal health problems. Doherty (2003) stated that biological parent reunification occurred more often when caregivers had a high school education, steady employment, comprehensive support services, and an absence of substance abuse issues.

Following their evaluations of the Norman Cash and Housing Assistance Program, Shook and Testa (1997) and Eamon (2004) concurred that when family participants received cash and housing help, length of stay in out of home placement was reduced overall by an average of 122 days. Eamon's (2004) work provides a

comprehensive overview of the Norman Program (NP). This initiative resulted from a consent decree agreement between the American Civil Liberties Union (ACLU) and the Illinois Department of Child and Family Services. The Norman v. Johnson (1990) holding stipulated that it was unconstitutional to remove children from their biological families solely on the basis of poverty. Reminiscent of the "no removals based solely on reasons related to poverty" statements made by Teddy Roosevelt at the White House Conference of 1910, the holding from this proceeding required the state to adhere to "reasonable efforts" by providing intensive cash and housing support services to poor families. Eamon (2004) additionally illustrated, by citing case law examples, that many children, despite lower court implementation of "reasonable efforts" provisions, continue to be removed from their biological caregivers solely on the basis of poverty.

"Using state level panel data, we find that socioeconomic circumstances, in particular income, parental work status, and single parenthood, affect the incidence of child maltreatment" (Paxon & Waldfogel, 2002, p. 465). Caregivers who receive consistent cash assistance from monthly welfare checks as opposed to income earned from wages reunify with their children at swifter rates; however, not all families are given the opportunity to continue to receive assistance following outplacement (Meier, Booe & Zeysing, 2005). In order to more effectively address the poverty related underpinnings of neglect and dependency, income support waivers must be tied to parallel the 15-month ASFA (1997) permanency planning timelines.

Caseworker Discretion

Caseworkers are often over worked and inundated with superimposing federal policies that don't adequately address the structural barriers that their families face. "Correcting the imbalance of power involves the sharing of information, including educating parents about the child welfare system and fully disclosing information about their case so that they can make informed decisions" (Petras et al., 2002, p. 236). According to the Urban Institute's (2001) New Federalism Child Welfare report, several states have implemented Statewide Automated Information Systems (SACWIS), Adoption and Foster Care Analysis and Reporting Systems (AFCARS), and Structured Decision Making (SDM) standards for accountability purposes, caseworkers are still using subjective decision-making processes to make removal, reunification, and termination determinations.

The aim of recent reform, according to the 2001 Urban Institute report, is to "propose a more customized and individualized approach to families" (p.12). Due to the changes in ASFA's permanency planning guidelines, workers now have only 12 months to engage families in the treatment process. If little progress is made within the first few months, workers begin to work more diligently toward finding alternative placement options for the child (Zeysing, 2005). Stein (2003), in addition to Smith and Donovan (2003), stated that caseworkers prefer to work with foster parents instead of biological caregivers following child outplacement because foster parents have more access to resources and are typically easier to work with. " An unanswered question of vital importance is how preventative efforts be given the necessary attention at the same time that foster care services are expanded so that they are available to all children who need them" (Whittaker & Maluccio, 2002, p. 108).

In child welfare services, although supervisor signatures are required, decisions are based upon disclosures made by individual family caseworkers. EES and CPS workers have the ability to engage in discretionary decision making on a daily basis. Though workers around the country are now required to use universal standardized risk assessment templates, individual workers ultimately still determine whether children will be removed, maintained, reunified, and or alternatively placed. EES workers additionally have the authority to cut off cash assistance to biological caregivers as a penalty for non-cooperation or compliance. One state's child protective services caseworkers are given the authority to discern which particular caregivers are worthy of TANF waiver provisions following the removal of the child from the home into foster care. They also possess the discretionary power to withhold needed supports such as access to streamlined substance abuse and mental health services (Meier & Booe, 2005).

Themes conveyed throughout the literature support the notion that caseworkers consistently spend more time during the 12 month outplacement period focusing on alternative placements in contrast to preserving the biological family unit due to ASFA's conflicting concurrent case planning stipulations (Stein 2003; Smith & Donovan 2003; Waldfogel 2000; Urban Institute 2001). This unrealistic approach to permanency presents an insurmountable strain on caseworkers, particularly those working to address maltreatment concerns reinforced by poverty. "If workers do not attend to the biological parents, they cannot compile the data necessary to sustain a petition to reunite a child with her or his parents nor the data necessary to sustain a petition to terminate parental rights" (Stein, 2000, p. 591).

Smith and Donovan's (2003) qualitative inquiry suggests that caseworkers are often subjected to restrictive working conditions that are reinforced and maintained by poorly developed public assistance and child welfare policy mandates. State level agencies that are required to adhere to these strict guidelines render caseworkers helpless in their quest to provide assistance to poor caregivers. "For example, if caseworkers deprioritize contacts with parents, decision makers who depend on caseworkers for knowledge about parents may fail to learn about important aspects of parent's lives, families may fail to receive services they need or want, especially under ASFA timelines, and important permanency decisions could be based on insufficient or inaccurate information" (Smith & Donovan, 2003, p. 560).

The authors further indicated that sensationalized child maltreatment media accounts may explain why caseworkers view the treatment of the biological parents as secondary to maintaining the foster family. "Media stories often portrayed tragedies as the result of faulty decision making or caseworker errors" (Smith & Donovan, 2003, p. 548). Huxtable (1994) additionally posited that the tendency to sensationalize child deaths by blaming caseworkers results in an exacerbated number of children being removed from the home.

Stein's (2003) work indicates that the tenets of ASFA are based upon "anecdotal rhetoric" instead of raw data. "Adoption and Safe Families Act (1997) and the Personal Responsibility and Work Opportunity Reconciliation Act (1996) rest on a common set of values that express, among other views, the conviction that (1) social policy should not reward women who choose to have children out-of-wedlock and to raise their children on their own at state expense and that (2) social policy should not provide the means for people who use illicit drugs to support their habit nor should a parent's use of illicit drugs

be rewarded by the state taking on permanently the role of the parent" (Stein, 2003, p.670).

Methods

The study that is the subject of this manuscript sought to explore and identify the following three questions:

1) How does the caseworker-client relationship influence reunification outcomes?
2) How does individual caseworker discretion influence reunification outcomes?
3) How does extended income support during child outplacement influence reunification outcomes?

Sample and Design

Two ninety-minute focus groups were conducted. Key state child protective services agency administrators from both EES and CPS selected 12 participants for inclusion in the relationships, decision-making, and income support as related to reunification outcomes inquiry. Three participants were administrators from a foster care agency in the state while the remaining participants were state protective service agency EES or CPS administrators, supervisors, and or front-line staff. This study was operationalized using Lincoln and Guba's (1985) naturalistic paradigm while additionally incorporating the key elements of Kreuger's (1994) focus group methodology. "A focus group is a carefully planned discussion designed to obtain perceptions on defined areas of interest in a permissive, non-threatening environment…conducted with approximately 7 to 10 people by a skilled interviewer" (Kreuger, 1994, p.6). The focus group sessions were conducted at two different points in time with 12 participants in attendance at the first meeting and 8 of the former 12 in attendance during the second group at one midwestern state's service center.

Procedure

First upon entering the group room, a non-judgmental atmosphere was created for participants, the consent form was reviewed , and the following methodology procedures were explained :all perceptions are valid; no right or wrong answers; open and honest communication is preferred; review informed consent and confidentiality issues; discuss intended use of feedback elicited (Einsidel, Brown & Ross, 1996). Following consent from all participants, I proceeded to discuss the nature of the inquiry and requested that the participants answer the first question about the caseworker client relationship. After 30 minutes had passed I requested that the group transition into discussing discretionary decision-making, which prompted a few participants to request further clarification regarding what I meant by term "discretionary decision-making". Following the passage of another 30 minutes, I continued by asking the group to discuss income support as related to reunification outcomes.

Data Collection

During the interviews, Lincoln and Guba's (1985) five constructs were utilized to guide the note taking procedure: "here and now constructions of individual workers; reconstructions of these entities in the past projections of these entities in the future; triangulation and; member checking" (p.268). Here and now constructions, reconstructions of the past, and projections of the future were all elicited and expressed via direct quotes in the final individual and group summary write-ups. Triangulation and member checks were initiated by sharing notes taken during the two sessions following the completion of each group. Official transcripts were not made readily available to group participants due to time constraints related to classroom limitations. In addition to note-taking, audio tape equipment was used during both interviews for verbatim transcription.

Following the completion of each focus group, the audio tapes were transported to the transcriptionist, group noted were reviewed, and recurrent themes were collapsed into summaries based on my notes for participants to review in the absence of the official transcripts.

Data Analysis

Lincoln and Guba's (1985) constant comparative method was used to analyze the data in Microsoft word. The process, according to the authors, consists of a procedure which entails: "comparing feedback to each category, integrating categories and properties, delimiting the theory, and writing the theory" (p.339). Workers were assigned initially to one of three categories: administrator, supervisor, or front-line worker but later collapsed due to the sensitive nature of the subject matter discussed.

Following the examination of the categories, some were collapsed into broader themes whereas others were partitioned out if relationships between/within themes were not clearly delineated. Grounded theory was used throughout the course of the data analysis process as a means to continually monitor the fit between my questions and the individual caseworker realities. Finally, the method also conformed to the rigor of Lincoln and Guba's (1985) trustworthiness standards by submitting the written notes to the group members following both 90 minute audio taped interviews so that they were given the opportunity to make any needed additions or clarifications.

Support for Rigor

Key characteristics of moderators should have high levels of interpersonal and communication skills, appear non-biased, and able to maintain control as well as flexibility within the group (Kreueger, 1994; Litoselletti, 2003). Lincoln and Guba (1985) additionally noted that trustworthiness consists of upholding the true realities of those working in the environment to which the inquiry is being made. Although it was not possible to evoke prolonged engagement for the purpose of this particular time-limited inquiry, credibility and engagement was achieved in the short run by honoring the workers experiences through the member checking process.

Notes were shared with workers as a means to adequately member check with them. Transferability regarding relevance to other contexts was mutually determined by a tenured Social Work professor, participants, and this researcher. Dependability in addition to confirmability was monitored by using two member checks and later conveyed using direct quotes derived from verbatim audio transcriptions. Finally, participants were given the option to elect to drop out by contacting the researcher in person or via e-mail or telephone.

Results

Interestingly enough, during the course of the inquiry, I began to realize that the literature terms I was using were not as familiar to the participants as I had initially expected. Instead of using the term "reunification", they were using the term "reintegration" and in contrast to "child outplacement" they were using the term "out-of-home placement". Additionally, by virtue of having a diverse group, many participants were entirely unaware of the concepts. For instance while talking about income support, EES workers knew exactly what I was talking about however, some foster care agency and CPS staff did not know what TANF was, although the focus groups were conducted in 2005. In regard to discretionary decision-making, some workers understood the basic construct while others did not. These reactions suggested that many of the participants were unaware of the findings in the literature.

Four major themes emerged following the first focus group: relationships; discretionary decision-making; income support; and service systems.

Theme I: Relationships

Participants repeatedly said that caseworkers need to be "open and honest" with their clients using a "client-centered approach". One participant stated that the manner in which workers engage families albeit a "direct" or "indirect" approach greatly influences the nature of the overall case outcome. Other workers posited that it is critical to inform families what "you're going to tell the court" and whether it's "good' or "bad" news. Several participants indicated that "families like to be praised" while others said it is difficult to achieve an alliance with a family when caseload sizes are too high. Participants also noted that frequent consistent contact with the same worker results in better outcomes.

Participants further stated that workers need to be "creative" in their work with families while simultaneously promoting the inclusion of client-driven decision making during all phases of the concurrent case planning process noting: "clients need to be a part of the plan…the solution". Caseworkers additionally suggested that clients are more motivated when they feel that they are "running the show." A few caseworkers lamented that the caseworker-client relationship is actually secondary to the more informal naturally occurring "extended family and extended systems" networks. Workers finally emphasized the importance of acknowledging "what resources they bring to the table". Another worker said that it is critical to initiate client conversations by asking: "Where do you want to start?" In her concluding statements about relationships, one worker posited "every interaction is an intervention."

Theme II: Discretionary Decision Making

In regard to discretionary decision-making, "creativity" is the preferred method of working with clients. Although several workers prefer a more "creative" discretionary approach to decision making, others advocate for a more universal standardized approach as a means to ensure equal access for all families. "While I think it's great that we have creativity, I also think that in order to ensure that services are maximized for all communities, and for all that we are responsible for as social workers, that we have to be responsible agents of what we're given." One participant said "…How are we ensuring that all of our caseworkers and all of our customers are getting all of what they deserve…that what's creative here is creative in County A…what's creative here is creative in County B". Other workers indicated that creativity and standardization are essentially irrelevant topics to discuss because "Attorneys and judges have the ultimate decision making authority…not individual case workers...Reunification-that's still dictated by our court system." Regional differences and worker proximity were also mentioned in regard to the manner in which decisions are made. In rural settings workers were more familiar with one another's roles, responsibilities and capabilities. "You can just walk across the hall and talk to your people". While in contrast, an urban site respondent reported that it's more difficult to assist families in crisis because "It's a bureaucracy…that gap of getting them re-established."

Theme III: Income Support

In most instances, immediately following outplacement, biological families lose their TANF cash assistance, medical benefits, and food stamps. The discussion of income support indicated that families often additionally lose their housing when their children are outplaced as a result of the immediate loss of TANF income: "It's really hard to get off ground zero without housing." Another participant stated, " They'd need to get a bigger apartment because there is no way we'd integrate four children back into a one bedroom apartment." Participants further noted that the loss of healthcare and counseling services benefits also present significant barriers for caregivers working toward reunification with their children.

Loss of cash assistance following outplacement ultimately prolongs the time children reside in foster care and too much time is wasted addressing other issues related to poverty as opposed to helping families overcome other barriers: " Yet we see time and time again that we spend tons of time talking to parents and helping them to adjust to the loss of income when the children are removed…That time could be better spent working towards reunification…You spend tons of time prior to reunification trying to figure out how to pay for all the things they need to get the bigger house again and get the utilities turned on again and get the home furnished again because of the losses that they had financially when the kids were removed". Workers stated that children are reunified more quickly when the continuity of TANF is sustained throughout the outplacement period. " And in those families where the financial support did continue, those children went home faster because she was able to maintain her home, legal employment, working on getting her GED, and some job skills and things." Another participant noted that " …There's no doubt that the length of stay is extended because finances are cut …If they don't have transportation to get kids to a medical appointment that placement will last more long term because their medical needs then will be more long term." Reunification

criteria primarily rests on the family's history with the child welfare system: number of previous contacts, prior and current case plan goal achievements, and ultimately "The court needs to be on board". Several participants concurred that " Poverty can play into it for some families …Poverty can slow things down." "But, we've never held out poverty as a reason why children don't return home…Poverty can't be the reason".

Theme IV: Service Systems

Workers posited that systemic constraints determine the manner by which workers collaborate with one another, by which interventions are used to help support families and whether policy actually reinforces reunification efforts. "Policy is black and white…It didn't say I couldn't do that…You know you've gotta kinda bend the rules." Workers insisted that the new collaborative client-centered Integrated Service Team (IST) approach to care has proven to be an effective method to address both material hardship and child abuse simultaneously. IST employees call themselves the "People in the pods" because EES and CPS staff are required to work in close proximity to one another instead of being relegated to separate departments on different floors of the building. Several participants further indicated that in-home case management services and programs provided by family preservation, foster care, and adoption agencies are extremely helpful when responding to poor families struggling to confront substance abuse, mental health and domestic violence issues.

Conclusion

The overall findings in this inquiry suggest that workers do value the worker-family relationship. However, some view the immediate worker-client relationship as secondary to the inclusion of extended familial supports particularly as related to sustained more long-term outcome achievement. Most workers additionally agree that client involvement during all phases of the reunification process is critical.

Several participants additionally note that most child welfare decision making rests in the hands of attorneys and judges as opposed to individual caseworkers; however, being "creative" and "bending the rules" was perceived as being more helpful to clients than "going by the book." Many group participants concurred that they would be "able to focus on what we need to focus on if finances were in the picture in terms of their aid continued." One group member said that she wouldn't have to figure out how to get "clients gas and transportation if they received a TANF waiver during outplacement." Other group members indicated that more availability of intensive case management services might serve to mitigate outplacement.

Successful caseworker-client relationships lead to promising outcomes. However, alliances cannot be achieved in the absence of basic needs. Discretionary TANF waivers may or may not give authority to individual caseworkers to discern whether biological caregivers are worthy or unworthy of cash assistance, thereby rendering parents helpless in their quest to reunify with their children. TANF waivers must be made available to all CPS families so that they may sustain stability while attempting to address the real issues at hand.

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Shaping Attitudes in Public Child Welfare: An Innovative MSW Training Program

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Children investigated by child welfare are at significant risk for poor cognitive, emotional, social, behavioral and economic outcomes. In 2000, California formed the Child Welfare Services Group to propose changes in how child welfare services are delivered, the CWS Redesign. California State University, Long Beach's child welfare training program developed its complement. Fundamentally, Redesign calls for partnering with families and communities to strengthen families, prevent unnecessary placements or re-unite families successfully. These changes are a paradigm shift in attitudes toward birth families and communities. In a qualitative study, interns logged their observations and subsequent impressions of CWS-Client encounters to explore how attitudes are learned. Majority of interns observed positive, collaborative encounters and perceived birth parents as motivated. Their impressions support introducing interns to birth families on the front-end of CWS training.

Key words: child welfare, social work training, family preservation

As of July 1, 2005, there were over half a million children in foster care in the United States (C-CFSR, 2006). Most came from families that were unable to provide them with essential nurturing in a sober and safe environment. Of these children, 46% had experienced neglect, 27% were exposed to physical abuse, 11% to sexual abuse, and 7% to emotional abuse (NSCAW, 2005). Despite the fact that the majority of children in foster care have a court order for family re-unification services, statistics show that only about half of all children entering out-of-home care will successfully reunite with a parent (AFCARS, 2001).

The National Survey of Child and Adolescent Well-being is the first national representative study on the wellbeing of children who have been brought to the attention of child welfare services. The survey showed that of those families investigated for child maltreatment, only 11% had children placed in out-of-home care, with the remaining 89% left at home (NSCAW, 2005). Of the families whose children remained at home, less than one out of four received services from child welfare services (CWS) after the initial investigation. In the Los Angeles County Department of Child and Family Services (DCFS), "each year up to 33% of all referrals represent repeat referrals of the same family from the previous year" (*Redesign*, p. 13).

The NSCAW study (2005) also determined that all of the children, regardless of whether they were placed out-of-home or offered CWS services, were at high-risk for compromised development. On the Bayley Infant Neurological Screen (BINS), 53% of those tested were measured to be at high-risk for developmental delay. These results were consistent with the Battelle Developmental Inventory (BDI) mean scores at a full standard deviation below normal with 31% scoring two standard deviations below. The

Vineland Adaptive Behavior Skills test (VABS) was used to measure the children's social functioning and 38% were found to have "fewer" social skills, a level twice lower than what would be expected in a normal sample. These children were five times more likely to have behavior problems than their peers, and one quarter of them were reported by caregivers as having delinquency problems (again five times the rate of their peers in the general population.) Of the children between 11 and 15, about 25% reported having had sexual intercourse.

To summarize, most children investigated by CWS for possible maltreatment remain in the home, and few receive any further services beyond the initial investigation, regardless of the likelihood that this child and family will be reinvestigated at a future date. This lack of follow-up is a huge missed opportunity given that the children of investigated families are on a negative developmental trajectory toward cognitive, emotional, social and behavioral problems.

In California, the situation has become even more serious. California contains only 13% of the nation's total child population, yet it is home to 20% of the nation's foster children (CA Stakeholders Group, 2003). In 2000, California responded to these challenges by forming the Child Welfare Services Group, comprised of 60 locally and nationally known experts in the public and private child welfare community. The stakeholders group reclaimed the original vision of seeing: "Every child living in a safe, stable and permanent home, nurtured by healthy families and strong communities". *The CWS Redesign: The Future of California Child Welfare Services* (CWS *Redesign*, final report 2003) has been adopted as the blueprint to provide competent CWS to California's most vulnerable children and families. The CWS, *Redesign* was one of two major initiatives of the state legislature that have converged to produce a new climate. The second is the passing of AB636: *Child Welfare System Improvement and Accountability Act,* which established a statewide outcome-based accountability system. If universities are going to meet the *Redesign's* mandate to "develop and sustain a high-capacity, competent and satisfied child welfare workforce who is prepared to fulfill the essential functions of the *Redesign*ed child welfare system" (*Redesign*, p. 31), then universities that train MSWs in public child welfare must make a comparable paradigm shift in its internship program. "Transformative change involves three ingredients: (1) clear vision of a new reality; (2) specific tactics to get there, and (3) a means of checking progress along the way" (*Redesign*, p. 22). The California State University, Long Beach (CSULB) MSW internship program is meeting this challenge with its innovative training program, the *CWS Learning Plan*; the first cohort (class of 2006/2007) has completed its initial phase of training.

Training Interns in Public Child Welfare

There has been "marked growth in the quality and quantity of training in child welfare; however, there is still unmet need for rigorous evaluation of these newly developed components of training" (Doris, Mazur & Thomas, 1995, p. 479). In 1974, Congress passed landmark legislation in the federal Child Abuse Prevention and Treatment Act (CAPTA; Public Law 93-273; 42 U.S.C. 5101). The act provided states

with funding for the investigation and prevention of child maltreatment, conditioned on states' adoption of mandatory reporting law. The impact of mandatory reporting was a surge in reports overwhelming the states' supply of competent professionals to investigate, intervene and care for abused children. By the 1980s, the care of abused children and their families had reached a crisis (Doris et al., 1995) and the unstructured, in-house and on the job experience supplemented with workshops and seminars could not meet the demands for a competent work force. In response to the crisis, federal Title IV-E funds were created in the 1980s to form university-child welfare agency training programs. "The US General Accounting Office (GAO) found the university-agency training partnerships to be promising practices for addressing the staffing crisis in child welfare, in part by improving both recruitment and retention (GAO, March 2003).

Training in child welfare has three critical components: (1) attitudes; (2) knowledge; and (3) skill-building (Leung & Cheung, 1998, p. 670). Clapton and Cree (2004), in an exhaustive review of the literature, found that transferring classroom knowledge into applied practice is difficult. "The nature and future of the relationship between 'field' and 'classroom' is crucial if learning for practice is to be integrated yet it appears that the extensive literature on these two pillars of social work education has yet to produce a working synthesis to integrate learning for practice" (Clapton & Cree, 2004, p. 12). This is no more critical than in public child welfare. How we think about vulnerable children and families, how we intervene and how we measure success are dependent upon our ability as professional educators to effectively integrate classroom and field. Partnership between university faculty and in-the-field practitioners is a golden opportunity to get it right. Universities by the mid-1990s developed explicit, written competencies in child welfare. "Descriptions of these competencies are plentiful, but evaluations are limited—evaluations are primarily focused on contents and immediate outcomes of training. Rarely do researchers report empirical evidence to identify the long-term effect of CPS training" (Leung et al., p. 670).

Research on the effectiveness of training is sorely limited. "Although training in child welfare as an intervention to promote effective performance on the job (transfer of learning—TOL) as well as staff retention, there is not a preponderance of empirical evidence to support this practice" (Curry, McCarragher, & Dellmann-Jenkins, 2005, p. 931). Vinkur-Kaplan (1986) in a national sample, surveyed child welfare workers and supervisors to evaluate the workers' perceptions of the effectiveness of received trainings. The factors that students rated most highly were: relevance, qualified training staff, adequate agency support, and sufficient time off. Jones, Stevenson, Leung and Cheung (1995) in another national survey, found that states' training programs emphasized 7 CPS priorities: case planning, cultural issues, family preservation, interventions, investigation and assessment, legal issues, and substance abuse. Although "some states report that their training efforts have been evaluated, minimum research has focused on the long-term effectiveness of CPS training" (Jones et al., p. 669). Leung and Cheung (1998) in a quasi experiment compared improvements in knowledge and performance of child welfare trainees to current workers. They followed 152 trainees and 52 controls (present CPS workers) over two years. The research team found that although trainees had significantly better scores in knowledge and skills from pre to post training, that over time, they were not more knowledgeable than those caseworkers who learned exclusively on the job. As importantly, some attitudes

changed as a function of training, but most did not. Trainees in child welfare entered with attitudes that they retained regardless of the trainers' efforts to shape them. Although knowledge deficits can be compensated by supplying more information, and skills can be learned through guided practice, "attitudes are clearly not so easily influenced or changed" (Stevenson, Cheung & Leung, 1992, p. 2).

Shaping attitudes in public child welfare: an exploratory study, presents an innovative training program to improve attitudes, knowledge, and skills of graduate-student interns. It also explores how this unique integration of theory and field in a university training program influences the intern's attitudes toward vulnerable families. Given the lack of published studies on the impact of child welfare training, starting with an exploratory study provides the best opportunity to yield new insights and set the ground work for further research. "Exploratory studies are very valuable in social work research" (Rubin & Babbie, 2005, p. 124), when breaking ground into an area that has limited research.

Purpose of the Study

This study explored the *CWS Learning Plan's* impact on emerging perceptions and attitudes of MSW interns toward birth families and communities as they began their hands-on work with public child welfare in Los Angeles County. This qualitative study explored the initial three months of the MSW intern's public child welfare field experience.

Programs and Strategies

California CWS "Redesign"

The Child Welfare Services *Redesign* is a long-term strategic plan to help California realize a new vision for child welfare. The *Redesign* emphasizes five goals, to: PREVENT child maltreatment; PRESERVE and strengthen families while the child continues to live at home; RESTORE family capacity for placed children to safely return home; REBUILD lives for placed children who will not be able to return home; and PREPARE youth to enter adulthood as members of a family/community. The *Redesign* shifts the focus from "rescuing" children to building stronger families, partnering with communities and providing planned, evidence-based interventions for children and families that yield explicit, measurable outcomes.

The Los Angeles County Department of Child and Family Services (DCFS) has adopted specific evidence-based practices to achieve the *Redesign's* goals including Points of Engagement (POE), Structured Decision Making (SDM), Team Decision Making (TDM), Community Partners (CP) and Permanency Partners Program (P3). Public child welfare is not only composed of structures, policies and practices, but also perceptions, attitudes and shared meaning. Historically, the public child welfare system has operated from the belief that individual families are the root causes of maltreatment, and as a result, the structural or institutional problems inherent in our society have been largely ignored. This attitude of "parental blame and punishment does not necessarily make children safer and holds unintended consequences for child and family wellbeing" (*Redesign*, p. 24). These consequences include failing to achieve permanent families

prior to emancipation for many youth, as well as failing to provide at-risk families with the services required to modify their child's negative developmental trajectory. To be effective, Children Social Workers (CSW) need to shift their attention from "substantiating" abuse to creating collaborative, respectful and empowering relationships with the birth families. CSWs need to value the birth family as the client (and/or resource) and not the "problem". In order for the *Redesign* to be implemented effectively, we need to understand the initial experiences that shape a social worker's personal attitudes, as it is these attitudes that will ultimately shape the culture of public child welfare.

The CWS Learning Plan

Overview of the CWS LP

Ideally, interns will have the opportunity to follow a specific case from a Hotline call, dependency investigation, disposition hearing, and team planning to resolution. The intern would be instrumental in helping to link troubled families with relevant and timely community services. All of the experiences of the MSW interns are carefully nurtured and guided by one of two field instructors, both DCFS supervising county social workers assigned exclusively to the CWS internship project. The field instructors' experience in DCFS gives the interns invaluable wisdom and expertise, while their exclusive connection with the CWS gives focus and attention to the student's learning needs.

Objectives

The CWS LP was developed to prepare students to be leaders in the DCFS' work force who could meet the current challenges and implement the *Redesign*. The three principal objectives of the CWS LP are to:
1. Move students systematically through child welfare PROCESS from Hotline calls to Permanency Planning programs— thus exposing MSW interns to the experiences, challenges and opportunities for change at each important juncture
2. Work on the FRONT END to teach students how to maintain and strengthen family relationships—preventing unnecessary out of home placements and/ or returning children to safe, nurturing families
3. Partner with COMMUNITIES to establish collaborative relationships and to successfully link high-risk families with community agencies and resources that not only can help strengthen families but help to sustain them

The CWS LP initiates students to both the processes and the strategies of the *Redesign* by starting MSW interns in the Emergency Services Department (ER). In this two-week assignment, interns shadow Hotline calls and "ride along" on maltreatment investigations. The ER assignment is followed by a week in Dependency Investigation Services (DI) where the student shadows assessments of family and community collaterals. This introduction to the ER and DI is intended to give students an experience-based context to appreciate the complexities of *the work* while exposing students to Points of Engagement (POE) strategies including Structured Decision Making (SDM). The interns are each assigned to a preceptor at the beginning of their fieldwork. The preceptor, a case-carrying CSW, selects a specific case or cases for the

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intern to follow starting with a family supervised by DCFS where the child remains in the home receiving Family Maintenance (FM) services. The intern co-facilitates interventions with their preceptor, who also includes the student in other activities surrounding that child and family, such as court hearings and Team Decision Making (TDM). As the student becomes more skilled and confident the CSW will select a second case, in which the intern will assume a more primary role. The CWS LP is structured to expose MSW interns to POE strategies from Hotline to case disposition, so that students will experience the logic and continuity of front-end decisions.

Strategies

1. Shadowing Emergency Services and Dependency Investigations

Typically a child and family are brought to the attention of DCFS via a call to the Hotline. This is true whether the reporter is mandated, such as a teacher, physician or social worker, or a member of the community such as a concerned neighbor or relative. DCFS recently embraced POE as a set of strategies for making the transfer of responsibility from front-end investigation to actual service delivery both seamless and timely. POE, as all programs in the Department, utilizes the research based, objective assessment tools of SDM. These tools are completed at each critical decision point in the life of the case to guide workers in their decision making, including response time, whether to open a case, family strengths and needs, child safety and possible need for out of home placement, and when it is appropriate to return a child home or close a case. SDM discriminates low, moderate, high and very high-risk cases to assure a more appropriate response. SDM combined with safety assessment is used determine placement decisions and to PREVENT low risk cases from entering unnecessary placements. POE also uses TDM strategies to expand the decision making body to include multiple stakeholders such as extended-family members and community partners. In the CWS Learning Plan, MSW interns are assigned to a specific CSW in Emergency Services and Dependency Investigation Services, so that they can shadow POE activities, and learn POE strategies through actual case experience.

2. Co-leading family maintenance cases with an assigned CSW

The second principle of the *Redesign* is to PRESERVE families in their communities. Specifically in Los Angeles County, one of the three key goals in implementing the *Redesign* is to reduce reliance on detentions. Once a family has been investigated and accusations of maltreatment have been substantiated, the child may remain in the home if safety can be reasonably assured. A family in this situation may elect to be supervised voluntarily, or the CSW may decide that the case would be better managed through involuntary court supervision. In either case, the family receives family maintenance services from a CSW. Consistent with the *Redesign*, family maintenance services help families build successful and long-term partnerships with community agencies and resources. MSW interns learn directly through co-leading with the preceptor (case carrying CSW) how to PRESERVE and strengthen families while the child continues to live at home.

3.   Community networking activities and exploration of community context (systematic planned activities lead by the CWS Field Education Consultant)

One of the most significant changes proposed in the *Redesign* is the idea of partnering with communities to support and strengthen families. It is critical that students at their orientation to public child welfare learn how to work within a community. To help students become effective in community work, the CWS LP asks students to participate in regular meetings that focus solely on applying a Social Ecology Model in public child welfare. These discussions, *Community Consultation Meetings*, help students to think from a *person-in-environment* perspective, and allows for problem solving with colleagues on how to identify helpful community services and agencies and how to link families to relevant community partners. *Community Consultation Meetings*, lead by the CWS Field Education Consultant (University faculty), are a focused effort to introduce students to established community partners in their Service Planning Areas (SPA) in Los Angeles County, and to participate in a dialogue about what services are lacking in the community. Students are also encouraged to attend community-planning meetings and to visit specific agencies for added exposure. Once a student takes a case, he/she is asked to connect the children and their families to community partners; this helps teach the intern the skills and strategies of effective linking. If a family is successfully linked to an effective community partner, that link not only contributes to a host of positive changes right away, but will also help sustain that family's progress after exiting DCFS supervision—and PREVENTING future maltreatment.

4.   Assignment of a placed child (or siblings) that are either in a kinship or non-relative foster placement with a court order for family re-unification services

The MSW intern is assigned to a preceptor (case carrying CSW) who supervises and supports the intern's learning opportunities to RESTORE family capacity for placed children to safely return home. Student interns have an opportunity to support Family Visitation Plans and to link to Community Partners their assigned families. The plan is to have each student facilitate both a kinship and non-relative foster placement to help the student understand their unique opportunities and challenges.

Methods

Design

According to Rubin and Babbie (2007) "One of the key strengths of qualitative research is the comprehensiveness of perspective it gives the researcher. By going directly to the social phenomenon under study and observing it as completely as possible, you can develop a deeper understanding of it" (p. 237).

This is an exploratory study of interns' individual field research within the CWS training program. The study employed qualitative methods in the form of semi-structured observations of intern training encounters. Interns were asked to log their qualitative observations of CSW-Client or Intern-Client interactions and their subsequent impressions on semi-structured client-logs. The client-log is consistent with the typology: *environment* (department, activity and client), *role* of the observer, and *impressions*. Interns during initial encounters move between continuums from complete

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observer, observer-as-participant, to complete participant. The observation questions were formulated to help interns in the process of observation and researchers during content analysis to differentiate between the *emic* perspective – trying to adopt the beliefs, attitudes and other points of view shared by the members of the culture being studied, and the *etic* perspective – allowing researchers to maintain their objectivity as an outsider and to raise questions about the culture they are observing that wouldn't occur to members of that culture (Rubin & Babbie, 2007, p. 247).

Interns

All 16 interns from the fall 2006 CWS program were invited to participate in the study, and all had been selected from the California State University Long Beach MSW graduate program. Selection was based primarily on having good academic standing and a sincere motivation to work with this population. The CWS internship is a specialized stipend fieldwork program (under the Title IV-E funds) to prepare MSW students in public child welfare for Department of Child and Family Services. Students in the program have a one-year commitment to work for DCFS immediately following graduation.

Procedures

The 16 CWS interns were introduced to the research and invited to participate on August 30, 2006. Fifteen of the 16 CWS interns volunteered and signed Consents. Although the CWS fieldwork placement began the first week of September, students did not shadow in Emergency Service until late September and Dependency Investigations until mid-October. Most students however, were assigned a preceptor by mid-September and began facilitating or co-facilitating family maintenance services that allowed them to log encounters as observers or observer-participants of CSW-Client interactions. All data was collected by November 22, 2006, the end of Fall academic semester. Client-log forms were available to the interns at their fieldwork site, along with a locked "mailbox" in which to deposit the anonymous logs.

Instrument

The researchers for the purpose of this study created the semi-structured client-logs to capture the environment, role of the observer, and impression of the intern as she observed interactions between CSW (or, self in the role of CSW) and a client. Encounters included listening to Hotline calls, determining differential response categories, Team Decision Making planning, interviewing clients at home or in the community, interviewing collaterals, and contacts with community partners. Interns were asked to make systematic observations describing their environment (department, activity, and client), their role in the observation (observer, observer-participant or participant) and their impressions.
To explore the question of what shapes child welfare workers' attitudes and culture, interns were asked on the client-log to respond to three open ended questions: (1) Impressions of birth parent, kinship or foster caregiver? (2) Best way to approach a similar situation in the future? (3) Your future role in public child welfare? Additionally, to assess interns' use of evidence-based practice in making clinical

decisions, interns were asked on the client-log to rank 'learning opportunities' that helped them understand the encounter (i.e. classes, field seminar, intuition).

Analysis

Semi-structured observation logs were used to assess interns' developing attitudes regarding child welfare populations and practice decisions. Borrowing a conceptual framework from the goals for public child welfare employees under the Child Welfare Services *Redesign* the variables of attitudes and practice decisions were assessed according to their degree of a *collaborative, respectful* and *empowering relationship* with the birth family and use of e*vidence based practice.*

Both manifest and latent content of client-logs were coded under the typology of environment, role and impression. For example within environment, department, activities and client were coded; within role, the role of the observer was coded; and, within impressions, attitudes and perspectives were coded. Interns' perceptions of the quality of the CSW-Client encounter were analyzed from strengths perspective: (1) Was the client respected as an expert on their own life (Cl Expert)? (2) Was the client allowed to be an active participant (Cl Active)? (3) Was the encounter collaborative (Collaborative)? (4) Was the CSW engaging of the client (Engaging)? (5) Was the client empowered (Empowered)? (6) Was the encounter solution focused (Solution focus)? And, (7) Was the focus on the future (Future focus)? Client-logs were also analyzed by coding the entire log for comprehensive meaning.

Results and Discussion

Fifteen (15) of the 16 student-interns volunteered to participate in the study. The fifteen interns completed client-logs for a total of thirty-eight (38) encounters. The environments that the interns logged were evenly divided between ER (n = 15) and FM (n = 15) with a few from DI (n = 3), Permanency Planning (n =3), and Adoptions (n=1) departments within DCFS. All of the logged encounters were face to face. Twenty-five (25) of the encounters were in the client's home, eight (8) were in the community, and two (2) were at TDM meetings. The interns logged CSW-birth parent encounters twenty (20) times, CSW-child encounters fifteen (15) times, CSW-non-relative foster caregiver once (1) and CSW-Kinship foster caregiver once (1). One (1) intern did not identify the client in the encounter.

The interns, as expected, had different roles in the encounters. The intern was a complete observer in nineteen (19), observer-participant in nine (9), and complete participant in ten (10) logged encounters. Interns were very likely to be complete observers in Emergency (ER) encounters (n= 13/15) and not likely in Family Maintenance (FM) encounters (n =3/15). Similar to ER, interns in Dependency Investigation (DI) encounters were complete observers (n= 3/3). Whereas, interns in Permanency Planning (PP) (n= 3/3), Family Reunification (FR) (n =1/1) and adoptions (n =1/1) were either observer-participants or complete participants.

The client-logs captured a range of positive impressions by the interns regarding the quality of observed CSW-Client interactions. Primarily the interns perceived the encounters as collaborative, respectful and empowering family relationships. Interns observed CSW's respect their client as the expert on their own life; allow their clients to

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be active participants; build a collaborative relationship with their client; engage and empower their client; and stay solution focused and future focused. The positive attributes assigned to their observations, though, were not evenly distributed across environments. FM observations were universally positive; whereas ER, although mostly positive, were not as strongly positive. There was a distinct relationship between whether the encounter was in Emergency Services (ER) or Family Maintenance (FM) and the intern's positive impression of the encounter.
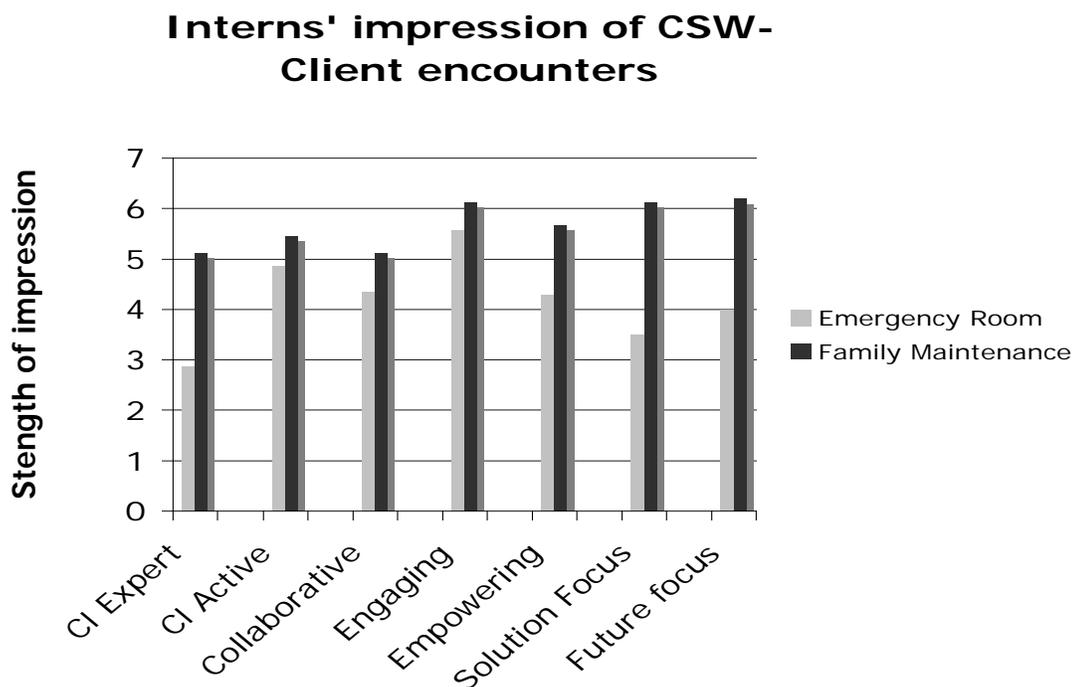
Interns' Observation Environments
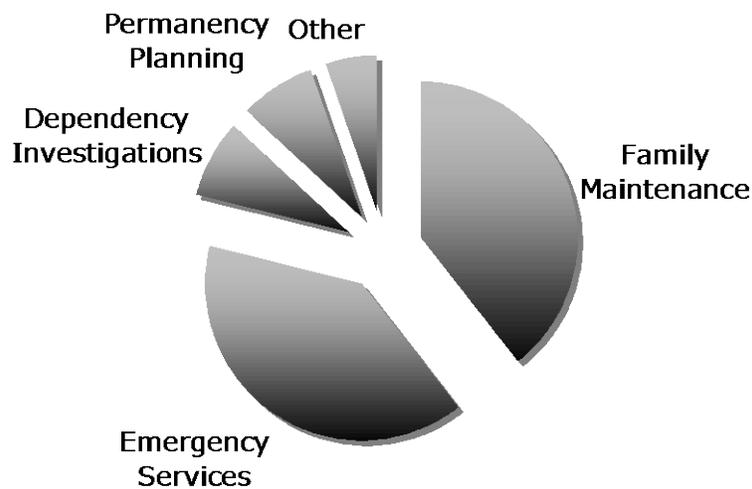
Figure 1: Child welfare department in which the intern observed CSW-Client encounters

Interns were asked to rank what they perceived to be most influential in understanding what they were observing: "Reflecting on the following 'opportunities for learning', what helped you understand this client-CSW or client-Intern interaction?" Interns ranked their *intuition* as most influential (x=5.63), *DCFS trainings* as second (x =5.34), *supervision* as third (x=4.67), *classes* including written materials as fourth (x=4.16) and *field seminar* as last (x=3.45), on a seven point Likert scale, from least to most helpful. The students' beliefs about what influences their learning is concerning. The students think that their own intuition (what they brought to graduate school) has more influence on their understanding of a professional intervention than what they are learning either in the classroom or in weekly field seminar at the University. These

heuristic beliefs are counter to evidence based practice that requires social workers to research best practices when making clinical decisions—drawing upon explicit learning and current journal articles to inform decisions.

Interns' impression of CSW-Client encounters

Figure 2: Interns' impression of CSW-Client encounters

      The question that this study hoped to illuminate is how the environment, role and impressions shape emerging attitudes and culture of new workers in public child welfare. The observations of birth families appeared to make strong impressions on the students. Students perceived birth parents, primarily, as cooperative, motivated and wanting services to help them and their children. Those students who observed positive collaborative CSW-parent encounters often wrote that the experience motivated them to do child welfare. Not all students observed cooperative birth families; a birth mother was observed to be demanding and controlling not only to the CSW, but to the children and other family members. Some of the interns expressed empathy for the parent. A few students talked about the parent being overwhelmed either with their parenting or the case plan. One student wrote that the mother appeared depressed and sad.

      In these encounters the interns frequently logged that they would like to be advocates. One student put it succinctly, "to advocate for the needs and well being of the children and to assist their families in being able to do so". A student logged that meeting with a parent was an enlightening experience after reading the case report and

that she will in the future meet with the parent sooner and more often. Two interns logged that they had the opportunity to talk with the father of the children. One intern noted that the father could be a resource when the mother was unavailable or incapable of parenting and the other intern noted that she was surprised at how talkative and candid the father was, noting "he gave more information than needed". In summary the experiences for the interns of observing birth families was rich and meaningful. As one intern wrote, "this just gets me excited to start working the case. I am happy to be part of child welfare."

Limitations and Implications for Future Research

Given the small sample size (n = 15) and that it was a sample of convenience, the results of this study cannot be generalized beyond the fifteen interns that participated in the study. Also, the IUC program is only offered to a select number of graduate social work programs in Southern California. Thus, the results may only apply to interns completing specialized training in public child welfare in Los Angeles County.

This study can help inform educators of MSW graduates entering public child welfare. This qualitative study indicates that students benefit from shadowing on the front-end in child welfare. Future research could explore the feasibility of applying the IUC Learning Plan within other university-based Title IV-E child welfare training programs. The long term impact of this training on CPS workers' effectiveness and retention would best be addressed in a longitudinal study.

Suggestions for Future Training

Clearly, the CWS LP structure has successfully given student-interns a comprehensive and systematic exposure to DCFS operations, organization culture, and diverse career opportunities for CSW's. The varied shadowing experiences have gently guided students through the challenges of child welfare practice. This phased approach fosters appreciation for the actual work. Similarly, expanding the student-interns role to observant-participant and complete participant has an empowering effect on students, building confidence in their work capacity, thus mediating future burnout. Through these environmental exposures, students can make informed decisions about the workforce. This structure should be maintained through the academic year.

From a practical standpoint, the systematic exposure should be modified to include a designated number of core environment-activities rather than solely based upon academic calendar or preceptor assignments. For example, many student-intern shadowing experiences were delayed due to unit staffing changes (promotions, reassignments, etc). If core activities are assigned, then student-interns will be assured purposeful unit exposure with minimal interruptions.

The student-intern early interactions with birth mothers, critical community resources, and collaborative interactions between DCFS and community partners creates an "other-centered" perspective which supports a strengths-based approach to child welfare practice. At the outset, student-interns are exposure to an integrated approach to child welfare practice as opposed to compartmentalization. This community partner exposure and the invaluable experience of Family Maintenance (vs. Permanency

Planning cases) enable interns to appreciate and collaborate and with birth families. This vital model of client advocacy should be continued as well.

The interns' primary reliance upon intuition in decision-making clearly warrants early academic exposure to evidence-based practices (EBP). Within the CWS LP, students have been introduced to EBP in Community Partners Orientation. However, given the volume of trainings offered to date, linking the information may prove challenging. This information will be infused throughout the academic year to insure better integration.

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Client Home or Agency Office? How Do We Decide Where to See Our Clients?

Harriet W. Meek

Decisions about location of services sometimes appear to be made more on the basis of agency preference than assessment of need. Today the profession has enough experience with service locations that it is possible to develop more clear guidelines for the decision about where work with clients should take place, in the client's home or nearby community or in the practitioner's office. This study was conducted with two purposes; 1) to identify at a higher level of evidence the various reasons for seeing clients in their own homes and nearby community setting; and 2) to demonstrate how readily available information can be used to gradually increase the level of evidence by which practice decisions are made.

This review serves two purposes. It helps clarify the optimal location for social work services. It also demonstrates a way of increasing the strength of our evidence base using data that is readily available.

The human services serve a wide range of clients in different situations. One way the field has coped with its breadth is to divide itself into areas of specialization; medical, school, child welfare, clinical, etc. In recent years a new area of specialization has emerged, home-based practice, cutting across the usual lines between fields. Family preservation is one form of home-based service; other less specialized formats also exist within the domains of child welfare, mental health, juvenile delinquency, services to people with handicaps, the elderly and others who have difficulty getting to the office. Many of these services provide intensive, flexible supports and a form of family therapy that takes place in the family home. The several varieties of home-based services often operate in situations of crisis, usually when there is danger of a family member being removed to foster care, hospitalization, etc. It is unusual for a single agency, or agency program to provide services both in client homes and the office.

The social work code of ethics (NASW, 1999) emphasizes respect for the dignity and worth of the person and suggests decisions about the location of care should be made on the basis of a careful assessment of individual and family needs. Assessments are made in both home- and office-based services, but it appears that once a client family has arrived at a particular agency, an assumption tends to be made that the *location* of service will be whatever is usual for that agency. Thus, client families who are first seen by an agency organized around family preservation or another form of home-based service are quite unlikely to be seen in the office. Those who first come for help at office-based programs are likely to stay there, though a few may be referred to home-based programs.
It can be argued that families who need these services are the ones referred to the home-based agencies and for the most part this is probably true. However, our Code of Ethics (NASW, 1999) advocates making care decisions on the basis of a specific assessment of particular individuals and families which is not always done in relation to the optimal

location for care.   We are now in a position to make a more informed and specific decision. A more formal study of this situation would be a useful project for further research and may be made more possible through the conceptualization provided by this review.

Methodology

This appraisal should be considered an intermediate step in the production of stronger evidence about practice. In research related to social work practice, the questions are often not sufficiently conceptualized to allow the design of studies that will produce high level evidence. Intermediate work is often needed, often substantial enough to be worth calling it *research* in its own right. Most research design tends to treat this part of the research process as if project conceptualization is a relatively simple matter, but often it is not. This analysis serves as a demonstration of this mid-level of conceptualization.

The paper uses three sources of data to examine decision making in regard to whether a client or family should be seen in their home or in the office. Underlying the methodology is an assumption that the question under study has not yet been conceptualized sufficiently to design a more definitive study. The data sources used in this study are: 1) a literature review; 2) ethnographic field notes from a practitioner's workshop; and 3) the author's examination of the situation from her role as expert practitioner. The results from examining these data offer further conceptualization of the question, "Should this client/family be seen at home or in the office?" and provide a roadmap, more detailed than existed previously, for further study.

Important to the thinking behind this study is the idea of a taxonomy of evidence, a concept not often discussed in social work practice circles. Practitioners often seem unaware there are *levels* of evidence, a hierarchy based on a classification of the *strength* of evidence available.   Several schemes grade levels of evidence according to consistency, quantity and quality, requirements provided by the Agency for Healthcare Quality and Research (AHRQ) (Finklestein, 2005).   One oft-cited scheme is the relatively elaborate one presented by Guyatt, et al. (2000).   An abbreviated model used in medicine that seems useful for human service practice is the Strength of Recommendation Taxonomy (SORT) (Finklestein, 2005).

> The randomized controlled trial (RCT) is the most rigorous study design. According to SORT, RCTs that deal with patient-oriented outcomes and include concealment, double-blinding, intention-to-treat analysis, and complete follow-up (and meta-analyses or systematic reviews of such randomized trials) provide a level of evidence (LOE) of 1. Observational studies, such as cohort and case-control studies (and systematic reviews that include them), are less rigorous in their design, and they are given an LOE of 2. Level 3 evidence, the lowest level, is assigned to consensus guidelines, expert opinion, usual practice, etc, or to studies that look at intermediate or disease-oriented outcomes.
>
> Finklestein (2005, 1032)

In present human service practice, most evidence is likely to be at Level 2 or 3, rarely at Level 1. Workers are often dealing with questions that are difficult to conceptualize and

direct practice decisions are most often made on a case by case basis. The human service practitioner's main question is likely to be "What will be best for this family? or "What will help Mrs. Jones?" rather than decisions on behalf of *groups* of clients.

Our conceptualization of the client's situation may not be adequate for the design of a randomized controlled trial (RCT), but our careful observations, thorough assessments and, over time, developing expertise in working with people dealing with similar situations can still contribute to the profession's evidence base. Practitioners can help collect evidence by writing about their experiences and compiling these accounts. Later it will be possible to gather together accounts of similar experiences and contrast and compare them, developing a clearer conceptualization of the issues and collecting evidence at a higher level on the taxonomy.

This discussion is concerned with evidence that is probably at Level 3 according to Finklestein's (2005) taxonomy. Although this is the least strong form of evidence, it *is* considered evidence and when combined with similar work, could be used to help in the conceptualization of an issue preparatory to the gathering of higher level evidence. These three sources of information also serve as an informal triangulation device used to shed more light on different situations that may indicate whether work in the home or office is most appropriate or suggest more evidence is needed before a clear decision can be made.

A Brief History of Home Based Services in the United States

Human service workers always function in a particular context and these contexts shift over time. This makes it useful to take a brief foray through the history of home-based services in order to understand how we have arrived at our current situation.

The human service professions in the USA have their roots services provided in client homes (Hamilton, 1940), though the practice of seeing clients primarily in the office became more common during the middle part of the 20th century. With the exception of child welfare, by the 1960s in the USA it would have been unusual for an entire course of intervention to be carried out in a client's home. The reasons for this shift are complex; they have to do in part with the incorporation during this time of psychoanalytic ideas into social work's knowledge base, resulting in a tendency to value therapeutic work more than problem solving, attempts to improve the environment and clarify the systems in which people live. This is another area that might warrant further, more formal, study.

Well before the 1960's it was clear some people were more difficult to help than others. These were often identified as individuals and families who seemed disorganized, found it a challenge to make use of in-office services and did not appear to respond well to the methods offered in the clinical settings of the time (Bandler, 1967; Pavenstedt, 1967). During the 1970s many of the agencies providing office-based services were mental health programs that later, because of funding demands, began to follow an increasingly medical model. Prior to about 1980 it was possible for these agencies to be more fluid in their decisions about the needs of individual clients and families and the location of care. One agency known to the author had traditionally seen most people in the office, but also reached out to clients in rural communities and geographic areas where it was understood it might be difficult for clients to come to the office. Home visits, sometimes repeated frequently, were actively encouraged on a programmatic level.

Social workers and psychotherapists carried the materials they needed for work with individuals and families in their cars and did much of their work in client homes across a large geographic area. As funding began to be more constrained, administrative limitations began to be placed on more expensive practices. Since on the surface it looked as though these outreach activities were more costly, they began to be prohibited. Later, it became clear that such things as failed office appointments also added to the expense of care in other ways, and home-based programs began to develop.

By the late 1970's, concern had also developed about the large numbers of children who were taken into foster care and never returned to their families. As a result, changes were made in public policy that encouraged an emphasis on keeping children with their own families and in their own homes, the 1980 Child Welfare Act. About the same time agencies began to be formed that reached out to clients who were not being served effectively by office-based services. Services aimed at providing intensive services for vulnerable families began to emerge (Hooper-Briar, 1995).

Family preservation services are the most specialized of the home-based services. Family preservation services almost always take place in client homes or nearby in the local community. These programs are organized specifically to preserve the family via attention to the following principles (Hooper-Briar, et. al., 1995): an emphasis on the protection of all members of the family, especially children; the family *[rather than the individual]* as the focal point of services; services are available, culturally, psychologically and geographically; services are organized via a strengths perspective; developed along a continuum; and with planning that is inclusive of all groups (Williams, 1994). Thus, family preservation services are aimed specifically at the best interests of the family, generally try to keep the family together and functioning as effectively as possible (by the family's definition) and with the wellbeing of all the family's members in mind (Hooper-Briar, et. al., 1995). Family preservation services are primarily found in child welfare, usually offering flexible and often creative supportive services, frequently operating in situations of crisis, but sometimes also as a preventive measure.

During the 1980s agencies began to see people primarily at home; others continued to use the office as their main base. During this time, concern over the decision as to home or office appears to have been made more on the basis of the client's membership in a poorly defined group than their specific needs. This tendency has persisted. Now, after more than twenty years of serving some clients in their homes and communities and others in offices, it appears that we should be able to begin making decisions about venue of service on the basis of specific need rather than assumptions.

Client Home or Agency Office? Some Findings

The remainder of this paper identifies circumstances reported as having led to the decision to see an individual or family in their own home, along with other situations that appear to have led to a decision for work in the office. It suggests some conditions where clear enough indicators exist to allow more elaborate studies to be developed that could produce a higher level of evidence for or against their use. Other situations may indicate the need for further information at a more basic level.

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Who is seen at home? Who is seen in the office?

By looking at the descriptions of clients seen in both settings and reported in the literature, it became possible to identify, in a general way, those for whom each service location was used. The evidence for home- vs. office-based care falls within the third level (least strong) of the Strength of Recommendation Taxonomy (SORT) (Finklestein, 2005). At the same time, it is clear some of the client situations identified by the literature and other sources are considerably stronger than others. These findings are grouped by strength of evidence.

A caveat: A limitation to the literature

The social services have developed in a branching way, rather like a deciduous tree. Areas of specialization have evolved, with sub-specialities forming out of the main trunk, eg. mental health, child welfare, medical, school, etc. Home-based services have developed, not from the branches, but from the main trunk with especially strong links to child welfare and mental health. This means early literature about home-based work tends to be found in general bibliographic sources, while later it moves to child welfare and mental health. The literature search was not at all straightforward; it was necessary to use synonyms and think carefully about related words in order to make use of the usual library databases. Also, since home-based work grew, in part, from family therapy and the family therapy literature had earlier emerged as a separate area of study out of individual mental health, this growth pattern was evident in the literature.

This literature review located papers on "home visits" until about 1980, mostly in child welfare and occasional mention in the mental health literature, until family therapy began to be prevalent. By that time, the question had shifted to whether clients were better seen as individuals or in a family format. Whether the intervention should take place in the client *home* had not yet appeared as a question. Material about home visits in the older sense seemed to disappear from the literature, though, certainly, some social workers continued to make regular home visits.

Some people were already experimenting with home-based work during the 1960s and 1970s. Pavenstedt, Sander, and Bernard conducted an important study in the Boston area of a group of clients who were then called "hard to reach" (Pavenstedt & Sander, 1965; Pavenstedt, 1967; Pavenstedt & Bernard, 1971). This was an ambitious study, interdisciplinary, with work in client homes and the hospital clinic. A senior social worker named Louise Bandler was on the study team and wrote movingly of her work with these families, especially in the book called "The Drifters" (Pavenstedt, 1967). In a class with Mrs. Bandler during the 1970's, the author remembers discussion about the social worker helping with the dishes or (literally) scrubbing the kitchen floor in client homes. Mrs. Bandler clearly thought that for some people it was necessary to work on this very practical level, on an issue of concern to the client, long before work of the sort we might call "therapeutic" could be done. It has been a long time since one has heard of a social worker getting on their hands and knees to help scrub a dirty floor!

With the 1980 Child Welfare Act, the idea of family preservation emerged in earnest and work in the client home became more common. Even so, in the literature there was a gap of nearly fifteen years with almost no apparent recognition of the question as to where clients are best seen.   Hansen and Epstein (2006), speak of clinical data mining, an interesting way of exploring agency records that might be used to

demonstrate that actual decisions, not just assumptions, were made. This was not yet seen as a possibility when the current study was being conducted. Interestingly, the literature on family preservation did not show up in an explicit way while conducting the literature review for this study. Searching made use of terms such as in-home, home-based, home visit, etc. It is as if the people who did home-based work assumed the home was the proper venue and those who habitually saw clients in the office assumed the office was the best place for intervention. The exception seems to be those people who fit the most generally accepted definitions of suitability for home-based work, people who are disorganized and/or where a family member is at risk for out of home placement.

Findings from the literature: Situations where home-based services are recommended

Welfare services for people who require protection are advocated by Fuller (2004), Napoli and Gonzalez-Santin (2001), Tracy and McDonell (1991), and Denby, Alford and Curtis (2003). Services involved with leaving and returning to family life were another area where home-based resources were often recommended, ranging from intervention in school phobia (DiGiuseppe & Wilner, 1980); adoption (op. cit) and reunification (Frankel, 1988). As might be expected, the transition points during which a family member moved toward or away from the family received particular emphasis.

Another expected home-based population involved people who were unable or unlikely to keep office appointments (Tracy & McDonell, 1991; Morris, 2003), including those who were incapacitated or homebound (Soreff, 1983), those with very young children (Napoli & Gonzalez-Santin, 2001; Tracy & McDonell, 1991), very mobile families and those who appeared to expect immediate gratification and magical solutions (Cortes, 2004).

Further expected populations for home-based services were people at risk of out of home placement, (Sheidow & Woodford 2003; Napoli & Gonzalez-Santin, 2001; Seelig, et al. 1992; Cortes, 2004; Frankel, 1988; Soreff, 1985). People who had experienced repeated hospitalizations without resolution (Fuller, 2004; Soreff, 1983; Friedman, 1962) and those with threatened hospitalization where family interaction appears to contribute were also thought to especially benefit from home-based work (Fuller, 2004; Soreff, 1983).

Friedman (1962) described somewhat related situations, including families where further estrangement was a danger or where it was important for family to maintain responsibility for the patient and their illness within the family. Friedman also spoke of situations where it was important for the family not to deny a "bad" part of itself by the hospitalization of one of its members, including also a history of disruptive alliances and splits (1962). Other writers advocated home-based services for families when a child had been assigned an inappropriate role by other family members, eg. the Infant King/Queen (DiGiuseppe & Wilner, 1980); where severe distress existed simultaneously with a strong wish for independence (Soreff, 1985) and family crises (divorce, illness, accident, death) (DiGiiuseppe & Wilner, 1980). Finally, in-home services were recommended for isolated individuals and families (Soreff, 1985).

Situations concerning difficult-to-engage clients constituted another main venue for home-based services. Fuller (2004) and Cortes (2004) wrote about clients who seem resistant, suspicious, shy about the office and involuntary clients. Morris (2003) spoke of clients who had difficulty recognizing the worker might be truly interested in their well-

being. Friedman (1962), Woods (1988) and Corets (2004) wrote about people whose resistances were expected to interfere with office-based therapy and where there was reason to think they might be overcome by work in the home.

Situations where it was thought home-based work might facilitate the professional intervention useful to heighten the "real" context; make use of the participant-observer role of the therapist, encourage more active involvement of family and possibility of immediate analysis of family behavior in situ or bring family behavior to quicker focus were advocated by Friedman (1962) and Woods (1988). Bury (2002) advocated home-based work with families who were in the midst of a potentially violent crisis under certain conditions, while Morris (2003) recommended work in the home for families who needed support, validation and the creation of a "sense of possibility." Cortes (2004) and Morris (2003) also drew attention to the use of home-based services in relation to a wide range of family members, especially those who would not come to the office.

In summary, services typically recommended for work in or near client homes include basic services for people needing protection, resources needed around the transitions of separation from families and the return to living with one's family, especially people at risk of out of home placement and those who have difficulty keeping appointments or who are difficult to engage in an intervention or treatment process. Less often mentioned were situations where it was thought the home venue might facilitate the therapeutic process.   Although some of the specifics of these situations are perhaps rather obscure, the broad categories are mentioned often enough that a case could be made for their inclusion in Finklestein's (2005) Evidence Level Two. Certainly further study of these categories could now be made in order to provide additional evidence testing of these observations.

Findings from the literature: Situations where in-office services are recommended

When speaking of arranging for therapeutic and supportive services, home-based services still constitute the exception to the rule, which means it is rare for the literature to report on specific recommendations for in-office care.   The situations named in this section should not be considered the only venues where office-based care is recommended.

The range of possibilities for outpatient psychotherapy has expanded greatly over recent years. Fonagy (2004), who has conducted extensive studies of multiple forms of psychotherapy, says we know ". . . precious little about who is likely to benefit from what type of therapy. . . " (p. 357). He says a range of approaches appear to be effective for many conditions, though they are often constructed from ". . . a collection of interventions of varying specificity. . ." (op cit.) which makes it very difficult to identify specific characteristics. Fonagy also warns against the propensity for both researchers and clinicians who have become accustomed to one or another method of treatment to develop preferences for some and to negate others.

Sheldon Roth (2000, pg. 97), writing about the difference between a psychotherapeutic and a psychiatric diagnosis, identifies qualities that "encourage" the use of psychotherapy. For Roth, motivation, insight and flexibility are internal qualities that bode well for psychotherapy. On an interactive level, he lists honesty, the ability to tolerate frustration, the capacity to bear affect and a sense of humor. On an interpersonal level he identifies warmth, responsiveness, dyadic resonance and the pressure to

communicate. Holding Fonagy's (2004) cautions and Roth's (2000) recommendations in mind when reviewing the literature on individual psychotherapy, it seems possible to extrapolate some further recommendations for location of care. Outpatient mental health services in an office setting appear to be offered primarily to relatively well-organized clients who can keep scheduled appointments. People who identify their difficulties as "internal", between parts of their own personalities rather than between themselves and others or the environment, are likely to be well-suited for in-office work.

Other situations where in-office intervention are recommended are crises involving the need for protection or social control that cannot be maintained in the client's home, (Fuller, 2004) and situations involving children who are no longer living in the home (DiGuiseppe & Wilner, 1980). DiGuiseppe & Wilner (1980) go further to recommend in-office treatment for specific symptoms such as stuttering, enuresis, encopresis, tics, trichotillomania, thumb sucking and learning disabilities. They also say some violent families are better seen in the office, specifically where it seems better to "divide and conquer" rather than try to fight overwhelming odds. The same authors identified situations where there is a preoccupation with sexual difficulties as being more appropriate to couples work, not involving the whole family. DiGuiseppe and Wilner (1980) go farther, saying that families with a particularly vulnerable and overcontrolling parent respond more positively in the office situation. Finally, they identify divorced families, depending to some extent on their degree of continued bitterness, as benefiting from in-office work, saying it may be useful to work toward developing the capacity in each individual to handle conjoint work later on. One further situation was involved with those families whose goals are rather different from those of the agency and the worker. Muller (1986) suggested the use of a neutral setting, neither the home or the office, under these circumstances.

A practitioner's workshop looks at the question

About ten years ago, members of a small supervision group led by the author realized they were repeatedly asking, "How do we decide where to see the client?" In this organization services had traditionally been provided in client homes, but after funding sources began requiring more medical-model assessment and planning, staff were encouraged to see some people in the office as a money-saving device. This decision was left to staff. Over time the group began to realize their ongoing supervisory meeting functioned like the practitioner's workshops described by Rustin (1997), supporting practitioners working with difficult client groups. Following Rustin's model, this practitioner's workshop began keeping notes about their discussions, usually beginning with case material, exploring what was taking place with clients and with particular attention to the relationship between client and worker. The following represents some of the more coherent field notes made at that time.

- circumstances appear to exist in which the *worker's* need (and ability to function therapeutically) must be taken into account; this might sometimes have to do with a decision toward either home- or office-based care.
- it is important to face the reality of the situation and provide a service which has the best *manageable* (for both family and worker) chance of providing a helpful ntervention.

The group was surprised to discover they were identifying situations in which they thought care *in the office* might be indicated. These included:

- families living in multigenerational, overcrowded circumstances where there was difficulty providing a semblance of privacy, especially when it seemed helpful for only part of the extended family group to be included,
- marital treatment or other interventions when family members were seriously impulsive and unable to refrain from outbursts of temper and threatened/actual violence,
- situations where there was actual, and considerable, danger to the worker in the family home, and
- situations where the house was infested with filth (e.g. excrement) or insects Some families best *seen at home* were also identified by the practitioner group.

These included:

- situations where there was severe discord between parent and child,
- situations where the worker did not sufficiently understand the situation underlying the stated problems,
- situations where the worker suspects the family was not disclosing a full or accurate enough picture to allow help to occur, and
- families who were so disorganized that they could not manage to keep appointments.

Home-based services tend to be directed toward clients identified as disorganized and unlikely to keep regular appointments; whose households are described as chaotic, and where workers complain that clients do not follow through on agreed-upon tasks. Children in these families often do not do well in school; they are also more likely to be in trouble with the police and the legal system. Conversely, *office-based services* are more likely to be offered to people who can keep regular appointments, and perhaps individuals and families without children. Some people with specific symptom pictures may be more likely to be referred to office-based care; the details vary considerably (Meek & Ware, 1996). It may sometimes be assumed that certain groups of people are organized enough to make use of the office, eg. single adults without children, more value judgments ("they ought to…") than evidence has demonstrated.

The effect of the service setting on client and worker: Comments from an expert practitioner

Both worker and client have reactions to the service setting. *Workers* can face a considerable emotional onslaught when they enter client homes. This may range from simple discomfort with different customs, ways of arranging furniture and greeting guests, to frank confusion and disorientation due to unfamiliar ways of being and relating. Sheer numbers of people and different ways of dealing with emotions may also cause confusion. A worker may experience distaste, even horror, at having to sit in a place where it looks as though a child or animal may have urinated or where cockroaches

are visible. All of these conditions affect the worker's ability to think clearly and respond appropriately (Meek & Ware, 1996).

The fact of such events taking place *must* be acknowledged by agency administrators and appropriate supports provided for staff. This is not always the case; there is a large tendency to turn a 'blind eye' as if these events almost never happen and can be ignored. In addition, workers who have experiences like these are not often encouraged to reflect on their reactions. Instead, they are encouraged to catch their breath, recover as soon as possible and not spend much time thinking about it (Meek & Ware, 1996).

The home-based situation allows the worker to gain a more accurate view of the client and family in their home environment. It allows reluctant clients to be seen in their own homes, where they may be more comfortable. They may also feel more valued by the worker taking the trouble to come to them, along with many other possible benefits of the home-setting for particular individuals (Kadushin & Kadushin, 1997).   The office, however, allows the worker to make these observations against the backdrop of many repeated observations of different families and individuals in the same office situation, which can allow subtle differences to emerge (Winnicott, 1941). It also allows workers to feel more safe, less likely to be confused or harried and thus, more able to think clearly about the family and their situation and in the short run, is programmatically less expensive. There are advantages and disadvantages to both practice situations.

With today's emphasis on collaborative work, it seems important to weigh these observations in a direction that favors the family rather than the worker. In order to establish a truly collaborative relationship with a family, maybe it is important for a worker to experience a sense of the confusion and disorganization the family lives with every day. Or, perhaps, it only seems disorganized to the worker? If it is true that it is useful for the worker to experience the conditions faced by the family (and we think it probably is), then it becomes especially important that workers receive special help in recognizing and work with their previously unacknowledged reactions to clients, families and their situations. All too often social workers, counselors and others in similar positions are told that they must be self-aware but are given few suggestions about how self-awareness might be developed. *The result often appears to be a fending off or denial of the awareness of any negative feelings or behaviors in relation to clients until the situation has escalated to an unmanageable level* (Meek & Ware, 1996). At the same time, there is a point at which the worker may be so overwhelmed by the home situation that it becomes impossible to think. Therefore it is suggested that for every worker and every client, an equilibrium must be found -- between client needs and worker needs – that is part of the decision about location of services.

Toward More Evidence Based Practice

The triangulation of three sources of information used for this study points out several situations in which it appears clients should be seen at home and one situation which suggests these clients might better be seen in the office. These are: 1) families at risk for a member's out of home placement and families where a member is returning home or being added to the family; 2) disorganized clients or others who cannot come to the office; and 3) people with multiple psychiatric hospitalizations when family dynamics

seem to be at issue. Families where violence or uncontrolled anger was a problem were thought to do better in the office (eg. marital problems) or at least a neutral setting out of the home. Each of these situations was supported at the third evidence level (Finklestein, 2005) via several literature citations, the practitioner workshop and the author's experience. These situations may be ready for further, more stringent investigation that holds the promise of obtaining a stronger level of evidence.

Figure 1. Families for whom services in client homes are recommended, along with a few situations where for an office or neutral setting is recommended.

Home-based services are recommended for:

- Situations when a family member is at risk of out of home placement
- Situations when a family member is returning home or being added to family
- Families where a member cannot/will not come to the office
- Families where there are physical limitations and/or transportation problems
- Families with several young children
- Families with a large degree of disorganization
- Families with multiple psychiatric hospitalizations and/or where family dynamics seem to be an issue
- Isolated individuals
- Clients and families who are difficult to engage
- Enmeshed families
- Clients who define their problems as being outside themselves
- Families with idealized or demonized children

Office-based or neutral setting is recommended for:

- Clients who define their problems as being inside themselves, eg. internal conflict,
- Families where violence or uncontrolled anger is a problem (eg. severe marital difficulty)
- Single parent families where the therapist is the opposite sex and the client has a strong tendency to sexualize relationships

It should be noted that the identification of people for whom office-based services are recommended was not the purpose of this study. By no means does this list suggest thees are the only situations for which office-based services are recommended.

A number of situations suggesting home-based services were also supported at Level Three with fewer citations than the above but also with substantial support. These included: 1) enmeshed families; 2) clients who define their problems as being outside themselves; 3) families with idealized or demonized children; 4) families where it may be

useful to include family members who would not come to the office. These situations may also be ready for trials at higher levels of evidence strength.

Many situations were suggested by the literature, the practitioner's workshop or the author that were idiosyncratic, very specific and mentioned by only one or two sources. These included 1) clients who are resistant, shy, suspicious, overcontrolling or extremely vulnerable; 2) clients who have difficulty transferring gains made in therapy to the home; 3) families who need a great deal of support and validation; 4) situations where distress exists along with a strong wish for independence; 5) families where medical and psychiatric difficulties were combined; 6) family crises; 7) extremely mobile families; 8) families expecting immediate gratification and magical solutions; 9) isolated individuals and families 10) situations where it seems helpful to bring behavior into quicker focus. Because these items were mentioned by only one source, it is thought further investigation should be conducted on these situations before higher level investigation is attempted.

Finally, there seem to be a few situations that suggest care in the office is indicated, though this was not the primary intent of this assessment and should by no means be taken to mean these are the only circumstances in which in-office care is recommended. One such situation, supported at a relatively strong level, is the situation mentioned above regarding violent or very angry family members. People who are extremely angry with each other seem to do better if seen in a neutral setting or the office. This is because most people are likely to behave themselves in public and may need a little distance from the immediacy of the home in order to hear the other person and/or involve themselves in problem solving. Another group who appear to do well in the office are those people who define their difficulties as internal conflict, eg. "one part of me says -----; another part says -----." These people are quite clear that their difficulty is inside themselves; their work is internal, not *inter*personal. They tend to be relatively well organized and seem to need a different sort of care, a service that offers the space to look within themselves, hear themselves think (Meek & Ware 1996). They are not the typical home-based client, but occasionally are caught up in home-based services, which may not be the best resource for them. Further information is needed about this group of clients.

Conclusions

This review has explored the question, "How do we decide where to see our clients?" via literature review, the findings of a practitioner's workshop and the author's practice experience. One goal of the assessment was to begin the development of an evidence base for decision-making about location of services in individual cases by examining existing data and beginning the process of conceptualizing the issues. A second goal was to demonstrate how practitioners can help in the development of a stronger evidence base for practice. A brief history of services to clients in their own homes was presented, along with suggestions about possible reasons for the shift from home- to office-based services within the last century. Several client situations are identified as being ready for testing at a higher level of evidence strength. Others are identified as needing further observation and data collection at a lower level of evidence strength and a few situations are given that seem to indicate the need for office-based

work. It is hoped that this discussion can serve as a base for further studies aimed at identifying stronger evidence and that human service workers can use it as a model from which they can increase their participation in the development of an evidence base for practice.

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Measuring Service Effectiveness for Families

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While most professionals do not dispute the fact that evaluation is necessary to determine whether agencies and practitioners are truly providing services that meet clients' needs, information regarding consistent measures on service effectiveness in human service organizations is sparse. A national survey of 250 not-for-profit family service organizations in the United States (52.8% return rate) yielded results relevant to client identified needs and agency effectiveness measures in serving today's families. On an open-ended survey item, 52.3% agencies indicated that poverty represented the most pressing problem among today's families because other psychological needs also take priority. Over two thirds of these agencies used multiple methods to evaluate their services. Clients' feedback and outcome measures are the most popular methods. The findings reveal agencies' difficulties in determining what or who decides if the most appropriate services are being provided for the target population. Limited data collected on outcomes and impact may impose additional difficulties in program design and planning.

Key Words: Family Service Centers, Needs Assessment, Service Effectiveness, Outcome Measures.

Questions about social work practice effectiveness have long been debated. While the focus of these questions has been on evaluating how practice is connected to needs, the most recent discussions have stressed the importance of utilizing reliable and valid measures to identify evidence-based practice (Roberts & Yeager, 2004). As governmental, privately funded, or managed care entities have begun calling for justification of costs and services delivered, an increasing trend has developed for using needs assessments and service evaluations as primary methods to justify practice choices (Gassman-Pines & Yoshikawa, 2006; Toffolon-Weiss, Bertrand, & Terrell, 1999). Wall, Timberlake, and Farber (2000) found that not only do many working-but-poor families not have adequate resources to support their daily living, these families also exhibit the greatest psychological distress and personal wants. Pecora (2003), in his intensive study of various family service evaluations, praised these working families for demonstrating their strengths and resources and urged that service effectiveness evaluation should include measures of clients' positive thoughts and social support.

Unfortunately, poverty is highly associated with disparity in service access and basic need fulfillment, such that many low-income families do not have sufficient knowledge about accessing the health and human services that are available to them (Goldstein, Safarik, Reiboldt, Albright, & Kellett, 1996; Lott & Bullock, 2007; Smith Fawzi, Jagannathan, & Cabral, 2006). In order to link services to needy families, federal programs in the United States have provided incentives to state and local governments for funding family service initiatives. These initiatives include measures of process and

outcome effectiveness aimed to identify service accessibility and client successes (Administration for Children & Families, 2006; Pecora, McAuley, & Rose, 2006). With the growing trend of greater importance being placed on evaluation as a primary component in service fund development, service providers must identify the utilization and application of evaluation measures in relation to service delivery and outcome. However, many family service programs have found the evaluation task challenging, particularly as it is related to specifically defining and measuring outcomes (Pecora, 2003). Bruner (2006) summarized some major criticisms of family service agencies when he stated that "the focus of much evaluation is wrong" because service providers "never look at relationships, only program content" (p. 238). As a response to these criticisms, this article reports the results of a nationwide study in the United States which examined whether such a challenge of outcome evaluation existed. It analyzes the types of family services being provided, those services perceived as needed, and the use of evaluations to measure program or service effectiveness. It aims to respond to the criticism that most human service organizations do not have a systematic plan to assess whether and to what degree their services have improved client conditions.

The Need

The family service movement that evolved in the 1990s stressed the importance of family support and the delivery of diverse services to enhance families' capability to achieve independence. Historically, family service centers provided community-based or home-based services, "in the belief that [many of] these families may not be amenable to conventional office-based clinical or educational services" (Whittaker, 1991, p. 1). Today, both home-visiting programs and center-based services represent service trends that share the same philosophy of improving the well-being of children, providing support for parents, and promoting healthy families (Doan, Bernstein, Swartz, & Levin, 2000; Endres, 2000).

Social service programs in the United States evaluate service effectiveness using a variety of methods, all of which have evolved over the course of time (Jacobs, 2003). For example, Long, Williams, and Hollin (1998) studied the effectiveness measures of alcohol treatment programs in terms of length of treatment and types of delivered services, while Mulroy and Lauber (2004) utilized a logic model to assess federally-funded intervention services provided to families at risk of becoming homeless. Using another strategy, ten Brink, Veerman, de Kemp, and Berger (2004) utilized a program model to assess events that occurred during intervention interactions as part of outcome measures for a family preservation program. Quality improvement data are also often used in hospital and other service settings to determine effectiveness of program operations (Colton, 2000; Evans, Boothroyd, Armstrong, Greenbaum, Brown, & Kuppinger, 2003; Fitzgerald, Molinari, & Bausell, 1998), and focus groups are sometimes used to assess the satisfaction of primary care patients (Schwarz, Landis, Rowe, Janes, & Pullman, 2000). Finally, outcome measures are used in various social service settings to determine client satisfaction, to make inferences about service quality, and to evaluate service content (Beck, Meadowcroft, Mason, & Kiely, 1998; Granello, Granello, & Lee, 1999; Spector & Mukamel, 1998).

In general, most evaluations are focused on analyzing the progress but not the impact of services on clients (Endres, 2000). Because many evaluations are centered solely on staff performance and client utilization measures, researchers in the social services now recommend the use of various types of evaluation models that include process, developmental, and outcome research data in the analysis (Navy and Marine Corps Family Service Centers, 2004; Reid, 1988). Constant feedback is required to improve service effectiveness. Therefore, some researchers advise that developing a framework for evaluating program efficacy should be a priority during the service planning stage (Bailey et al., 1998).

More recently, empowerment evaluation, or "the use of evaluation concepts and techniques to foster self-determination" (Patton, 1998, p. 152), has been used as a strategy to develop "an innovative street outreach intervention that can be measured and evaluated, to transfer evaluation knowledge from the researcher-expert to the program stakeholders, and to help overcome evaluation implementation obstacles" in a community-based HIV-prevention program (Secret, Jordan, & Ford, 1999, p. 120). This method is thought to be useful for evaluation purposes when "...the goals of the program include helping participants become more self-sufficient and personally effective" (Patton, 1998, p. 152). Thus, the focus on self-sufficiency and other future-oriented concepts of program success is considered an integral part of evaluation.

In the field of family services, client satisfaction data appear to be widely utilized as a method for evaluation. A brief review of the literature on client satisfaction revealed its uses for evaluation in at least three interrelated ways. First, client satisfaction surveys are designed to support the delivery of community-based services. Examples include a pilot cost-share service coordination program for the elderly (Bear & Sauer, 2000) and a client-focused study addressing the need for health care services (Jimmieson & Griffin, 1998). Second, evaluation of treatment focuses on client improvement. For example, Wong (1999) focused on how to assess improvements in antisocial behavior in adolescent inpatients, while Baker, Zucker, and Gross (1998) compared improvement in adult inpatients in a program implemented in both locked and unlocked facilities across several variables. Third, client feedback is analyzed in behavioral health care for service planning purposes (Mitchell, 1998). Satisfaction, improvement, and continuous feedback are the primary assessment areas when evaluating the perceived success of program deliveries.

As demonstrated, the literature provides numerous examples of program evaluations of family service organizations, the types of services they provide, and clients' perceptions of services. However, program evaluations of family service organizations are frequently criticized for the inconsistent implementation of evaluation measures, methodological deficits, and the absence of valid outcome evaluations (Reid, 1988; Rowland, Bowever, Mellor, Heywood, & Godfrey, 2001). Further, few of these studies focused on defining the outcome before services are delivered or the process by which service needs for families are evaluated. In the absence of such information, this study utilized data obtained from members of a national membership organization of family service agencies to identify effectiveness measures used for evaluating service delivery.

Method

To address the criticism that most human service organizations do not have a systematic plan to assess whether and in what degree their services have improved client conditions, a survey study was designed. The study population was the member agencies of The Alliance for Children and Families (ACF), formerly known as Family Services of America. These member agencies are private and nonprofit child- and family-serving organizations in the United States and Canada. A survey and a cover letter were sent to 250 U.S. agency directors whose names and addresses were provided by ACF. The survey, which took approximately 10 minutes to complete, included items in three major areas: (1) services delivered; (2) service needs; and (3) use of evaluation measures on service effectiveness. To facilitate a common understanding of the terminology used, the questions on types of organizations and program/outcome measures were both closed-ended to provide specific choices and open-ended to include "other category" answers.

In addition, four specific open-ended questions were included: "What is(are) your agency's service target(s)?" (to identify the service population); "What are the characteristics of the families in need?" (to assess the agency's view on service needs); "What are the most needed services for today's families?" (to assess trends in family services); "How does your agency evaluate the effectiveness of family services?" (to assess the methods of evaluation). Respondents were also asked to include materials pertaining to their evaluative efforts so that the researchers could identify and place these evaluation methods into categories based on the literature: client data, clients' feedback, process or progress evaluation, and outcome studies.

The survey was first mailed to 20 randomly selected agencies to test face validity of the instrument. Two senior staff members of a family service center provided input to improve its content validity. The final version of the questionnaire was then mailed to all 250 ACF member agencies. Two follow-up letters were subsequently mailed to encourage a higher return rate. While responses were confidential, respondents were also provided the opportunity to indicate on a separate document whether they wished to receive a copy of the findings.

Findings

More than half (52.8%, n=132) of the 250 agencies returned surveys. Of these agencies, 84.8% indicated they targeted services to the general public, 36.4% provided services to a specific population, and 21.2% indicated that they provided services to both the general public and a specific population. These agencies provided a wide range of services. The most frequently provided services were family and individual counseling (provided by 98% of the agencies), family life education (83%), services related to domestic violence (71%), services for the elderly (59%), substance abuse treatment (48%), and teen pregnancy/parenting services (45%). Other specific services included drunk driving intervention programs, family resource centers, legal services, multilingual services, pre-trial intervention services, prison services, visitation centers, and volunteer services, as well as services provided for compulsive eaters, the hearing impaired, those needing disaster response, and the mentally ill.

An open-ended question prompted respondents to identify characteristics of families in need. Although all of these agencies target the low-income families, only 52.3% of them reported poverty (or low income) as one of the top characteristics of today's families in need. Other characteristics included lack of job skills, having mental health problems, alcohol or other drug use, family relationship problems, lack of education, living in isolation, single parent households, and family violence. Both basic and psychological needs were taken into consideration when needs were being assessed. Another open-ended question solicited responses related to how the agencies evaluated the effectiveness of their services or programs. Responses represented a wide range of evaluation methods that were categorized into client measures, clients' feedback, process or progress evaluation, and outcome measures. We added an additional category "community indicators" to include needs assessments and other community-wide reports on specific problems or population characteristics.

One hundred and one agencies (76.5%) reported using more than one evaluative method. A total of 253 methods were categorized. Among the indicated methods, the most used could be categorized as "client's feedback," including three methods: client satisfaction surveys (45.5%), client's verbal feedback (10.6%), and follow-up clinical assessment with clients (7.6%). Another widely employed category of evaluation was "outcome studies" that included general outcome measures such as earnings (39.4%), pre-post test clinical outcomes (17.4%), and impact analysis (1.5%). Needs assessment (6.1%) was used by a few agencies. This low usage of needs assessment as an evaluative measure may be explained by the fact that this method is usually not perceived as a service effectiveness measure.

In terms of the use of multiple measures, it was found that most agencies (62.9%) used two measures, while a similar number of agencies used either one measure (11.4%) or more than two measures (13.7%). However, 16 agencies (12.1%) indicated that they did not conduct specific evaluation activities to determine service effectiveness.

Table 1. Evaluation Methods Utilized by Responding Family Service Agencies

Evaluation Method Used	Number of Agencies	% (n=132)
Client Satisfaction Survey	60	45.5%
General Outcome Measures	52	39.4%
Quality Assurance	23	17.4%
Clinical Pre-Post Test of Outcome	23	17.4%
General Program Evaluation	16	12.1%
Utilization of Services and Case Review	15	11.4%
Clients' Verbal Feedback	14	10.6%
Process Evaluation or Progress Notes	12	9.1%
Staff Survey / Input from Staff	10	7.6%
Follow-up Clinical Assessment with Client	10	7.6%
Number of Client Served	8	6.1%
Community Indicators/Needs Assessment	8	6.1%
Impact Analysis	2	1.5%

Total percentage does not add to 100% because multiple responses were given (See Table 2).

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Table 2. Number of Measures Used

Number of Measures Used	Number of Agencies	% (n=132)
0 measure used	16	12.1%
1 measure used	15	11.4%
2 measures used	83	62.9%
3 measures used	8	6.1%
4 measures used	4	3.0%
5 measures used	4	3.0%
6 measures used	2	1.5%
Total	132	100%

Respondents also identified the variables used by their agencies to measure and assess program development and effectiveness of outcomes. In terms of program development, most respondents (n=112; 84.8%) indicated their agencies utilized family input as an evaluative measure, 100 agencies (75.6%) used staff input to develop program goals, 89 agencies (67.4%) used duration and length of services as an indicator, and 51 agencies (38.6%) identified their success through input from other agencies. In addition, range and type of services (n=49; 37.1%) and intensity of services (n=46; 34.8%) were also examined. Twenty-eight agencies (21.2%) indicated they used other variables to measure program development, but they did not specify their variables or indicators.

When addressing the use of outcome measures, these agencies identified many process evaluation variables to assess whether outcomes had been met. These variables included service utilization, acquisition of communication skills, and client retention in the program. Responding agencies indicated the "alleviation of family problems" (n=100; 75.8%) and "clients' participation in services" (n=99; 75.0%) as the most important outcome measures. Other evaluation variables, with at least one-half of respondents indicating their use in outcome evaluation, were "family relationships" (n=81; 61.4%), "mental health status" (n=80; 60.6%), and "communication skills among family members" (n=66; 50.0%). The least used outcome measures were: "quality of life" (n=42; 31.8%), "employment and earnings" (n=21; 15.9%), "health status" (n=17; 12.8%), and "opportunities for education and/or training" (n=13; 9.8%). Thirty-one agencies (23.5%) indicated the use of other variables, such as depression, family situations, contract compliance, and institutionalization or recidivism rates as a means of assessing outcomes.

Discussion

It is not surprising to receive a low response rate from human service organizations, especially when the focus is about practice evaluations. Nevertheless, the response rate (52.9%) in this study was within the acceptable range. Though limited in sample size, these respondents report a variety of evaluation methods on services that target families, mostly related to the process and satisfaction of services delivered. Being

critical in perspective, however, the authors found that the most frequently reported method of evaluation was client satisfaction, which is most often used a post-intervention measure that does not aim to determine long-term effectiveness. In practice, client satisfaction surveys do not usually identify other variables that may impact outcomes, such as clients' strengths and constraints, sudden family crises, or other unmet needs, given that these other variables are especially likely when the clients have a transient living condition or are vulnerable in their ability to seek further assistance (Nardi, 1999). Most satisfaction surveys or interviews provided responses at one point in time: the moment of response. However, it would be best if longitudinal data were included before, during, and after the intervention has taken place. While client measures suggested how often services were provided and how many clients were served, most of the data were demographic in nature (e.g., age, race, education and occupational status), focusing on the client as "vulnerable to acquiescence and social desirability," not on how the services have helped them (Calsyn & Winter, 1999, p. 402). Although most agencies (76.5%) had applied multiple measures to measure service effectiveness, client data and satisfaction surveys seem to represent the norm. It is advised that family service agencies follow the first rule of evaluation: Apply a variety of measures to gain multidimensional and time-series perspectives from agency staff, clients, families, and communities (First Author & Law, 2003).

The second rule of evaluation relates to careful interpretations. Whether ascertained through the review of client feedback information, treatment outcome observation, or the use of quality improvement data, even the most methodologically sound evaluation data on effectiveness may be misinterpreted, misunderstood, or skewed. Reid (1988) states,

> No matter how it is done, assessment of effectiveness comes down to human judgment…. Different sources of effectiveness data - practitioners, clients, collaterals, research observers, and so on - may have differing conceptions of what is effective. (pp. 45-46)

The issue is related to the use of diverse and representative evaluations from which data can be generated from a variety of angles, but interpretations may be selective, depending on who is using and reporting the data. On the contrary, the lack of data also poses a serious concern. The fact that 16 agencies in this study did not have evaluative data and do not conduct specific service effectiveness evaluations raises our awareness about priority-setting among service organizations. If evaluation is viewed as a form of research, direct services seem to take a top priority. The question is: How do we know services are provided in the right direction? Even if services provided appear to be effective, what or who will determine the type, amount, or duration of services delivered for the target population? How would the agencies know if the client needs and other conditions have been appropriately addressed?Proving program effectiveness through evaluative measures is beneficial to clients and agency staff in terms of increased client functioning and decisions regarding program continuation, modification, or discontinuation. There may be other benefits to evaluation as well, including two often overlooked influences that should be incorporated into the evaluation framework: social policy and accountability. Evaluation data collected by and for family service

organizations have the potential to influence social policy. Knott, Weissert, and Henry (1999) indicate, "The leaders of national philanthropic foundations have long been active in informing public policy makers about their organizations' accomplishments and lessons learned in health care and other issues" (p. 342). The same philanthropic foundations that review program proposals and evaluation data may also make recommendations that impact federal policy formation. In this age of the new federalism, where development is replete, devotion to "the responsibility for setting priorities, eligibility, and resource allocation of social policies, programs, and entitlements from the federal government to each of the 50 states" should be considered directly linked to concrete evaluative efforts (Schneider & Netting, 1999, p. 350). It is important for evaluation data to truly reflect the needs of the community so that clients will continue to receive appropriately targeted services. Agencies that lack solid evaluation criteria or evaluation methods will face difficulties when informing clients, staff, administrators, other organizations, and policy makers about the impact of the change offered by their services.

The need for accountability in social services is also supported by Taber (1988) who stated, "Careful design and implementation of programs can provide social work with a viable mechanism of accountability to society" (p. 115). Family service practitioners and administrators cannot ignore the fact that evaluation data are also used to redesign programs that are not as cost-efficient or service-effective as originally intended. It is essential to have evaluation tools that accurately measure service effectiveness and guide change in program design when necessary. Long (1987) used the "black box" concept to illustrate the limited analysis of the relationships between process and outcome. Programs without either the process or outcome elements being evaluated offer "little guidance on how to change programs to improve their effectiveness" (p. 551). As this study elucidates, there are sometimes gaps between concrete service provision and the continued evaluation of service outcomes. One limitation of this study was its inability to ascertain whether the response gaps between service provision and outcome measurements were accurately reflected. Given the responsibility to address both service delivery and evaluation, it is imperative that the evaluation framework include both the instrument to measure change and the process to document and outline predicted service directions based on outcome data.

Research on effectiveness of family services, both in private practice and within human service organizations, has been a challenge for many years. However, as practitioners debate their evaluation focus, information on methods and ethical issues continues to emerge. By considering process and outcome measures, practitioners can create a research environment conducive to positive change, especially in terms of helping agencies to justify their participation in program service evaluation. Guided by knowledge of methodological shortcomings ethical issues related to research, suggestions for instrument development and selection, and the desire to ensure true program effectiveness, researchers are now being challenged (Brindis, Hughes, Halfon, & Newacheck, 1998; Calsyn & Winter, 1999; Kuechler, Velasquez, & White, 1988; Nardi, 1999; Toffolon-Weiss et al., 1999). We suggest that future research be conducted to identify a variety of evaluative methods analyzed by function, type of family service organizations, and target client systems. Through an analysis of these data, evaluative methods will be identified to support best practices and strengthen the service delivery

processes for serving different client populations. With better support and knowledge, agency administrators will be better equipped to report evaluative results and to support services designed especially for the families who do not have a voice.

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