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FAMILY PRESERVATION JOURNAL

A Publication of the *Family Preservation Institute*

Volume 4 Issue 2 1999

**Behavior Problems of Maltreated Children
Receiving In-Home Child Welfare Services**

*Ferol Mennen, William Meezan, Gino Aisenberg,
and Jacquelyn McCroskey*

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Preservation Services: Identifying Instrument Domains**

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Reactions from Consumers and Providers**


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Community: A Case Study**

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**The Effectiveness of Court Mandated Intervention Versus
Voluntary Services in Child Protective Services:
Abbreviated Version**

Loring Jones, Irene Becker and Krista Falk



PLUS a review of current resources

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The *Family Preservation Journal* is a refereed biannual 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.

Manuscripts should conform to American Psychological Association style, with an optimal length of 18 pages, not to exceed 25 typed, double-spaced pages (excluding tables and figures), with an alphabetical list of references. Also include a diskette copy using WordPerfect v 5.1 or v 6.1, or v 8.0 for PC.

Provide five copies of the manuscripts; 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.

Please submit all materials to **Family Preservation Journal**, Family Preservation Institute, School of Social Work, New Mexico State University, P.O. Box 30001 Dept. 3SW, Las Cruces, NM 88003-8001.

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Editorial

Roles and Expertise

We all take on roles, probably several each day. Parent, worker, consumer, spouse, or shortstop, the roles we play are varied and complex. After one's own family, perhaps the roles of consumer and worker are most important to Family Preservation. How do we come to play these roles, and in what ways are they changing, or should they change? Often, neither the worker or family set out to play their roles, but through the twist and turns of life, the opportunity to serve and preserve a family presents itself. At a recent conference, a group of workers spoke of how, rather than having a career goal to do Family Preservation, Family Preservation found them. Many of the families probably say the same thing! In the fields of mental health, developmental disabilities, and adoption, families may seek Family Preservation services; rarely do families involved in juvenile justice, corrections, or child welfare systems look for Family Preservation. Family Preservation finds them. And thus the roles begin.

The traditional helping process sees the worker in the role of "expert" and the family as the "client" or consumer at best. The role of expert is defined as having, involving, or displaying special knowledge or skills derived from experience or training. Professionals and agencies at times believe they are most knowledgeable of what the problems are in a family. Workers, playing the expert role in the helping professions, have degrees, workshops, and experience, which provide them with special insight and perspective on what happens to and within families.

The starring role belongs to the family – not only in the role of consumer but more critically in the role as family expert. Who knows better the history, the pain, and the secrets than the family? Not recognizing the family as an expert greatly limits the options available and forces workers to grope for answers without the family members' insight. Furthermore, one could argue that not viewing the family as an expert is an elitist extension of the medical model. Is this effective with families? Is this ultimately fair to families? How can justice ever be achieved when families are labeled and dehumanized? Is it because workers lacking the skills, support, and training fall back on being the only expert? In what ways do agency policies and caseloads contribute to the need for workers to assume some control over their professional life by not sharing the stage in the role of expert?

Families engaged as experts empower themselves as well as workers. The family (no matter what configuration, size, or color) is the most important and influential part of our lives. The family is the basic unit of our society, the source of lessons and memories, good and bad. Who knows this better than the family members?

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Together in the role of partners, the family and worker can develop new skills, discover new options, and provide alternatives. Professionals gain a great deal when they share the role of expert. Success and the satisfaction of seeing families succeed through growth and change can only be achieved through this sharing.

The insight families bring in the role of expert is not limited to their own family. Families have a unique view of how an agency, and indeed, the total service delivery system, functions. Who, other than the family, is in a better position to provide program designers, policy makers, and administrators this most critical feedback? Yet, unlike business or even politics, social service programs rarely view families as consumer experts.

While many programs explore a family-centered approach to their work, policies and practice methods serve individuals and agencies. From hours of operation, to assessment tools, families have little input as consumer experts in regard to what works for them. In the few agencies where families are in the role as policy and program experts, a different environment exists and morale seems higher. Professionals behave as professionals when families are present, not only in staffings, but in board meetings as well.

Having consumers at the table is not new (Community Action Agencies did it back in the 1960s). What is new is viewing and equipping families as experts. Simply reserving a chair for family experts at the board table is not enough. Professionals receive years of education and days, if not weeks of training, enhanced with experience before they provide input in the program design. Policy makers, as recognized leaders in communities, have facilitation skills honed over time. And so we must be prepared to support the development of families in the role of expert.

Through the leadership of commented Family-Centered administrators utilizing training, child care, and power sharing some agencies, such as the Department of Human Services in El Paso County, Colorado; and the Division of Child & Family Services, Salt Lake City, Utah, have succeeded in developing a cache of family experts. These experts are an integral part of the agency, from policy committees, to practice techniques to public relations. By valuing families as system-wide experts, administrators have streamlined and focused their services. For example, in El Paso County Colorado, Temporary Assistance to Needy Families (TANF), is used with Family Preservation as a prevention program. An added benefit is the recognition that additional resources exist in the community, both formal and informal. Family Preservation workers bring expertise in the role of a professional working in collaboration with the family. The family is an expert in their experience within their family and with the service delivery system. This Family Expert paradigm may require a

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philosophical shift in how human services and indeed society at large view and treat families.

The effort agencies put into involving families as experts has been justly rewarded. And it is the right thing to do. When we as professionals, recognize the family in the role of expert, we all benefit through better practice, programs and policies.

Alvin L. Sallee

Behavior Problems of Maltreated Children Receiving In-Home Child Welfare Services

**Ferol Mennen, William Meezan, Gino Aisenberg, and
Jacquelyn McCroskey**

This study evaluates the level of behavior problems in a previously little studied group—children with founded cases of abuse and neglect receiving child welfare services in their own homes. A sample of 149 maltreated children, living at home, were evaluated on the CBCL as they entered a service program to which they were referred by a large public child protective service system. These children were found to have elevated levels of behavior problems, with 43.6% scoring in the problematic range, a rate similar to children entering foster care. Practice and policy implications of these findings are discussed and highlighted.

Introduction

The abuse and neglect of children is one of the most serious social problems facing our country. The number of reported cases of child maltreatment now stands at 44 cases per 1000 children (U.S. Department of Health and Human Services, 1998). Serving these children and their families is the responsibility of public child welfare systems.

Research has shown that abuse and neglect may have both short- and long-term negative consequences for many of its victims. In addition, numerous studies have documented the high rates of emotional and behavior problems of children in the foster care system. What has not been documented is the prevalence of emotional and behavioral problems in children served by the child welfare system but not placed in foster care—children with founded cases of maltreatment who are under the supervision of child protective services but receive services in their own homes. The reason for such a gap in the literature may lie in the fact that in-home services are frequently directed at the parent(s) in order to help determine whether the family should be preserved. Case assessment under such circumstance first focuses on the child's safety. Once determined that the child can be maintained safely in the home, the assessment then turns to the parent(s) and family's dynamics in order to resolve the concrete, personal, behavioral, and interpersonal problems that led to the maltreatment incident; intervention is often aimed at the parents or the family constellation to avoid placement rather than at the child's condition. Under these circumstances, the potential service needs of the maltreated child is often overlooked, since

the service focus is on parental skills enhancement and the resolution of parental problems, rather than on the consequences of the maltreatment on the child.

This study looks at the rates of emotional and behavioral problems in a more narrowly delineated sample of maltreated children than other studies in the literature. It looks only at children under the supervision of the child protective service system and receiving services in their own home. This sampling choice was made to understand the unique service needs of this large and important population—children who have been found to be maltreated but whose safety representatives of the child protective service system believe they can be adequately protected at home. We explore this issue to determine whether these children have service needs apart from their parents—service needs which seemingly, under many circumstances, go unaddressed by the current child welfare system. We hypothesize that this will be the case, since children receiving in-home services have been victims of maltreatment, and maltreatment has been known to put children at risk for behavioral and emotional dysfunction in broader samples of maltreated children taken from numerous settings. If this is found to be the case, recommendations will be made to ameliorate this situation, since we believe that the public child welfare system has a responsibility to provide services to children under their supervision, whether or not they are placed in foster care.

Psychological Effects of Abuse and Neglect

Research has clearly established that victims of child abuse (sexual, physical, or a combination) often incur serious emotional and behavioral problems as a result of this trauma. Sexual abuse has been linked to higher levels of depression (Mennen & Meadow, 1994; Moran & Eckenrode, 1992; Wozencraft, Wagner, & Pellegrin, 1991), anxiety (Johnson & Kenkel, 1991; Mennen & Meadow, 1993), low self-concept (Caviola & Schiff, 1989; Hotte & Rafman, 1992), and behavior problems (Cohen & Mannarino, 1988; Einbender & Friedrich, 1989). Substantial rates of post-traumatic stress disorder (McClellan, Adams, Douglas, McCurry, & Storck, 1995; McLeer, Callaghan, Henry, Wallen, 1994), and major depression (Kaufman, 1991), have also been found in samples of sexually abused children. One study (Merry & Andrews, 1994) found that 63.5% of the sexually abused children in the sample continued to qualify for an Axis I diagnosis one year after their abuse had ended.

Physically abused children have also been found to suffer from depression (Allen & Tarnowski, 1989; Flisher, Kramer, Hoven, Greenwald, Alegria, Bird, Camino, Connell, R., & Moore, 1993; Kazdin, Moser, Colbus, & Bell, 1985; Livingston, Lawson, & Jones, 1993; Toth, Manly, & Cicchetti, 1992) and post-traumatic stress disorder (Famularo, Kinsherff,

& Fenton, 1992; Haviland, Sonne, & Woods, 1995; Livingston et al., 1993). Attention-deficit disorder also has been associated with the occurrence of physical abuse (Famularo, Kinsherff, & Fenton, 1992; Livingston et al., 1993). One study found that 79% of the children entering a treatment program for physically abused children and their families qualified for an Axis I diagnosis (Kolko, 1996). And there have been consistent empirical findings that relate physical abuse to externalizing behavior problems, including aggression, conduct disorders, and behavior problems (Famularo, Kinsherff, & Fenton, 1992; Livingston et al., 1993; Pelcovitz, Kaplan, Goldenberg, Mandel, Lehane, & Guarrera, 1993; Prino & Peyrot, 1994; Trickett, 1993).

Less is known about the emotional and behavioral problems associated with being a victim of neglect, as research has focused on issues of development rather than on the psychopathology or psychiatric sequelae that results from this interpersonal insult. Studies have found that neglected children are more withdrawn, have poorer social skills (Egeland, Sroufe, & Erickson, 1983; Rino & Perot, 1994), and have poorer academic achievement (Kendall-Tackett & Eckenrode, 1996; Wodarski, Kurtz, Gaudin, & Howing, 1990) than demographically similar, non-neglected children. Because such developmental problems are related to the emergence of social and behavioral problems, however, it is reasonable to assume that neglected children are at increased risk for such problems.

Rates of Emotional and Behavioral Problems in Children Entering Out-of-Home Care

Research has clearly established that many children who enter the foster care system display emotional and behavioral problems and that negative experiences within the foster care system increase the likelihood of negative outcomes. In some cross-sectional studies, the rates of emotional and behavioral problems among foster children is truly alarming. One foster care health assessment program found that 60% of the evaluated children had emotional problems and 29% had behavioral problems (the number with both types of problems was not noted) (Halfon, Mendonca, & Berkowitz, 1995). Ratings in the clinical range on at least one scale of the Child Behavior Check List (CBCL), the most commonly used measure of behavior problems and frequently considered a measure of psychopathology in these studies, have been found to be 82% in a Canadian sample (Thompson & Fuhr, 1992), 47% of a California sample (Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998), 78% in a Tennessee sample (Glisson, 1996), and 31% in a second California sample (Urquiza, Wirtz, Peterson, & Singer, 1994). In Washington, 72% of a sample of protective services cases were indistinguishable from the emotionally disturbed children in the most intensive mental health treatment program in the state (Turpin, Tarico, Low, Jemelka, & McClellan, 1993).

A Canadian study found that foster children were very similar in symptom scores to children served in mental health facilities. Further, the authors of this study reported that 70% of their foster care sample had a history of treatment for mental health problems, and that 20% of their clinical sample had a history of placement in the foster care system (Stein, Evans, Mazumdar & Rae-Grant, 1996).

Little is known about the rates of emotional and behavioral problems in child welfare clients receiving services in their own homes. Until recently, family preservation and other in-home programs were concerned primarily with issues of cost-savings, and placement avoidance was considered to be the only (or at least the most important) outcome measure of importance. In addition, workers used the assessment of child safety to guide their actions, often without taking child functioning into account (Heneghan, Horwitz, & Leventhal, 1996; Rossi, 1992). One study that did employ the CBCL to evaluate seriously disturbed children receiving family preservation services found that the mean score for children after services was in the borderline clinical range (Wells & Whittington, 1993).

Method

The data reported here were collected as part of a larger study of families in Los Angeles County receiving in-home child welfare services. Families were contacted within two weeks of referral to in-home services, and in the original study were randomly assigned to either traditional public agency services or to a more comprehensive family preservation program (for a full description of the program and its evaluation, see McCroskey & Meezan, 1997). One child in each family was identified as the index child for purposes of the study; whenever possible, this was a child in school, since this age group was of particular interest to the funding source. When the family had more than one school-aged child, the index child was chosen randomly from the pool of elementary school children in the family.

Measures

The Child Behavior Check List (CBCL) (Achenbach, 1991) was completed as part of the research protocol for all index children six years of age and over. The CBCL is a widely used report of children's behavior problems, and has been considered a measure of child psychopathology in a number of studies concerned with children involved in the child welfare system (for example, Glisson, 1996; Clausen, et al., 1996; Wells & Whittington, 1993). It is completed by the child's caretaker and yields a Total Problem Score, scores for Internalizing and Externalizing Behaviors, and nine problem syndrome scores. The manual (Achenbach, 1991) reports Cronbach alphas of .96 for the Total Problem Score, and from .89 to .93 for the Internalizing and Externalizing scales. Alphas on the subscales range from

.54 to .93, with the sex problems subscale having the lowest alpha. Test-retest reliability at one-week was reported to be .95 for non-referred children on the problem scores. For referred children, the average reliabilities for the subscales are reported to range from .70 to .93.

Validity of the CBCL is supported by numerous studies, which have reported significant correlations between it and other problem measures (Achenbach, 1991). T scores have been developed to allow comparison by gender and age. The standardization sample had a mean score of 50 on the Total Problems, Internalizing, and Externalizing scale. A score of 60 on the Total Problem, Internalizing, and Externalizing scales has been established as the clinical cut-off point, with scores between 60 and 63 designated as the borderline range and scores above 63 considered to be in the clinical range (Achenbach, 1991). Thus, scores below 60 are considered within "normal" limits.

While the normative sample differed significantly from the current sample in a number of important ways, including race/ethnicity (fewer children of color) and socio-economic status (few children from poor homes), the CBCL has been widely used with children similar to those in this study and was thus assumed to be appropriate for use. For example, this instrument has been used with abused children (see, for example, Trickett, 1993; Trickett, Aber, Carlson & Cicchetti, 1991), neglected children (see, for example, Wodarski, Kurtz, Gaudin & Howing, 1990) foster children (see, for example, Clausen, Landsverk, Granger, Chadwick, & Litrownik, 1998; Glisson, 1996), and special-needs children adopted out of foster care (see, for example, Groze, 1996; Rosenthal & Groze, 1994).

Sample

The 240 families participating in the study had a founded case of abuse or neglect, had a dependent child living with them, were under the supervision of the child protective service agency, and were deemed appropriate by their public agency worker to receive child welfare services in their own homes. Thirteen percent of the families had at least one child placed outside of the home prior to the start of the project. In addition, many of the families were drug and/or alcohol involved (50%), had domestic violence present (24%), were involved with the penal system (24%), and/or had housing problems (23%). More detailed information on the original study sample, and the sources of information used to capture information about it, is available elsewhere (McCroskey & Meezan, 1997; Meezan & McCroskey, 1996).

Of the 240 families in the study, 149 had index children above the age of six, and these care givers completed the CBCL. The children upon whom parents reported averaged 10.0 years

old (s.d.=2.81). Forty three percent of the children were male and 57% were female. The sample included 73 Latino children (49.0%), 41 African-American children (27.5%), 31 white children (20.8%), and four children of other backgrounds (2.7%). The most common reasons for referral to child protective services were physical abuse (43.0%), neglect (22.1%), and sexual abuse (16.8%). Emotional abuse accounted for only 3.4% of the referrals. Information on the referral reason was not available in 14.8% of the cases.

Results

The maltreated children in this sample had significantly higher scores on the CBCL than the sample of children on which the instrument was normed. The study sample mean on the Total Problem Score of 56.68 (s.d.= 13.08) was significantly higher than the normative group ($t = 6.08, p < .0001$). Similarly, the mean of the study sample children on the Externalizing score was 57.27 (s.d. = 13.72), significantly higher than the normative group ($t = 6.30, p < .0001$). And the Internalizing score of 54.68 (s.d. = 11.58) was more than 4.5 points higher than the normative group ($t = 4.70, p < .0001$). (See Table 1). Thus, while the mean CBCL score for this sample was not in the clinical range, the group's mean was elevated on all three dimensions when compared to a normative sample, indicating that, on average, these children were reported to exhibit more problematic, if not clinically pathological, behavior than the standardization sample.

Table 1. Comparison of Child Behavior Checklist Scores for Child Welfare Clients vs. Normative Samples*

	Standardization Sample N=2368		Study Sample N=149		t	df	p
	M	S.D.	M	S.D.			
Total Problems	50.05	9.94	56.68	13.08	6.08	158.94	<0.000
Externalizing	50.07	9.71	57.27	13.72	6.30	157.47	<0.000
Internalizing	50.12	9.72	54.68	11.58	4.70	161.38	<0.000

* t test for unequal variances

Group means are only one way of determining the degree of behavioral disturbance in a sample of children. Examining the scores of individual children might be a better way to

ascertain the number of individual children who might be at risk for emotional or behavioral problems within the sample. This can be done by examining the number of children who actually scored within the clinical range in this sample as compared to the normative sample.

The CBCL scales are normed so that 95 % of children fall in the normal range of scores, leaving 5% in the problematic range (2% in the borderline range and 3% in the clinical range) (Achenbach, 1991). In the study sample, 43.6% of the children scored in the problematic range on Total Behavior Problems, with 10.1% in the borderline range and 33.6% in the clinical range of problems. On the Externalizing Scale score, 42.3% of the sample was in the problematic range, with 9.4% in the borderline range and 32.9% in the clinical range. The Internalizing Scale score had 36.2% of the sample scoring in the problematic range, with 13.4% in the borderline range and 22.8% in the clinical range. (See Table 2).

Table 2. Comparison of Child Welfare Client Sample and Normative Sample for Clinical Scores

	Normal Range		Borderline Range		Clinical Range		Borderline + Clinical Range	
	Study	Normed	Study	Normed	Study	Normed	Study	Normed
Total Behavior Problems	56.4%	95%	10.1%	3%	33.6%	2%	43.6%	5%
Externalizing	57.3%	95%	9.4%	3%	32.9%	2%	42.3%	5%
Internalizing	63.8%	95%	13.4%	3%	22.8%	2%	36.2%	5%

Of particular interest is the way in which these in-home service children compare to children in foster care. Two studies (Clausen et al., 1998; Urquiza et al., 1994) evaluated children entering the system as was done in this study. However the Urquiza et al's (1994) study used earlier CBCL norms, and thus, it is not possible to make a statistical comparison. When this sample is compared to the Clausen et al., sample, there is no difference between the two samples on any of the three scales of the CBCL (See Table 3).

Table 3. Comparison of In-Home Clients with Children Entering Foster Care

	Study Sample (In-Home)		Clausen, et al. (1998) Sample (Foster Care)		t	df	p
	M	S.D.	M	S.D.			
Total Problems	56.68	13.1	57.00	13.8	0.22	387	0.587
Externalizing	57.27	13.7	56.15	14.6	0.67	387	0.748
Internalizing	54.68	11.6	54.4	11.5	0.15	387	0.559

Analysis of variance revealed that demographic factors had little relationship to scores on the CBCL. (See Table 4). Race did not differentiate scores on the Total Behavior Problem score ($F = 0.06$, $p > 0.95$), the Internalizing score ($F = 0.16$, $p > 0.90$), or Externalizing score ($F = 0.29$, $p > 0.80$). There were also no differences between boys and girls on the Total Behavior Problem score ($F = 0.04$, $p > 0.80$), the Internalizing score ($F = .44$, $p > 0.50$), or the Externalizing score ($F = 0.62$, $p > 0.40$). In addition, the child's age was not related to the Total Behavior Problems score ($\eta^2 = 0.149$, $p > 0.20$), or the Internalizing score ($\eta^2 = 0.073$, $p > 0.35$). There was, however, a relationship between age and externalizing problems ($\eta^2 = 0.18$, $p < 0.05$). Similarly, when the subjects were placed into the dichotomous age groups of pre-adolescence (those 12 and under) and adolescence (over 12), there were no differences between the two groups on Total Behavior Problems ($F = 2.04$, $p > 0.15$) or on the Internalizing score ($F = 0.14$, $p > 0.70$). However, age did predict scores on the Externalizing score ($F = 5.35$, $p = 0.02$)—younger children showed fewer externalizing problems than older children.

Table 4. CBCL Scores by Demographic Variables

		Total Problems			Externalizing			Internalizing		
		M	F	p	M	F	p	M	F	p
Age	Under 12	55.73	2.04	.155	55.55	5.35	0.22	54.46	.14	.713
	12 & Over	59.12			61.36			55.24		
Gender	Male	56.93	.04	.839	56.25	.62	.434	55.41	.44	.507
	Female	56.49			58.03			54.13		
Race/ Ethnicity	African-American	56.37	.06	.981	55.98	.29	.831	53.60	.16	.920
	White	57.19			59.03			54.84		
	Latino	56.53			57.29			55.16		
	Other	58.75			56.50			55.50		
Type of Maltreat- ment	Sexual Abuse	56.12	.25	.858	54.12	1.06	.369	55.84	.13	.939
	Physical Abuse	58.01			59.38			55.17		
	Neglect	57.15			55.85			56.18		
	Emotional Abuse	53.80			58.60			53.00		

The type of abuse also failed to predict any differences in the scores; there were no significant differences between children who were sexually abused, physically abused, emotionally abused, or neglected on their Total Behavior Problems score ($F = 0.25$, $p > 0.80$), their Internalizing score ($F = 0.13$, $p < 0.90$), or their Externalizing score ($F = 1.06$, $p > 0.35$).

Discussion

The results of this study indicate that many abused and neglected children under the supervision of the child welfare system who receive in-home services appear to have emotional and behavioral problems. In this sample, 43% scored in the problematic range on Total Behavior Problems. This rate is much like the rates found in samples of children in the foster care system. When compared with the two California samples (those that measured children entering the system), the study sample is very close to the rate of 47% in Clausen et al.'s (1998) sample; in fact there is no statistical difference between the mean scores in the two studies. It is higher than the 31% in Urquiza, et al.'s (1994) sample. Although the rate of behavior problems in the sample is lower than those found in Glisson's (1996) Tennessee sample and Thompson & Fuhr's (1992) Canadian samples, these differences might be due to differences in sampling procedures and other methodological

choices. Glisson's (1996) study evaluated the functioning of children before they entered care, and Thompson and Fuhr's (1992) study measured children who were already in care.

The only significant finding in relationship to demographic factors was that younger children had lower scores on the Externalizing scale than older children. It appears that older children in this sample have more problems with their acting out behavior than younger children. The reasons for this are unclear; age itself is not the reason, since the CBCL is standardized to control for the differences in age related behaviors (Achenbach, 1991).

Perhaps older children are more able to act out if left in their home environments under their parents' supervision. Or, perhaps the older children in this sample had experienced a longer duration of maltreatment, and that experience has had a cumulative effect that increases over time, particularly in reference to acting out behaviors. Or, perhaps because parents are better at reporting externalizing behavior problems (Costello & Angold, 1988), it would be in this measure that such a time effect might be evidenced. It is possible that internalizing problems also increase with age, but that parents are less able to recognize those problems and report them. If this proved to be true, it would be in line with other studies that have found that the duration of abuse is related to increased symptom severity, particularly in sexually abused children (for example, Bagley & Ramsey, 1986; Sirles, Smit & Kusama, 1989; Friedrich, Urquiza, & Beilke, 1986).

This study adds to that rather meager literature on race/ethnicity and child maltreatment. Like the majority of those studies (for example, Mennen, 1995; Wyatt, 1990), this study did not find that race/ethnicity was related to the level of symptoms in maltreated children. Likewise, gender failed to be related to the level of behavior problems in this sample of children.

It is important to note that the type of maltreatment was not related to the level of behavior problems in these children—symptom scores of neglected children were no different than those of children who suffered from active abuse. This is noteworthy because the relationship between neglect and mental health problems has received little attention (Dubowitz, 1994). Thus, these findings add to the growing suspicion that neglect has serious mental health consequences for children, and that much more research is needed on the its psychological and emotional effects.

This study has implications for policy and practice in child welfare. It lends support to the contention that the experience of maltreatment can result in emotional and behavioral problems. Children who also experience the disruption of removal from their own home and

the dislocation of an out-of-home placement may have additional mental health problems beyond the behavioral problems measured by the CBCL. But, the results of this study support the assertion that children under the protection of the child welfare system, whether they are receiving foster care or in-home services, have similar rates of emotional and behavior problems. It is thus likely that it is their shared experience of maltreatment that is related to the similar rates of elevated problem scores.

This finding highlights the need to attend to the emotional and behavioral problems of children in maltreating families receiving in-home services. Unfortunately, child assessment and the treatment of their emotional and behavior problems has often received less emphasis than parental rehabilitation in the provision of public child welfare services when a child is left at home. Many child protective agencies have been primarily parent focused, and have been concerned with increasing parenting skills, improving the physical surroundings, and securing mental health, drug, and alcohol treatment for maltreating parents (Heneghan, Horwitz, & Leventhal, 1996; Schuerman, Rzepnicki, & Littell, 1994). While this continues to be an important aspect of services to these families, the mental health needs of the children must also receive attention since the deleterious effects of maltreatment cannot be ignored.

This is not to suggest that every child who enters the protective service system will need mental health services; in this study, just over half of the children did not have elevated CBCL scores. Rather, it is to suggest that every child who enters this system should be screened for emotional and behavioral problems, and when found, should be offered service to ameliorate problems. The data suggest that in-home child welfare services need to pay greater attention to the children it protects. Perhaps the system has neglected these children because of the urgency of serving parents in order to keep families together, but clearly there is a price to pay for inaction on this front.

The parent-child system is a transactional one—not only does the maltreatment affect the child, but the child's symptoms influence the parents and their interaction with the child (Bronfenbrenner, 1979; Kadushin & Martin, 1981; Walsh, 1996). While it may be the maltreatment that causes the child's emotional and behavior problems, the resulting symptoms may sustain and exacerbate the maltreatment. A behaviorally disordered child may make it very difficult for a parent to employ new discipline measures learned in parenting class. A depressed withdrawn child may make it hard for a neglectful mother to increase her interaction with and care of her child, since difficult children bring out less effective parenting in care givers. Services that address the child's problems (in individual, conjoint, or family treatment) can help remediate the child's symptoms and aid the parent in reacting more appropriately to the child. Research in sexual abuse has confirmed that

both parent and child treatment is more effective than either parent only or child only treatment (Deblinger, Lippmann, Steer, 1996).

Limitations

While this study is important in that it is one of the first to attempt to evaluate the level of problems in children receiving in-home child welfare services, there are a number of limitations that should be noted. First is the measurement of symptoms. The CBCL has a number of advantages that make it appropriate for this kind of study. It is the most common measure employed in measuring child problems making the data easily comparable to other studies, is easy for caretakers to use and understand, is relatively easy to administer, and measures children on a number of dimensions. However, it may not give as accurate an assessment of a child's functioning as desirable. More comprehensive measures, provided by multiple informants, evaluating children on different dimensions of functioning, would give a more comprehensive picture of a child's functioning within the context of a maltreating family (Achenbach, 1995; Meezan & McCroskey, 1997; Pecora, Fraser, Nelson, McCroskey & Meezan, 1995).

Second, the sample size needs to be larger to better allow small differences between groups to emerge when they are present and statistically significant. While relatively large for this kind of study, when comparisons are made between groups, the cells become rather small and may possibly obscure some small but important differences.

Third, this study did not have a measure of the severity of maltreatment that would have helped elucidate the relationship between this dimension and the level of symptoms. It may be that it is the severity of the maltreatment rather than the type of maltreatment that is more related to psychopathology. This is a chronic problem in research on maltreatment and psychopathology and one that needs more attention. The Severity of Maltreatment Scale developed by Barnett, Manly, and Cicchetti (1993) offers promise as a way to attend to this issue but was not available at the time of the study.

Additionally, it should be remembered that maltreating parents, particularly those with high physical abuse potential, perceive and evaluate their children's behavior more negatively than other observers or those with less abuse potential (Kolko, Kazdin, Thomas, & Day, 1993). It is therefore possible that the high frequency of elevated CBCL scores in this study is a result of parental bias rather than problematic behavior. However, it should be remembered that these children's scores are very similar to those of maltreated children in foster care who were evaluated by their foster parents rather than their maltreating care giver (Clausen et al., 1998).

Finally, it should be remembered that it has long been recognized that child maltreatment and child behavior problems are interactional (for an early investigation into this issue, see Kadushin & Martin, 1981). Not only can maltreatment result in children's behavior problems, but difficult children, including those with behavior problems, may generate more abusive and neglectful behaviors from their parents. Thus, the reader is cautioned that a causal link has not been established in this study, and that the correlations reported here are the result of relationships whose directionality has not been established.

Future Directions

The results of this study highlight the need to devote more attention to the problems, treatment, and outcome of children and maltreating families who receive child welfare services in their own homes. This requires more cooperation among researchers, child welfare organizations, government, and private funding sources in developing resources, designing studies, and carrying them out in a way that is both scientifically rigorous and attentive to the realities of practice in a complex system. Not until we are able to meet that challenge will we understand these families, their children, and the most effective ways to help them.

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Measuring Consumer Satisfaction in Family Preservation Services: Identifying Instrument Domains

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Measuring consumer satisfaction in the social services has become an important source of feedback for the improvement of service delivery. Consumer satisfaction has recently been incorporated into family preservation evaluation. This article reviews instruments used to measure consumer satisfaction in family preservation services and other related areas. Trends in current practice are examined and instrument dimensions are identified. Finally, some recommendations are made about the application of consumer satisfaction measurement in family preservation services.

As social workers, we acknowledge that client input helps us to assess the effectiveness of the services we provide. Knowing how consumers are coping after our intervention and whether our services are making an impact are valuable components of evaluation research with future implications for program planning and development. Likewise, knowing whether consumers are satisfied and to what degree they are satisfied is useful information that can contribute to the improvement of programs and the delivery of services. In addition, having information about the effectiveness of our programs facilitates addressing questions posed to us by legislators, public officials, funding sources, and the general public (Damkot, Pandiani & Gordon, 1983).

The field of consumer satisfaction has grown rapidly in the past two decades providing researchers, program evaluators, administrators, and practitioners with a variety of instruments with which to measure client satisfaction. In the last decade, technology has provided researchers with the means to reduce the time involved in the collection of data, provide greater anonymity to respondents, and offer almost instant analysis of data. These two factors, then, facilitate and encourage consumer-based research in the social services.

Faced with the task of measuring client satisfaction in family preservation services as part of a university-state contract, the purposes of our investigation were to understand the state of consumer satisfaction in family preservation, identify trends, select helpful tools and ideas, and share our findings with an interested audience.

An initial review of article titles and abstracts in the social work literature database revealed that client satisfaction in family preservation services is not a well developed area; therefore, we reviewed the literature with the following goals in mind: (a) collect samples of instruments used for measuring consumer satisfaction with family preservation clients or samples of instruments that could be modified for the purpose of measuring such services, (b) examine trends in this type of measurement, and (c) identify dimensions of consumer satisfaction in family preservation services. This article then describes instruments used to date to measure client satisfaction in family preservation services (FPS) and in related areas. We examine trends in current practice and offer suggestions regarding client satisfaction domains for inclusion in data collection and measurement instruments.

Consumer Satisfaction Instruments in Family Preservation Services: A Brief Background

Until recently, family preservation evaluation research did not include measuring consumer satisfaction with services. In family preservation services as well as in other human services, public social service agencies are not typically supported economically by clients (Reid & Gundlach, 1983), and therefore agencies lack the incentive to measure client satisfaction. This may have been one of the reasons for the lack of consumer satisfaction measurement. Secondly, public social service entities tend to "maintain a monopoly over the services they deliver" (Giordano, 1977, p.35) causing consumers to have little or no choice among service providers, and in this situation, it seems unnecessary to know whether clients are satisfied with the services. Additionally, "perhaps...the low value placed on client judgment" (Russell, 1990, p.43) may contribute to the lack of interest in consumer satisfaction in FPS. Finally, in a situation where resources for evaluation are limited, researchers may be less likely to focus on the undeveloped realm of consumer satisfaction measures when funding tends to focus on outcomes, not determined by consumer input, as accepted measures of effectiveness. This is especially true when there is, at best, a tentative relationship between consumer satisfaction and outcomes (Denner & Halprin, 1974(a); Larsen et al., 1979; Lebow, 1982). All of these factors have contributed to the lack of emphasis on client satisfaction. On the other hand, Magura and Moses (1984) point out that as resources in child protective services decrease and the demands for provider accountability increase, it would behoove agencies to rely "on feedback from clients, who certainly are in a good position to know whether and how they have been helped" (Magura & Moses, 1984, p.100).

One of the earliest attempts to measure consumer satisfaction in the area of family preservation was made in the mid-1980s (Hayes & Joseph, 1985). Mail and telephone surveys were employed by Hayes and Joseph to determine client satisfaction with family-based services (FBS). Pecora and his colleagues (1991) found that the few FBS programs

who were engaged in gathering client satisfaction data were using this information informally to gauge client satisfaction rather than as a formal component of program evaluation. Pecora, et al., also pointed out that most of the instruments utilized in consumer satisfaction up to that time tended to consist of global measures of client satisfaction and lacked specific questions or items that were behaviorally anchored. They suggested that "developing more objective outcome measures that focus[ed] on specific areas of child, parent, or family functioning" (p.277) might improve satisfaction outcome studies. Consistent with these types of suggestions, we reviewed some recent applications of client satisfaction measurement.

A Review of Selected Consumer Satisfaction Instruments

An initial search for general information on client satisfaction was undertaken. Databases storing articles in peer-reviewed journals in social work, the human services, health, psychology, mental health, and program evaluation covering the period between 1970 and 1997 were searched by one of the authors. From the vast number of articles located, 47 were selected for their relevancy to the area of interest. Two unpublished reports on mental health consumer satisfaction that were brought to our attention by colleagues were included in the review. Four on-line sources and four journal articles on touch-screen surveys were reviewed as well. Although these did not concern human services specifically, the authors were exploring the possible feasibility of utilizing the latest electronic devices in measuring consumer satisfaction. The total number of articles reviewed was 57. Of these, 14 described survey instruments and included information on the use of the instrument and psychometric properties, if the latter were available. These instruments ranged from a generic form of client satisfaction, e.g., Client Satisfaction Questionnaire and its various versions (Larsen et al., 1979; Nguyen et al., 1983; Roberts & Attkisson, 1983) to measuring satisfaction with parent education, e.g., Parent Education Satisfaction Scale (Poertner, 1985).

A second search for instruments used specifically to measure client satisfaction with family-based or home-based (sometimes also referred to as intensive family preservation) services and/or closely related services was carried out. The social work and child welfare related literature yielded the following: two FPS question guides for qualitative research projects (one a journal article, the other a dissertation); one interview instrument geared for child protective services clients in which consumer satisfaction was a component of the instrument (in a book); one quantitatively measured instrument on consumer satisfaction with social services (in a journal). The literature yielded a total of four instruments on consumer satisfaction with family preservation services, children's protective services, and social services in general. Contacts with the following institutions yielded five additional instruments: School of Social Welfare, University of Kansas, Lawrence, KS; Behavioral

Science Institute (BSI), Seattle, WA; Research and Training Center for Children's Mental Health, University of South Florida, Tampa, FL; The Chapin Hall Center for Children, University of Chicago and (working jointly with) Westat, Inc., Rockville, MD. Of the published studies evaluating family preservation services that were reviewed, only one study included a consumer satisfaction component (Pecora et al., 1991). In this study, the Consumer Satisfaction Survey, based on the BSI/ Homebuilder's instrument, was utilized. As stated earlier, we reviewed instruments found in the literature or brought to our attention by colleagues and associates; therefore, it is possible that not all instruments of this kind have been included in this review.

A brief profile of the consumer satisfaction instruments reviewed follows. They have been grouped into two categories: Family Preservation and Traditional Family-Based and Social Service Instruments. The instruments in the latter category were included in the review because they are related to our area of interest and because, in the light of the scarcity of FPS instruments, we were open to the possibility of their adaptability (with some modification). Of the nine instruments, reliability has been established for only two—Magura and Moses' *The Parent Outcome Interview* and Reid and Gundlach's *Measurement Scale of Consumer Satisfaction with Social Services*, both non-FPS instruments. (See Tables 1. and 2. for a more detailed description of all the instruments.)

Family Preservation Instruments

Behavioral Science Institute/Homebuilders. The BSI's Homebuilders (1996) program uses a 12-item instrument consisting of closed and open-ended questions covering case outcomes, therapist competency and availability, goals, and a final open-ended question for additional comments.

Consumer Satisfaction Survey of Washington State. This 11-item instrument (State of Washington, 1997) is based on the BSI/Homebuilders survey and consists primarily of closed-ended questions covering outcomes, therapist competency and availability, satisfaction with services, and a final section for comments.

Family Preservation Services - Client Satisfaction Questionnaire, State of Kansas. A survey developed by the University of Kansas School of Social Welfare (1997) for use by the State of Kansas, the 19-item Client Satisfaction Questionnaire consists primarily of closed-ended questions covering therapist/worker competency, sensitivity and availability, and satisfaction with the services, the agency, and the therapist/social worker. Two final open-ended questions address the most helpful thing about having received family

preservation services and suggestions for changes or additions to services. A Spanish translation of the instrument is available.

National Evaluation of Family Services, Caretaker Interview - Interim. As this article is being prepared, a national evaluation of family services is being undertaken by Westat, Inc. of Rockville, MD, The Chapin Hall Center for Children at the University of Chicago, and the James Bell Associates in Arlington, VA (1997) under a federal grant administered by the Department of Health and Human Services. The evaluation is being carried out in four states: Kentucky, Tennessee, New Jersey, and Pennsylvania. The interim interview instrument includes a group of 12 questions (#33- #44) that may be categorized as client satisfaction items and address worker competence in terms of communication, availability, assistance with accessing services, and counseling as well as services, outcomes, goals, household repairs and safety.

Family Preservation Services interview guide. Keaney (1994) developed an interview guide for surveying parents who had received both child protective services and home-based family preservation services (FPS). The face-to-face interviews were guided by the following three questions:

- (1) What are the parents' perceptions of the use of authority in protective service,
- (2) What are the qualities in the approach of the FPS and the protective workers to the families that the parents identified as helpful and unhelpful, and
- (3) What are the parents' views and experience with service continuity? (p.105)

Question guide for parents'/primary caretakers' views of family-centered, home-based service. Coleman and Collins (1997) developed a question guide for interviewing parents and primary caretakers on their views of family-centered, home-based services. The following three open-ended questions guided the interview:

- (1) What was the most helpful in your counseling with (Therapist)?
- (2) What did not help, or what did you dislike about counseling?

Table 1. Characteristics of Consumer Satisfaction Survey Instruments in Family Preservation and Related Fields

Instrument & Type	No. & Type of Items	Outcome Items	Worker/Therapist	Agency/Program
<u>Family Preservation Instruments</u>				
BSI/HOMEBUILDERS, self-administered	12 items: 9 closed-ended with space for comments, 3 open-ended; yes/no to a 5-level response set; 1 allows a neutral response	7 items re: Use/Prac, Progress, Cont. Use, Therapist Conseq., Resid., Prog. Help, Before-After	4 items	1 item
Consumer Satisfaction Survey of Washington State, self-administered	11 items: 10 closed-ended, 1 labeled "comments;" 5-level response set with a neutral response choice for 5; yes/no & N/A for 1 item	2 items re: Before-After, Goals	6 items	1 item
Family Preservation Services - Client Satisfaction Questionnaire, State of Kansas, self-administered	19 items: 17 closed-ended, 2 open-ended; 5-level response set with a "No Opinion" option	None	14 items	None
Nat'l Evaluation of Family Services, Caretaker Interview - Interim, direct face-to-face	12 closed-ended, in the client satisfaction section; 5-level and 3-level response sets and yes/no	2 items re: Goals and Better	6 items	2 items

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Instrument & Type	No. & Type of Items	Outcome Items	Worker/Therapist	Agency/Program
Family Preservation Services Interview guide (Keaney), direct face-to-face	3 main guiding open-ended, semi-structured questions	None	Addresses qualities in worker's approach	Addresses qualities in the FPS approach
Question guide for parents'/primary caretakers' views of family-centered, home-based service (Coleman & Collins), direct, face-to-face	3 main guiding open-ended, semi-structured questions	Re: Probl. After	Asks what was most helpful in consumer's counseling with their therapist	None
<u>Traditional Family-based and Social Service Instruments</u>				
The Parent Outcome Interview (Magura & Moses), direct, face-to-face	85 main questions with follow-up questions	10 items re: Before-After, Resid., Coping Skills, Sch/Social Better	27 items	10 items
Measurement scale of consumer satisfaction with social services (Reid & Gundlach), self-administered	35 closed-ended; 5-level response set ranging from a low of 1 to a high of 5	2 items re: Better	18 items	13 items

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Instrument & Type	No. & Type of Items	Outcome Items	Worker/Therapist	Agency/Program
Parent Satisfaction questionnaire (Johnson & Hall), self-administered	30 close-ended; 4-level response set ranging from strongly disagree (1) to strongly agree (4) with no neutral choice	6 items re: Probl. After, Understand, Coping Skills, Access	13 items	3 items

Abbreviations Key for Outcome Items: Access—Client's learning to access needed services as a result of program/intervention. **Before-After**—Comparison of present family situation to commencement of work with program. **Better**—Things and/or life have gotten better since using agency services. **Cont. Use**—Continued use of skills learned. **Coping Skills**—Client's learning coping skills & handling of child's problem as a result of services. **Goals**—Extent to which identified goals were met. **Probl. After**—Asks what happened with respect to the problems after FPS. **Prog. Help**—Helpfulness of program/services. **Progress**—Progress made on goals. **Resid.**—Residence/location of children at termination of services. **Sch/Social**—Client's handling of school and social situations better as a result of services. **Therapist Conseq.**—Therapist actions which had consequences. **Understand**—Client's understanding of child's problem as a result of services. **Use/Prac**—Useful or practical things family worked on.

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Table 2. Emerging Domains in Consumer Satisfaction Survey Instruments in Family Preservation and Related Fields

Instrument & Type	No. & Type of Items	Client Empowerment Items	Cultural Competency Items	Strength Approach Items
<i>Family Preservation Instruments</i>				
BSI/HOMEBUILDERS, self-administered	12 items: 9 closed-ended with space for comments, 3 open-ended; yes/no to a 5-level response set; 1 allows a neutral response	None	1 item	None
Consumer Satisfaction Survey of Washington State, self-administered	11 items: 10 closed-ended, 1 labeled "comments;" 5-level response set with a neutral response choice for 5; yes/no & N/A for 1 item	1 item	1 item	1 item
Family Preservation Services - Client Satisfaction Questionnaire, State of Kansas, self-administered	19 items: 17 closed-ended, 2 open-ended; 5-level response set with a "No Opinion" option	1 item	1 item	2 items
Nat'l Evaluation of Family Services, Caretaker Interview - Interim, direct face-to-face	12 closed-ended, in the client satisfaction section; 5-level and 3-level response sets and yes/no	1 item	None	1 item

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Instrument & Type	No. & Type of Items	Client Empowerment Items	Cultural Competency Items	Strength Approach Items
Family Preservation Services Interview guide (Keaney), direct face-to-face	3 main guiding open-ended, semi-structured questions	None	None	None
Question guide for parents'/primary caretakers' views of family-centered, home-based service (Coleman & Collins), direct, face-to-face	3 main guiding open-ended, semi-structured questions	None	None	None
<u>Traditional Family-based and Social Service Instruments</u>				
The Parent Outcome Interview (Magura & Moses), direct, face-to-face	85 main questions with follow-up questions	1 item	None	2 items
Measurement scale of consumer satisfaction with social services (Reid & Gundlach), self-administered	35 closed-ended; 5-level response set ranging from a low of 1 to a high of 5	None	None	None
Parent Satisfaction questionnaire (Johnson & Hall), self-administered	30 close-ended; 4-level response set ranging from strongly disagree (1) to strongly agree (4) with no neutral choice	2 items	7 items	1 item

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- (3) After family preservation services, what happened with respect to the problems you were experiencing?

Traditional Family-Based and Social Service Instruments

The Parent Outcome Interview. Magura and Moses (1986) from the Child Welfare League of America developed an 85-question interview instrument to use with clients receiving traditional child protective services. The items consist of both closed-ended and open-ended questions with most containing sub-questions or follow-up questions covering outcomes and worker competency. Reliability reported $R = .31$, $\alpha = .84$ was based on the internal consistency measure of change ratings. The instrument has been found to have construct validity (mean $\gamma = .35$ for all domains) which indicates "a moderate tendency toward positive change ratings when more services have been received" (Magura & Moses, 1986, p.237). When the average change measures were compared to those of the Child Well-Being Scale, the convergent validity was low $R = .11$ "indicating that measuring case change by interview and by the scales yields different results" (p.239). Face validity was intuited (problem areas were categorized by content analysis) but not formally examined.

Measurement scale of consumer satisfaction with social services. Reid and Gundlach (1983) developed a 34-item scale to measure client satisfaction with social services. The closed-ended items cover worker competency, agency-related activities, and outcomes. Reid and Gundlach found the scale to be reliable ($\lambda = .995$).

Parent satisfaction questionnaire. Developed by Johnson and Hall (1992), the Parent Satisfaction questionnaire is a 30-item scale consisting of closed-ended questions covering outcomes, worker competency, sensitivity, program/treatment effectiveness, agency availability and cost.

Findings

As indicated earlier, this review was done from an exploratory perspective. We were interested in discovering and describing the existing methods of measuring consumer satisfaction in family preservation services. However, in an attempt to give some structure to our investigation, we evaluated the nine instruments using the following criteria: length; types of questions (i.e., structured/unstructured); self administered or interview format; psychometric properties; and themes/domains. From the first literature review involving general client satisfaction instruments, we noted that some common categories in consumer satisfaction instruments tended to be Accessibility, Helpfulness, Respect, Availability,

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Continuity of Care or Service, Resource Availability, Resource Accessibility, and Outcomes. We looked for these categories and remained alert for others that might emerge during our review of the selected nine instruments.

Noting that some of the categories concerned the actions and/or attributes of the professional helper (e.g., accessibility, helpfulness, respect, availability), we decided to collapse these into one general category: worker/therapist competency. The categories termed continuity of care or service, resource availability, and resource accessibility were grouped into a second category we called agency/program quality. We adopted the outcomes category as named. The three categories—worker/therapist competency, agency/program quality, and outcomes—were the three dimensions that dominated the items in the nine instruments reviewed and solicited the majority of the information sought from respondents.

Under worker/therapist competency, issues related to availability, helpfulness, respect, confidentiality/privacy, communication (including ability to listen and understand), responsiveness (including prompt response to phone calls and messages), accessibility during a crisis or emergency, appropriate referrals, and facilitation of needed services were addressed. The agency/program domain addressed issues regarding the services, helpfulness of the program, availability and accessibility of the agency, the atmosphere of the agency, whether acceptance was felt by the client and whether consumer would refer friends to the agency. Outcome items addressed the following issues: progress made on goals, extent to which goals were met, useful or practical things family worked on, coping skills learned and handling of child's problem as a result of services, continued use of skills learned, residence/location of children, comparison of present family situation to situation prior to services (i.e., what happened with respect to the problem after FPS), helpfulness of program, client's improved handling of school and social situations as a result of services, client's learning to access needed services as a result of program/intervention.

As we studied the items in the nine instruments, we noted an emerging theme of empowerment-based statements and questions. This worker/therapist attitude or approach had not been observed in the general client satisfaction literature, and, therefore, no category as such existed in the literature reviewed. Of the nine selected instruments, we noted that five included client empowerment items. The Parent Satisfaction questionnaire contained two client empowerment items; one empowerment item was found in each of the remaining instruments (Consumer Satisfaction Survey of Washington State, the State of Kansas Family Preservation Services - Client Satisfaction Questionnaire, the National Evaluation of Family Services-Caretaker Interview, and the Parent Outcome Interview). Empowerment items asked (1) whether the consumer's opinion had been sought regarding the problem and the

services wanted; (2) about the amount of involvement or inclusion of the consumer in making a service plan and setting goals; (3) whether the consumer was included in making decisions about the children; (4) what the family had tried to do in the past about the problem.

Closely related to empowerment, another category of strengths-based items was noted in five of the instruments. The State of Kansas Family Preservation Services-Client Satisfaction Questionnaire and the Parent Outcome Interview each contained two items written from the strengths approach. The Consumer Satisfaction Survey of Washington State, the National Evaluation of Family Services-Caretaker Interview, and the Parent Satisfaction questionnaire each included one strengths-based item. Strengths approach items asked (1) whether the worker gave the consumer hope or confidence that progress could be made, or reviewed the progress being made by the consumer; (2) whether the worker helped the consumer to see his/her good points as well as his/her problems; (3) whether the worker recognized what the consumer is good at doing; (4) whether the worker focused on the strengths and successes of the consumer's family. Strengths approach items of this nature did not appear in the general client satisfaction instruments.

Another emerging theme noted was cultural competence. While researchers discussed the implications of cultural diversity and cultural sensitivity in measuring client satisfaction (Ellmer & Olbrisch, 1983) and tested an instrument that had been translated into Spanish (Roberts & Attkisson, 1983), general client satisfaction instruments did not include items related to cultural competency. Items related to cultural competency appeared in four of the instruments reviewed. Three of the instruments (BSI/Homebuilders, Consumer Satisfaction Survey of Washington State, and the State of Kansas Family Preservation Services-Client Satisfaction Questionnaire) included one item addressing cultural competence; the fourth instrument (Parent Satisfaction questionnaire) addressed this issue in seven of the items. The presence of cultural sensitivity and competency on the part of the worker or staff was sought through items that addressed (1) respect for and understanding of the consumer's cultural beliefs and values, (2) the consumer's level of comfort in talking about what his or her culture and race had to do with the present situation, (3) whether the services received had been offered in the language preferred by the consumer, (4) whether the language spoken by the worker had interfered with the consumer's receipt of services, (5) whether having a worker of a different race/ethnicity from the consumer's had interfered with the outcome of consumer's situation, and (6) whether the consumer considered it important to have a worker of the same ethnic background as the consumer.

Discussion and Recommendation

We looked at the instruments within the context of an administrative application, that is, how well and how expeditiously the instrument can be utilized in reporting on-going feedback to administrators and supervisors about how services are being not only delivered but also received by consumers. From the viewpoint of management application, we found several instruments that contained aspects that we deemed useful for management application, but we did not find one instrument that satisfied every aspect.

For our application, qualitative methods were not a viable option; however, in some cases, agencies may want to carry out qualitative studies in order to get as clear a picture as possible of their clients' level and areas of satisfaction. This would require specialized interviewer training, and the data collection/analysis tasks would involve considerable time. Depending on the number of clients interviewed and the basis of selection of the participants, it may be difficult to develop a representative sample, and thus generalizability would be limited. For our administrative application, the practice and service delivery dimensions are identifiable; however, if the domains were to appear unclear to others, or other issues warranted an exploratory approach, we would suggest a consideration of the Coleman and Collins' and Keaney's format. Also, in some cases, qualitative research may be used on a small scale to supplement on-going quantitative research (e.g., focus groups, in-depth interviewing). For the present, however, we find that an instrument amenable to measurement on a large scale and timely feedback may be more appropriate, though not as rich in information as qualitative interviewing might offer.

Three of the instruments reviewed—The Parent Outcome Interview, the National Evaluation of Family Services Caretaker Interview, and the Measurement Scale of Consumer Satisfaction with Social Services—are not FPS-specific. As mentioned earlier, they were reviewed in light of the scarcity of FPS instruments, and we wanted to see if they could be modified to acquire a FPS focus. The first two require a face-to-face interview, and again, this demands time and trained staff that few agencies may be able to afford. In addition, these instruments are lengthy and only a select number of items can be classified as measuring client satisfaction. To modify these would break the integrity of the larger survey of which they are a part. The third instrument is too general for our purposes and too many changes would need to be made to adapt it to FPS. In addition, to modify it to this degree would jeopardize its psychometric properties. It covers three out of the five domains and may be viewed as lengthy (34 items) by some.

Johnson and Hall's Parent Satisfaction questionnaire is not an FPS-specific instrument, but it was developed for use in the Alternatives to Residential Treatment Study. This instrument

covers all six domains (including 7 items on cultural competence); its questions are balanced in terms of being positively and negatively phrased; the response choices are consistent throughout ('strongly disagree,' 'somewhat disagree,' 'somewhat agree,' and 'strongly agree'); it is self-administered and simple to score. We endorse the approach utilized to cover critical domains, provide balanced responses, and offer simplicity in its administration and scoring.

The strengths of the BSI/ Homebuilders instrument are that it is self-administered, emphasizes outcomes (seven outcome items), and includes an open-ended question at the end. Some redeeming features of the Washington State instrument are that it is self-administered, covers all six domains, the responses are anchored on a five-point scale, and it is clearly worded to let the consumer know that it is measuring levels of satisfaction with services. We liked the length of the Kansas instrument (19 items) and that it includes two open-ended questions and seventeen items anchored on a five-point scale with consistent response choices, i.e., 'always,' 'usually,' 'sometimes,' 'rarely,' and 'never' and, therefore, easy to score.

As can be seen from the above descriptions, none of the instruments would be deemed as the "perfect" instrument in terms of construction and management utilization for measuring consumer satisfaction in family preservation services. Several come close and, with modifications, may be transformed into useful, low-cost, and expeditiously administered and scored instruments.

After reviewing these instruments, we suggest a "hybrid" approach combining the attributes of some of the instruments. This hybrid might look something like this: it would have between 18 and 24 items; the items would be balanced in terms of positively and negatively phrased statements (or questions); several items would be phrased to clearly indicate that satisfaction with services is being sought; all six domains would be addressed, with at least two or more items covering each of them; the responses would be anchored on a four or a five-point scale; it would be a self-administered survey that could be done over the telephone so as to increase the response rate; and the last item or two would be open-ended questions. Some of the survey items would be composed based on consumers' responses to the interview questions from the qualitative studies described earlier. An instrument that combines these features would best begin to meet the needs of this administrative application.

Conclusion

Consumer satisfaction clearly represents an emerging body of research in family preservation services. As with many developing fields, the role of research in the practice of developing consumer satisfaction instruments appears to be in its initial stages. The psychometric properties of satisfaction instruments were discussed in only a small minority of the selections in our review. This could be due to a lack of resources allocated to empirical assessment and the newness of this area of research. In the absence of this information, an assessment of the various instruments' value is incomplete. It is conceivable, however, that as this area of research evolves, the reliability and validity of the instruments will become routine in the evaluation of FPS consumer satisfaction instruments. This is critical for using these instruments at the individual clinical and/or program level.

Once the reliability and validity of the instruments are established, then discussions can focus on the items or domains that seem to be more sensitive to consumer issues. For further explanation on testing instruments for validity and reliability, see DeVellis (1991). Attention can also be devoted to areas that appear to be most closely linked to other measures of outcomes, for example, families staying together after the completion of services.

Our review yielded little information around the implementation of these instruments. The limited discussion is partially due to the format of some of the material. Many of the entries in our review included only the instrument with no discussion. Nevertheless, as researchers currently struggling to develop a viable consumer satisfaction strategy, a review of the learning related to mail, phone, and other methods of survey administration would be helpful. The routine discussion of these trends would facilitate greater collaboration among researchers pursuing similar goals.

Although the instruments were rarely evaluated empirically, there did seem to be some apparent strategies for selecting items for inclusion in the surveys. One approach attempted to assess the degree to which family preservation practitioners were utilizing sound practice principles ranging from treating consumers with respect to providing effective services. These items seem to have potential to direct supervision and provide useful feedback about actual practice. Another set of issues was related to competency at the agency level, and a third set of issues dealt with the effectiveness of the services as they related to outcomes for the consumers of the services.

It was interesting to note that the concepts related to worker competence seemed to resemble solid practice principles that would be viable in most family service settings. There were, however, a few items succinctly targeted at family preservation principles, i.e., provision

of concrete services (housing, food, transportation), intensive clinical services, amount and intensity of services. At the outcome level, there were outcomes related to families staying together that seemed to be easily identifiable with family preservation.

Although the last portion of this paper focused on the administrative utility of consumer satisfaction, the instruments in this review have relevance to many types of FPS practice. Each of these different types of information seems to have the potential to provide valuable feedback to the practitioners, administrators, and researchers committed to providing effective family preservation services. At the worker and agency level, routine information would allow the two groups to assess and compare their ability to provide competent services. The outcome information would also allow the professionals at all organizational levels to determine the effectiveness of their services, generally and by specific population groups, i.e., single parents, specific ethnic groups, etc. Additionally, this information has immense potential for promoting the value of these services to key constituent groups like funders, referral sources, judges, and other community agencies. Finally, this information has immense potential for contributing to the understanding of the relationship between consumer satisfaction and its component parts and other measures of input, process, and outcome.

Consumer satisfaction in FPS is an emerging field of evaluation committed to assessing the key dimensions of its services—from competent practice to effectiveness for its consumers. Some newer arenas of practice are being added to the realm of domains, like cultural competence and consumer empowerment. Although empirical assessment of reliability and validity is presently rare in this arena, there is some degree of hope that as these measures continue to be developed and improved, these types of evaluations will become more commonplace. As this occurs, the potential of the measures we reviewed will expand. Many items were targeted to specific dimensions of practice, which is useful for evaluating worker competency and integrity of services. Other items aimed at consumer satisfaction with the family preservation models are critical to program level evaluations. As more and more of the instruments are empirically assessed and improved, there is a great potential for using consumer satisfaction information to assess, monitor, and improve the implementation of family preservation.

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Intensive In-Home Family-Based Services: Reactions from Consumers and Providers

Elaine Walton and Alfred C. Dodini

An intensive family preservation program was examined through interviews with 31 families who received the services and four caseworkers who provided the services. The primary finding from interviews with both care givers and caseworkers was that a positive therapeutic relationship between the worker and the client family contributes most to the success of the program. Workers who provided the services stressed the need for making concrete services available as well as clinical intervention and skills training, and they were adamant about screening families for appropriateness before including them in an intensive, in-home program.

Background

Since 1970, intensive family preservation services (IFPS) have been employed by child welfare agencies in various ways and with varied outcomes (Fraser, Nelson, & Rivard, 1997; Rossi, 1992). In many program evaluations, the services were found to be effective in strengthening families and in preventing out-of-home placements (Berry, 1992; Carroccio, 1982; Fraser, Pecora, & Haapala, 1991; Kinney, Madsen, Fleming, & Haapala, 1977; Magura, 1981; Pecora, 1991; Sudia, 1982; Walton, 1997; Wharf, 1988). Some researchers found the services to be effective also in reunifying families after out-of-home placements (Walton, 1998; Walton, Fraser, Lewis, Pecora & Walton, 1993). In other studies, little or no difference was found between the results for the experimental and control groups in evaluating the effectiveness of IFPS programs (AuClaire & Schwartz, 1986; Feldman, 1990; Schuerman, Rzepnicki, & Littell, 1994; Yuan, McDonald, Wheeler, Stuckman-Johnson, & Rivest, 1990). Some studies did show IFPS programs to be effective but suggested the effects were modest and decreased over time (Feldman, 1991). Recent critics suggest that IFPS programs fail to resolve crises and do not improve family functioning to the degree that children may remain home safely (Gelles, 1996; MacDonald, 1994) and suggest that perhaps the momentum has shifted too much in the direction of family preservation at the expense of child protection (Maluccio & Whittaker, 1997).

Since the main purpose of IFPS programs was to reduce the numbers of children placed in out-of-home care, the success or failure of the services has been determined primarily by

the numbers of children remaining in their homes. It was assumed (inappropriately in many cases) that the factors that keep a family together also enhance family functioning. However, measuring family functioning, or the family's quality of life, was difficult and often overlooked (Frankel, 1988; Walton, 1996). Moreover, those targeted for intensive services were frequently either (a) families identified by caseworkers as likely to benefit from the services but for whom out-of-home placement was not truly an imminent risk (the primary criteria for inclusion), or (b) those families for whom intensive services were used as a last ditch effort and had been labeled as the "most difficult" families (Denby, 1995; Schuerman, Rzepnicki, & Littell, 1994; Walton & Denby, 1997). In both cases, intensive services were probably inappropriate, and issues were clouded as to the real value of IFPS.

From the mixed findings and conflicting opinions it would seem that (a) IFPS programs are not to be regarded as a panacea; (b) the effects of these services are difficult to measure; and (c) it may be inappropriate to compare findings from program evaluations when methodologies are inconsistent or flawed. Practitioners and policy makers are left with a number of questions, such as Which services are most helpful? for which families? at what point along the service continuum? In attempting to answer these questions, researchers too frequently failed to listen to the opinions of the consumers (i.e., the families). Moreover, programs have been too frequently developed with little input or feedback from the front line workers—those ultimately responsible for providing the services.

The purpose of the current study was to examine one IFPS program through the perspectives of the caseworkers who delivered the services and the families who received them. The consumers are in an ideal position to identify barriers to service delivery as well as ways to overcome the barriers. Their input is invaluable in developing policies and programs and in determining the requirements for a healthy working alliance between workers and families. The relationship between providers and consumers has a significant influence upon the family's willingness to trust the workers and to participate in the program, as well as in the overall effectiveness of the services (Drake et al., 1995). Therefore, drawing on the input of consumers and front-line workers, the intent of the study was to build on existing knowledge in (a) defining effective IFPS practice, (b) determining which elements of the service were most effective in meeting the needs of recipients and the goals of IFPS providers, (c) identifying needed improvements in service delivery, and (d) making recommendations regarding for future IFPS programs—both from the perspectives of the families served and the workers who provided the services.

Methodology

To obtain information from consumers and providers of IFPS regarding their experience, opinions, and recommendations, interviews were conducted with recipients of the services and with the caseworkers responsible for providing the services.

Sampling Procedures

All families who received IFPS through the Western Region of the Utah State Division of Child and Family Services (DCFS) between January, 1995, and February, 1996, were included in the sampling pool—a total of 72 families. Of these families, 31 were interviewed; 19 could not be located; 3 were confirmed to have moved out of the area; 3 refused to be interviewed; 8 were not approached due to their distance from the Provo, Utah, area; 2 were not approached due to their current involvement in law suits with DCFS; and files for 6 of the families were not found.

Graduate students in social work at Brigham Young University interviewed the caretakers (parents) of the families who received services. The interviews took place during March and April of 1996. Four of the caseworkers who provided the services to the families were also interviewed by a graduate student in social work at Brigham Young University.

Data Collection: Interviews with Consumers and Providers

Interviewers questioned the caretaker regarding (a) family demographics, (b) general satisfaction with the services provided by DCFS, (c) the nature of and the degree of satisfaction with their interaction with the caseworkers, (d) family functioning and the impact of IFPS on the family, and (e) overall opinions concerning the program's effectiveness and appropriateness for their family.

The family preservation workers were questioned regarding their opinions concerning the program design including (a) training, (b) assessment of families for selection to receive the services, (c) the philosophy of IFPS, (d) the strengths and limitations of service delivery, and (e) the nature of their interaction with the clients.

Description of Services, Providers, and Consumers

Family Characteristics. The typical family consisted either of dual birth parents (38.7%) or single parents (38.7%), living in a rented home (51.6%), with three children. Female care givers out-numbered males by three-to-one and had an average age of 36.9 years. The care

giver's average level of education was 13.9 years. The sample group was predominantly white (93.5%), and families received their income primarily from employment (74.2%). The primary allegations upon which the referrals were based were physical abuse (35.3%), emotional maltreatment (23.5%), sexual abuse (11.8%), failure to protect (11.8%), and physical neglect (5.9%). These percentages were similar to the percentages for all referrals to the agency during the same period of time with the exception of a higher percentage of referrals for physical neglect in the total referral population than in the sample group (18.0% compared to 5.9%). Six of the 31 families involved ungovernable or acting-out adolescents.

Caseworkers. Four female and two male caseworkers were directly involved with the families in providing the intensive services. The average age of the caseworkers was 27.4 years. Two held the MSW degree, and four held bachelor's degrees. The average years of experience with DCFS were 3.7 years.

Treatment/services provided. The services provided were based on the Homebuilders™ model (Kinney et al., 1991) and consisted of an array of in-home, family-centered interventions designed to prevent out-of-home placement. Most of the families who participated in the IFPS program were selected after a 30-day CPS investigation and assessment period; however, families could be included in the program at any time prior to case closure. The decision to include them in the program was made by supervisors and caseworkers in a regular staffing meeting; however, the family preservation workers who would be given the cases were not generally present at those meetings. The criteria for inclusion in the program were (a) high risk of removal, and (b) the family's need for more intensive services. This IFPS program was distinguished from other child welfare programs within the agency primarily by its intensity. Over a period of 60 days (on average), caseworkers visited the families multiple times during the week and spent large blocks of time with the family as situations demanded. Moreover, they were on call 24 hours a day, seven days a week to deal with crises or emergency situations with the families. This intensity was made possible by relatively small case loads of four to six families. Treatment plans were flexible, comprehensive, and tailored to the unique needs of each family. Included in these plans were services such as (a) intensive counseling; (b) concrete services such as food, financial assistance, homemaker services, and transportation; (c) skills training, including the areas of homemaking, communication and parenting; (d) assistance with family organization and planning; (e) preparation for court; (f) tracking services for children; (g) referrals for other resources; and (h) other in-home support services from specially trained caseworkers. Specific treatment goals were established by the families with the workers' assistance and most frequently included improvement in the areas of (a) family communication skills, (b) parenting skills, (c) anger management and conflict resolution, (d) school attendance, (e) condition of the home, and (f) caseworker/client relationship.

Clients received a mean of 16 contacts over 10.5 weeks with approximately 2-3 contacts per week.

Limitations

The study was limited because of the small, biased sample of consumers. The fact that only 31 were interviewed out of a pool of 72 families is indicative of the kind of families who typically receive intensive services (i.e., transient, multi-problem families). The 31 families who were interviewed were certainly not a representative sample. They were the families who were available and willing to be interviewed. In other words, they were less transient, less likely to be involved in legal difficulties, and more likely to be kindly disposed toward DCFS intervention. This sample of 31 families would be much more likely to fall into the most-likely-to-succeed category rather than the most-difficult-to-serve category, and the results should be interpreted within that context (i.e., feedback from relatively stable families who want help with their problems).

The study was limited also by the small sample of caseworkers who were interviewed. Only six caseworkers were involved in providing intensive preservation services, and only four of those were available for interview. Just as the families were, in a sense, self-selected for the study, the caseworkers were also self-selected. However, that seems to be a defining characteristic of IFPS workers. Although it is difficult to articulate an adequate job description or set of criteria for this particular brand of social worker, clearly required is an intrinsic set of values which drives the workers to be intensely and intimately involved in the lives of struggling families—a characteristic which may set them apart from other child welfare workers (Walton, 1998).

It is acknowledged that this is not a rigorous program evaluation with variables that are controlled in relation to each other. Rather, it should be viewed as interesting and informative feedback from consumers and providers who were likely to be the most invested in the helping process.

Results

Data were collected and opinions solicited from both consumers and providers of the intensive services.

Consumer Opinions

Consumer opinions were categorized as to (a) the worker's most helpful activity, (b) treatment goals, (c) the quality of the interaction between the family and the worker, and (d) overall satisfaction with the worker and the services provided (Table 1).

Table 1. Consumer Opinions

Consumer Opinions	N=31
Worker's most helpful activity (%)	
Sincerely cared and was a good friend	16.7
Taught useful skills	10.0
Referred to other resources	10.0
Home visits	10.0
Helped establish family boundaries	10.0
Got a tracker for the children	10.0
Improved communication within the family	6.7
Provided concrete services	6.7
Worker believed in the family	6.7
Most important treatment goal chosen by the family (%)	
Improved communication within the family	44.8
Enhancing parenting skills	17.2
Establishing a relationship with the worker	6.9
Improving conflict resolution skills	6.9
Improving physical condition of the home	6.9
Progress toward goals (%)	
A lot	69.0
A little	20.7
None	10.3
Importance of goals (%)	
Important	93.1
Not Important	6.9
Was the service what was needed (%)	
Yes	82.1
No	17.9

Overall reaction to the services (%)

Extremely satisfied	36.7
Satisfied	30.0
Neither satisfied or dissatisfied	13.3
Somewhat dissatisfied	16.7
Dissatisfied	3.3

Overall reaction to the worker (%)

Very satisfied	56.7
Somewhat satisfied	23.3
Neither satisfied or dissatisfied	3.3
Very dissatisfied	16.7

Client caseworker relationship and consumer satisfaction. The relationship between the family and the worker emerged as the single-most important determinant of the effectiveness of the services and the family's willingness to participate in the intervention. Sixty-seven percent of the families reported that they were satisfied with the services provided, but 80.0% reported being satisfied with the worker. These expressions of cooperation between the families and the workers resulted in families reporting that the worker's conduct was courteous (82.8%), that the worker cared about the family (82.7%), was available when needed (79.3%), and could be depended on when the family was in need (75.9%).

Treatment goals. A total of 93.1% of the families considered the treatment goals to be important and worth pursuing. Improved communication within the family was most frequently selected as a treatment goal (44.8%). Other goals included enhancing parenting skills (17.2%), establishing a working relationship between the worker and the family (6.9%), improving the physical condition of the home (6.9%), and improving conflict resolution skills. Sixty-nine percent of the families reported progress toward reaching their goals with an additional 20.7% reporting at least a little progress. Of the families surveyed, 82.1% reported that the services were what was needed at the time to help them. Of the remaining 5 families, 3 expressed resistance to any outside intervention in their families. The other two stated that the services provided were not what was most needed to deal with what they perceived as the most important issue in the family. For most who were willing to give the program a chance, they categorized IFPS as a welcomed source of new ideas and methods for dealing with the challenges of raising a family.

Caseworker Opinions

The workers who were interviewed unanimously agreed that IFPS programs are an improvement over the once-or-twice-a-month in-home services that have been the mainstay of family service programs. They were generous with their comments in evaluating the model, and, for the most part, their comments were consistent. Because of that consistency, and because of the small number of workers who were interviewed ($n=4$), their opinions are only reported collectively in summary fashion.

The workers appreciated having the time to really listen to the client's story and approach the problem from a more supportive and less adversarial position. The increased amount of time spent with the family allowed them to be more patient with the clients and work toward gradual, sustained improvements rather than toward a quick fix which would likely not endure beyond the worker's contact with the family. Workers also valued the greater degree of autonomy they felt in service selection and delivery and the support for the program from administration.

Concrete services. Workers valued their ability to fill more than just a single clinical role in helping the family, and they viewed a wide variety of service options—especially the provision of concrete services—as an essential component of the program. They felt that helping the family with some of the more mundane concerns instilled an atmosphere of support that promoted the family's investment in the helping process—that investment being what workers considered a critical family trait if any success was to be realized. Workers were, however, frustrated by the amount of "red tape" they had to deal with to get access to cash for immediate concrete needs.

Appropriate screening of families. Workers agreed that there can be significant obstacles to overcome in establishing a working relationship; and, for that reason, they felt it was essential that the families targeted to receive IFPS be appropriately screened. They noted that decisions for including families in an IFPS program were usually made by supervisors or others who had little or no direct contact with the families and were not in a position to determine the family's willingness to participate in the program. They complained further that the decision to offer intensive services is too frequently based solely on the risk of removal. They felt that parents may, in fact, be the best judge as to whether the intensive services would be helpful. They further suggested that pro-active involvement rather than removal, as the primary criterion for service, would reduce the amount of time spent dealing with some family's suspicions and more quickly engender trust. They recommended that IFPS workers be allowed to interview families prior to their selection to receive services in

order to assess their willingness to participate in the process and the degree to which the family might benefit from intensive services.

Program design. Workers stated that the program design is an improvement over prior models but needs additional flexibility with regard to the degree of intensity and time limitation of the services. Moreover, they wanted access to additional resources (such as respite care and home making services). They recommended an intermediate level of service intensity between the standard "in-home" service (two or three visits per month) and IFPS (two or three visits per week) for those families that might not be able to deal with the intense and intrusive nature of IFPS.

Training. Some of the workers held the MSW degree with clinical training and others had a bachelor level degree in social work or related field. There were mixed opinions regarding the degree to which graduate education enhanced workers' effectiveness, but they agreed that appropriate training in clinical theories and intervention methods as well as available community resources is essential in dealing with many of the kinds of problems confronted by IFPS workers.

Obstacles. IFPS workers reported that they were viewed initially as CPS workers—unwelcome intruders. Often they found it a difficult and sometimes impossible task to break through the stereotypical perspective held by many families. Families were uncertain as to their roles in this new relationship and how to respond to the extensive and intrusive nature of the workers' involvement in their lives. Workers reported the positive side to the uncertainty was that families were looking for answers and new ways of dealing with the problems in the home and were willing to consider the possibility that this new approach might help. Once the workers were able to convince families they were there to help rather than to remove the children, they were more tolerant of the families' problems and recognized that families had many strengths. Likewise, the families were more willing to accept the help they knew they needed but for which they had been afraid to ask.

Discussion

In an effort to more clearly define effective IFPS practice, both workers and consumers were interviewed. Both groups valued the approach of IFPS with a flexible delivery design and a wide variety of available services tailored to the individual needs of the families being served. The goal of preventing unnecessary removals and working to improve family functioning was endorsed and applauded. Workers recognized the need for a positive and supportive relationship rather than a punitive one with the client family as being key to successfully reaching the goals of IFPS. Moreover, the families generally placed a higher

value on the caseworker who provided the services than they did on the services. These findings should not come as a surprise. A number of studies have placed primary emphasis on the importance of the therapeutic relationship (See, for example, Berman, 1991; Duncan, 1992; Edwards & Bess, 1998; Werner-Wilson, 1998). The findings also support the research of Bean (1994) who found through in-depth interviews with families that there was frequently a profound sense of loss and grieving after termination of an intensive relationship with IFPS caseworkers.

There are several implications in the findings which enhance the pre-eminent role of the client caseworker relationship. First, caseworkers should be selected carefully. Intensive involvement with struggling families is emotionally demanding work, and the qualifications for that role may have more to do with personality and personal values than with education and experience. It is noteworthy that the workers who were interviewed for this study frequently maintained contact with families for years, and families called upon them when they needed additional help rather than letting problems worsen. Also, in the same agency, a set of interviewers associated with a separate evaluation found that 80% of the family preservation workers reported that they had used their personal funds to purchase items of critical need for families in emergency situations (e.g., diapers, food, or warm clothing) when Agency resources were not available or slow in arriving (Walton, 1999). Ironically, the personality characteristics which enable social workers to reach out to families in meaningful ways are the same characteristics which may precipitate early burnout. Consequently, flexibility in service guidelines, agency backup, and the support inherent in a team approach may be as important as the characteristics of the worker. Also, in the final analysis, it is the education and training of the worker that will make it possible for him/her to deliver services in a professional, comfortable, and competent manner and with the least risk of burnout.

Along with the need to select caseworkers more carefully is the implication for selecting client families more carefully. Targeting the right families for the right services is not a simple procedure and has been the focus of much study and debate (See, for example, Denby, 1995; Schuerman, Rzepnicki, & Littell, 1994). Evaluations for IFPS programs have produced confusing and conflicting findings when intensive services seem to have been wasted on families not truly at risk or families too dysfunctional to benefit. Moreover, too many program evaluations have targeted families for intensive services based solely on risk of out-of-home placement.

The caseworkers, interviewed for this study, suggested that the best way to select families for intensive services would be to rely on the opinions of the families, themselves, along

with the opinions of workers assigned to provide the services. This supports the findings of a previous study (Walton, 1991) in which an IFPS program was employed in reunifying families after out-of-home placement. It was found that one of the most important correlates for successful reunification was the parents' opinion regarding the best place for the child. Caseworkers in the current study wanted to be given the opportunity to interview candidate families in order to determine their attitudes and their willingness to receive intensive services. This should not be viewed as a desire to select only the "cream" of the child welfare families (i.e., families who would likely be resourceful enough to make progress without intensive intervention). Rather, it should be viewed as a desire to select families who want to remain intact and who want help.

The authors encourage program developers and evaluators, in future research, to test the notion that the opinions and desires of the families and the front-line providers should be primary variables in making decisions for service delivery. In addition to more appropriate targeting decisions and flexibility in service delivery, it is anticipated that the mutual and sincere commitment to participation by both the workers and the family members would result in more appropriate selection of treatment goals, a greater degree of compliance in working toward the accomplishment of those goals, and a greater likelihood of goal attainment.

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Coordination of Family Preservation Services in a Rural Community: A Case Study

Richard Freer and Kathleen Wells

Family preservation programs designed to prevent the out-of-home placement of children depend on the coordination of services from multiple agencies. Little is known regarding how coordination occurs. This case study examined this issue. Information was sought from all workers who provided services to each of five families and from families' case records. Thirty-one workers were interviewed with a semi-structured interview schedule containing rating scales and questions with open-ended response formats. Case records were reviewed with a case record review form. Analyses of data revealed the following. Services were coordinated to a moderate degree but that coordination deteriorated over time. Workers elaborated how aspects of communities, human service agencies, workers, and families affected coordination. Implications of findings for future research were drawn.

Introduction

Coordination of human services, such as social, mental health, health, educational, vocational, and recreational services, has been discussed extensively across service systems (Corrigan & Bishop, 1997; Crowson & Boyd, 1993; General Accounting Office, 1992; Hunter & Friesen, 1996; Kolbo & Strong, 1997; Stroul & Friedman, 1986; Thomas, Guskin, & Klass, 1997).

Coordination has been defined variously. Definitions include enhanced communication and cooperation (Auluck & Ikes, 1991); co-location of services (Dryfoos, 1994 cited in Knapp, 1995); shared resources (Cutler, 1994 cited in Knapp, 1995); redefined professional roles (Robison, 1993); integrated referral systems (Marzke, Chimerine, Morrill, Marks, 1992 cited in Knapp, 1995); and redesigned and integrated public service systems (General Accounting Office, 1992). Despite this variability, definitions tend to emphasize either the coordination of services provided to clients or the coordination of systems through which services are delivered.

Coordination of human services is believed to carry many benefits. These benefits include meeting the complex problems of America's families, especially those who are poor (Center for the Study of Social Policy, 1996); enhancing the accessibility, appropriateness, and use of services (Kolbo & Strong, 1997; Schorr, Both, & Copple, 1991); facilitating integration of knowledge from diverse disciplines (Thomas, Guskin, & Klass, 1997); and promoting the goals desired for clients and their families (Center for the Study of Social Policy, 1996). Moreover, some argue that the synergy created by the effort to coordinate services will increase the likelihood of client goal attainment (Corrigan & Bishop, 1997). Corrigan and Bishop (1997) have concluded that coordination is no longer an option but rather is a necessity and professional obligation.

There is growing concern, however, that the effort to coordinate human services may also carry risks. These risks include confusion among service providers over authority and accountability (Kusserow, 1991); loss by clients of their privacy (Kusserow, 1991); fragmentation of services (Bruner, 1991) and inefficient practice (Kolbo & Strong, 1997); and poor client outcomes (Golden, 1991 cited in Knapp, 1995). Kolbo and Strong (1997) note that some service providers may feel that cases are out of their control and that their work is subjected to obtrusive and unwanted scrutiny.

At present, we have limited knowledge regarding the coordination of human services. This is particularly true for clients and especially for clients living in rural communities (Kelleher, Taylor, & Rickert cited in Cutrona, Halvorson, & Russell, 1996). We lack basic descriptive knowledge of how services for clients are coordinated and with what effects. At the theoretical level, we lack theory to explain the variability in coordination of services to clients.

Study Purpose

The present study is a beginning effort to contribute to knowledge in this area. It examines the coordination of a wide range of public and private human services to families participating in a family preservation program in a rural county.

Background

Coordination of Services in Family Preservation Programs

Coordination of services to clients is a central component of the family preservation program model (Child Welfare League of America, 1989). Family preservation programs are designed to keep children at risk of out-of-home placement with their families (Tracy,

Haapala, Kinney, & Pecora, 1991). Typically, such programs are based in one service system such as the child welfare system but rely on services provided by other service systems such as the mental health system.

Several investigations of family preservation programs have examined some aspect of service coordination (cf., Beckler, Mannes, & Ronnau, 1991; Howard & Johnson, 1990; Landsman et al., 1993; Yuan, McDonald, Wheeler, Struckman-Johnson, & Rivest, 1990). For example, Yuan and her colleagues examined the relationship between agencies with which the State of California contracted for family preservation services and local child protective agencies. Based on site visits made to three family preservation programs, investigators identified factors they believed facilitated service coordination. These included the use of memoranda of understanding to establish guidelines for coordination, the presence of a liaison to coordinate work among agencies, and the provision of ongoing training for staff.

Howard and Johnson (1990) examined the relationship between the private agencies with which the State of Illinois contracted for family preservation services and local Division of Children and Family Services (DCFS) agencies. Based on intensive interviews with private agency and DCFS workers and personnel, investigators identified factors they believed facilitated and impeded coordination. Facilitators included prior positive relationships between agency and DCFS workers, the presence of a liaison to coordinate work, and use of group meetings to resolve problems that arose. Several impediments to coordination were named. These included delays in referring clients to family preservation programs, philosophical differences regarding the role of family preservation, disagreements over when and how to involve the courts in cases, and controversy over use of DCFS to monitor families, after termination from family preservation programs.

Beckler, Mannes, & Ronnau (1991) examined the implementation of the Intensive Home-Based Intervention Services Program, a family preservation program administered by the New Mexico State Youth Authority through contracts with private agencies. Based on stakeholders' (i.e., staff from contracting agencies, staff from the Youth Authority, and community and system personnel) answers to open-ended questions, investigators identified two impediments to coordination of services—lack of clarity regarding roles of workers involved with the same family and disagreements over appropriateness of clients referred to the family preservation program.

Landsman, et al., (1993) studied the Families First Program of Minnesota, a family preservation program administered by Minnesota's State Department of Human Services. Investigators examined relationships among the Families First of Minnesota providers and

representatives of other human service agencies. Of particular interest was the referral process and ongoing interaction between referring and provider agencies. They conducted focus groups with Families First provider staff, completed interviews with key informants such as provider directors and representatives of other human service agencies, and obtained surveys from provider workers and supervisors. Investigators concluded that interagency conflict regarding decisions to place children and use of funds limited coordination of services in the Families First program.

Taken together, these investigations provide a useful starting point for an examination of service coordination in family preservation programs. They suggest that coordination of services in family preservation programs is problematic and some reasons why this may be the case.

These investigations are limited, though, by a reliance on the points of view of managers and administrators. None included all workers involved in the provision of services to individual families. None explicitly explored the range of facilitators of and inhibitors of coordination reported in the literature.

Coordination of Services to Abused and Neglected Children

Investigations of coordination of services to abused and neglected children in non-family preservation programs suggest additional explanatory domains. For example, Hallett and Stevenson (1980) investigated aspects of inter-professional cooperation in treatment of child abuse cases. They found that workers lacked knowledge of professions other than their own. This "widespread ignorance about the training, role, and perspectives of other professions" inhibits coordination (Hallett & Stevenson, 1980, p. 23). They also found two facilitators of coordination—group process and public opinion. They noted that well-defined organizational procedures help to provide structure for the work of field staff and those in supervisory roles and that workers' anxiety regarding public exposure of their mistakes provided "a powerful impetus to interagency coordination" (Hallett & Stevenson, 1980, p. 5).

Lyon and Kouloumpos-Lenares (1987) examined collaborations among clinicians and state children's service workers treating child sexual abuse victims. The identified group process as a facilitator of coordination. They found, among other things, that weekly meetings among all workers involved promote coordination of services, especially in complex cases. Baglow's (1990) model of child abuse treatment posits another inhibitor of coordination—sadness over the "horrendous situations encountered in families where child sexual abuse has occurred" (p. 522).

Coordination of Services in Rural Communities

Investigations of service delivery in rural communities (Bachrach, 1885; Davenport & Davenport, 1984; Farley, Griffiths, Skidmore, & Thackeray, 1982; Ginsberg, 1971; Martinez-Brawley, 1981; Martinez-Brawley, 1990; Whittaker, 1986) document human service professionals' views that services in rural communities are limited; that human service professionals in rural communities need to function as generalists rather than as specialists; and that rural clients may have a bias against seeking help from professionals. These findings suggest that coordination of human services in rural communities differs from that in urban communities but we lack an empirical investigation of this issue.

Study Aims

We sought to fill a gap in knowledge of coordination of human services, specifically family preservation services, to families in rural counties. In the present study, we had two goals. The first goal was to describe the services delivered to families and how they were coordinated. The second goal was to elaborate the ways in which facilitators and inhibitors of coordination identified in the literature affected service coordination.

Method

Study Design

We used a case study design. Following Yin's (1993) typology, we employed a descriptive, retrospective, single-site, embedded case study design (Yin, 1993). As such, it focused on one case (a family preservation program), in one site (one rural county in one state), and on several units within the case (five families who received services in the program). Information about each family was sought from the family's case record and from interviews with workers involved in providing services to the family. Such designs are appropriate when a study's purpose is to provide in-depth description in order to illuminate critical issues of importance to a field (Patton, 1990) or to develop hypotheses.

One weakness of this design is the retrospective nature of the data obtained. To help overcome this deficiency, we used several strategies. To encourage accurate recall of subject families, each worker reviewed a family's case record prior to our interviews with them. To promote a comprehensive assessment of service coordination, we asked all workers involved with each subject family to participate in the study. We asked each worker to describe his or her involvement with a family from the date of referral through four weeks

after service termination. To correct for biases introduced by reliance on a single data-collection method, we used both quantitative and qualitative measures.

Approach to Sampling

Purposeful, rather than probability sampling, was used to select the case (the program) and units within the case (the families) (Patton, 1990). Purposeful sampling depends on the selection of an "information rich" sample elaborate understanding of the phenomena under study.

Selection of the case. The family preservation program investigated was selected for study because it requires coordination of services, is mature, and is part of a rural service system. All workers involved with the same family are asked to identify common goals, develop joint service plans, and use therapeutic methods and techniques that are mutually compatible and do not confuse the client. The program has been in continuous operation for the past ten years. The county in which the program is located is rural. Its population was less than 70,000 in 1990.

Program description. The program is housed within the county's Department of Children and Family Services (DCFS). The goals of the program are to prevent the out-of-home placement of abused and neglected children and to improve family functioning. The program resembles most closely the Homebuilders model (Nelson, Landsman, & Deutelbaum, 1990). It is intensive (up to 35 hours of service are provided weekly); brief (services are provided up to 90 days); and flexible (services are available seven days a week, 24 hours a day). Public and private health, education, child welfare, welfare, mental health, and vocational services are available to families. The program is small. It has served an average of 25 families per year over the past five years.

We believed the program to be an ideal case in which to study a complex process such as service coordination.

Selection of subject families. Subject families were identified using a two-stage procedure. In the first stage, families who had been discharged from the program within the past 12 months were selected using the following criteria. These were (1) the family had an abused or neglected child at risk of out-of-home placement; (2) the family had been involved with workers from at least three agencies; and (3) the family had been involved in the family preservation program for at least one month but no more than three months. Twelve of the 25 families served by the program within 12 months of the beginning of the study met these

criteria. (The remaining families were either reunification cases or were still receiving services.)

In the second stage, families were selected if they required from a moderate to a great deal of coordination of the services they received in order to succeed in the program.¹ Eight of the 12 families identified in stage one met this criterion. Three of the 8 families could not be located. The remaining five families comprised the study sample.

We believed these families to be ideal because they required coordination of services from multiple agencies in order to be successful, had been enrolled in the program for a sufficient period of time, and had been discharged recently from the program.

Selection of study respondents. Workers were selected for participation in the study if they had been involved directly in the delivery of services to one of the five subject families.

Thirty-seven workers qualified as respondents for the study. Of the 37, 31 agreed to participate. Of the six who did not participate, three could not be located; two refused; and one was asked not to participate by a third party. Of the 31 respondents, seven were involved in the delivery of services to more than one family. As a result, some respondents were interviewed about more than one family. We did not consider this to be a limitation because we had multiple respondents for each family. The number of respondents interviewed for each of the five subject families follows, with the number of respondents who could have been interviewed for each one in parentheses—8(9); 12(14); 6(8); 7(8); 11(11).

We believed these respondents to be ideal. They had the knowledge needed to provide detailed information regarding the coordination of services to the five subject families.

Study Concepts and Measures

We used three measures in this study—a case record review form, a semi-structured interview schedule, and a rating scale. These measures were designed to obtain data to describe study respondents and subject families and to measure the major study concepts noted below.

Services received. Services were conceptualized in terms of their type, number of units received, and duration of services. These concepts were measured with the case record review form. This form was used to obtain information that was recorded in a family's DCFS file.

Other critical elements of service use were also assessed. These elements included the services needed and the quality and appropriateness of services received. These elements were assessed with the semi-structured interview schedule. For example, a respondent was asked to identify the services the family needed in order for their problems to be resolved.

Service coordination. Following Auluck & Ikes (1991), service coordination was conceptualized as the communication and cooperation that exists among workers involved with provision of services to one family. Communication and cooperation were assessed with the semi-structured interview schedule. The schedule contained questions pertaining to communication and cooperation that occurred among all workers who provided services to a subject family at each of five stages of the service-delivery process (referral, assessment and planning, service delivery, termination, and initial after-care (up to one month following termination of services)). For example, a respondent was asked how communication occurred during the assessment and planning of services for the subject family.

Respondents also rated the extent to which workers communicated as needed to meet the needs of the family and the extent to which workers cooperated as needed to meet the needs of a family. On these scales, a rating of 1 meant "not at all"; a rating of 7 meant "to a great extent." These questions were asked for each of five stages of the service-delivery process noted above.

Facilitators of and inhibitors of coordination. The fifteen facilitators and inhibitors identified in the literature were condensed and re-conceptualized as eight domains. They included the following: public pressure or opinion regarding child welfare agencies; laws or court-orders; relationships among agencies; specific agency policies; professional background of workers; issues pertaining to the nature of family preservation work; interpersonal relationships among workers; and group dynamics. We assumed that each domain might facilitate or impede coordination depending on a family's situation.

Respondents' views of each domain were assessed with the semi-structured interview schedule. For example, a respondent was asked how specific agency policies affected the coordination of services that occurred in the subject family under discussion.

We also evaluated whether program processes intended to support coordination—development of common goals and joint service plans—were followed. These concepts were assessed with the case record review form. Data obtained included presence of written treatment and after-care plans as well as the dates of meetings held and the names of workers at each meeting.

Descriptive information. Information needed to describe study respondents (job description, education, and role with a subject family) was obtained from the semi-structured interview schedule. Information needed to describe the subject families was obtained from the case record review form (family structure, ethnicity, and number of children at risk of placement) and from the semi-structured interview schedule (family problems and goals of the intervention).

Procedures for Data Collection

The first author obtained permission to conduct the investigation from agencies that employed potential respondents. He then obtained informed consent from one of the adults in each of the five subject families so that they could be studied.

The case records of each subject family were reviewed to identify workers involved in provision of services to each family. (The case record review was also conducted at this time.) Informed consent to participate in the study was obtained from study respondents. The first author told respondents he was conducting his dissertation research; that he had no affiliation with agencies involved in the study; and that he would maintain the anonymity of their responses.

Interviews with respondents took place in respondents' offices and took from one to two hours to complete. Prior to the conduct of each interview, a respondent was given the family's DCFS file to review to refresh his or her memory of the family.

Data Analysis

Case record review data. To establish the reliability of data obtained from the case record review form, the first author recorded information from a DCFS file onto the case record review form for one subject family. His research assistant coded the same file. The answers of the two recorders were compared and found to be identical. The first author then reviewed the files of the remaining four families.

To analyze case record review data, the following variables were calculated. Calculations included the number of units of service per type of service noted, length of service per type of service noted, number and timing of group meetings held, names of all workers at each meeting, family structure, ethnicity, and number of children at risk of placement. Presence of written treatment and after-care plans was noted. Calculations were made for each family and then across families.

Interview form data. The analysis of the eight domains (public pressure or opinion about child welfare agencies; relationships among agencies; specific agency policies; nature of the work; professional background of workers; inter-personal relationships among workers; laws and court-orders; group dynamics) proceeded in the following four stages. First, audio-tapes of interviews were transcribed and read for errors by the first author and by respondents. Few errors were found and respondents made no requests to delete responses or to add material.

Second, the text was subjected to a content analysis (Miles & Huberman, 1994) to confirm the presence of content relevant to the eight domains about which respondents were queried. To perform this analysis, the first author and his research assistant independently read the text and conceptualized the content. They compared content areas and resolved discrepancies through discussion. This process was repeated until their conceptualizations agreed.

Third, the consistency with which interview text could be placed into one of the eight domains was tested. Investigators independently coded one interview from three of the five subject families. This process demonstrated that the domains could be used reliably.² The text for all interviews was then coded. Analyses completed in stages two and three confirmed the presence of the eight domains abstracted from the literature.

In the fourth stage, we read the text within each of the eight domains and elaborated how coordination was facilitated or inhibited within each.

Rating scale data. To analyze quantitative ratings of the communication and cooperation that occurred, respondents were selected randomly from the respondent pool for each family until five respondents were selected who had not been involved in the delivery of services to any other family. The means and standard deviations of their ratings for each of the five families were calculated. The mean and standard deviation for families considered together were calculated also.³

Findings

Description of Respondents

Of the 31 respondents, seven were therapists or counselors from either community mental health centers, schools, private social welfare agencies, or residential treatment programs; four were family services workers and four were case aides from DCFS; four were case managers from private psychiatric hospitals or residential treatment programs; three were

school principals and three were protective service workers from DCFS; and two were intensive family preservation therapists in private practice. One respondent held one of each of the following jobs: parent facilitator in private practice, educational coordinator at a private child development agency, assistant director at a private child welfare agency, and juvenile court officer.

Of the 31 respondents, 26 had a college education. Eleven had baccalaureate degrees, thirteen had master's degrees, and two had doctoral degrees. Five had less than a college education. The mean length of time respondents had worked in their current position was six years.

Description of Families

As Table 1 shows, families had one or more children at risk of out-of-home placement. Three of the five were comprised of a child, the child's mother, and the child's grandmother or great-grandmother; one consisted of a child and her mother; and one consisted of a husband and wife and their children. All were white. Four of the five included one adult with a non-substance-related mental disorder. Four of the five included one adult with a substance-related mental disorder, such as alcohol dependence. In short, families had severe, complex, and chronic problems. Preservation of the family was a goal in all cases. Children in two of the five subject families were placed sometime between assessment and after-care. (However, six months after completion of the study, at least one child in each subject family had experienced a placement.)

Table 1. Description of Families by Descriptor and Subject Family

	Subject Family				
	1	2	3	4	5
Descriptor					
Number of children at risk	1	5	2	1	1
Ethnicity	White	White	White	White	White
Family structure ^a	MGC	MFC	MGC	MGC	MC
Problems ^b					

Descriptor	Subject Family				
	1	2	3	4	5
	M (SA)	M (LD)	M (PD)	M (SA, D)	M (D)
	G (S)	F (SA)	G (DV)	G (none)	C (RA, DL)
	C (DD)	C (LD, AO, A)	C (DD, SBH)	C (BD)	

^a Family structure is classified into one of three types. MGC means a family comprised of a mother, grandmother, and child. MFC means a family comprised of a mother, father, and child(ren). MC means a family comprised of a mother and child.

B Problems are noted in parentheses. Each problem is next to the person who has the problem. Persons are defined by family role where M=mother, F=father, C=child, and G=grandmother. Problems are defined by type where SA=substance disorder, s=schizophrenia, D=depression, LD=learning disorder, DD=developmental delay, PD=personality disorder, DV=domestic violence, RA=running away, SBH=severe behavioral problems, BD=degenerative brain disorder, SO=sexual acting out, and DL=delinquency.

Services Provided

Families spent a mean of 15.8 weeks in the intensive family preservation program and initial after care (up to four weeks after termination from the intensive family preservation program). All were involved with at least seven workers from at least three agencies. As Table 2 shows, all families received 8 of the 10 types of services used.

Three of the families received the majority of services that respondents believed they needed. Two did not. The number of services respondents believed were needed, followed in parentheses by the number that were delivered, for each subject family is as follows: 3(0); 11(9); 8(6); 5(4); and 6(2). Five families did not use recommended counseling services such as family therapy. Three families did not use recommended residential or day treatment services. Two families lacked parenting skills-training services. One family lacked assessment and diagnostic services.

Table 2. Units of Service by Service Type and Subject Family

Service Type ^a	Subject Family				
	1	2	3	4	5
Case Management	10	17	12	12	14
Intensive in-home therapy	7	5	9	8	4
Individual counseling	7	30	7	6	33
Group counseling	7	5	3	7	29
Food, cash, clothing	2	3	0	0	0
Transportation	4	0	4	1	0
Protective services	1	1	1	1	1
Placement	1	1	1	2	3
Homemaker services	4	33	0	0	0
Diagnostic assessment	1	1	1	1	1

^a Units of service differ by service type. Case management is recorded in number of weeks; in-home therapy in number of sessions; counseling in number of sessions; food, cash, or clothing in number of instances; placement in number of out-of-home placements during family preservation service; homemaker services in number of visits; diagnostic assessment to number of times assessed. All families received protective supervision services from DCFS while receiving family preservation services.

Respondents varied widely in their assessment of the appropriateness and quality of services provided to these families. All five families rejected some of the services offered. For some respondents this constituted evidence that services were inappropriate. In four of the five families, respondents were split concerning the quality of services provided.

In sum, although families did not use all of the services respondents believed they needed, they used a range of services over a relatively brief period of time. Respondents disagreed as to whether the services received were of high quality.

Coordination of Services

Respondents rated the coordination of services received as moderate. To evaluate respondents' views of the degree to which workers cooperated and communicated in the provision of services to the five families studied, we randomly selected five respondents for each family who did not provide ratings for any other family. The ratings of this sample of 25 respondents were used to calculate the mean ratings of coordination (i.e., communication and cooperation) for each stage of the service delivery process. As the mean ratings in Table 3 show, respondents believed that cooperation was consistently better than communication but that both deteriorated over time.

Table 3. Mean Ratings of Communication and Cooperation by Stage of Service

Service Stage	Communication			Cooperation		
	M	SD	n	M	SD	n
Referral	5.17	(1.75)	23	5.91	(1.44)	23
Assessment	5.33	(1.58)	24	5.79	(1.32)	24
Service delivery	5.46	(1.44)	25	5.71	(1.23)	24
Termination	4.65	(2.23)	17	4.83	(2.03)	15
After-care	4.21	(2.39)	14	4.31	2.56	13

Note: The higher the score is, the greater the communication or cooperation. The number of subjects differs because subjects rated only those stages of the service-delivery process in which they were involved.

In four of the five families, the case record lacked evidence of a meeting at which all workers involved with the family were present. However, respondents' answers to the interview schedule revealed that numerous meetings were held for each family. The number of times workers for each family met is as follows: 14 (family 1), 11 (family 2), 8 (family 3), 6 (family 4), and 12 (family 5). Meetings tended to be small. Of the 51 meetings held, 38 were comprised of two to three workers, with the remainder comprised of four or five workers. Discussions tended to focus on specific issues, such as the attempt to obtain a

specific service for a family rather than on clinical issues. In four of the five families, the case record lacked a written treatment plan or after-care plan.

Facilitators and Inhibitors of Coordination

Analysis of text within each of the eight domains studied revealed how coordination was facilitated or impeded within each one.

Agencies' policies. The policies of agencies that affected coordination pertained to program philosophy, structure, function, billing procedures, and approaches to working with other agencies.

The following were viewed as facilitating coordination: administrative support for the value of services provided by other agencies; understanding of the services provided by other agencies; mechanisms for communication with other agencies; and small caseloads that allow workers the time to coordinate services.

The following were viewed as impeding coordination: policies which prohibit involvement of workers from multiple agencies in the assessment of families; program structure which limits access to workers from other agencies; policies which limit worker autonomy regarding handling of families; confidentiality policies that restrict communication with workers from other agencies; and approaches to billing that prevent reimbursement for time spent coordinating services.

Nature of the work. Characteristics of both families and workers affected coordination of services. For example, the following were viewed as facilitating coordination: children who are perceived as likeable; children who elicit an empathetic response; and parents who are perceived as "good" or highly motivated to change.

The following were viewed as impeding coordination: children or parents whose behavior is highly unstable or who resist service provision and workers who fail to do their jobs.

Disciplinary background or training of respondents. Efforts to minimize differences in professional status among respondents working with the same families were viewed as facilitating coordination. Perceived differences in service philosophy (child protection or family preservation) were viewed as inhibiting coordination.

Relationships among agencies. Formal and informal agreements among agencies affected coordination of services. With respect to formal agreements, respondents viewed written

agreements regarding services to be provided and the presence of mechanisms by which information regarding service provision could be shared as facilitating communication. Respondents noted, however, that a formal agreement between two agencies in which one regulated the work of the other impedes coordination.

With respect to informal agreements, the presence of unwritten quid pro quo agreements facilitated coordination. For example, a juvenile court filed court petitions for a mental health agency, which enabled that agency to bill Medicaid for services. In return, the juvenile court officers were given access to emergency placements that were unavailable to other referral sources.

Interpersonal relationships among workers. Relationships among workers affected coordination. Prior positive experiences were viewed as facilitating coordination. Respondents also viewed such relationships as impediments to coordination, when they foster an informal or disorganized approach to work with a family.

Generally negative views of workers from one agency, considered as a class, also impedes coordination.

Group dynamics. Group meetings for workers involved with a family facilitate coordination, when these meetings allowed individuals to express their beliefs and feelings or were based on concepts understood by all participants.

Public pressure. Public criticism of DCFS affects coordination of services. Calls by members of a community to DCFS regarding treatment of a specific child, may promote greater attention to a child's needs.

Regulations and court-orders. Federation regulations such as the regulations that mandate the confidentiality of information pertaining to treatment of substance disorders (42 CFR, part 2) inhibit coordination. Court-orders that mandate sharing of information facilitate coordination.

Discussion

This investigation examined the coordination of human services provided by multiple agencies to abused and neglected children and their families in a rural county. It did so by studying intensively the way in which coordination occurred for five families who recently received such services; by gathering data from several sources, including all workers

involved in providing services to each family; and by using both qualitative and quantitative methods to do so.

We found that families received a range of human services of uneven quality, that these services were coordinated to a moderate degree, and that coordination tended to deteriorate over time. Workers met frequently to discuss families; however, there were no meetings at which all workers involved with a family were present. When workers met, conversations focused on procuring services for families rather than on how services fit into a clinical treatment plan for addressing families' needs. Our analysis of workers' responses showed how agencies' policies, nature of the work with the families of abused and neglected children, disciplinary background of workers, relationships among agencies, interpersonal relationships among workers, group dynamics, public pressure, and regulations and court-orders worked to affect the coordination that occurred. These findings confirm those from prior investigations by showing the relevance of each domain. These findings extend prior knowledge by showing the importance of all of these domains and by doing so in a rural service system.

Future Research

Based on these findings, we propose a conceptual framework to guide future research in this area. In this framework, coordination is conceptualized as being affected by specific factors within four spheres of influence: the community context, the service-delivery system, the program context, and the characteristics of clients receiving services. At this stage of knowledge development, however, we are unable to identify the way in which these factors interact or the magnitude of their effects on coordination.

Community context. With respect to community, we propose that the size of a community, its level of knowledge or concern regarding abuse and neglect, and the resources it has available to address abuse and neglect affect the degree to which workers coordinate the services they provide.

For example, in this investigation, the community studied is small and relies on personal relationships to guide transactions of many types. Egregious cases of child abuse and neglect are known and public agencies are pressured to respond to the needs of abusive and neglectful families. Workers also are known in the villages and towns in which they work. We speculate these factors worked to facilitate the coordination of services families received.

Service-delivery system. With respect to the service-delivery system, we propose the following factors affect coordination: the number of agencies and workers involved with a family; the level of consensus regarding workers' roles, particularly with respect to who has the power to define, in the case of conflict, the work around which coordination is to occur; the formality of mechanisms to promote coordination; the extent of monitoring of coordination; and the compatibility of agencies' treatment philosophies and conceptualizations of clients' problems.

For example, in this investigation, a minimum of seven workers were involved with each family, yet the service-delivery system lacked formal agreements regarding how they were to coordinate the services they provided. (Agreements that did exist were bilateral.) As a result, there were no mechanisms to handle conflicts regarding philosophy of services (such as how to define the primary client) or conflicts regarding family needs (such as how to define clinical goals). We speculate these factors worked together in this community and service-delivery system to promote behavior designed to maintain workers' relationships with one other, such as the suppression of divergent views regarding treatment of individual families. At times, personal relationships aided coordination and at others, they impeded coordination. At their best, however, personal relationships among workers were unable to ensure coordination throughout families' involvement in the intensive family preservation program studied.

Program context. With respect to the programmatic context, we propose that the degree of program stability and the level of program implementation affect service coordination.

For example, in this investigation, the stability of the program promoted relationships among workers, especially between the family preservation therapists and DCFS workers. These relationships facilitated coordination. By way of contrast, the program's failure to promote development of clinical treatment and after-care plans, conduct of meetings at which all workers involved with each family were present, and discussion of critical issues relevant to the provision of short-term services to families with chronic and complex problems inhibited coordination.

Client context. With respect to clients, we propose workers' perceptions of clients' attractiveness and motivation to change affect coordination of services.

For example, in this investigation, workers expended extra effort for children they considered attractive, thereby facilitating coordination of the services such children received. By way of contrast, workers' efforts on behalf of clients whose problems seemed

intractable waned over time thereby limiting coordination of the services such clients received.

Conclusion

This study documents that coordination of human services is a complex task. It also serves as a cautionary note to any who might presume that coordination will occur simply because it is mandated.

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Footnotes

1. To confirm that families receiving services required the coordination of services from multiple agencies, the director of the family preservation program and one of her experienced workers reviewed the record of each family and then independently rated, on a seven-point Likert-type scale, the extent to which interagency coordination would have been necessary to successful treatment of the family. A rating of 1 meant that "little or no coordination" was needed, while a rating of 7 meant that a "great deal of coordination" was needed. The ratings were compared and differences were resolved through discussion between the two raters. No family received a rating of less than 5. The eight families with ratings of 6 or 7 were contacted to obtain their permission for

inclusion of their family in the study. Three of these had moved and the remaining five agreed to participate in the study.

2. In this study, each paragraph of text was placed independently into one or more categories by two investigators. This process was considered a reliable one if investigators agreed in the way in which they classified text 80% of the time (Miles & Huberman, 1994).

Reliability was defined as the extent to which investigators independently placed text in the same categories. For the text examined, this occurred 85.9% of the time.

3. Differences in mean ratings were not tested with statistical tests due to the non-random sample employed in this study and inadequate power.

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The Effectiveness of Court Mandated Intervention Versus Voluntary Services in Child Protective Services: Abbreviated Version

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The general objective of this research was to compare the relative effectiveness of court mandated services versus a voluntary service plan in preventing in child maltreatment recidivism. Four-thirty-two children were selected at random from among children in a large California County who were receiving in-home services under a court mandate or a voluntary plan. Protective services files of study children were reviewed to derive study data.

Type of plan did not make a difference on case outcome. Children were more likely to remain in the home at the end of the service delivery period in families that received voluntary plans. However, when other factors are controlled, the advantage of a voluntary plan disappears. Moreover, similar rates of recidivism were noted between both types of plans after the case was closed.

Introduction and Literature Review

A child protective service worker must decide after investigating and substantiating a child abuse complaint whether to request the court to mandate services with the caretaker, or to develop a voluntary plan. Court-ordered services are assumed to provide an element of social control that protects the child, and provide a stimulus that enhances the likelihood that families will utilize needed services. Proponents of voluntary plans assert that court intervention introduces an adversarial element into the worker client relationship that works against the therapeutic change process (Wilk & McCarthy, 1986). However, one study, which examined the differences between court intervention and voluntary treatment, found that court involvement did not necessarily make a person less amenable to treatment (Irueta-Montes and Montes, 1988). Court intervention may limit the number of families who might seek voluntarily services because they see the court as punitive, and they fear legal consequences. DePanfilis (1982) claims that despite mandatory reporting laws, private agencies are equally concerned about referring their voluntary cases to a sometimes impersonal system of reporting and investigation. A voluntary option is assumed to increase the number of families receiving services, perhaps at earlier stages of risk, and thus prevent the need for more expensive "after the fact" services.

On the other hand, voluntary plans may place children at more risk due to lowered ability by the worker to see that a caretaker utilizes services. Voluntary plans may be more costly because if they do not work, CPS workers must still file for court intervention. Surprisingly, there is a paucity of empirical data utilizing child protective samples to help identify which choice would be the best for social workers to take. DePanfilis (1982) using data from a small quasi-experimental study utilizing a protective service sample, found that voluntary cases had lower placements rates, shorter stays in placement, and briefer periods of treatment.

Some support these programs as a cost savings alternative to out-of-home care. Others remain skeptical on how effectively in-home services prevent child maltreatment (Schuerman, 1991). However, research is available from other fields of service which has examined whether voluntary or court-ordered treatment is effective. The following are studies from domestic violence, substance abuse, and mental health fields. All of these are settings that CPS clients are likely to be found, so they do have some relevance.

Rosenfeld (1992) reviewed twenty-five studies that collectively cast doubt on the assumption that mandatory psychotherapeutic treatments are effective in reducing incidents of violence between spouses. In many of the studies he reviewed, the choice was between court-ordered intervention and arrest. He asserts the differences in the reoccurrence of intimate partner violence between subjects receiving court-ordered treatment, those arrested, and persons who do not receive any treatment are small. Also, he reports that many subjects withdraw from court-ordered treatment, indicating that legal system involvement does not motivate unwilling clients. On the other hand, Dutton (1986) used a quasi-experimental design to examine post-conviction rates of fifty men who completed a court-ordered treatment plan against those who received nothing at all. He found that the treatment group had a thirty-two percent lower recidivism rate during a three-year follow-up period. Dutton concludes that court orders improve the protection for women who opt to remain in a relationship with a husband who would not seek treatment voluntarily.

A review of the current status of drug control programs asserts that coerced treatment can work equally as well as voluntary treatment (Inciardi, McBride, & Rivers, 1996). Many addicts would not seek treatment without court intervention. They also point out that not all those mandated to attend treatment actually show up or remain engaged. They suggest the severity of the sanction and the likelihood of it being imposed, are critical in determining whether people remain in treatment. They do concede that effective treatment alternatives to incarceration are cost-effective.

Wells-Parker (1994) used meta-analysis to review the literature on drinking and driving programs and asserts that rehabilitation is more effective than coercive interventions like license revocation. She argues for a combination of strategies, such as sanctions, combined with therapy, education, and monitoring. Schottenfeld (1989) in a review of the literature finds involuntary treatment for substance abuse is an impediment to treatment. Those who are being involuntarily treated tend to deny problems related to substance abuse. Voluntary clients are more likely to admit the problems of addiction and withdrawal. However, he does note that it is possible to voluntarily admit a problem and accept services even with a court order.

Cournos, Mckinnon, and Stanley (1991) compared the records of fifty-one involuntarily medicated and 51 voluntarily medicated patients in a psychiatric hospital. They found that forced medication did not speed the return a patient to the community or get the patient to eventually comply with taking of medication. No differences were found between groups in discharge rates, compliance with staff, or relapse. However, initial improvements in the patient's mental health was noted. Most of the studies findings are mixed and are not done with protective service samples, which limits their use by protective service workers.

Methodology

The general objective of this research was to compare the relative effectiveness of court-mandated services versus a voluntary service plan in child maltreatment cases in preventing recidivism. The study was a retrospective descriptive case record analysis. The specific aim of the analysis was to identify characteristics associated with success and failure under each type of plan. The population consisted of all 1898 children for whom a petition was filed or who were given a voluntary plan for child maltreatment reasons between January 1st and June 30, 1995 in San Diego County, and who initially received services in their home. The Department of Social Services (DSS) Management Information System (MIS) was used to identify the potential sample. DSS is the public agency charged with child protection in San Diego County. Four-hundred-thirty-two children were selected at random with the additional rule that only one child per family could be included in the sample.

Two study groups are available for comparisons on outcomes. The first group is made up of children whose caretaker received a voluntary service plan, and the second group received a court mandated service plan. Study groups were compared on case outcomes. Voluntary cases referred to by DSS as Family Maintenance (FM) receive services for up to six months with an option to receive services for another six months. Children were followed for an additional six months after DSS closed the case to determine if there was a referral or reentry.

Case outcomes are described in Table 1.

Table 1. Outcomes During Service Delivery

Dependent Variable	Court Mandated	Voluntary
Successful	Child still with caretaker or relative	Child still with caretaker
Unsuccessful	Child in out-of-home care	Child in out-of-home care
Outcomes 6 Months after Case Closure		
Dependent Variable	Court Mandated	Voluntary
Successful	No referral or reentry	No referral or reentry
Partially Successful	Rereferral to CPS but no reentry	Rereferral to CPS but no reentry
Unsuccessful	Reentry into CPS	Reentry into CPS

Sources of Data

Study data were derived from case record review and from computerized data files at DSS. The archival data came from official documents from the Dependency Court or were prepared for the Court by DSS social workers. Data in these files describe child, caretaker, and family characteristics, the alleged abuse and history of prior CPS involvement, and case outcomes. Files contain social studies, court reports, police reports, psychological evaluations, risk assessments, medical records, social work logs, service referrals, etc..

Collection of data was carried out by social work graduate-level research assistants. Abstractors were trained until they had basic knowledge of child protective services, the Dependency Court Systems, the organization of case record files, and skill in the consistent application of variable definitions. Abstractors demonstrated an inter-rater reliability of .90 on a common case. A second reliability check was done on a second common case at the midpoint of data collection. Reliability was over .90 for all abstractors at that check. A manual was developed to guide and standardize abstraction efforts.

Findings

Attributes of the Study Children

Table 2 describes the study children. Depending on the level of data, chi-square, t-tests, and one-way analysis of variance are used to describe group differences.

Table 2. Selected Characteristics of Study Group Children

Variable	Total		Court Mandated (N=213)		Voluntary (N=231)		Signif.
	N	%	N	%	N	%	
Child's Gender							
Male	220		109	51.2	111	50.7	
Female	212		104	48.8	108	49.3	
Child's Ethnicity							
White	179		80	37.6	99	45.2	
Hispanic	128		79	37.1	49	22.3	
African-American	96		43	20.2	53	24.2	.919
Other	28		11	5.2	17	7.8	
Characteristics							
School Problems	68	15.8	41	18.7	27	12.7	.088
Severe behavior problems	62	14.4	41	18.7	21	9.9	.009
Mental illness	55	12.8	41	18.7	14	6.6	.0001
Learning disabled	49	12.0	28	12.8	15	7.0	.046
Medical Problems	48	11.1	30	13.7	18	8.5	.083
Developmental delay	41	9.5	29	13.2	12	5.6	.007
Runaway	25	5.8	18	8.2	7	3.3	.028

Variable	Total		Court Mandated (N=213)		Voluntary (N=231)		Signif.
	N	%	N	%	N	%	
Juvenile delinquency	22	5.1	17	7.8	5	2.4	.011
Living Arrangements of Child							
Both biological parents	120	27.8	55	25.3	65	30.8	.209
Mother	360	83.3	190	89.2	170	78.0	.002
Father	157	36.3	77	36.5	80	36.9	.936
CPS History							
Previous referrals	293	68.9	161	70.8	132	63.7	.001
Previous placements	153	35.6	96	44.2	36	16.9	.0001

No significant differences were noted on age between study groups. The mean age of a child in the Court Mandated group was 2.73 (sd=1.2), and the mean age of a child in the Voluntary group was 2.62 (sd=1.10). The difference was not significant. Slightly more males were found in the sample than females, but this difference was not significant either. White children were more likely to have been given court-mandated plans, but only at a level approaching significance ($p<.098$). Hispanics were more likely to have received voluntary plans ($p<.001$).

The problem characteristics reported are assumed to represent risk factors that social workers might use to determine what type of plan is given, and might present variables that would determine whether a given plan succeeds or fails if not addressed by services plan. Children in families that received court-mandated plans had significantly more (or at levels approaching significance) characteristics than voluntary plan children. School problems were the most common characteristic. Court-ordered plan children were more likely to have severe behavior problems, mental health difficulties, learning difficulties, and developmental delays than voluntary children.

Approximately 36% of the children live with their biological father. More children in the court-mandated group live with their biological mothers. Siblings and non-related adults are more likely to be present in the households of children receiving voluntary plans. From the data, it is difficult to identify who the non-related adult is, but this person may be a

paramour of the care-taking parent. This person was not coded as such because information on the relationship was not available in the file. A child in the Voluntary group had a mean 2.06 (sd=1.40) siblings and a mean of 1.79 siblings (sd= 1.38) lived in the child's home. Court-mandated group children had on average 2.16 (sd=1.5) siblings, but only 1.48 (sd=1.44) of those siblings lived in the home. A possible explanation for this difference is that the siblings not in the home are in placement.

A large proportion of the children in the study were actually reentering the CPS system. Children in families who received court-ordered plans had a more extensive history of contact with protective services than did children in the voluntary group. They were far more likely to be in a family that had a previous referral ($X=3.57$, $sd=3.26$ vs. $X=2.41$, $sd=2.80$), or the child had been in out-of-home placement than the voluntary group. Some of the referrals could have been unfounded. The placement rates are a better determinant of previous child maltreatment since they indicate that a complaint was substantiated. The out-of-home placement was most frequently the County Receiving Home for Children. A CPS history may be considered by the social worker as a higher risk family, therefore needing court intervention.

Attributes of the Biological Mother

Table 3. Selected Characteristics of the Biological Mother for Court Mandated vs. Voluntary DSS Cases

Variable	Total		Court Mandated		Voluntary		Significance
	N	%	N	%	N	%	
Marital Status							
Married	139	32.6	59	27.2	80	37.7	
Separated	39	9.1	18	8.3	21	9.9	
Divorced	70	16.4	49	22.6	21	30.0	
Widow	10	2.3	5	2.3	5	2.4	
Single/never married	104	24.4	53	24.4	51	24.1	
Married to natural father	124	29.0	51	23.3	73	34.3	.019

Variable	Total		Court Mandated		Voluntary		Significance
	N	%	N	%	N	%	
Special Characteristics							
Perpetrator of abuse	288	66.2	162	74.3	126	59.2	.001
Drug abuse	227	52.7	134	63.8	88	41.3	.0001
Domestic violence	185	42.9	90	41.5	95	44.6	.513
Alcohol abuse	172	39.9	110	50.5	62	29.1	.0001
Criminal history	120	27.8	78	35.8	42	19.7	.0001
Abuse history as child	105	24.4	60	27.5	45	21.1	.122
Mental illness	71	16.5	50	23.0	21	9.9	.0001
Medical problems	61	14.2	34	15.6	27	12.7	.395
Incarceration	60	13.9	42	19.3	18	8.5	.001
Non-English speaking	48	11.1	17	7.8	31	14.1	.025
Income Sources							
AFDC/GR	213	51.6	102	46.6	111	52.1	.104
SSI/SSA/UI	30	5.8	19	8.7	11	5.0	.073
Employed	114	26.4	58	26.5	56	26.3	.987

* Single, marital history unknown; ** differences from 100% due to rounding error and for some variables such as marital status and income sources, much data was missing; *** N's may fluctuate due to missing data.

No significant differences were noted between groups on age or ethnicity. The average age of the mothers was 31.32 (sd=7.01). Mothers in the voluntary group were more likely to have been married at some point, married to the child's father, or divorced, than mothers in the Court Mandated group. Marriage may be viewed by workers as a protective factor that reduces risks in families.

Mothers who received a court-mandated plan had significantly more problem characteristics than mothers who received voluntary plans. Court mandated mothers had a mean of 2.29

(sd=.157) problem characteristics, while mandatory plan mothers had a mean of 2.91 problems (sd=.136, $p<.025$). The mothers in the court-ordered group were significantly more likely to be a perpetrator of the abuse, have substance abuse problems, have a charged criminal history including incarceration, and were less likely to be English speaking. The large numbers of problems noted in the court-ordered group may have been the reason they were seen as needing more intrusive and coercive interventions. High rates of domestic violence were noted in the study families, but is equally distributed between groups.

The voluntary group is slightly more likely, but only at a level approaching significance, to rely on public assistance. Slightly more families in the court mandated plan group received some sort of public aid.

Less data were available on fathers than mothers. About twenty-five percent of the children did not have any data recorded on their fathers. Because of missing data, the impact of fathers is not reported upon in this paper.

Home Environment

Table 4 describes characteristics of the child's household and neighborhood, as well as their source of social support.

Table 4. Characteristics of the Family Environment

Characteristic	Total		Court Mandated (N=219)		Voluntary (N=213)		Signifi.
	N	%	N	%	N	%	
Environmental Problems							
Unsafe housing	106	24.5	64	29.6	42	19.7	.017
Inadequate housing	71	16.4	42	19.4	29	13.6	.109
Social Support*							
Church membership	82	19.0	48	22.1	34	16.0	.109
Extended family	294	68.1	159	73.8	135	64.0	.038
Church support	115	26.6	48	22.3	67	11.4	.031

* Percentage indicating received support from any of the following.

More children in the Court mandated group than the voluntary group lived in unsafe or inadequate housing. This difference is only approaching significance. "Inadequate Housing" referred to conditions in the house such as overcrowding, shelter residence, exposed electrical sockets, and non-working appliances. "Unsafe housing" referred to the behavior of the residents in the house which placed the child at risk. Examples of this behavior included drug dealing, weapons in the house, or gang membership. Unsafe and inadequate housing was found in greater frequency in the court-mandated group, which may be another indicator of risk. This risk resulted in the social worker pursuing legal intervention.

"Social support" refers to the provision of concrete help (child care, loan, food, etc.), and the provision of emotional support (advice, counseling, consoling, visitation). The court-mandated group was slightly more likely to belong to a church ($p < .109$), but was less likely than the voluntary group to access support from a church ($p < .031$). The court-mandated group was more likely than the voluntary group to obtain support from the extended family.

Protective Service Case Attributes

Table 5 describes the type and perpetrator of the abuse.

Table 5. Type of Abuse and Perpetrator

Abuse Type and Perpetrator	Total (432)		Court Mandated (N=219)		Voluntary (N=213)		Signif.
	N	%	N	%	N	%	
Physical Abuse	153	35.4	81	37.3	72	34.0	.467
Mother	83	19.2	47	21.5	36	16.9	.229
Father	55	12.7	33	15.1	22	10.3	.140
Other*	37	8.6	15	6.8	22	10.3	.196
General Neglect	126	29.2	61	28.1	65	30.8	.467
Mother	117	27.1	57	25.6	60	28.2	.484
Father	33	7.6	23	10.5	10	4.7	.023
Other**	8	1.9	3	1.4	5	2.3	.451
Caretaker Incapacity	75	17.4	43	19.8	32	15.2	.206
Mother	49	11.3	39	17.4	30	14.1	.436

Abuse Type and Perpetrator	Total (432)		Court Mandated (N=219)		Voluntary (N=213)		Signif.
	N	%	N	%	N	%	
Father	15	3.5	11	5.0	4	1.9	.074
Other**	3	0.1	1	0.5	2	0.9	.546
Severe Neglect	72	16.7	40	18.4	32	15.2	.366
Mother	68	15.8	38	17.4	30	14.1	.351
Father	9	2.1	6	2.7	3	1.4	.333
Other**	2	—	2	0.9	0	0.0	.162
Sexual Abuse	57	13.2	30	13.8	27	12.7	.740
Mother	1	—	1	0.5	0	0.0	.323
Father	21	4.9	13	5.9	8	3.8	.292
Other**	34	7.9	16	7.3	19	8.9	.539
Failure to Protect	56	13.0	36	16.6	20	9.4	.028
Mother	47	11.0	30	13.7	17	8.0	.056
Father	14	3.2	8	3.7	6	2.8	.624
Other**	4	0.9	2	0.9	2	.1	.978

Overall*** Perpetrator of Abuse

Mother	323	74.8	171	78.1	152	71.4	.108
Father	133	30.1	78	35.6	55	25.8	.027
Other	88	20.4	40	18.3	48	22.5	.271

* Can have more than one type of abuse or perpetrator; ** Other categories include stepparents, parent's boyfriend/girlfriend, other relative, other non-related person; *** Represents a collapsed variable from other categories; **** Note difference of perpetrator in this table from special characteristics is that this perpetrator refers specifically to current episode. In special characteristic could have been a perpetrator at other time.

Failure-to-protect was the only protective issue that distinguished among groups. Failure-to-protect is a protective issue that occurs in conjunction with other forms of abuse. Mothers who were perpetrators of this form of abuse were also more likely to be found in the court-mandated plan group. Failure-to-protect is present when one caretaker is not the perpetrator of the abuse, but either acquiesces, or does not have the ability to shield the child from

further abuse or neglect. This factor would suggest added risk to the safety of the child which would require careful consideration in pursuing the protection of court oversight. Generally, court-mandated plans were used when the father was the perpetrator. This choice was especially true in cases of general neglect and caretaker incapacity. No significant differences were noted between groups on who reported the abuse incident.

Services and Conditions

The next series of tables reports on services and conditions provided during the six month to a year period of service delivery. Court reports, service plans, and case summaries provided a list of services given to the child, caretaker, and family. These items were reviewed by abstractors to provide data for the tables reported below. Social workers also provided comment on utilization of services, which answered the compliance question. For example, if a parent completed a set of parenting classes, they were coded as completed, even if there were indications at some point that the parent was not attending classes. If she/he started classes, but never finished, they were coded as not utilizing the service.

Court-mandated cases were opened an average of 480.57 days ($sd=527.52$), and voluntary cases were opened about 187.37 days ($sd=106.53$) ($p<.0001$). As expected, court-mandated cases were opened for longer periods of time than voluntary cases. The longer period of service is consistent with the higher level of problems found with this group. The large standard deviation with court-mandated cases suggests a wide variation among those cases in the amount of time they were open. Voluntary cases were expected to be opened six months. Table 6 provides a report of the mean number of services provided by case type. Also, given in the table is the percentage of clients given at least one service of the specific type.

Table 6. Service Type and Utilization

Service Type	Total (432)		Court Mandated (N=219)		Voluntary (N=213)		Signif.
	Mean (%)	SD	Mean (%)*	SD	Mean (%)	SD	
concrete services provided	1.25 55.8%	1.54	1.36 59.8%	1.51	1.10 51.2%	1.43	.08 .296
concrete services utilized	1.17 53.7%	1.47	1.30 58%	1.50	1.03 49.3%	1.42	.048 .306

Service Type	Total (432)		Court Mandated (N=219)		Voluntary (N=213)		Signif.
	Mean (%)	SD	Mean (%)*	SD	Mean (%)	SD	
clinical services provided	1.75 79.1%	1.36	1.99 84.5%	1.40	1.48 75.4%	1.18	.126 .001
clinical services utilized	1.46 69.4%	1.36	1.82 79.5%	1.45	1.10 60.1%	1.14	.001 .0001
substance abuse services provided	.805 49.8%	.95	1.18 59.9%	1.15	.716 39.8%	.973	.0001 .0001
substance abuse services utilized	.95 37.0%	1.03	.959 49.4%	1.14	.441 25.4%	.837	.0001 .0001
residential services provided	.147 12.0%	.420	.215 17.4%	.502	— 6.6%	—	— .002
residential services utilized	.127 8.9%	.387	.192 15.6%	.479	— 4.7%	—	.001 .001
family services provided	1.17 76.95	1.01	1.21 80.4%	.986	1.13 71.6%	1.04	.401 .033
family services utilized	.979 63.7%	1.00	1.08 73.1%	.957	.878 71.6%	1.04	.021 .001

* percentage receiving at least one service.

1. Concrete services include travel-related, recreation, employment/training for adult, income support/public assistance, child care, medical dental, emergency shelter, housing, clothing, furniture, car repair, legal services, and food.
2. Clinical services include family therapy/counseling, psychiatric evaluation, individual counseling/therapy, domestic violence services, parent/teen/child support/counseling group.
3. Residential services include day treatment and residential services.
4. Family services include parent training, financial and budgeting, homemaker, parent/child conflict management, educational services for child, family planning, independent living, and parent anonymous.

Court-mandated cases were more heavily serviced than voluntary cases. Court cases received on average 6.46 ($sd=3.82$) services, while the voluntary group received a mean 4.91 ($sd=3.51$, $p<.0001$) services. Except for concrete services, the court-mandated group

either received more services in each category, or the percentage of subjects in that group receiving the service category was larger. It would be expected that the court-mandated group would receive more services based on the amount of time opened, but the percentage receiving at least one service of a specific type adjusts (at least partially) for that difference. The provision of more services to persons with court-mandated plans is a reflection of the need to serve the greater risk identified earlier.

The impact of the court-mandated supervision can be seen in the utilization of services. Consider the number of subjects receiving clinical services. Approximately 85% of the court-mandated group and 75% of the voluntary group received those services. Almost 60% of the court-mandated and about 40% of the voluntary group utilized those services. A service was considered utilized if the client completed the service. Similarly, 77% of the court-mandated group finished substance abuse treatment and only 59% of the voluntary group who received substance abuse treatment completed that service. Similar patterns were noted on most of the service category. These data suggest that court mandates provide the stimulus to complete services. Table 7 describes the number and type of contacts clients had with DSS and their social workers.

Table 7. Social Worker Contacts with Family

Contact Type	Total (427)		Court Mandated (N=215)		Voluntary (N=212)		Signif.
	Mean	SD	Mean	SD	Mean	SD	
Office Visits	1.36	2.65	1.56	3.15	1.16	2.01	.126
Home Visits	7.50	6.40	6.73	6.41	8.29	6.31	.012
Phone Visits	28.49	38.63	36.25	48.38	20.64	21.72	.0001
Field Visits	2.58	4.04	2.65	4.47	2.51	2.51	.736
Total Contacts	82.92	91.51	97.58	114.24	68.04	56.81	.001
Visit with Whom?							
Parent	17.15	17.87	19.00	21.98	15.29	12.14	.031
Family	3.20	6.00	3.88	7.35	2.51	7.35	0.18
Child	6.61	5.48	6.45	5.68	6.79	5.28	.515

Contact Type	Total (427)		Court Mandated (N=215)		Voluntary (N=212)		Signif.
	Mean	SD	Mean	SD	Mean	SD	
Service Provider	17.99	26.61	22.23	32.63	13.68	17.66	.001
Sibling	6.94	8.77	6.26	9.75	7.62	7.60	.109
Friend/neighbor	1.03	2.90	.94	3.35	1.11	2.37	.537

Contact information was gathered from case narratives and includes all recorded contacts between case opening and case closing. Home visits refers to social worker's contacts in the child's home. Field visits refers to social workers contact with schools, agency treatment programs, etc. Overall, the court-mandated group had more contacts. Surprisingly, voluntary cases received more home visits. It is possible that the demands of court cases make it more difficult for the worker to find the time to make home visits. Court-ordered cases received more contact of every type except home contact, particularly phone contacts, than the voluntary group. The researchers expected that court-mandated cases would have received significantly more contacts because of their higher risk and because they were opened for a longer period of time than voluntary cases.

No differences were found between study groups in meeting conditions in the case plans. About 83% of both groups completed conditions stated in the service plan. Voluntary cases were more likely to be required to keep contact with a social worker (61.2 % versus 45.2% $p<.001$). Court-mandated cases were more likely, but only at a level approaching significance, to have treatment ordered (64.8% versus 56.8%, $p<.071$) to have no contact with drugs or alcohol (55.8% versus 46.5%, $p<.068$). Both groups had similar records of compliance with conditions.

Outcomes

Types of plans were used to describe different categories of outcomes at case closure. The interest was if the case penetrated the system any further, such as entering out-of-home care. Public policy would regard cases that entered foster care as a failure. Figures 1 and 2 on page 6 describes study outcomes.

Cases were also examined six months after case closure. The purpose of this analysis was to determine if there was a re-referral for abuse and/or system reentry as an additional measure of determining success or failure. Analysis was a three-step process. First, cases

were examined to determine if the child was still in the home at the end of the case closure period. Second, among the remaining cases where the study child still remained in the home, the case was followed for six months to determine if there was an additional referral. Finally, those cases with a referral were subject to further observation to determine if the case reentered the system.

Table 8. Outcome Variables

	Total (429)		Court Mandated (N=216)		Voluntary (N=213)		Signif.
Outcome	N	%	N	%	N	%	
Case Outcomes at the End of the Service Delivery Period							
In own home	356	82.9	168	77.8	188	88.3	
Placed with relatives	46	10.8	28	13.0	18	8.5	
In placement	27	6.3	20	9.3	7	3.3	.008
Referrals during the Follow-up Period							
At least one referral	161	45.2	72	42.9	89	47.3	
No referrals	195	54.8	96	57.1	99	52.7	.229
Reentry during the Follow-up Period							
Reentered system	128	79.5	56	77.8	72	80.9	
No entry	33	20.5	16	22.2	17	19.1	.384

Voluntary cases were more likely to be in their home at case closing than the court-mandated cases. Court-mandated cases were more likely to be out-of-home. Placement included foster care, group homes, the County's receiving home for children, and adoption. Three runways were categorized as in placement since they were not in their own home. Consistent with public policy most children went to the home of relatives if they were removed from their parents' home.

Table 9 uses Logistic regression to assess the relative importance of the variables that predicted child removal. Not all variables could be entered because many were highly correlated with one another. For example, most of the contact variables were highly

correlated. Therefore, only total contacts were chosen for entry into the model since it was the strongest predictor of outcome at the end of the service delivery period. Home contacts positively correlated with the child remaining in the home ($r=.200$, $p<.01$). All other types of contacts were inversely related with the child remaining in the home. Also, most of the problem characteristics were highly correlated so only the summary variable, total characteristics was chosen. Mother's drug ($r=-.134$, $p<.01$) and alcohol abuse ($r=-.104$, $p<.05$) history of incarceration ($r=-.129$, $p<.01$) and total number of characteristics ($r=-.131$, $p<.01$), are associated with removal at case closure. Only total number of the mother's characteristics was entered.

**Table 9. Predicting Child Removal at the End of the Service Delivery Period
Logistic Regression**

Variable	B	S.E.	Wald	Significance	Exp B
Type of Case	-.2142	.3329	.4141	.5199	.8072
Total Characteristics: Child	-.0938	.0707	1.7588	.1849	.9105
Total Characteristics: Mother	-.1669	.0728	5.2550	.0219	-.0920
Living with Mother (1,0)	1.8150	.3642	11.8447	.0006	3.2919
Public assistance Received (1,0)	.9332	.3318	7.9107	.0049	2.5427
Church Support (1,0)	.4457	.3742	1.4183	.2337	1.5616
Family Services Used (1,0)	.5855	.1950	9.0133	.0027	1.7959
Condition: Keep contact with social workers	.4019	.3234	1.5436	.2141	1.4946
Total Contacts by Social Worker	-.0075	.0531	5.9925	0.144	-.1029
Homelessness (1,0)	-1.5517	.4661	11.0847	.0009	.2119
Constant	.9183	.4335	4.4871	.0342	

1=in own home; 0=removed from home.

1=yes; 0=no.

Whether one received a voluntary plan or court plan is no longer important when other significant variables are entered for control. The total number of problem characteristics the

study child's mother has, the receipt of public assistance, an experience with homelessness, the number of family services used, the number of social work contacts with the family, and if the child lives with the mother still predicts whether the child remains in the home.

The number of problem characteristics a child has was no longer predictive of case outcome. What is important in determining outcome is the number of problem characteristics a mother has. Possibly the issue for social workers is whether the mother can deal with the child's problems, and not whether the child has problems. The condition of remaining in contact with the social worker and receiving support from a church is no longer predictive of outcome.

Because of the shrinking sample size, no further logistic regressions were completed. High rates of rereferrals were noted for both groups. No differences were found between groups on whether a referral for child maltreatment was received during the follow-up period. Receiving a court mandate for services does not protect against future referrals. The mother's drug abuse history is predictive of all three outcomes (removal, $r = -.134$, $p < .01$; re-referral, $r = .107$, $p < .05$, re-entry, $r = .102$, $p < .05$). The mother's alcohol abuse is associated with rereferral ($r = .107$, $p < .05$) but not system reentry. Married parents ($r = -.114$, $p < .05$), and particularly those living together ($r = -.121$, $p < .05$), were less likely to receive referrals or system reentry. The more siblings the study child has, the more likely there will be a referral. More siblings may increase the chance that a reporter will observe child maltreatment in a family ($r = .099$, $p < .05$). Children living with their biological mother were not as likely to be removed as children living in other circumstances ($r = .287$, $p < .05$). Living with a biological mother did not predict any of the other outcomes.

The number of referrals for maltreatment previous to the service period predicts both whether there was a new referral ($r = .236$, $p < .01$) and reentry ($r = .162$, $p < .01$). Receiving and using substance abuse services was associated with a rereferral ($r = .174$, $p < .01$) but not reentry. A condition of no drugs or alcohol in the case plan was also associated with rereferrals ($r = .121$, $p < .05$) and reentry ($r = .131$, $p < .05$). These characteristics suggest the difficulties that clients have in successfully completing drug treatment. Almost 80% of the cases with a new referral entered the service system. The receipt of public assistance (AFDC, SS, SSI, GR, or Unemployment Compensation) was predictive of whether there was a new referral ($r = .224$, $p < .01$) or reentry ($r = .205$, $p < .01$). Again, whether someone reentered the protective service system did not differ according to the type of plan given. The number of phone contacts ($r = .179$, $p < .01$) and contacts with family ($r = .092$, $p < .05$) predicted removal and a re-referral during the follow-up period. Perhaps social workers had spent more time with relatives of caretakers who were having difficulties since it might become necessary to remove those children.

Surprisingly, the type of abuse, or who the perpetrator was, did not predict removal of the child at the conclusion of service delivery. If the father was the perpetrator, it was more likely that there would be new referrals ($r = -.119$, $p < .05$) and a system reentry ($r = -.156$, $p < .01$). When the mother was a perpetrator, a referral was more likely ($r = .214$, $p < .01$) but did not predict system entry. Ethnicity or race (Hispanic or White) did not predict any outcome.

Summary and Discussion

The type of plan did not make a difference on case outcome. Children were more likely to remain in the home at the end of the service delivery period when they received a voluntary plan. However, when other factors are controlled, the advantage of a voluntary plan disappears. Moreover, similar rates of recidivism were noted in the follow-up period between study groups. High rates of new referrals and system reentry were found for both study groups.

Workers assigned cases according to the level of risk. Families having a high number of risk factors received court-ordered plans. Factors associated with stability (family structure, marital status, source of income, preschool) were associated with receiving a voluntary plan.

Clients who received court-ordered plans were more likely to utilize the services provided. This finding reaffirms one of the underlying rationales of court intervention; that it spurs individuals to use and complete services. On the other hand, differences were not found on whether conditions specified in the case plan were completed. The amount of service contact, except for home contacts, was predictive of outcome in an inverse manner, but the length a case was open was not associated with any outcome. Social workers also may be providing more contact with difficult cases.

Mothers' characteristics were strongly associated with case outcomes. Fathers' characteristics were not. Study children were more likely to live with the mother than father. Children who lived with their biological mother fared better than children who did not. Social workers may be reluctant to remove a child from a biological mother because of attachment concerns. Fathers are also important in predicting success when they are married to the biological mother of the child. Marriage may be taken by social workers as an indicator of stability. Drug and alcohol abuse on the part of the mother was an important problem characteristic associated with case failure. Over one-half of the caretakers had a drug problem at some point. Recycling these families in and out of the system will not end until effective means of addressing drug problems is available for this population. Receiving public assistance (AFDC, General Relief, SSI, Social Security, or Unemployment

Insurance) was associated with successful outcomes. These forms of public aid may have at least guaranteed a minimum level of resources for the families. Most of the study children lived in families that experienced high levels of deprivation. These findings have implications for welfare reform. The loss of benefits could result in more referrals and children in care.

Implications for Practice

Since differences on recidivism between study groups were not found, a greater use of voluntary plans is warranted. The use of voluntary plans is a prudent course of action that would free up resources to pursue more effective means of intervention. Social workers could use the time they now give to court preparation and appearances in making home visits. Home visits were associated with a child remaining in the parents home at the end of service delivery.

Families that receive public assistance are more likely to avoid recidivism than families without that aid. Provision of basic needs seems essential to keeping children with their families. The most important type of services in preventing recidivism were those that helped the parent(s) carry out a parental or family function, for example, parent training or homemaker services. Substance abuse or clinical services did not prevent recidivism. It may be that families that respond to family services are families whose major problem is a lack of competence which is addressed by family services. Substance abuse services go to families with more intractable problems. It also the type of problem where relapse is expected.

One factor that was used in case assignment that can be discarded is the number of problem characteristics a child has. The findings of this research suggest it is the mother's functioning and ability to deal with the child's difficulty that is the more relevant issue.

The number of previous CPS referrals was also predictive of re-involvement with CPS. An alternative would be to restrict court cases to a narrow range such as those where substance abuse is present and previous referrals to CPS have been made. These characteristics seemed to be the greatest empirical indicators of risk.

Implications for Research

This research utilized a retrospective case review. One factor conspicuously absent from the research was a measure of the internal motivation of CPS clients and their reaction to service delivery. It is very likely that subjects in the court-mandated group who already had

more referrals represented a different motivational group than the group remanded to voluntary assistance. Both of these factors are important in determining utilization of services and outcomes. One way to increase the validity of the comparison is to complete a prospective study. This sort of design would collect data directly from directly from clients at pre and post services. Similarly, the outcomes used in this research were limited. Self-report or observational measures of family and caretaker change might reveal some benefit to a particular plan not measured in the outcomes used in this research.

There may be other factors which contribute to success in in-home services. The researchers focused only on those variables that distinguished the two study groups. Future analysis of this data will examine other factors. Research also needs to continue to examine risk assessment. A good portion of the study children would return to CPS once their case was closed. This recycling is troubling since it suggests in the current service patterns are not effective for a substantial number of families.

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Review of Current Resources

The Managed Care Answer Book for Mental Health Professionals. Gayle McCracken Tuttle and Dianne Rush Woods. (1997) Bristol, PA: Brunner/Mazel, Inc.

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This book, written for mental health professionals, is designed to address key issues related to practice in a managed care environment. For those private providers who do not want to practice within a managed care environment, options entitled "practice diversification" are offered. Gayle McCracken Tuttle and Dianne Rush Woods have incorporated their own practice experiences, writings, research related to industry trends, and presentations at workshops and conferences into this "nuts-and-bolts" (p. vii) work titled *The Managed Care Answer Book for Mental Health Professionals*.

The six chapters are organized to address the background of a changing practice arena, critical issues affecting private providers, group practice, payment and risks, marketing, and diversity in practice. Chapter 1 provides the background for the change of psychotherapy from a "cottage industry" to an industry of practice in the world of third-party practice (managed care). Issues discussed include such topics as practitioner's concerns, trends, definitions, accountability, stages of development of managed care, quality and accreditation, training, panels, and costs.

Chapter 2 is the most comprehensive and important section, written for providers who are considering entering the world of managed care. This chapter considers key issues that address how managed care will assist providers in their practice and may hinder their practice if they do not adhere to certain expectations. Specific issues addressed in this chapter include team members, treatment philosophy, provider profiling, credentialing, treatment planning, care management, outcomes measurement, utilization review, case manager relationships, triangulation, client advocacy, pitfalls to avoid in working with

managed care companies, continuum of care, and contract issues (confidentiality, termination, terms, policies, auditing).

Chapters 3-5 are written for the provider who appears to have made the commitment to pursue practice in a managed care arena. Topics such as group practice, payment and risks, and marketing are considered. Chapter 3 considers a variety of available group structures and basics in forming a group practice, group operations, and selling your individual practice. Chapter 4 considers issues related to payment to providers, capitation, profits, and other related financial arrangements. Chapter 5 gives the providers suggestions for how to market their practice in a managed care environment, including such topics as potential markets, outreach, use of panels, linkages to "primary care doctors," and developing marketing plans including responsiveness to the current market as well as future markets.

Finally, Chapter 6, titled "Life after Managed Care," makes suggestions to providers for diversifying their practice such as the "private-pay market," direct provider group contracting with non-managed care groups, and diverse provider group collaborations.

Overall, this book has many strengths. The book is written both from a research base and practical application for private providers considering practice in a managed care environment. Each chapter is designed to be utilized, based on the stage of development of the provider in this quest. The question and answer format, extensive visual exhibits throughout the book, and appendices will be valuable for providers as well as a comprehensive introduction for students of direct practice in social work and other disciplines who are planning to work in a managed care environment.

One area of weakness in the book is its limited discussion of provider practice in a managed care environment with the public sector. The introductory chapter has a brief discussion about the public sector related to the question, "What about the impact of managed care on Medicaid service for children, adolescents, and their families?" (pp.11-12) Recent national studies of public child welfare agencies indicate that over half of these systems have managed care initiatives in their states or are planning to consider managed care initiatives. (GAO, 1999; McCullough, Payne, Langley, & Thompson, 1997) Although there are commonalities in this expanded public sector market that the private medical/behavioral/mental health provider could utilize in this book related to managed care, there are some distinct differences for future consideration. Notably, the differences that private providers should consider in offering their services to public child welfare in a managed care environment include the following: child welfare clients are typically "involuntary" and involve third party interests (such as judges, special advocates, parents, caseworkers, foster or adoptive parents). (Lutz, 1999; Pecora, Massinga, & Mauzerall, 1997)

Child welfare systems generally lack clinical protocols. (Lutz, 1999; Pecora, Massinga, & Mauzerall, 1997) Cost and utilization data may not be consistently available for child welfare systems.

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Somebody Else's Children: and the Struggle to Save America's Troubled Families. John Hubner and Jill Wolfson. (1996) New York: Three Rivers Press.

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Somebody Else's Children is a dramatic and engaging look into the inner workings of the juvenile justice system and child welfare system in Santa Clara County, California. Hubner and Wolfson examine the American juvenile justice system from two perspectives: the dependency or child welfare branch, and the delinquency branch. The result is a view of the juvenile justice system as a complex web of individuals bound together by esoteric laws and mind-boggling funding structures.

Somebody Else's Children is written with the narrative force of an epic novel and the urgency of first-rate investigative journalism. This realistic approach provides the reader a direct involvement with the lives of the children whose fate is decided by a complex and often contradictory family court system. The book has thirty-seven briefly written chapters that follow seven actual cases through the juvenile court system. Real case examples are used to highlight various situations that come under the jurisdiction of juvenile court. The situations include a dependency case in which the court must decide whether a teenage parent is responsible enough to care for a new-born baby, an adoption case involving a drug-addicted baby, a three-year-old child who was sexually abused, a violent eight-year-old involved in a custody battle, a gang-related aggravated assault case, a suicidal teenager, and a neglected teenager charged with murdering a social worker in his group home.

Somebody Else's Children has a number of practical as well as educational strengths. The authors captivate readers by using straightforward language and real-life stories to present an unusually levelheaded view of the American juvenile justice system. Their exhaustive detail and practical approach is informative and often very sad. In addition to the actual case scenarios, the authors begin each case with a short introduction to the social, economic, and political history of juvenile court as it pertains to its jurisdiction over the type of case presented. For example, chapter thirty-four provides a historical account to the major court

decisions, such as, *In re Gault* and *Kent v. United States* and how they shaped the juvenile court system as we know it today.

A major limitation of the book is its imbalance toward a consistently negative portrayal of the juvenile justice system. The authors present only the extreme and most difficult cases. These cases are "no-win" situations, which characterize the juvenile court system as a monstrous beast that preys on children and their families. A few more successful cases would have helped show the positive side of juvenile court and presented those who work within the system in a fairer way.

While *Somebody Else's Children* may not be the kind of book everyone wants to read, it certainly should be read by anyone interested in juvenile justice. Its novel-like style should appeal to many. It would make an excellent supplemental reader for any child welfare course at either the graduate and undergraduate level. In addition, legislators who want to gain an insight and understanding of the problems children encounter when they are brought to the attention of juvenile court would find this book most useful.

Full Reference: Hubner, J., & Wolfson, J., (1996). *Somebody Else's Children: The Courts, the Kids, and the Struggle to Save America's Troubled Families*. New York, NY: Three Rivers Press.

Assessing the Long-Term Effects of Foster Care -- A Research Synthesis. Thomas P. McDonald, Reva I. Allen, Alex Westerfeld, and Irving Piliavin. (1996) Washington, D.C.: CWLA Press.

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Many children are placed in family foster care or institutional care for varying periods of time each year. What is known about the long-term effects of such placement on their functioning as adults? McDonald, Allen, Westerfeld, and Piliavin explore this question by reviewing the surprisingly low number of outcome studies published between 1960 and 1992 in the U.S., along with a few studies conducted in Australia, Canada, France, and the United Kingdom (for a total of 29 studies).

Following a brief history of out-of-home care in the U.S., the authors assess the research methods employed in the studies and highlight common methodological limitations in such areas as sampling bias, sample attrition, and lack of comparison data or control groups. In the major section of the book, they then critically examine the major findings of each study in respect to outcome in the areas of adult self-sufficiency, behavioral adjustment, family and social supports, and personal well-being. They also consider the diverse factors associated with outcome, such as types and number of placements, age at placement and discharge, and caseworker activity. Finally, in a series of appendices, the authors summarize each of the studies reviewed as well as an additional group of investigations of homelessness and out-of-home care. On the basis of their review, McDonald, et al., appropriately conclude: "We believe that a particularly strong case can be made for [further] research on the long-term effects of out-of-home care" (p. 142).

Through their clear presentation and balanced critique, McDonald, et al., provide a comprehensive and useful synthesis of available research, while also stimulating varied considerations for further study. Especially impressive is their analysis of the methods employed by the researchers and the limitations of research undertaken thus far on the long-term effects of foster care. However, their presentation of suggestions for improving or expanding research in this area of child welfare is limited. Further consideration of the

continuing challenges and potential approaches to the study of the effectiveness of foster care in general would have been valuable. For example: How can we deal with the issue of examining systematically the impact of foster care placement on adult functioning, when so many factors in the adult lives of former foster children can intervene to influence their development and functioning? How can we attain adequate control or comparison groups in future studies?

Although this volume offers little direct guidance for practitioners and administrators or policy makers seeking practice guidelines, McDonald et al. make an important contribution to the study of foster care outcomes. In particular, they provide a valuable research synthesis that can guide investigators, students, and educators in their efforts to explore such a complex phenomenon in child welfare.



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