FACTORS CONTRIBUTING TO SUCCESS AND FAILURE IN FAMILY BASED CHILD WELFARE SERVICES: FINAL REPORT

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AN ANALYSIS OF FACTORS CONTRIBUTING TO FAILURE IN FAMILY-BASED CHILD WELFARE SERVICES IN ELEVEN FAMILY-BASED SERVICES AGENCIES:

EXECUTIVE SUMMARY

The proliferation of family-based placement prevention services since the enactment of the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) has highlighted the need for more comprehensive information about the structure, practices, and outcomes of family-based programs. Previous evaluation studies have demonstrated the effectiveness of family-based programs in preventing placement among the families they serve (Bryce, 1970; Goldstein, 1973; Hutchinson et al., 1983; Kinney et al., 1977; Wolock et al., 1977), but little has been known about the characteristics of the families, the services they receive, or the relationship of family and service characteristics to outcome. This study sought to fill that void.

This monograph presents an overview of findings from the final report of the two-year federally funded research study: "An Analysis of Factors Contributing to Failure in Eleven Family-based Service Programs." It begins with an introduction to family-based services and to the research study; section two provides descriptive information derived from a survey of 90 social workers employed by the participating agencies during the period under study and offers a structural typology of family-based programs based on these data. The third section discusses indicators of success and failure in family-based services; the fourth provides descriptive information about the families in the study; the fifth summarizes the family and service characteristics related to case outcome; and the sixth section offers conclusions and implications for practice.

1. INTRODUCTION

Family-Based Services: A Definition

Family-based social work practice views the family as the client, emphasizing both the interdependence of family members within the family and the crucial connections between the family and its larger context or environment. In seeing the family as a social system that functions and transacts within its environment, family-based social work owes much to General Systems Theory, a theoretical paradigm that focuses attention on the relatedness and interdependencies of the parts and the whole. Family-centered theory and practice has found a comfortable home within the field of social work, where family, neighborhood, and community have long provided focal points for program development and practice.

Although family-based service programs provide a broad array of services and use a variety of different service delivery models, they have several characteristics in common. First is their commitment to maintaining children in their own homes whenever possible; to accomplish this, the family as a whole receives service, not just the "problem child." Second, services are short-term and intensive, focusing on goal-oriented treatment plans families themselves help create. Finally, family-based programs provide comprehensive services delivered either directly by the family-based worker or in coordination with other providers.

Introduction to the Study and Methodology

This project studied eleven family-based pre-placement prevention programs in six states: Pennsylvania, Ohio, Minnesota, Iowa, Colorado, and Oregon. The primary goal was to identify the service and client characteristics that contribute to success and failure in family-based services and thus provide the field with empirically-based guidelines for the further development of family-based child welfare services. The

study looked at a wide variety of family-based programs whose broad geographical distribution ensured that the findings would be relevant to programs across the country. In sum, the project was designed to advance the state of knowledge in family-based services by:

- o providing a nationally relevant data base and analysis;
- o developing a typology of family-based pre-placement preventive programs based on program similarities and differences;
- o developing working definitions of success and failure that accurately reflect current family-based practice; and
- o identifying the range of factors associated with and predictive of success or failure in family-based services.

Data were collected in on-site interviews with agency administrators and family-based program administrators, supervisors, and workers; through a survey of 90 past and current family-based service workers who carried cases selected for the sample; and through a review of 533 closed case records, including equal numbers of families in each agency who experienced placement and who remained intact at the end of services. Most of the cases were opened between 1982 and 1985.

Introduction to the Programs

Five of the eleven family-based service programs studied in this project operated out of public social service agencies:

Family Therapy Unit, Iowa Department of Human Services, Ottumwa District;

Intensive Family Therapy Program, Boulder County Department of Social Services, Colorado;

Intensive Family Services, Children's Services Division, Oregon Department of Human Resources;

Intensive Services Program, Dakota County Human Services Department, Minnesota; and

Home-Based Family-Centered Services, Franklin County Children's Services, Ohio.

The first three could be characterized as office-based programs, while the latter two emphasized home-based work with families.

The other six family-based programs examined in this project were based in private social service agencies and, in one case, in a Community Mental Health Center which contracted with the public social service agency. These programs were:

Albertina Kerr Center for Children, Portland, Oregon;

Adolescent Day Treatment Program, Adams County Community Mental Health Center, Colorado;

In-Home Family Counseling Program, Iowa Children and Family Services, Ottumwa, Iowa;

Intensive In-Home Treatment Program, Lutheran Social Services of Minnesota;

Intensive Family Program, Catholic Family Services, Multnomah County, Oregon; and

Supportive Child/Adult Network Program (SCAN) of Philadelphia, Pennsylvania.

The first two were primarily in-office programs, while the other four were essentially home-based service programs. All the private agencies, except the Albertina Kerr Center, received the bulk of their referrals from public social service agencies.

Similarities and Differences Among Programs

The programs studied all shared a common philosophy of family-based services, including a belief in the importance of maintaining children in their own homes and empowering families to achieve this by enabling them to set their own treatment goals. In all, treatment focused on the whole family as the unit of service and the great majority of families received some kind of family therapy.

The programs varied in:

Location of service - Five were primarily in-office programs and six were primarily in-home.

Caseloads - In-home programs averaged caseloads of eight and in-office programs averaged 20.

Frequency of contacts - Varied from less than one face-to-face contact a week to more than two, with an overall average of five contacts in the first month of service.

Length - Length of services ranged from three to eleven months, with an average of seven months.

Teaming - Three programs used only individual workers, two teamed most cases, and six teamed one-third to one-half of their cases using co-therapy, team consultation, or a professional-paraprofessional team.

Placement rates - Varied from a low of 4% to a high of 25%, with an average of 16%.

The most significant differences between programs were due to their auspices, their structure and their location. Programs under public auspices tended to have workers who were more experienced, better paid, and who exhibited higher morale and less turnover. Location of service related more directly to program issues. In-home programs endorsed a more comprehensive, "hands-on" approach, and expended more time on travel and less time on case coordination and peer support. Client populations and kinds of services delivered were most similar between programs in the same state or in metropolitan areas, presumably due to similarities in socio-economic conditions and social welfare policies.

2. SOCIAL WORKERS IN FAMILY-BASED SERVICE PROGRAMS

Over half of the ninety workers who carried cases in the sample had master's degrees, most of them in social work. They had an average of more than eight years of professional experience. Worker turnover varied by program, although nearly 70% of the social workers questioned regarded turnover as low or moderate during the study period. The most important reasons they cited for professionals leaving the program

were: opportunities for advancement, job-related stress, and a need for change. When queried about their own career plans, nearly one-quarter of the workers had quit working in family-based services at the time they were surveyed in 1985. Another quarter planned to stay in their position indefinitely, and nearly one-third planned to stay on for one or two more years.

Worker Morale

Morale in the agency was perceived as average to high by more than 70% of the social workers, although a considerably larger proportion believed that morale was declining rather than increasing during the study period. In general the social workers perceived their job as very challenging, and as offering some professional autonomy. Workers perceived their relationships with co-workers as very friendly. They agreed less often that financial rewards and job security were adequate, that they had good working conditions, and that their agency offered opportunity for promotion. On the negative side, they felt fairly often that ambiguity about their job was a problem and that workloads were too heavy, and they reported some role conflict. Workers missed very few days of work due to illness or stress--an average of half a day in the previous month.

Caseloads and Caseload Management

Caseloads averaged 10.1 families for all social workers: the average highest caseload was 13 and the average lowest was 7.2. Workers spent the largest percentage of their time in in-person contacts (44.4%), followed by travel (13.2%), administrative tasks (12.9%), staffings (9.4%), phone calls (6.4%), collaborative work (5.3%), other activities (4.1%), and peer support activities (4%). Workers spent a median of two hours a week with each family, although this figure varied significantly among

programs. Most social workers saw the majority of their client families during the day, although evening appointments were used for a substantial number of clients. Weekend meetings were seldom held.

Teaming varied among sites: in some programs, social workers teamed with a paraprofessional within or outside of the agency; in others, a worker teamed with another professional person in the unit, in the agency or from an outside agency; sometimes teaming with the unit supervisor occurred. When paraprofessionals were involved in service, their most common roles were building parents' self-esteem, providing parent education and household skills development, and role modeling. There was great variation in the extent to which professionals and paraprofessionals worked together with their client families: sometimes a true team approach was used, while in other cases they worked independently with the family and fulfilled different roles.

Supervision and Training

Social workers reported that they received an average of 3.7 hours per month of individual and the same amount of group supervision, 4.4 hours of peer supervision, and 1.9 hours of consultation from an agency employee other than their immediate supervisor or from a consultant outside the agency. They spent an average of 6.4 hours a month in informal discussions about cases with coworkers. The frequency with which staff meetings were held varied, although two-thirds of the workers reported weekly staff meetings. These were most often used for discussion of agency policy and procedures, mutual support, case discussion, staff development and training, and socializing.

Workers generally believed that their supervisor spent about the right amount of time consulting with them on cases, attending agency or community meetings, attending to paperwork, developing new services and providing direct services. A large

percentage of workers felt their supervisor spent too little time on training. Thirty percent of workers indicated that their program had experienced a decrease in funds for training during the study period, and this was unanimously believed to have had a negative impact on the program.

Social workers reported that they attended an average of 2.6 workshops related to their job each year. Agency funds were more readily available for attending conferences and for purchasing outside consultation than they were for continuing education or for the purchase of books or films. Thirty percent of workers reported that their agencies had used outside consultants during the study period, and most believed the practice had a positive impact on their program. Workers read an average of 1.7 journals on a regular basis and made use of the agency's library about 15 times a year.

Eligibility Requirements and Prior Services

The most important factors determining clients' eligibility for family-based services, according to the social workers, were a child being at risk of substitute care, abuse, neglect or exploitation; referral by the public department of social services; the family having exhausted all other available services; and residence in a specific catchment area. Ineligibility for service was seldom noted, but the most likely situations were those in which a violent family member posed a danger to the worker, where there was a high risk in keeping a child in the home, and where no child was at imminent risk of out-of-home placement.

According to the social workers surveyed, more than one-half of the families had received public financial assistance such as AFDC, food stamps, SSI or Medicaid prior to becoming involved in family-based programs. Between one-quarter and one-half had received child protective services, subsidized or public housing, or out-of-home

placement of a child. Only a small percentage of families had received such supportive services as community mental health services, homemakers, parent education, support groups, substance abuse treatment, private therapy or counseling, school social work services or day care.

Worker Preferences and Attitudes

From a list of typical family problems, workers were asked to select those which they worked with best and those they found most difficult. There were very few that a large percentage of workers found hard to work with, though the most difficult appeared to be chronic neglect, substance abuse, and mental illness. At least half the workers believed they worked well with the following situations: problems of poverty, housing and homelessness, mental retardation and physical handicaps, employment problems, adolescent pregnancy, and adoption. Overall, workers believed that the families who most benefitted from family-based services were those who sought services voluntarily, were new to the service system, were in crisis, or presented adolescent rebellion as a problem. Family-based services were generally seen as being of little benefit to families who lacked motivation or did not desire services.

Treatment Models and Outcomes

Workers considered the following program characteristics most important for effective preventive services: encouraging families to assume greater responsibility and self-determination over their own lives; believing that most children are better off in their own homes; and gearing services to goal-oriented case plans in which clients determine and prioritize their own treatment goals. Among the program characteristics social workers ranked as least important to effective services were: brevity of services (no longer than 90 days); delivery of hard services such as moving, cleaning, and

grocery shopping with clients; and routine provision of services at night or on weekends.

When workers were asked to reflect on the termination of services, the reasons they most frequently cited were that the family was capable of functioning without services, that the family was stabilized and no longer in crisis, that a child was no longer at risk of placement, and that case objectives were at least partially met (Table 1). Social workers reported that more than half the families continued to receive public financial assistance at the time of case closure. Child protective service was the second most common continuing service, although it was provided to less than one-quarter of the families.

Workers reported that they recommended placement for a median of 5% of their cases; this ranged broadly from zero to 30% for the entire sample of workers. The most frequently noted circumstances under which placement was recommended included a child being at risk of serious physical or emotional harm due to the parent's, caretaker's or another adult's behavior, a child being at risk of serious physical or emotional harm due to his or her own behavior, and the exhaustion of all other services. When case outcome was a decision to place out of home, social workers perceived the family, the court, the department of social services and the primary worker as the parties most involved in the decision.

A Structural Typology of Family-Based Services

While the social worker survey was primarily intended to gather information on workers' attitudes about family-based services, it also provided the basis for a typology of family-based services programs. Two structural features were found to most strongly affect the operation of family-based programs: whether the program was located in a public or private agency and whether services were delivered primarily in

Table 1
Reasons Social Workers Often Terminate Family Based Services by Site

	SCAN	ICFS	IDHS	Dakota County	LSS	Boulder County	ADT	CSD	Multinomah County	Kerr	Total
a. case objectives were completely met	46.2	40.0	40.0	100.0	30.0	33.3	40.0	62.5	14.3	0.0	43.1
b. case objectives were partially met	77.0	53.4	60.0	100.0	90.0	88.9	80.0	100.0	87.5	83.3	78.7
c. the family was stabilized and no longer in crisis	69.2	53.3	100.0	85.7	90.0	77.8	50.0	100.0	100.0	66.7	78.4
d. the family was capable of functioning without services	53.9	66.7	80.0	100.0	80.0	88.9	60.0	100.0	100.0	83.3	79.8
e. a child was no longer at risk of placement	46.2	66.7	60.0	100.0	90.0	88.9	40.0	100.0	100.0	50.0	74.2
f. no change or movement occurred within a reasonable time period	38.5	13.3	20.0	0.0	50.0	0.0	20.0	25.0	12.5	0.0	22.4
g. no further change was possible at the time	61.6	20.0	20.0	28.6	50.0	22.2	20.0	28.6	37.5	16.7	34.1
h. the family decided to withdraw from services	0.0	0.0	40.0	14.3	0.0	0.0	0.0	25.0	25.0	50.0	27.0
i. the family reached a level of functioning comparable to most families in the community	38.5	20.0	0.0	85.7	0.0	11.1	0.0	25.0	25.0	50.0	27.0

Table 1
Reasons Social Workers Terminate Family Based Services, Other by Site
con't

	SCAN	ICFS	IDHS	Dakota County	LSS Boulder County	ADT	CSD	Multinomah County	Kerr	Total
j. the time limit for services set by the agency or the purchase agency was reached	16.7	13.3	0.0	14.3	0.0	0.0	20.0	62.5	62.5	33.4	22.8
k. the time limit set in a contract with the family was reached	7.7	0.0	0.0	57.2	0.0	0.0	25.0	37.5	62.5	16.7	20.4
l. the family was ready and able to accept needed services from another source	25.0	13.3	0.0	28.6	10.0	11.1	0.0	0.0	12.5	0.0	14.9
m. the family had a support system in the community	23.1	6.7	20.0	28.6	10.0	11.1	25.0	0.0	12.5	33.3	17.1
n. you were "burnt out" with the family	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
o. the child at risk was no longer in the family	30.8	26.7	0.0	0.0	0.0	11.1	20.0	0.0	0.0	33.3	15.8
p. other (please specify):	8.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	12.5	0.0	4.7

the home or in the office. Table 2 presents selected characteristics of public/private and in-home/in-office programs.

In-office programs enjoyed a high level of support from other units in the agency and had more highly educated workers (85% with master's degrees or above compared to 65% of in-home workers). They were also less committed to a "comprehensive" approach to family-based services (i.e., including 24-hour accessibility, high intensity in-home services and delivery of "hard" services) and had a greater belief in the effectiveness of in-office services. They coordinated with referring workers more frequently and in more ways. In contrast, workers in in-home programs believed that the home was the most effective location for service delivery, expended a higher proportion of time in travel (10-45% compared to 0-5% for in-office workers), and had more access to funds for professional development.

In private agency programs, workers reported lower salaries and higher turnover. Over 90% made less than $24,000 a year, while more than half of the public agency workers made more than that. Nearly three-quarters reported moderate to very high turnover compared to about a third of public workers. They also reported fewer terminations related to success with a family, more use of meetings for case coordination, and a greater belief that the chronically mentally ill and substance abusers could benefit from family-based services. One-third of the private agency workers reported getting more referrals than the program could handle.

In contrast, public agency programs had low turnover, workers with more years of experience in the agency (39% versus 7% with more than five years), richer support services in the community, more frequent termination of cases for positive reasons, higher salaries, and higher morale. Only 8% of public agency workers characterized morale as low to very low, compared to 28% of private agency workers.

Table 2
Characteristics of Public/Private and In-Home/In-Office Programs by Type

	Public		Private		Total
	In-Office	In-Home	In-Home	In-Office	
Worker's education in years $\bar{x}$	18.2	17.2	17.7	18.3	17.9
Number of years in agency $\bar{x}$	6.2	4.0	2.7	3.3	3.9
Hands-on Approach to Family Based Services $\bar{x}$	7.1	10.7	11.5	7.9	9.5
Too many referrals %	14.1	10.2	30.3	45.1	22.2
Frequency of Case Coordination Score $\bar{x}$	4.7	2.8	3.4	4.5	3.9
Time spent on Travel %	8.0	17.7	16.1	1.7	11.3
Salary $\bar{x}$	22,674	25,329	18,309	17,443	20,033
Turnover %					
Low	66.2	60.0	35.2	7.0	42.3
Moderate	18.9	40.0	33.5	34.9	29.9
High	14.9	0.0	31.3	58.1	27.8*
Community Resources Score $\bar{x}$	9.2	11.4	7.8	5.4	8.2
Morale %					
Low	7.4	10.0	25.5	33.7	19.8
Average	48.3	40.0	26.0	47.7	38.1*
High	44.3	50.0	48.5	18.6	42.1*
Cases Often Terminated with Successful Outcome %	83.9	100.0	63.1	45.9	71.0*

*$p<.05$

3. SUCCESS AND FAILURE IN FAMILY-BASED SERVICES

Although placement or non-placement is by far the most common measure of failure and success in family-based services, it is by no means the only measure, or even an adequate one. Funders and administrators concerned with "the bottom line" often regard preventing expensive placements as the only persuasive argument for family-based services. Clinicians, on the other hand, argue for an array of interrelated outcomes, including goal achievement and change in family functioning. Placement is not a failed outcome when it protects a child from serious harm; conversely, keeping a family together is not a success unless some change has occurred in the circumstances that brought the family into service.

In order to establish more refined, practice-based definitions of success and failure, administrators, supervisors, and workers were asked in the course of on-site interviews to define success and failure in family-based services. Their responses formed the basis both for the series of questions about success and failure developed for the social worker questionnaire and for the different outcome measures used in the case review instrument.

Social workers responding to the questionnaire clearly saw keeping the family together as the primary indicator of success, as long as it included stabilizing the situation, improving family functioning, and meeting the children's needs. Placements of all kinds were seen as failures. In their view the most important reasons for failure were a lack of motivation on the part of the family and delay in referral, so that services came too late to keep the family together.

The fact that social workers saw the other indicators of success and failure as strongly linked to placement status suggests that placement or non-placement is, indeed, a fairly reliable valid indicator definition of success or failure, from a practitioner's as well as a legislator's or administrator's point of view. For this

reason, it was used as the major dependent variable in the study. It was not, however, the only case outcome studied and its relationship to the other measures of outcome deserves a brief exploration.

Among the programs studied, placement rates ranged from 4% to 25%, with an average placement rate of 16%. Most studies of family-based services have not differentiated placement as a temporary intervention during service from placement as an outcome at the end of service, regarding, instead, any instance of placement as "failure." In this study, if a child entered placement during the service period and moved before termination to another type of placement or back home, it was counted as a temporary placement, not as an outcome. Temporary placement, in fact, turned out to be highly related to terminal placement (see Table 3). Indeed, nearly half the highest risk children in placement cases had been placed temporarily, while only 13% in non-placement cases were out of the home during service. This significant difference was maintained for all types of temporary placement, including placement with relatives. Respite care was too infrequent to test, since only three families received this service.

Goal achievement, a common indicator of outcome, was measured in this study by the proportion of family case objectives which were assessed by the case reader as partially or completely achieved. The majority of families in both placement and non-placement categories achieved at least half their case objectives. Non-placement cases showed a higher level of goal achievement, however, with the majority fulfilling three-quarters or more of their objectives, at least partially.

Perhaps of even greater importance in determining success or failure, non-placement cases also demonstrated a high level of change in family functioning, as measured by the Family Systems Change Scale, a brief scale that rated ten areas of family functioning and family-community interaction as to whether the family got

Table 3
Relation of Other Outcome Variables to Placement/Non-Placement[a]
(Percents)

	Placement	Non-Placement	Total
Temporary Placement of Highest Risk Child	45.2	13.2	19.2***
Goals Achieved			
None	16.5	13.9	14.4
1-50%	22.5	18.8	19.5
51-75%	22.2	12.9	14.6
76-100%	38.8	54.3	51.5*
Positive Change in Family Functioning			
None	40.3	11.9	17.2
Moderate	44.2	40.9	41.5
High	15.5	47.2	41.3***
Negative Change in Family Functioning			
None	48.6	82.7	76.4
Worse	51.4	17.3	23.6***
No Additional Services After Closing	7.4	30.0	25.8***

*p<.05
***p<.001
a. Data weighted to represent estimated incidence of placement and non-placement based on sampling lists.

worse, stayed the same, or improved in each area. Forty percent of the placement cases showed no positive change, and over half got worse in at least one area. Only 12% of non-placement families failed to show any positive change and less than 20% changed for the worse in any area. This does not mean that outcomes for the placement families were completely negative, however. They achieved a relatively high proportion of their goals, and about the same proportion as non-placement families (40%) achieved a moderate level of change in family functioning.

One final outcome indicator highly related to placement or non-placement was the service status of families at termination. Less than 10% of placement families were expected to be independent of services at termination, whereas nearly a third of non-placement families were not scheduled for further service. That two-thirds of "successful" cases require further resources from the human services system is not surprising, given the severity of the cases referred to family-based services and the relative brevity of the service. For the most part, these preventive family-based services were successful at what they set out to do--avert placement of children from families in crisis. Family-based programs do not seek to, nor could they be reasonably asked to help families solve all their problems.

4. CASE DATA IN ELEVEN FAMILY-BASED SERVICE PROGRAMS

Demographics

The majority of families in the study had incomes below the poverty level or were receiving AFDC, although this varied from site to site. The average age of the primary caretaker was 35 and over 80% were white and female; about half were married and had another adult living in the household. The median family size was four. The oldest child at highest risk of placement in the families averaged 11.5 years of age; 88% were the biological child of the primary caretaker, but less than half were the

biological child of the second adult in the family. Over half were judged to be at imminent risk of placement, while in 20% of the cases placement had been discussed but was not imminent. About 20% of the families had an extensive service history, and 26% of the highest risk children had at least one prior placement (Table 4).

Family Functioning

The severity of the families' problems at intake was indicated by the finding that they scored lower on all ten items in the Parental Disposition subscale of the Child Welfare League of America's Child Well-Being Scales than the protective services population studied by the authors of those scales (Magura and Moses, 1981, pp. 171, 187). In this study, families registered nearly twice as many problems on six of the scale items as the protective services cases did. Similar results were found for the oldest child's scores on the Child Well-Being Scales.

The most common problems reported in the family were parent-child conflict (62%), family relationships (53%), status offenses (29%), and delinquency (25%). Physical abuse, sexual abuse, and neglect were each found in about 20% of the cases (Table 5). More than half of the families received services which included family therapy, individual counseling, case management, and information and referral. Over a third of the cases also received child protective services, and about a quarter received other public social services, school social work or community mental health services. Only about 20% received parent education or paraprofessional support services; a similar number had children placed out of the home temporarily.

Table 4
Demographic Characteristics of Families by Site[a]

	Franklin County	SCAN	ICFS	IDHS	Dakota County	LSS	Boulder County	ADT	CSD	Multinomah County	Kerr	Tot
	n=48	n=50	n=50	n=50	n=50	n=50	n=49	n=36	n=50	n=50	n=50	n=533
Primary Caretaker												
Age x	29.3	26.8	30.9	36.4	39.4	36.8	38.5	39.8	38.4	37.5	36.9	35.3
Sex Female %	89.8	95.1	96.6	88.0	97.5	67.9	72.1	72.2	87.5	79.4	95.8	86.0
Married %	33.0	11.8	49.6	53.0	52.8	63.2	75.1	51.4	39.5	45.1	35.2	46.5
Divorced %	20.8	10.3	28.3	26.6	31.8	19.8	16.6	25.7	42.9	39.6	34.4	26.9
Non-white %	17.3	82.2	5.0	8.3	1.7	0.0	4.2	33.3	4.1	17.2	3.9	16.4
Employed %	20.9	6.3	27.5	35.5	69.3	68.9	64.1	76.0	69.8	33.1	51.3	46.3
Below Poverty Level %	82.4	90.0	75.6	56.2	38.1	38.6	0.0	25.0	N/A	N/A	52.1	54.6
AFDC %	75.7	83.9	59.5	50.6	3.2	18.1	0.0	8.3	16.0	6.8	8.0	30.9
Highest Risk Child[b]												
Age x	7.7	5.2	9.0	13.2	13.2	12.5	13.0	14.7	12.3	14.1	12.9	11.5
Sex Female %	50.9	50.7	47.3	53.2	49.5	51.8	42.7	32.4	56.5	57.7	36.0	48.5
Regular K-12 Class %	56.5	35.1	61.4	76.8	75.7	78.3	78.4	6.5	78.3	54.1	68.1	62.3
Biological Child of Caretaker %	93.7	87.6	97.9	93.1	84.8	84.6	70.3	88.2	98.9	81.0	88.3	88.0
Biological Child of 2nd Adult %	56.7	57.9	55.0	47.8	50.9	46.4	35.1	33.3	65.6	48.1	21.1	48.1
Prior Placement %	27.0	6.1	17.5	22.8	26.7	35.1	22.2	22.6	28.5	68.1	12.2	26.2
At High Risk of Placement %	87.3	25.7	48.8	56.8	65.9	80.0	25.7	76.4	70.3	79.3	16.2	56.8
Court-Ordered into Family-Based Serv. %	17.7	3.8	20.3	42.1	4.0	17.8	27.9	34.4	8.0	12.0	7.9	17.0

a Data weighted to represent estimated incidence of placement and non-placement based on sampling lists.
b Oldest Child at Highest Risk
c n=18

Table 5
Problems Identified by Referral Source and by all Sources By Site[a]

	Franklin County	SCAN	ICFS	IDHS	Dakota County	LSS	Boulder County	ADT	CSD	Multinomah County	Kerr	Total
Reason for Referral %												
Abuse	39.0	27.2	23.3	25.4	32.0	25.7	27.3	2.8	5.0	16.0	.3	20.8
Sexual Abuse	10.7	6.2	7.5	16.5	8.8	3.7	8.3	8.3	20.0	29.6	3.9	11.2
Neglect	55.9	44.3	13.0	7.5	7.2	8.4	.9	0.0	8.5	10.2	0.0	14.7
Delinquency	6.2	0.0	6.9	23.5	21.0	34.8	18.1	44.4	36.5	24.2	7.4	19.6
Status Offense	3.9	0.0	4.8	8.0	53.0	16.1	13.3	44.4	11.5	45.8	34.6	20.7
Child Substance Abuse	0.0	0.0	0.0	.5	12.8	12.4	5.3	19.4	2.1	20.6	7.7	7.0
Adult Substance Abuse	23.7	12.4	15.0	18.1	11.2	8.4	4.4	8.3	3.1	16.0	0.0	11.0
Adult Relationships	20.9	12.3	27.4	40.6	44.6	9.7	16.3	19.4	12.5	19.4	11.7	21.2
Parent-Child Conflict	14.7	8.7	24.7	46.4	88.8	63.5	75.4	61.1	52.5	65.2	28.2	47.5
Family Relationships	29.4	39.5	34.3	21.0	10.3	6.4	23.8	5.6	8.0	28.4	12.0	20.2
% With Problem												
Abuse	49.7	29.6	28.8	24.5	5.7	26.1	28.2	11.1	13.0	24.8	12.7	23.5
Sexual Abuse	14.7	11.1	10.9	17.0	12.0	8.7	8.3	11.1	37.0	50.8	12.8	17.8
Neglect	64.4	56.7	19.8	8.5	6.3	16.7	5.0	8.3	5.0	22.2	7.9	20.7
Delinquency	19.7	3.7	12.4	16.5	2.5	36.2	19.2	58.3	42.5	52.0	19.4	24.7
Status Offense	14.6	2.5	13.1	24.0	5.7	29.8	36.1	69.4	30.6	64.6	47.2	29.5
Child Substance Abuse	5.6	0.0	3.5	5.4	3.2	15.4	18.9	52.8	14.0	25.8	41.8	16.0
Adult Substance Abuse	37.8	21.0	21.9	15.0	0.0	26.4	8.6	27.8	31.2	37.8	19.9	22.4
Adult Relationships	50.2	33.3	61.6	49.1	31.2	60.8	73.3	61.1	59.5	57.4	50.3	53.1
Parent-Child Conflict	51.3	22.2	44.6	59.8	8.0	89.0	84.0	100.0	71.5	62.0	81.8	62.0
Family Relationships	69.5	88.9	63.7	40.5	12.0	31.1	58.2	41.7	36.8	80.0	54.2	52.8

a. Data weighted to represent estimated incidence of placement and non-placement based on sampling lists.

Outcomes

The primary caretaker attended most or all of the service sessions in about three-quarters of the cases; in about half, the highest risk child and second adult in the household attended most or all of the sessions. More than half of the primary caretakers were reported to have cooperated fully with services. Two-thirds of the case objectives were partially or fully achieved, and over 80% of the families showed positive change, most frequently including changes in behavior, family relationships, emotional climate, and perception of the problem (Table 6). Less than 25% got worse in at least one area; 10% dropped out, moved away, or terminated because a child ran away. Only a quarter were expected to receive no further services after their case was closed.

All of these outcomes differed significantly between placement and non-placement cases. Overall, 16% of the cases ended in placement. Children were placed in about equal proportions in foster homes, group homes or institutions, and with friends or relatives. The most common reasons for placement were parent-child conflict (33%), status offenses (18%), child behavior (18%), and delinquency (18%). Long-range planning was documented in the case record for 28% of the cases that ended in placement.

5. FAMILY AND SERVICE CHARACTERISTICS RELATED TO OUTCOME

Family Characteristics

In both bivariate and multivariate analyses, family characteristics had a somewhat stronger relationship to outcome than service characteristics, although, as will be discussed later, the two were really inseparable. Among the variables related to outcome at the bivariate level, the age of the highest-risk child, a history of prior placement, certain types of problems, the level of stress, and child and caretaker

Table 6
Case Outcomes by Site[a]
(Percents)

	Franklin County	SCAN	ICFS	IDHS	Dakota County	LSS	Boulder County	ADT	CSD	Multinomah County	Kerr	Total
Highest Risk Child Placed Temporarily	46.3	22.0	11.8	12.8	12.2	12.4	40.6	22.2	2.1	16.8	13.4	19.2
Estimated Placement Rate[a]	25.0	22.2	19.0	11.8	20.7	22.3	8.1	N/A	11.3	15.4	4.0	16.0
Restrictiveness of Final Placement[b]												
Relatives	50.0	38.9	30.8	4.2	0.0	17.6	12.0	11.8	8.7	4.3	16.7	20.0
Foster Home	7.1	33.3	34.6	75.0	40.0	29.4	32.0	17.6	13.0	52.2	12.5	29.8
Institution	0.0	0.0	23.1	12.5	24.0	29.4	44.0	47.1	21.7	21.7	12.5	22.3
% Attending most or all Sessions												
Caretaker	64.0	59.7	90.9	83.0	69.7	81.9	60.3	19.4	92.3	79.4	65.3	70.8
Other Adult[c]	30.9	26.8	39.3	70.3	62.5	66.4	40.1	14.3	59.3	58.6	62.0	49.3
Highest Risk Child	52.8	40.7	36.1	47.3	55.2	32.1	68.0	76.5	79.0	55.3	75.5	55.4
% of Caretakers Cooperating Fully with Services	58.9	47.0	60.7	52.9	59.2	54.5	83.3	26.7	60.9	40.6	61.1	55.7
% Positive Change in												
Behavior	88.5	48.8	67.2	63.2	67.6	54.6	78.0	60.0	86.9	71.6	83.0	70.2
Material Resources	53.7	30.2	8.6	8.7	4.3	35.7	32.5	0.0	0.0	18.7	15.1	20.5
Family Hierarchy	47.5	19.1	34.0	56.2	66.5	58.2	57.6	17.1	76.3	62.0	60.3	51.0
Family Relationships	62.8	46.8	62.8	54.3	62.8	66.0	71.1	58.8	85.8	69.4	75.6	65.4
Use of Services	92.1	72.1	41.6	18.1	11.5	52.4	53.9	48.6	45.1	52.2	21.2	47.2
Emotional Climate	71.3	62.4	44.7	49.4	56.4	47.2	95.5	54.3	80.5	68.1	82.9	64.3
Perception of Problem	81.5	71.6	34.0	39.0	49.7	51.4	74.4	29.0	88.7	62.9	76.4	60.1

Case Outcomes by Site (cont.)

	Franklin County	SCAN	ICFS	IDHS	Dakota County	LSS	Boulder County	ADT	CSD	Multinomah County	Kerr	To
% With Positive Change	100.0	76.6	86.2	75.8	73.3	65.5	92.1	77.8	88.4	80.8	95.5	82.8
% Worse in at Least One Area	7.3	25.8	23.4	11.8	27.6	36.8	20.1	47.2	12.0	19.2	33.7	23.6
Case Closed Because												
Goals Achieved	75.5	34.7	58.1	37.0	47.0	47.5	63.0	44.4	32.9	35.8	29.9	45.8
Time limit reached	8.2	19.8	0.0	4.6	18.3	3.7	15.7	0.0	39.0	28.4	0.0	12.8
Overall % of Goals Achieved	89.6	85.5	80.2	60.2	68.2	73.8	88.6	62.3	27.1	47.8	51.9	67.1
% With a Long Range Plan[b]	66.7	10.5	34.6	48.0	0.0	35.3	88.0	26.3	0.0	0.0	16.7	28.1
% With no Additional Services after closing	4.3	5.1	13.3	37.5	18.1	14.4	54.7	20.6	23.8	32.3	58.7	25.8

a) By family; estimated from sampling lists of placement prevention cases provided by agencies. Does not include assessment or reunification cases.

b) Placement cases only.

c) Includes only adult living in household.

scores on the Child Well-Being Scales all differed significantly between placement and non-placement cases.

The highest-risk children in placement cases were, on average, a year older than those in non-placement cases, and over 40% had experienced a prior placement. Less than a quarter of those in non-placement cases had been placed before. The greatest difference between placement and non-placement cases, however, was among children who had prior placements of three months or more in group homes or institutions. This group comprised less than 10% of the children at highest risk. Little difference in placement rates was found among children placed for less than three months or those placed in less restrictive settings. Children with prior placement due to parent-child conflict, child behavior problems, status offenses, delinquency, neglect, or adult relationship problems were also more likely to be placed again than were children with no previous placements or children placed for other reasons.

Placement and non-placement cases were also referred and treated for different problems. Families referred for delinquency or treated for status offenses or child behavior problems more often experienced placement. Overall, placement families had significantly more problems with delinquency, status offenses, child substance abuse, parent-child conflict, child behavior, child's peer relations, child's health or mental health, and adult substance abuse. Most of these problems were found more often in families with adolescent children at risk of placement. Placement families were also reported to be under more stress in the year prior to the termination of family-based services and to have both caretakers and children who scored lower on the Child Well-Being Scales.

Although motivation is usually seen as a client characteristic, it is a product of both the inclination of the family and the success of the worker in engaging them in service. Placement cases missed more appointments, an indication of lack of

engagement. Although there was a high level of participation in services by the primary caretaker, the second adult in the household, and the highest risk child in both placement and non-placement cases, less participation by both the primary caretaker and the highest risk child meant more likelihood that a placement would occur. Reflecting the difficulty of these cases, only a little over half of the primary caretakers were recorded as cooperating fully with services, but fewer than 10% of the families dropped out, moved away, or were closed as cases because a child ran away.

In analyses of several individual sites, children's age, number of problem areas in the family, and child and caretaker Child Well-Being scores were found to be the most important predictors of placement, suggesting that families with older children, more problems, and lower functioning children and caretakers face an increased risk of placement (Table 7).

Service Characteristics

At intake, imminent risk of placement reflects both the severity of the family's problems and the eligibility criteria of the program which regulate the timing of service. Of the cases that terminated in placement, 88.6% had children at imminent risk of placement at the time of intake, compared to 49.7% of the non-placement cases. Agency practices regarding temporary placement of children also influenced outcome. Nearly half the highest-risk children in placement cases experienced a temporary placement. Only 13% of the non-placement cases involved a temporary placement.

Programs, therefore, were more likely to place children who came to them at imminent risk of placement, who were already in placement at the time of intake, or who went into a temporary placement. Many programs restrict their services to families in which a child is on the verge of placement and exclude families for whom placement is an issue, but not imminent. Thus, they make their task of averting a

Table 7
Main Predictors of Placement/Non-Placement By Site
Means

	Franklin County	SCAN	ICFS	IDHS	Dakota County	LSS	Boulder County	ADT	CSD	Multinomah County	Kerr	Total
Number of Children at High Risk												
Placement	1.4	2.3***	1.5***	1.4**	1.0	1.1	1.0***	.7	.9	1.3	.5*	1.2*
Non-Placement	1.5	.2	.6	.7	.8	.9	.2	.8	.7	1.0	.1	.7
Total Number of Problems												
Placement	11.8***	10.7***	6.6	5.2	1.1	7.8*	7.6***	8.5	7.4	9.9	9.5*	8.0*
Non-Placement	7.8	8.1	6.0	4.4	1.0	6.7	6.0	7.9	6.7	8.9	7.5	6.4
Age of Oldest Child												
Placement	10.1*	6.7	13.1*	13.8	14.4	15.9	15.6*	16.2	14.7	13.6*	15.2**	13.3
Non-Placement	7.2	5.2	9.6	13.3	14.5	14.1	14.0	15.9	14.2	15.6	12.9	12.3
Number of Psychological Services												
Placement	1.9***	1.0	.6*	.5	.4*	.4	.8***	.4*	.3*	.3	.2	.7*
Non-Placement	.8	.7	.2	.4	.2	.3	.2	.1	.1	.2	.1	.3
Caretaker CWBS Score												
Placement	65.4**	56.7***	76.2	71.4	72.5*	69.5	54.0***	61.0	68.8**	61.2	72.9*	65.7*
Non-Placement	75.7	74.0	79.9	76.3	73.6	72.7	75.7	58.4	79.1	65.4	78.7	74.5
Lowest Child CWBS Score												
Placement	66.8**	72.3**	78.6**	68.7*	64.8***	72.5	49.4***	67.1	60.7	47.9	74.5	66.9*
Non-Placement	76.7	82.9	86.5	75.9	76.5	74.4	67.5	67.0	65.7	51.2	78.6	72.4
Length of Services (days)												
Placement	288*	251*	204	173	96	175	254	283	102**	107*	226	199
Non-Placement	199	363	238	152	84	142	321	341	132	168	248	211

* p<.05 One-tail T-test
** p<.01
*** p<.001

placement more difficult by the timing of services. However, only 28.5% of families with a child at imminent risk experienced placement; over 70% remained together.

Two factors--timing of services and family motivation--were also thought by the social workers to be the most important causes of failure with families. Caretaker cooperation, as measured by the Child Well Being Scales, and imminence of risk were both among the most important predictors of outcome in the analysis of individual sites (Table 7).

Other service characteristics also differed significantly between placement and non-placement cases. Adult relationship change and community change were less likely to be identified as case objectives in placement cases. Placement cases were also less likely to receive paraprofessional services directed toward increasing self-esteem (although fewer than 20% of all the cases studied received concurrent services from a paraprofessional worker). In multiservice agencies, placement cases had been known to the agency longer before being referred for family-based services. In many agencies, placement families were accompanied to appointments more and received more case management, advocacy, transportation, and psychological, psychiatric, and mental health services. Placement cases also received more protective services, crisis intervention and substance abuse treatment from the family-based unit as well as from outside agencies, and more different kinds of service overall.

The only service characteristics to emerge across several sites as among the most important predictors of outcome were psychological and psychiatric out-patient services for placement cases and a longer service period for non-placement cases. In many agencies, however, a mental health evaluation is routine before placement plans are finalized; since the sequence of services cannot be identified in this study, these may have *followed* a decision to place.

Interdependence of Family, Service, and Outcome

Although no single set of variables emerged which predicted placement for all types of families in all types of agencies, a pattern can be discerned by looking at key variables and examining their ranking in agencies with lower and higher placement rates (Table 8). Of the five programs with placement rates in the lower half of the range, four served families with higher caretaker Child Well-Being scores, fewer children at imminent risk of placement, and higher incomes. Three served families with fewer prior placements, fewer problems, and children with lower Child Well-Being scores. Only Multnomah County, which had the highest rate of placement in the lower range, served families which were above the median on most of these characteristics. Clearly, it is more possible to avert placement in a population with fewer risk factors.

The nature of the client population may also condition the service pattern observed in the programs with lower placement rates. Four of the five programs that made fewer placements also provided fewer different kinds of services directly (mostly confined to family therapy, individual counseling and information and referral services), made fewer temporary placements, and used directive interventions less. Three also made less use of psychological/psychiatric services and provided services over a shorter time period. It may be significant that of the programs with lower placement rates, only Multnomah County, which had the highest risk population, provided services primarily in the home, although the in-office programs also made home visits to 20% to 75% of the families in the first month of service. That family-based services are directed toward preventing residential placement in Boulder County may account for the otherwise anomalous situation of a program with a low-risk population providing more services, making more temporary placements, and using more directive interventions over a longer time period than is characteristic of the other agencies in this group.

Table 8
Patterning of Rate of Placement and Predictors of Placement[a]

	Family Characteristics						Service Characteristics						
	Low Caretaker CWBS	High Risk of Placement	Low Income	Prior Placement	Total Problems	Low Child CWBS	In-Home Services	Total Family Based Services	Temporary Placement	Directive Services	Psychological Services	Length of Service	Placement Rate
Kerr	-	-	-	-	+	-	-	-	-	-	-	+	-
Boulder	-	-	-		-	+	-	+	+	+		+	-
CSD	-	-	-	-	-	+	-	-	-	-	-	-	-
IDHS	-	-	+	-	-	-	-	-	-	-	+	-	-
Multnomah	+	+	-	+	+	+	+	-	-	-	-	-	-
ICFS	-	+	+	+	-	-	+	-			+	+	
Dakota		+	-	+	-	+	+		-	+	-	-	+
SCAN	+	-	+	-	+	-	+	+	+	+	+	+	+
LSS	+	+	+	+			+	+	+	-	+	-	+
Franklin	+	+	+	+	+	-	+	+	+	+	+		+
ADT	+			-	+	+	-	+	+	+	-	+	+

a) Minuses indicate weighted average for site is in lower 50%, pluses indicate weighted averages in top 50%. Median value is left blank. Weights are based on estimated placement rates is left blank.

Turning to agencies with placement rates at or above the median, four of the six served higher-risk families in terms of caretaker Child Well-Being scores, imminence of risk of placement, income level, and prior placements. Three served families with more problems than the median. Only two served children with CWBS scores below the median. Lutheran Social Services and Franklin County, the two agencies with the highest estimated placement rates (22% and 25% respectively), served the families with the most risk factors. Again, service delivery appears to be related to family characteristics, since five of the six agencies with higher placement rates delivered services primarily in the family's home; four of the six provided more services directly and made more use of temporary placements, directive interventions, and psychological services; and three delivered services over a longer period of time.

With the exception of the Iowa Department of Human Services, all of the programs with lower placement rates served non-placement cases for a longer period of time than placement cases. This difference was significant in Oregon Children's Services and Multnomah County (averaging 1 to 2 months more of service) and was an important predictor of non-placement in those sites. Among the agencies with higher placement rates, non-placement cases in Iowa Children and Family Services, SCAN, and Adolescent Day Treatment also received services over a longer period of time. The difference was statistically significant, however, only in SCAN, where length of service was also an important predictor of non-placement, averaging nearly three months longer for non-placement cases.

On their own, these predictors of placement provide important clues about the reasons for failure in family-based services. In their responses to the social worker questionnaire, workers identified families who had been in the service system longer and those who were less motivated as benefiting less from family-based services. They had more optimism than the case review data support about their success with

adolescents. It should come as no surprise, though, that families with more numerous and severe problems experience more placements. What is surprising is the degree to which service characteristics are related to family characteristics. For the most part, programs that offer more focused, shorter-term office-based services to families with fewer risk factors prevent placement in a higher proportion of cases. Programs offering more comprehensive, in-home services to families with more risk factors have higher placement rates.

6. CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

Both the social worker and case review data clearly indicate that all eleven programs follow a model that can be called family-based with reference to philosophy and focus. Social workers in these programs almost universally believed in the importance of maintaining children in their own homes and in empowering families to bring this goal about by setting their own treatment objectives. While their treatment approaches were not identical in terms of strategy or technique, all family-based workers focused their efforts on the entire family as the unit of service. Over 80% of the families received some form of family therapy. In nearly three-quarters of the cases, the primary caretaker participated in most or all of the contacts with the family-based worker; in half, the highest-risk child and another adult in the household attended most or all of the sessions.

Family-based programs can be defined not only by their focus on the whole family, but also by the intensity and duration of services. Families in these programs were seen, on average, about once a week for two hours during the first three months of service; services continued for about seven months. In-home programs with lower caseloads generally offered more intensive services, whereas in-office programs had higher caseloads and offered less intensive services.

The study found that the family-based programs were very successful in meeting their primary goal of keeping children out of placement. Overall, 84% of the families were estimated to be together when services were terminated (ranging from a high of 96% to a low of 75%). During family-based services, only 19% of the highest risk children had experienced a temporary placement. On average, two-thirds of the case objectives were achieved or partially achieved, and over 80% of the families experienced positive changes, with a majority showing improvement in behavior, family relationships, emotional climate, perception of the problem, and hierarchy.

Several implications for family-based policy and practice may be inferred from this study. They relate to structure, service delivery, and client populations in family-based services.

Structural Implications

1. Family-based services can be successfully delivered by public agencies.
2. Family-based services can be successfully delivered in the office for some client populations.
3. Low salaries and lack of training opportunities create worker dissatisfaction.

Service Delivery Implications

1. Services must be matched to the client population served.
2. Delay of family-based services increases the risk of placement.
3. Directive services (accompanying a client to an appointment, advocacy, case management, coercion, and recreational services) may not help families avoid placement.
4. Other concurrent mental health and social work services may not help families avoid placement.
5. Family-based workers are not recording long-range plans for placed children (although in some agencies this is not an expectation of the program).
6. Families may benefit from longer periods of service.

7. Families benefit from educational and supportive services.

8. Most families will continue to receive services after the termination of short-term family-based services.

Implications Regarding Client Population

1. Children with prior group or institutional placements are at increased risk of placement.

2. Families with more severe problems are at higher risk of placement.

3. Families with problems relating to adolescence are at higher risk of placement.

4. Families who are not motivated to receive services are at higher risk of placement.

While further research is certainly needed to refine the practice of family-based services and to identify which practice models work best with which populations, it is already clear from this study that family characteristics, services, and outcomes are interdependent. Despite the preference for short-term, in-home services that has been reflected in the literature on family-based services (Kinney, 1977 & 1978; Besharov, 1986), no simple formulation of service length or location can ensure high success rates. Just as direct service workers must consider each family's unique combination of strengths and problems, so administrators and program planners must assess the unique circumstances in which their family-based programs must survive and flourish.

CHAPTER I

INTRODUCTION

Family-based services have developed over the past twenty years as an innovative approach to serving families who do not respond to more traditional social service interventions. First adopted by private agencies, early family-based programs demonstrated impressive results in preventing out-of-home placements (Goldstein, 1973; Hutchinson, et al., 1983). The dramatic increase in the number of children in out-of-home care in the 1960's and 1970's, and increasing recognition of the limitations of foster family care as a solution to child welfare problems led in the 1970's to pre-placement prevention programs that diverted families at risk of placement into specially created units in public agencies, or into private programs established specifically to provide preventive or reunification services. The significant successes in obviating or delaying the need for child placement reported by these programs and the passage of the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272), which requires evidence of reasonable efforts to prevent out-of-home placement, have dramatically intensified interest in family-based services.

While the success of these early programs in preventing placement led to their replication in both public and private agencies, the field lacked empirically validated results. As interest in family-based services accelerated, questions arose concerning why all families did not benefit from these services. In 1984, the Office of Human Development Services requested proposals for research that would provide information on families in which placement was not averted, information that would lead to the development of better criteria for case management and planning. This research, undertaken by the The University of Iowa School of Social Work's National Resource Center on Family Based Services and Portland State University's Regional Research Institute for Human Services, is a response to that need.

FAMILY-BASED SERVICES: A DEFINITION

Family-based social work practice views the family as the client, emphasizing both the interdependence of family members within the family and the crucial connections between the family and its larger context or environment. In seeing the family as a social system that functions and transacts within its environment, family-based social work owes much to General Systems Theory, a theoretical paradigm that focuses attention on the relatedness and inter-dependencies of the parts and the whole. Family-centered theory and practice has found a comfortable home within the field of social work, where family, neighborhood, and community have long provided focal points for program development and practice.

Although family-based service programs provide a broad array of services and use different service delivery models, they have several characteristics in common. First is their commitment to maintaining children in their own homes whenever possible. To accomplish this, the family as a whole receives service, not just the "problem child." Second, services are short-term and intensive, focusing on goal-oriented treatment plans the families themselves help create. Finally, family-based programs provide comprehensive services delivered either directly by the family-based worker or in coordination with other providers.

Family-Based Services: Results

Among the programs developed since 1952 when Buel first publicized the St. Paul Family-Centered Project, family-based programs have been highly successful in helping families remain together. Kinney et al. (1977) reported an 85% prevention-of-placement rate for families with at least one child destined for institutional placement. Wolock et al. (1977), in comparing the relative effectiveness of a foster home program, a residential program and an own-home program with comparable problematic families,

found the own-home program to be more effective and dramatically less costly than the two substitute care programs. Bryce (1978) studied 96 families who were provided home-based services by FAMILIES, Inc., all of whom had a child who had been dispositioned for placement in an institution. Over the three-year study period, 73% of the children were maintained and effectively served at home. Taken together, the results achieved by family-based service programs strongly suggest a 70 to 90% success rate.

STATE OF THE ART: FAMILY-BASED RESEARCH

Since the early 1970s there have been several demonstration and evaluation projects involving preventive services to families at risk of having a child placed in the near future. These projects varied considerably in terms of referral criteria; type, intensity and length of service; client population; outcome criteria; and research methodology. Most of the earliest pre-placement projects were fielded by traditional child welfare agencies (e.g., Jones, Neuman and Shyne, 1976; Halper and Jones, 1981; Willems and DeRubeis, 1981), a pattern that has continued since the implementation of P.L. 96-272 in 1980 (Yoshikama, 1984). Early preventive programs differed from later family-based service programs largely in focus, intensity, and length of services.

Early Pre-Placement Prevention Programs Compared to Family-Based Programs

Whereas family-based service programs view the whole family as the client, earlier preventive programs focused primarily on the mother. In the projects studied by Jones, Neuman and Shyne (1976), for example, there was an average of 17 in-person contacts with the mother and only three with the father if he was in the home. "Intensive" services involved an average of two in-person contacts a month (Jones, Neuman and Shyne, 1976; Magura and DeRubeis, 1980; Jameson, 1980), or at most, one

contact a week (Halper and Jones, 1981; Lawder, Poulin and Andrews, 1984). Services also extended over a lengthy time period, often more than a year (Magura and DeRubeis, 1980; Yoshikama, 1984; Lawder, Poulin and Andrews, 1984). In several projects, two-thirds or more of the cases were still open at the study's end (Halper and Jones, 1981; Jones, Neuman and Shyne, 1976; Magura and DeRubeis, 1980; Yoshikama, 1984).

Research on more recent family-based services documents more intensive contact with the family unit for a shorter time period. In-person contacts may average two or three a week (Akamine, O'Neill and Haymond, 1980; Callard and Morin, 1979; Cautley and Plane, 1983; Leeds, 1984), over a period averaging as short as seven weeks (Akamine, O'Neill and Haymond, 1980) or as long as ten months (Lyle and Nelson, 1983).

More recent programs also tend to be more family-focused and more specific in their treatment orientation than earlier preplacement prevention programs. Compher's (1983) conceptual model for working with families at risk of placement describes a continuum of family needs, from lack of material resources to differing degrees of emotional and behavioral problems. He asserts that professionals working with such families must be prepared to assess family needs and to act both as case managers and as therapists.

Other authors emphasize the need for home-based services as a component of service delivery to prevent placement. In her evaluation of Homebuilders' in-home crisis prevention program, Kinney (1978) hypothesizes that a key component of the program's success was the use of in-home therapy. Kinney et al. (1977) also assert that in-home strategies are more realistic and informative for the therapist. Besharov (1986) analyzed several issues relating to troubled families, including placement issues and service delivery to intact families. He believes extensive in-home services which

target children can compensate for poor parenting and lack of family resources. Some studies have found in-home services to be related to placement prevention (Landsman, Leung and Hutchinson, 1987; Pearson, 1987).

Research on Placement Prevention Services

Research on family-based services has begun to identify factors associated with successful outcomes of service. Both the earlier preventive programs and the more recent family-based programs commonly use maintenance in the family home or placement as the measure of success or failure. There are numerous problems with using placement as an outcome indicator, however. First, studies of earlier placement prevention programs reveal that the majority of children in control groups remained with their families despite having been selected as "at risk" of placement in the near future (Jones, Neuman and Shyne, 1976; Halper and Jones, 1981; Lyle and Nelson, 1983). Second, there are strong indications that placement may be the most desirable outcome for *some* children.

Accordingly, many studies use additional or alternative outcome measures, including goal attainment (Jones, Neuman and Shyne, 1976; Akamine, O'Neill and Haymond, 1980; Cautley and Plane, 1983; Jameson, 1980; Leeds, 1984; Lawder, Poulin and Andrews, 1984), family functioning (Jones, Neuman and Shyne, 1976; Cautley and Plane, 1983; Halper and Jones, 1981; Willems and DeRubeis, 1981; Jameson, 1980; Leeds, 1984), and/or child functioning (Jones, Neuman and Shyne, 1976; Akamine, O'Neill and Haymond, 1980; Cautley and Plane, 1983; Halper and Jones, 1981). The factors that have been found to be related to case outcome, primarily placement or non-placement, can be broadly categorized as characteristics of service delivery or characteristics of client families.

Characteristics of Service Delivery

Several studies focused on the importance of *comprehensive services* in efforts to keep children in the home. Turner (1984) compared 50 children reunited with their natural parents after placement with 50 children who remained out of home. All children were placed as a result of parental problems rather than problems exhibited by the child. Turner found that the amount and variety of service affected the likelihood that children could remain at home. Families which remained united had received both more months of case management and more social services upon reunification. A review and critique by Jones et al. (1981) of research on families in protective and preventive services reports further evidence that a comprehensive program of services is more effective than any single service (see also Jones, 1985).

Leeds' (1987) five-state study of over 1,100 child welfare cases who received services to prevent placement examined the service- and practice-specific factors which affected success in keeping families united. Leeds found that mere case monitoring without adequate service delivery had a negligible effect on preventing placement, and the study proposed that a more comprehensive service approach should be offered to the most dysfunctional families if such programs were to be successful.

Haapala's (1983) overview and evaluation of the Homebuilders program identified factors affecting the success of home-based treatment with families at risk for placement. Haapala studied 41 children and their mothers involved with the program, as well as 14 Homebuilder therapists. Both children and mothers from families which stayed together cited more "therapist hard services," or tangible goods and services, than families in which children were ultimately placed out of home. Haapala reiterates that assessing and addressing the broad spectrum of family needs--therapeutic as well as concrete--is essential to success. A further study of the helpfulness of various aspects of in-home family therapy found the provision of concrete services by

therapists to be significantly related to placement prevention (Fraser and Haapala, 1985).

Hinckley (1984) studied the Maine Homebuilders programs, researching their success at preventing placement, the training and retention of staff, and issues of cost-effectiveness. Comparisons of the five Homebuilders programs in that state suggested that the multi-service agencies which had a greater quantity and variety of resources to offer clients were more successful than programs which specialized in home-based services. Burt's (1976) program evaluation of Nashville's Comprehensive Emergency Services System (CES) revealed sharp decreases in the incidence of child out-of-home placement for those families receiving services. Burt stressed that emergency services, which included daily 24-hour intake, emergency caretaker and homemaker services, and emergency shelter for both children and families, were essential in reducing placement statistics.

Laughlin and Weiss' (1981) evaluation of the Family Center, a community center designed to help prevent child abuse, found that the availability of specific kinds of material support were key to the program's success in engaging families and maintaining their progress. The provision of transportation to and from meetings, child care during parent support meetings, and an extensive socializing program for children all provided incentive and support to parents and ultimately affected the program's ability to decrease the rate of child removal from these families. Parent Support Services, in particular parent aides, parenting skill development, day care, and parent education, have also been found to be related to placement prevention (Landsman, Leung, and Hutchinson (1987).

Not all services, however, contribute to placement prevention. Some types of service are more characteristic of placement cases and may reflect activities routinely undertaken as a placement is being made. These services include psychological

evaluation, office visits within a primarily home-based service, telephone contacts and transportation (Landsman, et al., 1987; Reid et al., 1988). The involvement of health or mental health services have also been found to be associated with placement (Leeds, 1984; Reid, et al., 1988).

Jones et al. (1981) found that *contracting* with clients on specific goals, in addition to being theoretically consistent with social work values, has been demonstrated to be effective in some child welfare cases. However, they suggest that contracting's feasibility and effectiveness may vary, depending on the nature of the client's presenting problem. In addition, AuClaire and Schwartz (1986), in a study of 58 cases from a home-based social service agency for multi-problem families at risk of placement, and Kinney (1978) both surmise that contracting can be a key element in achieving success with dysfunctional families.

The impact of *staff training* on program success was also addressed in some studies. Jones et al. (1981) found that good staff training did indeed affect case outcomes, and that it was especially critical to have well-trained professionals conduct the intake, diagnostic and service planning phases of each case. Pecora et al. (1985) also addressed the importance of training workers in the specific skills and attitudes needed to use home-based, family-centered strategies effectively. Pecora's report on staff training with 72 staff members of social service and child welfare agencies demonstrated that many staff continue to hold more traditional therapeutic assumptions, assumptions that may undermine the success of family-based approaches. Other agencies required training in a variety of areas including child development (Jones et al. 1981), the dynamics of substance abuse (Day One Evaluation Report 1983), case management (Compher 1983, Heying 1985, Szykula and Fleischman 1985), community resources (Kinney 1978), and crisis intervention (Day One Evaluation Report 1983).

Characteristics of Families

Several studies have demonstrated that the *type and severity of family problems* affects the likelihood of successful treatment. Many distinguish between severely dysfunctioning families and families that are experiencing temporary crises for which they lack the emotional or material resources. Hinckley (1984) found that the Homebuilders program was equally effective with both groups, with success rates of up to 82% prevention of placement. Leeds (1984) found intensive family services to be more effective with the more dysfunctional families.

Szykula and Fleischman (1985) looked at the effectiveness of a social learning treatment program in preventing placement. Unlike Hinckley, they found that the program had better success rates with less abusive parents than with more severely abusive parents (parents who had had three or more reports of abuse). The study proposed that the program was more effective with parents who needed help managing child behavior appropriately than with more severely troubled families who needed a broader range and increased amount of service. Besharov (1986) concurs, reporting that the short-term and unsophisticated nature of many current services accomplishes little with the 40% of abusive/neglectful parents with "deeply ingrained personality disturbances." Jones et al. (1981), Cautley and Plane (1983), Turner (1984), Jones (1985), and Reid et al. (1988) have also found that programs were less successful with families who had more problems or problems of greater severity.

Similarly, Kagan's (1987) program evaluation of the Court-Related Youth Service, an alternative to out-of-home placement for troubled youths, revealed parental concerns about the program's effectiveness in addressing severe problems in youths. Behavioral problems did subside during youths' participation in the program, but parents consistently reported their concern that the program was not equipped to address the youth's long-standing, severe problems, including chemical abuse.

Rzepnicki (1987) examined current research to assess the data on stability after family reunification, including factors affecting recidivism. The review revealed several types of problems which contribute to recidivism: child's poor health, schizophrenia or behavioral problems in the child; acting out by the child; the parents' social or emotional problems; and family financial hardship (including inadequate housing, employment and income).

Prior placement has been identified in several studies as predicting further placement. Heying (1985) evaluated the San Diego Center for Children, a family-based program offered instead of, or in addition to, residential or day treatment for emotionally disturbed youths. Heying found that youths who had been involved in the social service system longer and had previously completed day or residential treatment were considerably more likely to be placed out of home. Similarly, Rzepnicki (1987) reported that reunified families were at greater risk of being recidivists when the child had had more than one previous placement or had been placed out-of-home for a longer period of time. Landsman (1985) also found previous placements for extended periods to be related to unsuccessful outcomes, while Leeds (1984) found single prior rather than multiple placements to be more predictive of a second placement.

Several studies reported that *age* impacted outcomes. Both Haapala (1983), Yoshikami (1984), and Rzepnicki (1987) all found that older children were more likely to be removed from the home. A high degree of *family motivation* was also a factor in determining success, according to Kinney et al. (1977), Kinney (1978) and Jones et al. (1981). Kinney suggested that the fact that many client families were facing crisis situations contributed to their commitment to the program and their willingness to make changes. Parental defensiveness and unwillingness to recognize problems have also been found to be related to outcome (Cautley and Plane, 1983; Reid et al., 1988).

Finally, *successful completion* of the program also increased the likelihood that out-of-home placement could be averted (Cautley and Plane, 1983). DeWitt's (1980) review of research on the comparative effectiveness of family therapy reported that premature termination may inhibit families from receiving the full benefits of treatment. Similarly AuClaire and Schwartz (1986) reported that clients who were graduated from or were "actively engaged" in treatment were in out-of-home placement less than those who did not complete the program. Friedman and Quick's (1982) program evaluation of a day treatment program for multi-problem adolescents also examined the relationship between successful completion of the program and out-of-home placement. Interestingly, outcomes were positive for all three groups--program graduates, those who attended over 50 sessions but did not complete the program, and those who attended fewer than 50 sessions. Only an extremely small minority of youths from any category were removed from the home.

RATIONALE FOR STUDY

Although research in the field identifies some specific factors that are related to outcome in preventive services and is suggestive of areas that bear further investigation, much of the research has evaluated the success of a single program (AuClaire & Schwartz, 1986; Burch, 1980; Day One Evaluation Report, 1983; Florida: Intensive Counseling Programs, 1982; Friedman & Quick, 1982; Heying, 1985; Hinckley, 1984; Kagan, 1987; Kinney et al., 1977; Kinney, 1978; and Lantz, 1985). In addition, although most studies have shown favorable outcomes in terms of maintaining families and keeping children out of placement, the few that have used multivariable statistical analyses have been able to explain only about a quarter of the variance in outcomes by the client and service characteristics studied (Jones, Neuman and Shyne, 1976; Halper and Jones, 1981; Cautley and Plane, 1983; Halper and Jones, 1981; Willems and

DeRubeis, 1981; Jones, 1985). This study, in contrast, is designed to allow for generalization across a wide range of family-based programs. The sample size is also sufficiently large to use multivariable analyses to test a broader array of predictors, including those identified in previous research as important. Thus, this study provides a more complete explanation of failure in family-based services.

The project, comprised three phases, and included eleven family-based pre-placement programs in six states. The primary goal of this research was to provide the field with empirically-based guidelines for the further development of family-based child welfare services by identifying service and client characteristics that contribute to success and failure in family-based services. The study as a whole was designed to provide information about a wide variety of family-based programs whose broad geographical distribution ensures that the findings are relevant to programs across the country. Thus, the project was designed to advance the state of knowledge in family-based services by:

- providing a database and analysis that are relevant on a national level and developing a typology of family-based pre-placement preventive programs based on similarities and differences among programs;
- developing working definitions of success and failure which accurately reflect current family-based practice; and
- identifying the range of factors associated with and predictive of success or failure in family-based services.

Chapter 2 describes the study's methodology. Chapter 3 presents the results of a survey of family-based workers and a structural typology of family-based programs. Chapter 4 examines various definitions of success and failure, the outcome measures employed, and their relationship to one another. Chapters 5 and 6 identify factors differentiating placement from non-placement cases in bivariate and multivariate analyses. Chapter 7 summarizes the results of these analyses and Chapter 8 presents a summary of the project findings, their implications, and areas for further research.

CHAPTER 2

METHODOLOGY

The programs described in this report comprise eleven family-based services sites included in a federally-funded, nationwide study of family-based pre-placement preventive services. Because this is a descriptive and correlational study which considers the impact of a wide variety of factors on outcome, specific hypotheses were not generated. Instead, three general research questions addressed the study's goals (the chapters which cover each of these questions are indicated in parentheses):

1. **What are the similarities and differences among a sample of established family-based programs? (Ch. 3)**
2. **What do social workers directly responsible for providing service to families at risk of placement regard as success or failure in a case? (Ch. 4)**
3. **What service and client characteristics are related to different outcomes? (Chs. 5, 6 and 7)**

It is only after the answers to these general questions are known that specific hypotheses can be generated to test the relationships between probable causes and effects in family-based services. At this stage, it would have been premature to restrict the study to a few of the many possible causal factors and to narrowly define outcome measures.

In the chapters that follow, there is first a description of each of the eleven family-based service programs in the study. These were derived from interviews with agency administrators, supervisors and workers; from the program materials provided by each agency; and from a survey of 90 workers in the programs who carried cases selected for the study sample. Although the family-based programs share common core characteristics, significant differences were found between programs in public and private agencies and between in-home and in-office programs. A typology of characteristics and service approaches is presented to provide guidance to state, local

and private agency child welfare administrators in developing family-based preventive programs suited to their agencies.

Chapter 4 discusses the nature and the interrelationships of the major outcome variables. Developing realistic expectations and definitions of success and failure has been one of the most difficult tasks in outcome research, in general, and in family-based services, in particular. Although placement prevention and family maintenance are the primary goals of family-based services, it is apparent that as outcome indicators they are not sufficient to capture the reality of service impact. To compensate for this limitation, several alternative outcome measures are identified. Using a variety of outcome measures should help workers and agencies recognize the positive impact of services, even when a placement is ultimately made.

In chapter 5, data from 535 cases in the eleven programs are presented. Coded from closed case records, these data provide a picture of family and service characteristics for independent samples of cases that ended in placement and cases in which the family remained together. While this chapter presents an overview of family and service characteristics and the differences between placement and non-placement cases in the study as a whole, these characteristics varied widely from site to site and, thus, the composite picture may not apply to particular sites. Nonetheless, these data establish a profile of family-based services in placement and non-placement cases which other programs may use for comparison. They also identify characteristics which differ significantly between placement and non-placement cases that may merit special attention in providing family-based services, regardless of the structure of the program.

In chapter 6, the relationship of service and client characteristics to placement or maintenance of the family is considered site by site. Variables which predict success or failure were tested in each of the 11 project sites, since unequal variances

prevented further aggregation. The sites are grouped by state since common policies and socio-economic conditions created similarities between programs in the same state.

Finally, in chapter 7, the factors that discriminate between placement and non-placement cases in both the overall data set and in the site-by-site analyses are reviewed and the interrelationship of family characteristics, services, and outcomes considered. This interdependence suggests that there is no single explanation for failure in family-based services, but that failure is conditioned by the interaction of these three areas of concern in each program. Chapter 8 presents a summary of the study findings, implications for family-based policy and practice, and recommendations for further research.

In addition to this report, documentation reports for each of the 11 participating study sites, including descriptions of policies, procedures, practices, and client outcomes have been made available to the agencies. These more detailed reports are summarized in this discussion.

AGENCY SAMPLE

The family-based programs studied were selected to represent a range of regional, population, and program characteristics. Five sites are public agencies, six are private or purchase-of-service. All the family-based programs were established between 1975 and 1983. They are, thus, examples of stable, rather than new services and were projected to have sufficient numbers of closed cases to provide a sample of 50 for the study. The eleven sites include:

1) *Supportive Child/Adult Network (SCAN)*, a private agency in Philadelphia, Pennsylvania which contracts witht he Department of Human Services, Philadelphia County Children and Youth Agency;

2) *Franklin County Children's Services*, a public agency in Grove City, Ohio;

3) *Dakota County Human Services*, a public agency in Burnsville, Minnesota;

4) *Lutheran Social Services (LSS),* a private agency in Fergus Falls, Minnesota;

5) *Adolescent Day Treatment Program (ADT)* in Commerce City, Colorado, part of the Adams County Community Mental Health Center;

6) *Boulder County Department of Social Services,* a public agency in Boulder, Colorado;

7) *Iowa Children's and Family Services (ICFS),* a private agency in Ottumwa, Iowa which contracts with the Iowa Department of Human Services;

8) The *Ottumwa District Office of the Department of Human Services (IDHS),* a public agency in Ottumwa, Iowa;

9) *Kerr Youth and Family Center,* a private agency in Portland, Oregon;

10) *Children's Services Division* of the Oregon Department of Human Resources;

11) *Catholic Family Services* in Multnomah County, Oregon, a private agency which contracts with the Oregon Department of Human Resources to provide family-based services in the Portland area.

In the early 1980's when this study was conceived, family-based services had been established primarily to divert children and youth from out-of-home placement. Families were referred only when placement was considered to be a real possibility. In public agencies, special units received families from other parts of the organization. Private programs, created specifically to provide family-based services, did not include the range or continuum of services offered in the public agencies, which were usually their principal, or sole, referral source. Although this pattern of service delivery continues to be dominant in the field, it should be recognized that this sample is not representative of agencies which deliver comprehensive child welfare services entirely from a family-based perspective.

WORKER SAMPLE

The first stage of data collection included on-site visits to each agency and semi-structured interviews with agency and program administrators and family-based

supervisors and workers. Written materials including reports, regulations, and statistics were also collected. This information was used to create a 105 item Family-based Services Inventory, the social worker questionnaire, which, in the second stage of data collection, was sent to all workers who saw families during the study period (see Appendix 1). The questionnaire and instructions were pretested in a family-based preventive service agency in Iowa not included in the sample (FAMILIES, INC., of West Branch, Iowa) and in the Des Moines offices of the Iowa Department of Human Services and Iowa Children and Family Services. The questionnaire was also reviewed for face and content validity. Revisions suggested during this process were incorporated into the final draft.

Questionnaires were distributed by project liaisons in the agencies to all workers still employed and mailed directly to those who had left the agency. All were returned to the National Resource Center in self-addressed stamped envelopes provided to protect the confidentiality of the respondents. The social worker questionnaire took about two hours to complete and included a wide variety of questions on worker demographics, agency and program characteristics, supervision and training, family characteristics, practice models, worker attitudes and preferences, and case outcomes. Several existing scales were incorporated into the questionnaire including scales from the *Professional Satisfaction Inventory* developed by Chess and Jayaratne; Maslach and Jackson's *Human Services Survey;* Halper and Jones (1984) treatment techniques scale measuring casework orientation; and scales measuring theoretical orientation to family therapy developed by Hamilton and Montayne. A scale comprising 14 items measuring orientation to family-based services, developed by Pecora et al. was also included. A total of 134 workers received the survey; of the 114 that were received by professional level social workers who carried cases during the study period, 102 were returned, an 89.5% return rate (Table 2.1). Approximately 80 of the questionnaires were completed

and returned promptly. As the size and variety of the case sample was dependent upon the completion of the questionnaire, the follow-up was quite rigorous. The National Resource Center contacted social workers who failed to respond (and their project liaisons) first by mail, then by telephone, and then by telegram. Through these methods another 35 questionnaires were returned. Of the 102 eligible questionnaires returned, 12 were not used in the data analysis because none of these workers' cases were drawn for the case sample.

CASE SAMPLE

The third and final stage of data collection involved the completion of an 106 item Case Review Instrument (Appendix 2). A study period was identified for each agency (Table 2.2) that was projected to include at least 25 pre-placement prevention cases which terminated with the placement of a child. Two types of cases - reunification and assessment - were excluded from the sampling frame. Reunification cases were defined as those in which the child or children at risk of placement had been out of the home for more than 30 days prior to the family's referral for family-based services or remained out of the home for more than 30 days after referral. Assessment cases included those cases in which families were seen only for assessment and not for treatment. Guidelines for identifying reunification and assessment cases were sent to the project liaisons in all sites in an effort to prevent such cases from being included in the sample (see Appendix 3).

A list of the families seen by the family-based program during the study period was drawn up by the project liaison in each agency. After identifying reunification, assessment, and placement cases, 25 sample cases and five replacement cases were selected from the list of non-placement cases using a table of random numbers. If there were more than 30 placement cases they were selected for the sample using the

same procedure. In most agencies, however, all the placement cases opened during the study period were used in the sample. In several agencies placement cases which were opened before or after the study period were used to attain a sample of 25. Similarly, such cases were drawn as substitutes when some of the cases originally selected for the sample were not usable. For example, if a placement case had a worker who had not completed the social worker questionnaire, the case was not included in the sample.

Other cases excluded from the sample included assessment or reunification cases mistakenly included in the sampling list, cases not opened during the study period, cases that had missing or incomplete case records (i.e. cases without demographic information), and cases that were still open. In three agencies (SCAN, Franklin County, and Lutheran Social Services) it proved to be impossible to find 25 eligible placement cases; therefore, those coded were weighted statistically so as to provide a balanced sample in each agency. In ADT both the placement and non-placement samples fell short of 25, but in roughly equal proportions, so these cases were not weighted in the analysis (Table 2.3). This increased the sample size from 533 to 535.

Coders were hired at each site by the project liaisons to complete the Case Review Instrument. The coders were, for the most part, undergraduate or graduate students of social work, although there were a few social workers and other professionals as well. The coders were trained, on-site, by NRC and RRI personnel; the training took place over a two-day period and was quite extensive. In addition to reviewing the case review instrument and the coding guidebook, the trainees coded a sample case and discussed it in detail with the trainer. The trainers also discussed the protection of human subjects and had the coders sign an affirmation of confidentiality and fill out a case reader information sheet (see Appendix 3). Inter-coder reliability is discussed in Appendix 4.

The project liaisons were instructed to supervise closely the coders' work, reviewing every tenth case, and both the coders and the liaisons were asked to contact the NRC if any coding questions arose. The case review instrument was designed to fit the case recording procedures of all the agencies and included some standardized items from their systems. It also included the Holmes *Schedule of Recent Experience* and an amalgam of the Child Welfare League of America's *Child Well-Being* (Magura and Moses, 1986) and *Family Measurement Scales* (Magura, Moses, and Jones, 1987). The instrument took an average of 1.5 hours to complete.

DATA ANALYSIS

The National Resource Center on Family-Based Services was responsible for the overall administration of the study, for its administration in Iowa, Ohio, Minnesota, Colorado, and Pennsylvania, for the analysis of data from these states (with the exception of Pennsylvania), and for the analysis of the data set as a whole. The Regional Research Institute for Human Services in Portland, Oregon, administered the study in Oregon and analyzed the data from Oregon and Pennsylvania. After coding and data entry were completed and the data cleaned of errors, the worker and case data were merged through a common worker number. This meant that each worker's responses were linked to the cases he or she had carried. After a lengthy period of combining information through additive and factor-based scales, the data set was analyzed using frequency distributions, cross-tabulation, correlation, T-tests, analysis of variance, factor analysis, and discriminant analysis.

Three different weighting systems were used in analyzing the data. The responses of the 90 social workers who had cases selected for the case sample are presented both as individual responses and weighted by the number of their cases that were included in the sample. The descriptive data in Chapter 3 are presented, unweighted,

for the 90 social workers. The comparisons of public and private, and in-home and in-office programs are based on one-way analysis of variance on the social worker data weighted by the number of cases (i.e. the responses of a worker with only one case in the sample would be counted only once, while those of a worker with three cases would be counted three times). This was necessary to give equal weight to each program.

Case data were weighted in two ways. As previously indicated, in agencies with fewer than 25 codable placement cases, both placement and non-placement cases were weighted to represent the equivalent of 25 of each. Again, this was necessary to give equal weight to each agency in the analysis and to provide equal numbers of cases in each group. When programs are compared to each other in chapters 6 and 7 the case data are weighted by the estimated incidence of placement in each agency, so as to present a more accurate picture of family and service characteristics than is provided by equal numbers of placement and non-placement cases, since, in reality, the latter are much more frequent. The estimated rates were derived from the sampling lists provided by the agencies by dividing the total number of placement cases by the total number of eligible cases, excluding assessment and reunification cases from both totals.

DISCUSSION

Several of the scales and variables used in the analysis require some explanation. Child variables were combined into a "highest risk child" variable for each case. This was the oldest of the children in the family who were at the highest risk of placement, not necessarily the "identified patient" nor the child that ended up in placement. Services were coded as to whether or not the family received the service from a specific source (the family-based unit, another unit in the agency, another agency, or an unknown source) not as to how much service was received. Thus, the

aggregated service variables represent whether or not the service was received by the family and how many different sources supplied it. The Holmes scale was weighted for severity and aggregated into a measure of stressful events experienced by the family in the year prior to the closing of the case. The Child Well-being Scales were aggregated to identify the average weighted score of the "highest risk child" and of the lowest scoring child and, using the items identified in a factor analysis by the scale's authors as a Parental Disposition Scale, into a weighted average of primary caretaker and child variables (see Magura and Moses, 1986, p. 324). Six of the items included in the original Parental Disposition Scale--Mental Health Care, Consistency of Discipline, Teaching/Simulation, Protection from Abuse, Abusive Discipline, and Threat of Abuse -- could not be included because of lack of information in the case records. Thus the two versions of the Parental Disposition Scale are not strictly comparable. Scale reliability is discussed in Appendix IV.

Sections of both the case review and social worker data were factor analyzed to group related variables and resulted in a reduction of the total number of variables. Social Worker attitudes and opinions about success and failure were analyzed in this way. The results of the analysis of success and failure are presented in Chapter 4. Case review variables grouped in this fashion included treatment problems, case objectives, and services. In all cases the variables that loaded the highest (.30 or more) on each factor were summed. Since their incidence and importance varied from site to site, the factor-based scales were not weighted by the factor loadings.

Some of the variables used in this study may be defined differently in other programs and studies, since common definitions of many of the characteristics of family-based services have not been established. In particular, "imminent" risk of placement has no clear time parameters. Both imminence of risk and other criteria used by referring agencies in selecting cases, therefore, are not empirically defined in

this study. Definitions for most of the variables may be found in the General Instructions for the Case Review Instrument in Appendix II. Following are definitions of the most frequently referenced variables that may vary in usage:

Case Management: Arranging for and coordinating services to a family.

Directive Interventions: A factor-based composite of: accompanying to an appointment, advocacy, outreach, case management, coercion, recreation, information and referral, therapeutic contract, and group therapy.

Educational Interventions: A factor-based composite of: role modeling, homework, and teaching.

High Risk of Placement: Placement imminent without family-based services or child in or just returned from a temporary placement lasting no more than 30 days before or after referral for family-based services.

Highest Risk Child: The oldest of the children at highest risk of placement in a family.

Objective: Most specific statement of what is to be achieved during service, according to the case or service plan. Does not include standard goals, e.g. Title XX goals.

Other Adult: A household member related to the primary caretaker by birth, adoption or marriage; a live-in boyfriend or girlfriend; surrogate kin (unrelated "aunt" or "grandmother", "spouse" of same sex, etc.); or a significant other (adult child, relative or friend) who plays an important role in the family but does not live in the household. Does not include individuals who live in the household but have no involvement with the family or the case (e.g. boarders).

Permanency Plan: A specific, written plan that takes into account the long-term needs and interests of the child for a permanent home.

Placement: Includes emergency shelter, supervised independent living, foster family home, group home/halfway house, institution for mentally retarded/developmentally disabled, residential treatment or psychiatric hospitalization, incarceration (jail, prison, reform school, detention facility), adoptive home, and formal or informal placement with a friend or relative if it is a response to the family's problems and not a routine visit (e.g. during holiday or with non-custodial parent).

Placement Case: A case in which a child was in placement or in which placement was planned or imminent at termination of the case with family-based services.

Primary Caretaker: A person who has legal or major responsibility for all or most of the children in the family and with whom the children primarily reside.

Private Agency: An agency which contracts with a public agency, which has primary responsibility for child welfare services, to provide family-based services; typically an agency controlled by a board of directors of private citizens rather than by a government agency.

Public Agency: A unit of government legally charged with the responsibility of providing mandated child welfare services.

Status Offense: An offense committed by a child which would not be a crime if committed by an adult (e.g. runaway, truant, ungovernable).

Treatment Problem: A problem identified within the family-based unit for which service objectives were established.

The results of this study are reported using frequency distributions based on the case data, actual workers' responses, and their responses weighted by the number of cases they carried. It is important to emphasize that in the samples from each site, placement and non-placement cases are about equally represented. This results in a gross over-representation of placement cases compared to their actual occurrence in the program. To correct for this over-representation, either data are presented

separately for placement and non-placement cases, or, when compared by site, the cases have been weighted by the estimated rate of placement in each agency.

To assess relationships to outcome, T-tests for interval level data and chi-square for nominal and ordinal level data were used, with placement or non-placement as the dependent variable. One-way analysis of variance was employed to identify similarities and differences between sites. A discriminant analysis was performed for each site to identify the characteristics which predicted placement or non-placement, in each program. To test the accuracy of the discriminant model, cases were categorized by the predictor variables as placement or non-placement cases then checked against their actual result outcomes, weighted for the ratio of placement to non-placement cases in the agency. The proportion of cases in which the results were correctly predicted indicates the completeness and accuracy of the set of predictors. In and of itself, the analysis of the eleven project sites provides valuable information on success and failure in family-based services. Each site provided a replication of the study, a basis for comparing predictors of success and failure, and a comparison of similarities and differences among the systems. The finding of predictors which are common to several sites provides strong evidence that these are important factors in the planning and delivery of family-based services.

Plans to aggregate the data from the individual sites and to repeat the analysis for subsets of public and private agencies and for the data set as a whole were not feasible due to differences in frequencies, variability, and missing data between the sites. Similarly, the three interrupted time series case studies originally planned were not completed since the social workers who volunteered for the studies either were not assigned suitable families who would agree to participate or left the agency before the studies could be completed.

CHAPTER 3

FAMILY-BASED SERVICE PROGRAMS AND THEIR SOCIAL WORK STAFF

This chapter comprises three parts. It begins with a description of each program's history, organizational structure and service delivery model as described by program administrators and supervisors. This information is presented first for the five programs operating out of public social service agencies, then for the six private agency programs.

The second part of the chapter presents information obtained from the questionnaire administered to social workers employed by all of these agencies. Data include the social workers' background, their philosophies of service, perceptions of the agency, attitudes toward clients, and definitions of success and failure in family-based services.

The third section, also based on the social workers' reports, presents an overview of differences between four types of family-based programs: public agency programs operating primarily out of the office, public agency programs that are home-based, private agency home-based programs, and private agency office-based programs. Major differences that distinguish public from private and home-based from office programs are also noted in this section.

PUBLIC AGENCY PROGRAMS

Five of the eleven family-based service programs studied in this project operate out of public social service agencies. These include: the Family Therapy Unit of the Iowa Department of Human Services, Ottumwa District (IDHS); the Intensive Family Therapy Program of the Boulder County Department of Social Services, Colorado (IFT); the Intensive Family Services program of the Children's Services Division, Oregon

Department of Human Resources (CSD); the Intensive Services Program of the Dakota County Human Services Department, Minnesota; and the Home-Based Family-Centered Services unit of Franklin County Children's Services, Ohio. The former three can be characterized as office-based programs, while the latter two emphasize home-based work with families. The following pages present a brief history and description of the organizational structure for each of these five public agencies:

Family Therapy Unit, Ottumwa District, Iowa Department of Human Services

The Iowa Department of Human Services (IDHS) is made up of six divisions. The Division of Social Services is responsible for statewide policy formulation and program development while the Division of Community Services provides direct services through its eight districts, each of which comprises a varying number of counties. The Family Therapy unit in the Ottumwa District of the Iowa Department of Human Services serves a fourteen county area in south-central Iowa.

The state's family therapy program had its origins in the early 1970's when efforts were made to reduce placements and recidivism at the Boys' State Training School by providing in-home family therapy using a team approach. This federally-funded effort was followed by LEAA grants in most of the eight districts. When these grants were discontinued in the early 1980's, the state DHS continued to fund family therapists, but increased caseloads and eliminated the earlier team approach.

At the beginning of the project study period, there was no formal statewide code or policy governing the work of the family therapy unit. At that time, each of the eight districts established its own policies and procedures within the general policies of the block grant. With the implementation of administrative rules for family-centered services in October 1985, a uniform statewide policy for family therapists (and all IDHS social workers) was created.

The philosophy of the family therapy program is based on the belief that children's needs are best met by their own families in their own homes. The family is regarded as the service recipient and the program goal is to preserve the family, either by preventing placement or by reunification. It is agency policy to offer family therapy to all families before a placement is made and to offer therapy selectively to those families with children already in placement. Therapists use a systems approach involving short-term/brief therapy with a limited, problem-solving focus.

In the Ottumwa district, family therapists see clients primarily in the office, although in-home work is done at times, often for assessment purposes. Families are usually seen over a three to six month period, weekly at first and then every two weeks as service draws to a close. IDHS family therapists provide only therapy; an IDHS case manager from the family's county office is responsible for arranging other supportive and concrete services.

Criteria for entry into the system include child abuse and neglect, risk of placement, pre-delinquency and delinquency, and court-mandated referrals. Families in need of service are referred to their county office; from there a referral to the district for family therapy may be initiated. Referrals may also come directly from probation officers, area education associations (school social workers), or under court order. The case manager or protective services worker who receives the case does the initial assessment. Should the family need preventive or reunification services, family therapy will usually be tried as a first step. If the family is assessed as needing more than weekly contact, or if chronic neglect or parent education is involved, IDHS staff in the Ottumwa district will generally recommend a referral to one of two purchase-of-service providers. If IDHS takes the case, a family therapist is assigned. The family therapist keeps the referring worker informed of case progress and makes suggestions

for additional services and referrals. If family therapy is unsuccessful, the case reverts back to the case manager.

Intensive Family Therapy, Boulder County Department of Social Services, Colorado

The Intensive Family Therapy program is part of the placement alternative package in Boulder County. The program was established in 1980 in response to Senate Bill 26 (Alternative to Out-of-Home Placement Act). It was one of the first counties in the state-supervised, county-administered system to utilize the option of diverting foster care funds into placement alternative programs. In the Colorado system, regulations, policies and a certain degree of monitoring come from the state, but the county actually has the power to allocate budgets and plan programs.

The Intensive Family Therapy Program is directed to severely disturbed, multiple-problem families. Its main function is to reduce very expensive residential placements, rather than to reduce foster home placements. More recently it has focused its services on reunifying families where a child is already in residential placement.

The two main emphases of the program are keeping children out of institutional placements and keeping families together. While the primary function of the family-based workers is to provide therapy, they also make referrals for other services if the family members need them; there is generally not a separate case manager for the family. Workers operate primarily in the office for several reasons: to maintain control of the environment; to save travel time; and to emphasize to the family that therapy is a professional activity. The main treatment approach is structural family therapy, but workers indicate their perspective is an eclectic one that blends a number of intervention styles.

Boulder is the only county in Colorado to have decentralized into three full service branch offices. Workers are part of the teams within these district offices. In

1984, a unit supervisor was added to give the program a representative in the agency and in the county Placement Alternatives Commission (PAC). This additional staff supervision provided some unity for workers dispersed across the three offices.

This unit supervisor screens all cases referred from intake or protective services. If there is a question about the appropriateness of the referral or the workability of the family, the unit will accept the family for four to six assessment sessions, after which a decision is made about continuing services. The expectation is that workers will serve at least 12 families at a time, but the caseload typically ranges from 15-17. Clients are seen weekly for about two hours. The PAC sets a 12 month limitation on services, although this can be extended if there are grounds for doing so.

Intensive Family Services, Oregon Children's Services Division

In 1971, Oregon's legislature created the Children's Services Division (CSD) to provide child welfare services, juvenile corrections programs and mental health services to families with out-of-control or delinquent children. Programs include: Protective Services, Preventive/Restorative Services, Foster Care, Residential Care Services, Day Care, Juvenile Training Schools and parole services. CSD is state administered and operates out of four regions, with branch offices in each of its 36 counties. Branch managers are accountable to regional managers who, in turn, are accountable to the CSD administrator. Two family treatment specialists operating out of the Central Family-based Services Program Office provide leadership, clinical consultation, training and program monitoring.

In 1980, the first four Intensive Family Services projects were implemented, based on a proposal approved by the 1979 legislature to divert money from the foster care budget to Intensive Family Services. Although the original proposal was to train CSD

staff to provide family treatment, the legislature required the program to contract with private family therapy providers.

Each of the four pilot projects was located in a different socio-cultural area and was selected for its relatively high number of children in placement. Based on the pilot projects' success, the program was expanded in late 1981 and 1982 to 16 projects. During this expansion, qualified private providers were not available in five of the locations; at these sites, new CSD employees were hired to provide Intensive Family Services. Project standards and regulations are the same for the "in-house" (state operated) projects as they are for the contracted programs.

Intensive Family Services is placed administratively under the Family-Based Services program. It is characterized by small caseloads (about 8 families per worker), and a time-limited service period of 90 days, although it may be extended. The program operates from a treatment model based on principles of family systems theory. The behavior of one family member is seen as necessarily affecting the behavior of other family members; the presentation of a "problem child" is viewed as an indication of a problem family, with the child having been consciously or unconsciously selected by the rest of the family as the symptom bearer. Family treatment is directed toward healing relationships between parents, as well as between children and their parents, and is broken down into three phases: assessment, treatment, and termination. About a third of the work done with families is accomplished through co-therapy.

Initally most family treatment was done in the home. After five years of studying their outcome data, however, it appeared that the same outcomes were obtained, regardless of whether the home or the office was used. There is a trend now toward working with the family in the office with the use of a one-way mirror and video equipment.

Intensive Services Program, Dakota County Human Services Department, Minnesota

The Intensive Services Program of the Dakota County Human Services Department was part of a 1979 initiative to provide alternatives to out of home placement. Minnesota is a state-supervised, county-administered system. The Department is governed by and accountable to a Human Services Board made up of the County Commissioners and comprises five divisions: Community Health, Social Services, Economic Assistance, Job Training, and Veteran's Services. Intensive Services is part of the Child and Family Services Section, one of two major components of the Social Services Division. The program also serves the Dakota County Court Services Department.

The Intensive Services unit provides intensive, in-home services to families in Dakota County facing the possibility of out-of-home placement. The program combines counseling services similar to those offered in community mental health centers with more traditional social services that emphasize outreach and work with the family in its environment. The focus is on the whole family and the program is designed to provide intensive therapeutic counseling in one to two hour meetings in the home for eight to twelve weeks; to provide educational and information services on subjects such as parenting, substance abuse, and sexuality; and to provide advocacy for services and benefits including housing, medical and legal services. Service delivery includes a formal assessment, an average of one contact per week, and a final meeting with the family and the referring worker for summary and feedback. The unit can also draw on the In-Home Child Welfare paraprofessional program which focuses on low functioning families who are not highly motivated, need help in parenting skills and lack supportive relationships.

The Intensive Services unit was originally part of the Placement Alternatives Program (PAP) initiated in 1980. The goals of this program were to prevent or shorten out-of-home placement, improve family functioning, offer a wide range of placement options, and recover part of the costs of placement from parents and third parties. The PAP was designed by an interagency team that included representatives from the court, nursing, and other community services as well as from various units within the department. Headed by the supervisor of the Intensive Service unit, the team designed a program with four components: an expanded Intensive Services unit, an In-Home paraprofessional and volunteer service, a new unit to develop shorter term, less restrictive placement alternatives, and an expanded recovery unit to increase outside support of placement costs.

The PAP program was fully operational in April, 1981. As a result of a cost-effectiveness evaluation in 1982, the PAP was refunded as part of the regular social services budget. Increased attention was given to the costs and benefits of teaming and of services extending beyond ten sessions since these were both found to be associated with higher placement rates.

After 1982, the unit supervisor was required to take on the supervision of other units in addition to Intensive Services, and caseloads were expanded from an average of four to five or six families per worker. A reorganization in January 1984 and the involuntary transfer of an Intensive Services worker to another unit contributed to declining morale, exacerbated by tensions between Intensive Services and other units over the comparatively low caseloads and better training opportunities available to workers. Conflicts within the agency culminated in a two-month strike (May-June 1985) which led to the resignation of several Intensive Services workers. (The study period for this project ended prior to the strike.)

Home-Based Family Centered Services, Franklin County Children's Services

Franklin County Children's Services (FCCS) is a family-oriented public agency located in Grove City, Ohio. It is a unit of county government with statutory responsibility and authority for providing child welfare services to a mostly inner-city population in Columbus. The agency is part of the executive branch of the state government and has primary responsibility for developing and implementing home-based family-centered services (HBFS). The HBFC program is administered by FCCS as a special program administratively placed within the Division for Services to Families and Children. A policy-making Board of Directors, composed of eleven members appointed by the County Commissioner, governs FCCS.

FCCS is one of four agencies delivering home-based services under an umbrella program. FCCS administers the program and purchases services from three private agencies, as well as providing two home-based teams directly through the HBFC unit. This program is considered unique in that it combines the efforts of public and private agencies, with the public as the lead agency and the others still having ownership of the program. This study focused only on the public unit, HBFC.

The program had its beginnings during a 1982 seminar that involved the National Resource Center on Family-based Services and various community agencies. Out of that meeting came a task force of public and private agencies who wrote a grant proposal to the Columbus Foundation. Forty thousand dollars in start-up funds were awarded to the project, with FCCS designated as the lead agency. The Community Mental Health Center, a settlement house, and a family service agency completed the consortium. The program began as a two-year pilot project in June 1983 and hired an outside consultant to evaluate the program. Results indicated that at the end of eighteen months, 90% of the families served remained intact as compared to 41% of

those referred but not accepted for services. Positive behavioral change was also demonstrated in those families served by the program.

The purpose of the unit is to provide time-limited (6-9 months) in-home intensive service to families at a time when a decision has already been made to place the child in a FCCS-paid placement. The program is viewed as a last resort to prevent placement and is also used for reunification of families whose children are already in placement.

Service is provided by a team composed of an MSW social worker, a paraprofessional BA/BS-level Family Specialist and a team supervisor. The social worker is responsible for the psychosocial diagnosis and the case plan; the family specialist provides concrete services and skills development. Intervention and assessment are based on a casework model that draws on cognitive and behavior theory, learning theory, reality therapy and family counseling. The team also does life-space work and advocacy. Much of the focus is on socialization and re-parenting in order to develop trust and help the family find its own strengths and develop community support systems. Workers cite three unique aspects of the home-based program: their ability to respond immediately to a crisis and to function like an extended family for those who have no such support network, while at the same time not inducing dependency; their ability to spend more time with families because of their reduced caseloads, particularly their ability to participate in family activities and recreation; and their ability to provide financial assistance, which is much more accessible than in a traditional service unit.

PRIVATE AGENCY PROGRAMS

Six family-based programs examined in this project are based in private social service agencies, or in one case, a Community Mental Health Center which contracts

with the public social services agency. These programs include: the Albertina Kerr Center for Children, Portland, Oregon; Adolescent Day Treatment Program (ADT), Adams County Community Mental Health Center, Colorado; In-Home Family Counseling Program, Iowa Children and Family Services (ICFS), Ottumwa, Iowa; Intensive In-Home Treatment Program, Lutheran Social Services of Minnesota (LSS); Intensive Family Program, Catholic Family Services, Multnomah County, Oregon; and the Supportive Child/Adult Network Program (SCAN) of Philadelphia, Pennsylvania. The first two are primarily in-office programs, while the other four are essentially home-based service programs. All the private agencies, except the Albertina Kerr Center, receive the bulk of their referrals from public social service agencies.

In-Home Family Counseling Program, Iowa Children and Family Services

Iowa Children and Family Services (ICFS), a non-governmental, non-sectarian, statewide human service agency with programs operating out of offices in several cities throughout Iowa, offers a number of programs, one of which (In-Home Family Counseling Program, Ottumwa, Iowa) was selected for this study.

The In-Home Family Counseling Program is a coordinated family intervention service designed to allow youths to remain in their own homes by offering a range of family-strengthening efforts. In-Home Family Counseling is used as an alternative to institutional, residential and/or foster care, or as a preventive service for families who may otherwise be potentially abusive, neglectful or headed toward family breakdown.

The program's philosophical commitment is to keep families together. In situations when this is not possible, the goal is to protect the children, achieve permanent plans for them, advocate for the family, and intervene to change the community's response to them.

In-Home Family Counselors spend the first one or two weeks observing the family in its environment. Visits at various pre-arranged times with the family allow the in-home counselor to complete a family assessment that details family relationships, conflict resolution abilities, socioeconomic functioning, family communication patterns, children's interrelationships, parental functioning, and how these dynamics may be involved in the presenting problem. Based on this assessment, the in-home family counselor develops a family treatment plan in conjunction with the entire staff and the referring worker. Direct service and family treatment usually begin two to three weeks after the start of the observation period.

The in-home family counselor, carrying a caseload of four to six families, provides intensive and ongoing service to the family. The counselor is responsible for the development and execution of the family's treatment plan. This may involve various activities, including counseling with individuals and families, teaching, role-modeling, and family advocacy. Since Ottumwa County is a rural area in Iowa and ICFS is often the only provider of in-home services, workers also perform paraprofessional tasks. Families are seen 2-4 hours a week for 6-9 months: 4-6 hours a week for a two-week assessment; 2-4 hours a week for 3 to 4 months of treatment; contact then decreases to every other week to test family maintenance prior to closure. Workers are expected to provide 48 hours of direct contact per month.

Eligibility for service is determined by the Iowa Department of Human Services, although families may refer themselves as well. An increasing number of cases are court referrals which take priority and go to the top of the waiting list. Clients have generally been through a period of service before they are referred to ICFS from IDHS, the community mental health center, or other services such as substance abuse counseling or homemaker services. Many clients, particularly those who have had

multiple IDHS workers, tend to be discouraged, hopeless and resistant by the time they reach ICFS.

The In-Home Family Counseling Program arose during a period of general interest in family-based services in the state. It began in Des Moines, in 1977, with a CETA grant and some United Way funds. IDHS made the promised referrals to the program and allocated funds to purchase services from it the following year. In 1978, Department interest prompted the opening of a program in Fort Dodge. The Ottumwa program was started in 1980 after IDHS interviewed five service providers and invited ICFS to start a program. In 1981, the Department of Human Services reorganized its districts and an office of ICFS opened in Burlington to serve the enlarged district. Other branches opened in Carroll (1982), Shenandoah (1982) and Creston (1985).

Several changes since 1984 have affected the In-Home Family Counseling Program, particularly in Ottumwa. In January 1984, IDHS modified its billing system so that only direct contact hours could be billed. Previously, indirect hours could be charged as well. This clearly presented financial problems for the program, as so much of the workers' time was spent in traveling to visit families.

The program is governed by an active Board of Directors and by IDHS regulations. Each Department has a Board committee that evaluates it yearly through staff, client and referring worker interviews and statistical reports. Authority flows from the Board through the Executive Director to the Assistant Executive Director to the Department Directors to the Program Supervisors to the line workers. Accountability procedures involve the reading by supervisors of all family service notes, spot reading of cases by both the Department Director and the clinical consultant, and IDHS review of cases by a purchase-of-service monitor.

Intensive In-Home Treatment Program, Lutheran Social Services of Minnesota

Lutheran Social Services of Minnesota (LSS) provides an Intensive In-Home Treatment Program to families who have at least one child at risk for out-of-home placement. The program covers sixteen counties in Minnesota; the central office for the site selected for this study was in Fergus Falls, Minnesota, a rural area in the western part of the state.

The program began in October 1981, one of the first four established in the state. Funding was initially provided by two counties and covered two staff positions. Four workers were added from 1983 to 1984; these workers were trained in strategic and structural family therapy and influenced the program in that direction. In January 1984, LSS reorganized into a system of six regions. In 1986, the original Intensive In-Home Treatment program was split along new district lines into two programs, one based in Fergus Falls and one in Burnsville. The Fergus Falls program is the one included in this study.

The family-based program is part of the statewide LSS organization, governed by a Board of Directors. The Executive Committee consists of a president and two vice-presidents (one for program, one for finances). Guiding personnel policies, management policies and values and ethics procedures are included in a statewide policy manual. The director of the Fergus Falls program is directly accountable to the regional director.

The philosophy and treatment approach are based in family systems and in-home work with the whole family. The family unit is viewed as the most viable option for resolving family problems, even when only one child is identified as having difficulties. The program adheres to the view that children are often placed out of the home not because families cannot change, but because community resources do not allow for the intensity of staff time, or orientation, that would help children remain in their own

homes. While the program provides family therapy, it also emphasizes working with the community and providing whatever concrete services are needed (transportation, cleaning, networking). Parent education, health services and support groups are also used when they are available. All services are based in the family home, unless a specific reason prohibits this, such as a need for live supervision, danger to the worker, or a need to meet outside of the home for therapeutic purposes.

Clients are referred solely from the contracting Department of Social Services and community corrections office. The program works closely with local county Departments of Social Services, schools, and other community human service professionals and resources to enhance total family functioning.

Intensive Family Services, Catholic Family Services, Multnomah County, Oregon

Intensive Family Services, a program administered by Catholic Family services through a contract with the Children's Services Division (CSD) of the Oregon Department of Human Resources, was one of four pilot projects begun in 1980 through a legislative initiative (see description of Oregon Children's Services Division). This program serves families in Multnomah County, the most populated and urban county in Oregon, and one of three counties comprising the Portland metropolitan area.

Currently the program operates out of the CSD branch office in Multnomah County. Cases are referred to the Multnomah program by a CSD social service worker who retains case management responsibilities. Services are provided to families for a maximum of three months initially. Each worker serves a minimum of nine families at a time, and service is based primarily in the family's home.

Families served by the family-based program are selected according to the following priorities: 1) families with a child at risk of placement in family foster care (including children in adoptive placements); 2) families with a child at risk for

placement in group care; 3) families with a child who has been committed to a state training school but has not yet been placed; 4) families with a child returning home from placement at a state training school; 5) families with a child returning home from group care; 6) families with a child returning home from foster care and who, without intensive services, would remain in substitute care; 7) families with a child for whom the permanent plan is returning home from substitute care; 8) children in placements who are at risk of removal to a higher level of care.

A majority of families served have an adolescent child who is seen as a high placement risk. Often these children are victims of physical or sexual abuse or have experienced serious neglect. In addition, they may be delinquent, truant, suicidal and/or chemically dependent. Because of the program's family therapy orientation, these problems are seen as systemic in nature.

Service begins with an in-depth family assessment in which the therapist develops an hypothesis for understanding the whole family system; this forms the basis for strategies or interventions. Families typically come to the attention of CSD when they are in crisis, a factor that increases the potential for change. Treatment focuses on restructuring the way in which family members respond to the "problem child", particularly the symptomatic behavior, and on creating new ways for them to understand this behavior. The majority of the cases receive co-therapy, often with one therapist directing and the other observing the session. Originally, the program used Multiple Impact Therapy as its primary mode of treatment, but currently MIT sessions lasting from four to six hours are used with only half of the families at some time during the course of treatment. The model used now draws heavily from both structural and strategic family therapy and follows three phases: assessment, treatment, and termination.

Supportive Child Adult Network (SCAN) of Philadelphia, Pennsylvania

The Supportive Child Adult Network, based at the University of Pennsylvania's School of Nursing, provides home-based intensive services to severely disadvantaged families in the city of Philadelphia. The program actually began in 1973, with the establishment of a Child Abuse and Neglect Multidisciplinary Team based at the nearby Philadelphia General Hospital. The Children's Hospital of Philadelphia, the Hospital of the University of Pennsylvania, the Philadelphia Child Guidance Clinic, and Presbyterian General Hospital were also involved in this team. At that time, SCAN relied on paraprofessionals who resided in the area and were trained and supervised by a staff of nurses, social workers and psychologists. Clients were referred to SCAN for preventive help by the participating hospitals.

In February 1975, the SCAN group was awarded a two-year federally funded Title IV-B Child Welfare Demonstration Grant, under which SCAN incorporated as a non-profit organization. In July 1977, SCAN entered into its first contract with the City of Philadelphia to provide protective services to children in their own homes. In July 1985, the Philadelphia City Children and Youth Agency became the sole referral source and the primary funding source for SCAN. Although it no longer accepts direct referrals from the hospitals, SCAN still maintains a professional and administrative link with some of the founding organizations.

SCAN is governed by an eleven member board of directors, elected to a two-year term. The board assumes responsibility for policy, while the program director, appointed by the board, is responsible for SCAN's operations and activities. There has only been one program director since SCAN's founding.

SCAN adheres to four central principles: belief in the value of home-based services; comprehensiveness of services to the child and family that include treatment of medical, social, environmental, psychological, and educational problems; commitment

to filling gaps in service with new programming while at the same time strengthening already existing services through joint ventures and collaboration; and dedication to high quality service for a population of disadvantaged children and their parents.

SCAN offers a multidisciplinary approach to services that combines social work, nursing, psychological services and medical consultation. Social work services offered by SCAN include protective casework, family counseling, and the teaching of daily living skills. Nursing services include home-based nursing care and the teaching of nutrition, child care and child development. Psychological services include evaluation, referral, and support for families in need of mental health services. Medical consultation services offer health supervision and outpatient pediatric care at SCAN's weekly clinic.

Families referred to SCAN are generally those for whom an indicated abuse or neglect report was filed and for whom involuntary protective services are required, or those families at risk of abuse or neglect for whom voluntary home-based services are desired. SCAN serves about 500 families a year and receives about twenty-five referrals each month. The majority of families receive services for nine to fifteen months.

A comprehensive assessment at intake is seen as essential in order to make the most efficient use of services and to prepare client families to use the services most effectively. The initial home visit always includes the public social services referring worker and the SCAN intake worker, and sometimes other members of the multidisciplinary staff. Following this visit, the comprehensive intake assessment takes 10 to 15 days and concludes with an intake study and Family Service Description. From there, the case is assigned to a direct service worker.

Albertina Kerr Center for Children, Portland, Oregon

The Albertina Kerr Center for Children (Kerr) is a private, non-profit agency serving families in the Portland, Oregon area. The family-based treatment program began in 1978 under a two-year, $200,000 juvenile justice grant aimed at deinstitutionalization and diversion of adolescents through family treatment. Family treatment was provided as needed, based on the philosophy that the treatment of children's problems must include the family since the fundamental problem is the family system.

Program staff are trained in structural and strategic family therapy, with an emphasis on behavioral and realistic approaches that will help keep children in their families. Kerr staff use individual counseling and some co-therapy, rather than a team approach. While Kerr therapists do their own case management, they have increasingly involved more community persons in collateral work.

The Kerr Center receives a large number of referrals from schools. Self-referrals, family, and other private parties account for one third of all referrals. Head Start and mental health clinics are also major referral sources, with the public social services department accounting for only 10% of all referrals.

Adolescent Day Treatment Program, Adams County Community Mental Health Center, Colorado

The Adolescent Day Treatment Program (ADT) is one in a continuum of services designed as alternatives to out-of-home placement under Colorado's Senate Bill 26. This bill created Placement Alternatives Commissions that are responsible for developing alternative-to-placement programs at the county level. (The Intensive Family Treatment program in Boulder County, Colorado, another study site in this project, was also created out of SB26.)

The Adolescent Day Treatment Program is under the auspices of the Adams County Community Mental Health Center. This is a purchase-of-service program rather than a program directly administered by the Department of Social Services. The program includes daytime therapeutic hospitalization and educational programming. It accommodates approximately 20 children, ages 12-17, who cannot be maintained in the regular school system, even with special programs. The ADT program represents the last attempt to work with these children before complete hospitalization or placement in residential treatment facilities is required. Every request for out-of-home care is reviewed by a Placement Alternative Resources Team (PART), an interagency group; during the study period, all referrals from PART were accepted by the ADT program. Some referrals come directly from the school district as well, and a few families (10%) are court-ordered for treatment.

When the program started, the emphasis was on developmental therapy. In 1982, a new director brought in family-based therapy as an integral part of the treatment program, thus transforming the medically-oriented model to a family-based one. Children are accepted into the program at any time during the school year and generally remain in the program from 10-12 months, although this can be extended. Families are seen once a week.

ADT is under the direction of three different agencies: the Department of Social Services, the Department of Education, and the Community Mental Health Center. CMHC administers the program and funding comes from three sources: social services SB26 money, Medicaid, and special education funds from the school district. The program must meet the standards of all three agencies.

SOCIAL WORKERS IN FAMILY-BASED SERVICE PROGRAMS

One of the primary data collection efforts of this study was to survey all social workers employed by the family-based service programs during the study period. The survey was designed to find out more about the workers; their opinions about their programs and their clients, their practice philosophy, and their assessment of what constitutes success or failure in their practice. The information that follows pertains to the unweighted data from the sample of 90 social workers who carried sample cases. Since there was not an equal number of social workers at each site, means for the unweighted data were checked against the weighted group means. When discrepancies were found, they are so noted.

Social Worker Demographics

There were 90 social workers in the study sample. Sixty-two percent were female, and their average age was 36.8 years. Eighty-two percent of the workers were Caucasian, 12% were Black, 4% were Native American and 1 was Philippino. Nearly 62% of the social workers were married, about 21% had never been married and 16% were separated or divorced. Fifty-two percent had no children of their own, while 40% of the workers had between one and three children.

The social workers had completed, on the average, 17.9 years of education. Nearly 17% had some post bachelor's degree education, 47% had attained a master's degree, and 14.6% had completed post-masters through post-doctoral work. Fifty percent of the workers held an MSW degree. While more than half of the workers did not have specific professional certification, 12% had ACSW certification, 4.4% AAMFT, and 20% state social work certification.

Social workers in the family-based programs had an average of 4.3 years of professional child welfare experience, 1.9 years of public social service experience, 3.9

years of individual therapy practice and 3.2 years of family therapy practice; combined, this makes an average of 8.2 years of professional social work experience at the beginning of the project study period. Volunteer work among social workers averaged 1.8 years. The social workers in the study had been employed by their agency for three and one-half years, on the average, and had been practicing family-based services in that same agency for an average of two and one-half years. The average work experience in individual therapy, social services experience and length of time employed by the agency were affected by the use of unweighted data; the weighted averages were 4.3 years of individual therapy experience, 1.6 years of public social services, and 3.9 years of employment with the agency.

Caseload and Caseload Management

The majority of workers noted that cases were assigned on the basis of openings in their caseload. About half said that cases were also assigned on the basis of geographic location and worker expertise.

Caseloads averaged 10.1 families for all social workers: the highest caseload, on average, was 13 and the lowest, 7.2. Workers spent the highest percentage of their time in in-person contacts (44.4%), followed by travel (13.2%), administrative tasks (12.9%), staffings (9.4%), phone calls (6.4%), collaborative work (5.3%), other activities (4.1%), and peer support activities (4%). Workers spent a median of two hours a week with each family, although this figure varied among programs. The average caseload size and the proportion of time spent in the various activities were slightly different in the unweighted data set; this shows that the disproportionate number of workers at various sites affected the averages. (Table 3.1) Social workers reported working an average of 42 hours per week.

Most social workers saw the majority of their client families during the day, although evening appointments were used for a substantial number of clients. Weekend meetings were seldom held. Appointment times and appointment location (in-home or office) were related to program structure and will be discussed later in this chapter.

Services and Case Coordination

According to the social workers surveyed, p*rior* to becoming involved in family-based programs, more than one-half of the families had received public financial assistance such as AFDC, food stamps, SSI or Medicaid. Between one-quarter and one-half had received child protective services, subsidized or public housing, and the out-of-home placement of a child. Only a small percentage of families had received such supportive services as community mental health services, homemakers, parent education, support groups, substance abuse treatment, private therapy or counseling, school social work services or day care.

During the time families were involved with family-based services, according to the social workers surveyed, more than half received public financial assistance. Between one quarter and one half received child protective services, and only a small percentage received the supportive services noted above.

At the time of case closure, the situation was much the same according to the social workers. Families continued to receive public financial assistance. Child protective service remained the second most common service, although at case closure it was provided to less than one-quarter of the families.

Social workers perceived the relationship between their family-based program and other community service providers including the public social services agency, mental helath agencies, probation, medical professionals and the courts as fair to good. Teaming varied among sites: in some programs, social workers teamed with a

paraprofessional within or outside of the agency; in others, a worker teamed with another professional person in the unit, in the agency or from an outside agency; sometimes teaming with the unit supervisor occurred. (Table 3.2)

When paraprofessionals were involved in service, their most common roles were building parents' self-esteem, providing parent education and household skills development, and role modeling. There was great variation in the extent to which professionals and paraprofessionals worked together with their client families: sometimes a true team approach was used while in other cases, they worked independently with the family and fulfilled different roles.

Case coordination between the referring worker and the family-based worker most frequently consisted of writing or updating case plans (quarterly), exchanging written progress reports (monthly), staffings (monthly to quarterly) and telephone contact (weekly to every two weeks). Social workers cited the following people as having the greatest influence in setting case goals: the worker or team assigned to the case, the referring worker, the adults in the family, and the court.

Supervision and Training

Social workers reported that they received an average of 3.7 hours per month in individual and group supervision, 4.4 hours of peer supervision, and 1.9 hours of consultation from an agency employee other than their immediate supervisor or from a consultant outside the agency. They spent an average of 6.4 hours a month in informal discussions about cases with coworkers. The frequency with which staff meetings were held varied, although two-thirds of the workers reported weekly staff meetings. These were most often used for discussion of agency policy and procedures, for mutual support, case discussion, staff development and training, and socializing.

Workers generally believed that their supervisor spent about the right amount of time consulting with them on cases, attending agency or community meetings, attending to paperwork, developing new services and providing direct services. A large percentage of workers felt their supervisor spent too little time on training. Thirty percent of workers indicated that their program had experienced a decrease in funds for training during the study period, and this was unanimously believed to have had a negative impact on the program.

Social workers reported that they attended an average of 2.6 workshops related to their job each year. Agency funds were more readily available for attending conferences and for purchasing outside consultation than they were for continuing education or for the purchase of books or films. Use of outside consultants was believed to have had a positive impact on their program according to most of the thirty percent of workers whose agencies had used consultants during the study period. Workers read an average of 1.7 journals on a regular basis and made use of the agency's library about 15 times a year.

Clerical Support and Office Space

Most workers in family-based service programs believed clerical support in their agency to be adequate to very good. Clerical support was generally available for typing letters, reports and case narratives, and for filing, answering the telephone and taking phone messages. Support was less readily available for typing dictation, completing case forms or making appointments.

Workers disagreed about the adequacy of their office facilities, although there was consensus about the adequacy of space for the purpose of paperwork, phone calls, agency meetings and client records.

Budget and Finances

Most workers had no input into their agency's budget. When they were asked about events that occurred within the program during the study period, more than one-third noted professional and clerical staff turnover, cost of living/merit increases for professional and clerical staff, and the addition of professional staff positions. About thirty percent cited a decrease in training resources, and agreed the impact to be negative.

Annual staff salaries in the eleven family-based service programs averaged $19,577. The large variance in the figure is attributable to differences between public and private agencies and will be discussed in a subsequent section of this chapter.

Turnover and morale

Worker turnover varied by program, although nearly 70% of the social workers questioned regarded turnover as low or moderate during the study period. The most important reasons they cited for professionals leaving the program were: opportunities for advancement, job-related stress, and a need for change. Workers believed that it was not very difficult to find qualified staff, that it was somewhat difficult to find individuals with the requisite experience, and that it was not difficult to find individuals willing to work in the home, at the available salary level, or with the required education or training.

Morale in the agency was perceived by more than 70% of the social workers surveyed, as average to high, although a considerably larger proportion believed that morale was declining rather than increasing during the study period. When queried about their own career plans, nearly one-quarter of the workers had, at the time they were surveyed in 1985, quit working in family-based services. Another quarter planned

to stay in their position indefinitely, and nearly one-third planned to stay on for one or two more years.

The social workers in the eleven programs seemed to have a fairly high level of morale, as measured by the Chess and Jayaratne "Professional Satisfaction Inventory" and Maslach and Jackson's "Human Services Survey." In general the social workers perceived their job as very challenging, and as offering some degree of professional autonomy. Workers perceived their relationships with co-workers as very friendly. They agreed less often that financial rewards and job security were adequate, that they had good working conditions and that their agency offered opportunity for promotion. On the negative side, they felt fairly often that ambiguity about their job was a problem and that workloads were too heavy, and they reported some role conflict. Workers missed very few days of work due to illness or stress, an average of .5 days in the previous month.

Client Population and Eligibility Requirements

The most important factors determining clients' eligibility for family-based services, according to the social workers, were a child being at risk--of substitute care, abuse, neglect or exploitation; referral by the public department of social services; the family having exhausted all other available services; and residence in a specific catchment area. Ineligibility for service was seldom noted, but the most likely situations were those in which a violent family member posed a danger to the worker, those in which keeping a child in the home was considered risky, and those in which there was no child at imminent risk for out-of-home placement.

Treatment Models and Outcomes

No specific school of family therapy appeared as singularly prominent in the family-based social workers' therapeutic orientation. While, as a whole, these workers rejected a psychodynamic approach, they felt neutral about behavioral, communication, structural and strategic orientations; that is, they were neither strongly for nor strongly against them. On the average, workers professed to endorse, at least to a moderate degree, a "casework" approach, as measured by Halper and Jones' (1981) treatment techniques scale. Variations in therapeutic orientation by type of program will be discussed later in this chapter.

The workers believed the following to be the most important program characteristics in delivering effective preventive services: that families are encouraged to assume greater responsibility and self-determination over their own lives; the belief that most children are better off in their own homes; and that services follow goal-oriented case plans in which clients determine and prioritize their own treatment goals. Among the program characteristics social workers ranked as least important to effective services were: brief services (no longer than 90 days), delivery of hard services such as moving, cleaning, and grocery shopping with clients, and services provided routinely at night or on weekends.

When workers were asked to reflect on the termination of services, the reasons they most frequently cited were that the family was capable of functioning without services, that the family was stabilized and no longer in crisis, that a child was no longer at risk of placement, and that case objectives were at least partially met (Table 3.3). Workers seldom terminated services due to the following reasons: they were "burned out" with a family, the child at risk was no longer in the family, the family had a support system in the community, or the time limit set in a family contract or by the agency was reached.

Workers reported that they recommended placement for a median of 5% of their cases; this ranged broadly from 0 to 30% for the entire sample of workers. The most frequently noted circumstances under which placement was recommended included a child being at risk of serious physical or emotional harm due to the parent's, caretaker's or another adult's behavior, a child being at risk of serious physical or emotional harm due to his or her own behavior, and the exhaustion of all other services. When case outcome was a decision to place out of home, social workers perceived the family, the court, the department of social services and the primary worker as the parties most involved in the decision.

Follow-up contacts were not made with all clients, according to most workers in this study. When it did occur, follow-up was more likely to be done by telephone than in person or in writing, and more likely to be accomplished within the first three months of case closure than six months or a year thereafter.

When workers were asked what percentage of their cases they regarded as successful, the average response was 67.7%. They most frequently cited the following as "success": the family was together when services were terminated, the family was stabilized and no longer in crisis, family members felt better about themselves, positive change had occurred in the family's interactions, behavior or communications, the adults felt more competent in their roles, children's needs were being appropriately met, and the presenting problem was resolved.

Conversely, workers believed that an average of 20.4% of their cases could be regarded as failures. Workers assessed their cases as failures when: parenting was still inappropriate to the child's needs, the family was not stabilized, case objectives were not met, the family continued to need outside help to deal with its problems, and no change had occurred in the family. When asked to give reasons for case failures, workers cited four primary ones: that the family was not motivated to change, that

the family was referred too late for family-based services, was not ready for family-based services, or refused services. In short, social workers believed that the most important reasons for their failure with families were lack of client motivation and poor timing of services.

Worker Preferences and Attitudes

Based on a list of typical family problems, workers were asked to indicate which ones they worked with best and those they found most difficult. There were very few types of cases a large percentage of workers found hard to work with, though the most difficult ones appeared to be chronic neglect, substance abuse, and mental illness. At least half the workers believed they worked well with the following situations: problems of poverty, housing and homelessness, mental retardation and physical handicaps, employment problems, adolescent pregnancy, and adoption.

Overall, workers believed that the families who most benefit from family-based services are those who seek services voluntarily, are new to the service system, are in crisis, or present adolescent rebellion as a problem. Family based services were generally seen as being of little benefit to families who lack motivation or do not desire services.

Summary

The ninety social workers in this study had an average age of 36.8 and an average of 8.2 years of social work experience when surveyed at the beginning of the project study period in 1985. More than half of the social workers had attained at least a master's level of education. Clearly these were not, on the average, young workers beginning their professional careers, but individuals with considerable experience and education.

Despite differences among sites, social workers in family-based services shared some common philosophical orientations, such as their belief in family empowerment and their preference for maintaining children in their own homes. No particular school of family therapy emerged as the predominant one, a finding that suggests that workers are eclectic or pragmatic in their approach to treatment.

Finally, several factors suggested that family-based workers felt quite positive about their work and their program's effectiveness: their estimated average success rate of 67.7%, their fairly high level of morale and their good working relationships both within the agency and within the larger community.

A STRUCTURAL TYPOLOGY OF FAMILY-BASED PROGRAMS

While the social worker survey was primarily intended to gather information on workers' attitudes about family-based services, it also provided the basis for creating a typology of family-based services programs. When the pattern of correlations within the social worker data was examined, it became apparent that two structural features most strongly affected the operation of family-based programs: whether the program was located in a public or private agency and whether services were delivered primarily in the home or in the office. Similarities and differences between in-office and in-home and public and private programs were examined in order to provide a clear picture of each program type. Such a picture, it was hoped, might be useful not only in planning family-based service programs, but also in anticipating the strengths and limitations of each type of program. Table 3.4 presents selected characteristics of public/private and in-home/in-office programs.

Public In-Office Programs

Although family-based services developed first in private agencies with workers seeing clients in their own homes, three programs in this study delivered their services

within public agencies and primarily through in-office contacts: The Ottumwa District Office of the Iowa Department of Human Services (IDHS), the Boulder County Department of Social Services in Colorado, and the Children's Services Division of the Oregon Department of Human Resources (CSD). The Iowa and Oregon programs are state administered and the Colorado one, state supervised and county administered. In Iowa and Oregon, the family-based programs are located in specialized units that serve other units in the same agency. Colorado family-based workers meet as a unit once a week with a unit supervisor; however, they are attached to regular service units which are geographically dispersed throughout the county.

Since each of these programs is embedded in a complex, multi-service public agency, it is most interesting to note that workers uniformly cited the good working relationships they enjoyed with other agency units. Indeed, these public, in-office programs experienced the best internal working relationships of all the programs in the study. They also reported good relations with the court, a significant comment given that they received a higher proportion of referrals from the court than any other type of program.

High caseloads were another feature of the public in-office programs, averaging up to 21.8 cases per worker, a figure twice as high as any other agency group. In order to manage high caseloads, workers reported coordinating services in more different ways and with more frequency, especially with referring workers, than in-home sites. As a whole, public in-office programs more often used supportive services than the private agencies did, and this included use of paraprofessionals, financial aid, and various kinds of therapy.

With the exception of IDHS, the public in-office programs reported that less money was available for conferences, continuing education, journals and other means of professional development than in in-home programs. IDHS and CSD also offered fewer

hours of individual supervision than other agencies, averaging 2.4 hours per week, as well as fewer staff meetings, one every two weeks. IDHS and Boulder County also spent less time on staff development and training during staff meetings than other agencies did.

Two of the three public in-office agencies reported terminating cases more often for positive reasons--family stability, absence of risk, and goal achievement--than private agencies. Workers in IDHS and CSD also viewed placement cases without permanency plans to be failures more often than workers in in-home programs did.

Other features public in-office programs (except IDHS) have in common are higher salaries, $22,674 on the average, and higher than average morale. All the public programs experienced low turnover; in two of the three public in-office programs, workers had been with the agency an average of 6.2 years, significantly longer than workers in other agencies.

In terms of practice, it is perhaps not surprising to find that in-office, public program workers subscribed less than others to a "hands-on" approach: 24 hour on-call service, two to three home visits a week, and the delivery of such "hard" services as moving, cleaning, and grocery shopping with clients. They also saw scheduling appointments at the convenience of the clients as a less important factor in delivering effective service. Finally, along with workers in <u>private</u> in-office programs, workers in IDHS and Boulder County tended to see the office as the most effective setting for delivering family based services.

In sum, the main characteristics distinguishing public in-office programs were: their good working relationships with other agency units, low turnover and higher morale, generally higher caseloads, and higher staff salaries.

Public In-Home Programs

Two in-home programs within public agencies were included in this study, the Intensive Services Program of, Dakota County Human Services Department, Minnesota and Home-Based Family-Centered Services, Franklin County Children's Services, Ohio. Since only one of the three family-based workers in Franklin County responded to the survey, comparisons on the basis of worker data are not possible. For this reason, only the Dakota County program is discussed in this section.

The Dakota County program was different from other programs in a number of respects. Workers reported serving the lowest proportion of low-income families (about 25%), having the lowest caseloads (an average maximum of 8.4 cases), spending the lowest proportion of time in direct contact with families (34%), the most time traveling (17.7%) and the most time in peer support activities (6%). Paraprofessional services, financial aid, and therapy were more available to clients in Dakota County than in other communities in the study.

In terms of supervision and training, Dakota County offered more hours per month than any other program: individual supervision (5), group supervision (6.2) and outside consultation (3.9). Workers in Dakota County did more journal reading and had the most access to funds for professional development. Although these workers had the highest average salaries ($25,329), they reported the sharpest decrease in the financial resources available to the agency during the study period. As might be expected due to the relative affluence of the population and the resources available to the program, workers reported the highest success rate with families (76.8%) and often terminated with them because they had reached a level of functioning comparable to other families in the community. They also reported the fewest failures due to lack of supportive services, means to meet basic needs, or community interference.

While exhibiting a number of unique characteristics, the Dakota County program shared some features with other public and in-home programs. Along with other public agency programs, workers reported higher salaries, low turnover, higher than average morale, the highest availability of paraprofessional, financial aid, and therapy services, and a high rate of positive case terminations. In common with other in-home programs, workers reported high commitment to a "hands-on" approach to family-based services, a belief in the greater effectiveness of service delivery in the home, more time in traveling, and more access to funds for professional development. Overall, the Dakota County program shared slightly more characteristics with other public programs than with other in-home programs and was markedly different from private in-office programs to which we now turn.

Private In-Home Programs

Although exhibiting a great deal of diversity, the four in-home programs in private agencies shared several characteristics. All except one were part of larger multiservice private agencies. The In-Home Family Counseling Program, Iowa Children and Family Services (ICFS), is part of an agency with several offices throughout the state of Iowa. The Intensive In-Home Treatment Program in Fergus Falls, Minnesota, is part of the extensive, statewide service network of Lutheran Social Services (LSS). Both programs serve predominantly rural areas. Intensive Family Services, Multnomah County, Oregon, contracts with the Children's Services Division of the State Human Resources Department to provide family-based services to residents of the greater Portland area and SCAN (Supportive Child Adult Network) of Philadelphia, the oldest of the private, in-home programs, is itself a multiservice agency unique in contracting with the city to provide child protective services to the largely black, urban population which it serves.

All these agencies received a higher proportion of their cases from the courts, and, all but one, the lowest proportion of cases from probation, police, the schools, self-referrals and referrals from other social service, health and mental health agencies, friends and neighbors. They were also similar in serving a high proportion of low income families, on average about three quarters of their cases.

Like workers in the public in-home programs, workers in these programs spent more time in travel, an average of 16.1%. Concomitantly, they spent the least time in peer support activities (2.8%). Compared to public in-office programs, they less frequently coordinated services through written or phone contacts with referring workers, and more often coordinated services with other providers in staff meetings. They also reported the highest participation of referring workers in setting case goals. Except in SCAN, private in-home programs made little use of outside consultants. All but Multnomah County, Oregon reported recommending placement in a higher proportion of cases (8.4%) than other types of agencies.

In terms of agency support, workers in three of the four agencies rated clerical support higher than in the other types of agencies. Salaries were low in all four agencies, averaging $18,309. Turnover was high, although not so high as in the private in-office programs. The only private in-home agency with low turnover was SCAN. Workers in the private in-home programs had, on average, less experience in working with families (2.2 years) and less experience in the agency (2.7 years).

Differences between in-home and in-office programs were clearly demonstrated by these workers' belief in the effectiveness of service delivery in the home and the importance of scheduling appointments at clients' convenience. Workers in all the agencies except Multnomah County also highly endorsed a "hands-on" approach to family-based services. With the exception of SCAN, workers believed that asking clients to determine and prioritize their own treatment goals was only moderately

important, an opinion that contrasts with the one reported by workers in the other agencies that this is quite to extremely important. Finally, workers in these agencies found that marital problems and families who were sophisticated about services were harder to work with than workers in other agencies did, and they felt that most of their families had different values from the majority of the community.

In summary, private in-home programs were distinguished by a high proportion of low-income families, fewer referrals from probation, police, the schools, and other social service, health, and mental health agencies, as well as fewer self referrals and referrals from friends and neighbors. They had the highest commitment to a "hands-on" approach to family-based services, the most involvement of the referring worker in setting goals, and the lowest belief in the importance of clients determining their own goals. They also had the least experience in working with families, the highest level of clerical support, and the least amount of peer support activities. They were the least likely to feel they worked well with marital problems and the most likely to feel their clients were different from other families in the community.

Private In-Office Programs

There were only two private in-office programs in the study. One was part of a multi-service private agency, the Albertina Kerr Center for Children in Portland, Oregon, and the other, an Adolescent Day Treatment program within the Adams County Community Mental Health Center outside Denver, Colorado. Like the public in-home programs, these two programs shared some characteristics, but were essentially very different from one another.

As in public in-office programs, these programs enjoyed a moderate level of support from other units in the agency. In terms of their use of time, they reported the least amount of direct contact with families (1.4 hours a week) and the least amount of travel time (1.7%). They had more frequent staff meetings and more

frequently used that time to coordinate cases with other providers. Private in-office programs reported having the least money available for professional development activities and less access to paraprofessional services, financial aid, therapy, school social work, support groups, and substance abuse treatment for their clients.

Workers in these agencies reported both the lowest success rates (57.6%) and the lowest frequency of termination due to family stabilization, child protection, and goal achievement. Like other private agencies, they reported low salaries, averaging $17,443, and high turnover. However, their workers were both the oldest (average age 45.2) and the most educated (average number of years, 18.3) in the study. Like other in-office programs, they believed the office to be the most effective setting for service, had a low commitment to a hands-on approach to family-based services, but a higher than average acceptance of the principles of strategic family therapy. These workers were more likely to report working successfully with chronic mental illness and to think that families with chronic mental illness or substance abuse problems benefited from family-based services.

In sum, the two private in-office programs had the least direct contact with clients, the least travel time, the least access to other services for their clients, and the lowest reported success rates. They also had the oldest workers and those who felt they worked best with the chronically mentally ill. Their practice philosophy was consistently more in line with a strategic approach to family therapy than workers in other agencies.

Comparing In-Office with In-Home Programs

Comparing in-office with in-home programs, twice as many in-office social workers (85%) reported a moderate or high level of support from other units in the agency as in-home workers (47%). In-office workers were also more highly educated (85% with Masters degree or above compared to 65% of in-home workers). They also

had less commitment to a "hands-on" approach to family-based services and a greater belief in the effectiveness of in-office services. They coordinated with referring workers more frequently and in more different ways. Except in Colorado, in-office workers often saw the lack of a permanency plan for a placed child as a sign of failure, whereas in-home workers only thought this to be a failure sometimes. Workers in in-home programs thought the home to be the most effective location for service delivery, expended a higher proportion of time in travel (10-45% compared to 0-5% for in-office workers), and had more access to funds for professional development.

Comparing Private with Public Agency Programs

In private agency programs, workers reported lower salaries and higher turnover. Over 90% earned less than $24,000 a year while over half of public workers made more than that. Nearly three-quarters reported moderate to very high turnover compared to about a third of public workers. They also reported fewer terminations related to success with a family, more use of meetings for case coordination, and a greater belief that the chronically mentally ill and substance abusers could benefit from family-based services. One third of the private agency workers reported getting more referrals that the program could handle. In contrast, public agency programs had low turnover, workers with more years of experience in the agency (39% versus 7% with more than five years), richer support services in the community, more frequent termination of cases for positive reasons, and, except in Iowa, higher salaries and higher morale. Only 8% of public agency workers characterized morale as low to very low compared to 28% of private agency workers.

CHAPTER 4

SUCCESS AND FAILURE IN FAMILY BASED SERVICES

Although placement or non-placement is by far the most common measure of failure and success in family-based services, it is by no means the only measure, or even an adequate one. Funders and administrators concerned with "the bottom line" often regard preventing expensive placements as the only persuasive argument for family-based services. Clinicians, on the other hand, argue for an array of interrelated outcomes. Placement is not a failed outcome when it protects a child from serious harm; conversely, keeping a family together is not a success unless some change has occurred in the circumstances that brought the family into service.

In order to establish more refined, practice-based definitions of success and failure, administrators, supervisors, and workers were asked during on-site interviews to define success and failure in family-based services. Their responses formed the basis both for the series of questions about success and failure developed for the social worker questionnaire and for the different outcome measures used in the case review instrument.

To establish empirically based definitions of success and failure, nineteen possible case outcomes were generated from the on-site interviews and then included in the social worker questionnaire. In response to the following question, "Thinking about the cases you regarded as successes, how often did the families have the following outcomes?", workers were asked to rate each of the possible outcomes on a scale ranging from "never" to "always". A factor analysis of their responses, weighted by the number of their cases which were included in the sample and using a principle-components solution and quartimax rotation, identified three factors underlying the nineteen outcomes. The first factor was by far the strongest and accounted for 37.7%

of the variance. It included ten of the nineteen possible outcomes, in the following order:

- The adults felt more competent in their roles.
- Positive change in the family's interactions, behavior or communication occurred.
- The family was stabilized and no longer in crisis.
- The family achieved its own goals.
- The family was together at the time services were terminated.
- The children's needs were being appropriately met.
- The family felt better about themselves.
- The family was able to solve its own problems without further outside help.
- All or most case objectives were met.
- The family told you they no longer needed your services.

As can be readily observed, this "success" factor includes a variety of possible outcomes, all of which are closely associated in the workers' minds with keeping the family together, i.e. non-placement.

The remaining two factors were much weaker, explaining only 16% and 8.7% of the variance, but gave some support to the idea that placement can be seen as a successful outcome as can the family's asserting independence from the worker by actively or passively "firing" him or her. The placement-as-success factor included four of the nineteen possible case outcomes:

- The child was protected from further harm by placement.
- Parental rights were terminated.
- The child at risk was placed but other children were maintained in the home.
- The child was placed with a relative.

The "firing" factor included an additional four of the nineteen outcomes:

- The family stopped keeping appointments.
- The family told you they no longer needed your services.
- The family was able to solve its own problems without further outside help.
- (Negative) All or most case objectives were met.

Fifteen possible outcomes that represented failure were also generated from the on-site interviews, included in the social worker questionnaire, and rated in the same fashion. A factor analysis of these items yielded five factors. The first, which accounted for 25.8% of the variance, included, in order: placement in a group or foster home, termination of parental rights, placement in an institution or for short term or respite care, inappropriate parenting, maintenance of all but the placed child in the home, and lack of a permanency plan. The second factor explained 17.3% of the variance and reflected unfavorable treatment outcomes including inappropriate parenting, continued instability, need for outside help, and lack of change, but not placement with a relative.

Finally, the items in the "firing-as-success" factor mentioned above--that the family stopped keeping appointments or said services were no longer needed--combined with lack of goal achievement and a continued need for outside help explain 11% of the variance and indicate that being "fired" can also be seen as a sign of failure. Two additional factors contained the same items with smaller loadings and represented, primarily, the individual variables, "the child at risk was placed but other children were maintained in the home" and "a permanent plan was not achieved for the child at risk". These latter two factors accounted for 8.7% and 7% of the variance, respectively.

The strength of the general "success" factor and the predominance of the placement-as-failure factor suggest that placement or non-placement is, indeed, a fairly good definition and failure, from a practitioner's as well as a legislator's or

administrator's point of view. For this reason, it is used as the major dependent variable in the study. It was not, however, the only case outcome studied and its relationship to the other measures of outcome deserves a brief exploration.

Most studies of family-based services have not differentiated placement as a temporary intervention during service from placement as an outcome at the end of service, regarding, instead, any instance of placement as "failure". In this study, if a child entered placement during the service period and moved before termination to another type of placement or back home, it was counted as a temporary placement, not as an outcome. This clarification did not change the fact that temporary placement was highly related to terminal placement (see Table 4.1). Indeed, nearly half the highest risk children in placement cases had been placed temporarily, while only 13% in non-placement cases were out of the home during service. This significant difference was maintained for all types of temporary placement including placement with relatives. Respite care was too infrequent to test since only three families received this service.

Goal achievement, a common indicator of outcome, was measured in this study by dividing the number of family's case objectives which were assessed by the case readers as partially or completely achieved by the total number of case objectives for which a level of achievement was indicated. The majority of families in both placement and non-placement categories achieved at least half their case objectives. Non-placement cases showed a higher level of goal achievement, however, with the majority fulfilling three-quarters or more of their objectives at least partially.

Perhaps of even greater importance in determining success or failure, non-placement cases also demonstrated a high level of change in family functioning. Since no measure of family functioning currently exists that could be applied to case record data, the Family Systems Change Scale, a brief scale that listed ten areas of family functioning and family-community interaction, was developed for this study. Case

readers rated each scale as to whether the family got worse, stayed the same, or improved in that area, or indicated that there was insufficient data in the case record to make such a judgment.

The number of areas of positive and negative change were them aggregated into separate overall measures that were strongly related to placement and non-placement. Forty percent of the placement cases showed no positive change and over half got worse in at least one area. Only 12% of non-placement families failed to show any positive change and less than twenty percent changed for the worse in any area. This does not mean that outcomes for the placement families were completely negative, however, since they achieved a relatively high proportion of their goals and about the same proportion as non-placement families (40%) achieved a moderate level of change in family functioning.

One final outcome indicator highly related to placement or non-placement was the service status of families at termination. Less than ten percent of placement families were expected to be independent of services at termination, whereas nearly a third of non-placement families were not scheduled for further service. That two-thirds of "successful" cases require resources from the human services system is not surprising, given the severity of the cases referred to family-based services and the relative brevity of the service. For the most part, these preventive family-based services were successful at what they set out to do--avert placement of children from families in crisis. The site by site analysis in chapter 6 indicates that placement rates ranged from 4% to 25% in the programs studied, with an average placement rate of 16% as projected from the sampling lists. Family-based programs do not seek to, nor could they be reasonably asked to help families solve all their problems.

CHAPTER 5

CASE DATA IN ELEVEN FAMILY-BASED SERVICE PROGRAMS

This section presents an overview of the case data collected on 533 families in the 11 study sites. Here we discuss, for the sample as a whole, information on family demographics, prior service and placement history, referral sources and problems, treatment problems and case objectives, types of services provided, length and amount of services, severity of problems and case outcomes. When significant differences were found between families who ended up with a child in placement and those for whom placement was prevented, the differences are so noted. Once again, it should be remembered that placement cases in the study are oversampled as compared with non-placement cases.

Family Demographics

The primary caretakers in the study sample were predominately female (86.1%) and Caucasian (83.8%), with an average age of 35.6 (Table 5.1). Nearly half of the primary caretakers were married, 36.1% were separated or divorced, 7.9% had never been married, and 7.2% were living with a boy or girlfriend at the time of intake to family-based services.

Few primary caretakers were regarded as intellectually low functioning (4.6%). Thirty-seven percent were considered unemployed and unavailable for work, 27% were employed full-time, 21% at least part-time, and the remaining 14% were not employed though available for work.

The largest occupational category for primary caretakers was homemaker (44.5%), followed by skilled labor, clerical or sales positions (22.9%), and personal services occupations (14.3%). Less than 10% were employed in each of categories of unskilled or professional positions.

Another adult was considered a significant family member in more than three-quarters of the study families. Most of these individuals were male (80.3%), and more than two-thirds were married to the primary caretaker. Forty percent of the second adults were employed full-time, and 20% at least part-time. Twenty-three percent were considered not employed and not available for work, while 15% were unemployed but available for work. The primary occupational categories for the second adult in the household were unskilled occupations (31.8%) and skilled, clerical or sales positions (31.9%).

Slightly more than one-half of the study families were living below the poverty level of $10,000 (53.2%), with an additional 26.7% existing on incomes ranging from $10,000-$20,000 for an average family size of 3.96. (Table 5.2).

Highest Risk Child

The oldest child at the greatest risk for placement was usually the oldest child in the family (71%). The second child was the highest risk child in about 18% of the families. Eighty-seven percent of the highest risk children were the biological children of the primary caretaker, while less than half of those in families with a second adult were the biological children of that adult (Table 5.3). More than one-quarter of the children in two-adult families were step-children of the second adult in the household.

The highest risk children were about equally represented in terms of gender. In terms of race, 82% were Caucasian, and nearly 13% were Black. The average age of the highest risk child was 11.86, with a standard deviation of 4.64. The highest risk children in placement cases were significantly older than those in families that did not experience placement at the time of case closure ($p<.05$).

The highest risk child was usually of normal intellectual functioning (93.3%), and nearly 60% were attending a regular school class, grades kindergarten through twelve.

Nearly 15% were enrolled in a special school class, and 13.5% were not attending school at the time of intake to family-based services.

Forty-one percent of the highest risk children in placement cases and 23.5% of the highest risk children in non-placement cases had some prior out-of-home placement experience ($p<.001$). The most common placement settings for the highest risk child were family foster care (17.6%), followed by placement with a relative or friend (12.8%), residential treatment facilities (12.2%), detention facilities (12%), and group homes (11%).

Not surprisingly, the highest risk children in placement cases were more often at imminent risk of placement at intake than the highest risk children in non-placement cases ($p<.001$). The number of children at risk in a family was also significantly related to case outcome; in other words, the greater the number of children at risk of placement in the family, the more likely that placement of a child occurred at the time of case closure.

Prior Service and Placement History

The majority of families had some social service history, though for varying lengths of time (Table 5.4). Nearly 18% had had service of less than one month, while almost one-third of the families had received services for more than 6 months prior to referral for family-based services. Over two-thirds of the families were new to the family-based service agency in the study (Table 5.5).

Examining the families' placement histories, it was found that 41.6% of the placement group and 24.1% of the non-placement group had had a family member placed at some time prior to intake to family-based services ($p<.001$). The most common reasons for prior placements were physical abuse (17.8%), parent-child conflict (8.7%), child behavior problems (7.1%), and sexual abuse (6.5%) (Table 5.6).

Referral Sources and Referral Problems

The public social services agency was the major referral source among all of the study sites, having referred 36.6% of the families. The court referred 14.9% of the families overall, 11% of the families were self-referred, 9.3% came from the school systems, and 6.2% from medical professionals.

The most common reasons for referral to family-based services, according to the referring workers' reports, were parent-child conflict (50.8%) and child behavior problems (38.7%). Other referral problems noted for moderate percentages of families include: delinquency (23.3%), status offenses (22.8%), adult relationship problems (20%), physical abuse (19.8%), family relationships (19.6%), and child relationships (17.5%). Significant differences between families who ended up with a child in placement and those who did not were found when the referral reason was delinquency ($p < .001$), with families in the placement group more likely to have been assessed with this referral problem (Table 5.7).

Treatment Problems and Objectives

According to the assessment by the family-based services workers, the major treatment problems for families included parenting skills (31.8%), family relationships (29.8%), parent-child conflict (24.9%), physical abuse (24.7%), child behavior (23.1%) and adult relationships (20.2%) (Table 5.8). Family-based service workers were more likely to assess status offenses ($p < .01$) and child behavior ($p < .05$) as problems in families who ended up with a child in placement, and adult relationship problems in families whose children remained at home, ($p < .01$).

Case readers in this study were asked to indicate all the problems identified in the case record, whether the information came from the referring worker, the family-based worker, or other sources in the case record. According to the case readers,

problems experienced by the greatest percentages of families included: parent-child conflict (66.4%), child behavior problems (66%), child relationships (55.2%), family relationships (54.2%), and adult relationships (52.7%). Out of all the problem areas, those which differed according to case outcome were delinquency, status offenses, child and adult substance abuse, parent-child conflict, child behavior, child health/mental health, and child relationships (Table 5.7). Significantly greater percentages of families in the placement group than in the non-placement group were assessed by case readers to have these problems.

When case readers studied the service plans developed by family-based services providers, it appeared that more than half of the families had at least one service objective focused on parenting issues (58%). Large percentages of families also had at least one service objective dealing with improving family relationships (38.4%), use of counseling services (36.8%), and child behavior issues (31.6%). Among families whose children did not experience placement at case closure, case plans were significantly more likely to have included at least one goal focused on changing adult relationships and intervening with the community ($p < .05$) (Table 5.8).

Services Received

Almost all of the families served by the 11 agencies received family therapy (94%). Between one-half and three-quarters of the families also received individual counseling for at least one family member (68.3%), case management (54.6%), and information and referral services (52%). Other services received by more than one-quarter of the families included: teaching (39.9%), child protective services (38.9%), homework (37.6%), advocacy (32%), marital counseling (28.7%), school social work services (27.9%), and accompanying a family member to an appointment or meeting (27.1%).

A number of services were found to be related to case outcomes. Families who ended up with a child in placement were all more likely to have received: accompaniment to an appointment ($p<.01$), case management ($p<.01$), advocacy ($p<.05$), substance abuse treatment ($p<.05$), transportation services ($p<.05$), and a number of mental health and psychiatric services, including: community mental health services, psychological testing, and psychiatric assessment/diagnosis ($p<.001$).

Supportive and concrete services were provided to relatively small percentages of families, as illustrated in Table 5.9. Parent education (20.7%), AFDC (29.4%), food stamps (24.9%), and Medicaid (22.2%) were the most commonly noted services in these categories. Many services were provided to so few families that their significance to case outcome could not be tested.

Families in family-based programs received an average of 10.5 different types of services, whether from the family-based provider or from another community agency. For the 11 agencies overall, more services were provided by the family-based unit ($\overline{X} = 5.77$) than by an outside agency ($X = 3.81$). Families who experienced placement received a significantly greater number of family-based counseling services ($p<.05$), counseling services from an outside agency ($p<.001$), total services from an outside agency ($p<.05$), total psychiatric/psychological services ($p<.05$), and total number of services from all sources ($p<.05$) (Table 5.10).

Paraprofessional services were provided to less than 20% of the families studied. These services were used most often for parent education, counseling, building self-esteem and child care. Self-esteem enhancement was used significantly more frequently for families whose children remained at home at case closure ($p<.05$) (Table 5.11).

During the course of service, brief placements were used for highest risk children in some of the families. It is an important finding that temporary placement of the highest risk child--whether in emergency shelters, foster family homes, group homes,

residential treatment, or with friends or relatives--was a strong predictor that services would end in placement ($p < .001$) (Table 5.12). Nearly 22% of highest risk children in the placement group experienced temporary placement in foster family homes ($p < .001$), 16.6% in residential treatment facilities, 14.8% with friends or relatives, and 14.5% in shelters during the time their cases were active with family-based services (Table 5.12).

Length and Amount of Services

In multi-unit agencies, families in the placement group experienced a significantly longer period of time between referral to the agency and referral to the family-based service program ($p<.01$). There was an average delay of 293 days for the placement group and 116 days for the non-placement group. The average number of days between referral to family-based services and the first face-to-face contact by the family-based worker was 13.5 for the entire 11 study sites. The number of days of service in the family-based program averaged 200, or about 6.5 months overall. There was an average of 20 days between the last direct contact by the family-based worker and the date of case closure.

The average number of failed contacts a month was .71 for placement cases and .56 for non-placement cases. This difference was barely significant, at $p < .056$. The average number of contacts in the first three months of service was 12.6 and in the first month of service, 5. No differences between placement and non-placement groups were found for these variables. Office visits were more numerous for placement cases than for non-placement cases, an average of 1.53 and 1.11 per month, respectively ($p<.01$).

Most of the families did not experience any change in their primary social worker during the service period (85%), 11.6% had one change of worker, and 3.4% had three or four workers during the time their cases were active with family-based services.

Severity of Problems

A weighted scale of stressful life events used in this study found significant differences between families whose children experienced placement and those that did not ($p<.001$). This indicates that families who experienced placement also endured a significantly greater number of stressful events in the year prior to case closure. Similarly, the primary caretaker and highest risk child's score as measured by the Child Welfare League of America's Child Well-Being Scales found placement families to be more dysfunctional than non-placement families ($p<.001$) (Table 5.13).

Although only 15% of the cases had additional child abuse reports filed during the time their cases were active with family-based services, this was more likely in families with a referral problem of abuse, or a family-based treatment problem of abuse, and in which final placement occurred because of abuse. The court was involved with 64.7% of the placement cases and 30.8% of the non-placement cases ($p<.001$).

Outcomes Based on Case Review Data

The extent of the primary caretaker's involvement in family-based treatment was important to the outcome of the case. Seventy-four percent of the primary caretakers in the non-placement group attended most or all of the sessions ($p<.001$), compared with 55% of the primary caretakers in the placement group. The highest risk child's involvement in service was also important: in 59% of the non-placement group, compared with 37% of the placement group, the highest risk child attended most or all of the family-based service sessions ($p<.001$) (Table 5.14). The involvement of the second adult in the household, in contrast, was not significantly related to case outcome, even when cases were controlled for whether that other adult resided in the family's home. About 45% of the second adults who lived in the household had attended most of the treatment sessions, and only 18% had attended few or none at all.

The most common reasons for case closing among non-placement cases were that case goals had been met or service had been completed. The most frequently cited reasons for closing among cases ending in placement were that a child had been placed out of the home or that the family had dropped out of service. These differences were statistically significant at the .001 level. Between 10 and 13% of the cases were closed for each of the following reasons: service was no longer effective; the family requested termination of services; and the family was no longer eligible for service or time limit had been reached (Table 5.15).

Following termination of family-based services, about 27% of the placement group and 16% of the non-placement group were transferred to another unit within the agency for further services ($p<.01$). About 30% of all families continued to receive services from one agency; nearly one-half of the placement group and 35% of the non-placement group continued services from more than one agency ($p < .001$) (Table 5.16).

A scale of ten different areas of change found significant differences between the placement and non-placement families in nine of those ten areas, with the placement group demonstrating fewer areas of improvement and more areas of negative change in behavior, material resources, family structure/hierarchy, family dynamics/relationships, affect/emotional climate, perception of the problem, community perception of the family, informal support network, and community involvement with the family (Table 5.17). The number of areas of positive change was significantly higher for the families whose children were prevented from entering placement ($p < .001$); the number of areas of negative change was significantly higher among the families who experienced out of home placement at case closure ($p < .001$).

The proportion of case objectives achieved or partially achieved was also related to case outcome: the average proportion of achieved goals was 56% for the placement families and 69% for the non-placement group ($p < .001$).

When placement occurred at case closure, the most common reasons were parent-child conflict (33.4%), status offenses (18.7%), child behavior (18%) and delinquency (17.5%) (Table 5.6). Thirty-two percent of the highest risk children in placement cases ended up in a foster family or group home, 21% in a residential facility, and 17.9% in an informal placement with friends or relalatives (Table 5.18). It should be noted that in 29.1% of the placement cases, it was not the highest risk child who ended up in placement, but another child in the family. (It should also be recalled that the highest risk child was defined as the oldest child in the family at the highest risk of placement; if there were two children at equal risk, the older of the two was the highest risk child for the purposes of this study). Long-range plans (or permanency plans) were found in the case record for 28% of the placement cases, and more frequently in the public than in the private agencies.

Summary

When placement and non-placement cases are differentiated in the entire sample of 535 families, we find first, that placement cases had a significantly older highest risk child and this child was more often rated at imminent risk of placement at the time of intake to family-based services. Second, the greater the number of children at risk of placement in a family, the more likely that the case would end with a child in placement. Third, placement was the more likely outcome when families, and in particular the highest risk child, had experienced prior out-of-home placements or temporary placement during the service period.

Certain problems were also significantly related to case outcomes. Placement was more likely to occur when the referring worker identified delinquency as a problem and when the family-based services worker assessed status offenses and child behavior problems. Adult relationship problems were more common in non-placement cases.

Overall problem ratings revealed a number of problems associated with placement: delinquency, status offenses, child and adult substance abuse, parent-child conflict, child behavior, child health/mental health, and child relationships.

With respect to treatment plans, several specific services were more likely to have been provided to families who ended up with a child in placement: accompanying a family member to an appointment, advocacy, case management, community mental health services, psychological testing, psychiatric assessment, substance abuse counseling, and transportation. Placement cases received, on the average, a greater number of different family-based counseling services, counseling services provided by an outside agency, total services provided by an outside agency, psychological and psychiatric services, and total services. Non-placement cases were significantly more likely to have had at least one objective in the treatment plan that focused on improving adult relationships or on intervening in the community. When paraprofessionals were used, parent self-esteem building was significantly more likely to be a function of the paraprofessional in non-placement than in placement cases.

Several other factors related to outcome deserve mention. The court was more likely to be involved with cases which ended in a placement than with those that did not. Primary caretakers and children at risk in placement cases had significantly lower scores on the Child Welfare League of America's Well Being Scales than their counterparts in non-placement cases.

Families prevented from child placement were more likely to have had services terminated due to completion of service goals, whereas families in the placement group were more likely to have terminated services due to the family dropping out or the child being placed. Following case closure with family-based services, placement families were more likely to have continued services, either with another unit of the agency or with an outside agency.

In short, at the bivariate level, higher risk at intake was predictive of case outcome, as were prior placement and temporary placement during the service period. The only demographic variable related to placement was age of the highest risk child, with older children more likely to end up in placement. A greater number of child focused problems (rather than adult or family focused ones) were also associated with placement.

The relationship between individual services and outcome is difficult to explain at the bivariate level. Although a number of directive or case management services and psychological/psychiatric services were associated with placement, it is unknown at what point in service these were provided, i.e. was transportation provided to take the child to the foster home when the decision to place had been made? Was accompanying or advocacy a trip to the court when a placement hearing was established? Was a psychological assessment done as a step in the placement process? Placement cases did receive a greater number of services on the average, but again, the timing of such services is unknown.

Non-placement was associated with a higher level of primary caretaker and highest risk child functioning, a greater degree of service goal completion, improvement in many areas of family functioning, and satisfactory case closure reasons. A greater degree of involvement in service by the primary caretaker and highest risk child predicted a more successful outcome.

CHAPTER 6

FACTORS ASSOCIATED WITH PLACEMENT AND NON-PLACEMENT IN EACH STUDY SITE

One of the main unresolved issues in family-based services is the determination of what contributes to placement or non-placement in different types of programs serving different client populations. By using the same instruments and data collection methods in eleven family-based programs, this study has identified characteristics among clients and services that predict, with varying degrees of accuracy, whether a case was a placement or non-placement case. It is hoped that these profiles will help family-based programs identify those families that are potentially successful and unsuccessful candidates for service as well as those services that will most enhance the ability of families to remain together.

While Chapter 3 detailed each agency's history and program and grouped them according to whether they were public or private, in-home or in-office, this chapter looks at each site, but this time according to differences in client population, in services, and in outcomes as measured by the case review. When viewed from this perspective, programs were found to vary most strongly by geography; that is, the programs with the most features in common were either in the same state, or in metropolitan areas. This pattern can presumably be accounted for by similarities in socio-economic conditions and social welfare policies within states and metropolitan areas.

Sites will thus be discussed in pairs, but it is important to note that each site has been analyzed individually. Statistical differences between even the most similar sites were such that individual analyses were more explanatory of differences in outcome. Differences in client population and frequency and scope of services among

the eleven sites dictated that the discriminant analyses to determine what factors differentiated placement from non-placement cases be conducted separately. Since the discriminant models contain only interval level variables and factor-based scores, other variables related to outcome in bivariate analyses of the sites are also presented. Similarities and differences between the sites, other variables related to outcome, and variables related to the discriminating factors create a context within which the discriminant models can be understood.

Many variables could not be compared directly between sites, either because they were too infrequent (occurring in less than 20% of the cases) or because they were unevenly distributed within placement and non-placement cases (as determined by F tests for equality of variance). It should be noted that the great majority of variables are not normally distributed, most being positively skewed, and thus these results should be interpreted with caution. The significance levels of variables which differed between placement and non-placement cases at the bivariate level on T-tests are noted in parentheses. Pairs of sites will be presented roughly in order of the strength of the predictive discriminant models developed, although in two states, Minnesota and Colorado, the model for the public agency was considerably stronger than for the private agency.

URBAN SITES

The two most urban programs, the Home-Based Family-Centered Service program in Franklin County, Ohio, and the SCAN program in Philadelphia, shared a number of characteristics. First, they both served younger children than the study average: 7.7 and 5.2 years on average for the highest risk child in the family compared to 11.5 years overall (see Table 6.1 for selected demographics by site). In keeping with the lower average age of the children and their urban location, the primary caretakers

were younger, less likely to be married or employed, and more likely to have incomes below the poverty level and to be receiving AFDC. The children were more likely to be the biological children of the primary caretaker and of the second adult in the family, if there was one. There were more children at high risk of placement in each family than in the other programs.

Not surprisingly, given their demographics, families were referred more often for neglect and family relationship problems and less often for parent-child conflict, delinquency, and status offenses (Table 6.2). Family-based workers more often identified neglect and parenting skills as treatment issues and defined improving parenting behavior as a case objective. (Improving family communication and relationships appeared as case objectives less often than in the other sites.)

Families in urban programs received many more individual counseling services, more case management, more child protective services, more public social work services, more community mental health services, and more psychological testing. They also received markedly more supportive and concrete services, including public health or visiting nurse services, parent education, money management counseling, financial aid, emergency cash assistance, special education services, and medical care. All together, these younger families in urban areas received nearly twice as many different kinds of service from the family-based programs and more than twice as many services from outside agencies than those in most other sites.

Both Franklin County and SCAN delivered services in the home, with an average of one to two contacts a week over a seven to eleven month period. (It should be noted that in Franklin County, the median length of service was six months, indicating that some cases with long service periods affected the mean length.) Both programs also made significant use of teaming: in Franklin County, all families were seen by a professional/paraprofessional team while at SCAN, about a third of the cases were

treated either by two professionals in co-therapy, by a professional-paraprofessional team, or by an individual worker with team consultation. While both programs used temporary placements more often than other sites, these were more often placements with relatives or friends, as were the placements the programs made at the termination of services (Table 6.3). In both programs, change was reported in the areas of material resources and the use of services more often than in other sites and the overwhelming majority of case objectives were partially or completely achieved. Despite the numbers of services made available to urban families in these programs, less than 5% were expected to function entirely independently of social services once services were terminated by the family-based program.

Franklin County Children's Services

The Home-Based Family-Centered Services program in Franklin County, Ohio, served slightly older children than SCAN and 27% of the highest risk children in the families had experienced a prior placement. Nearly 90% of the highest risk children were assessed as imminent risk of placement at the beginning of family-based services and more children in each family were at high risk than in any other site. More families were referred for adult relationship problems and court-ordered into service than at SCAN. The Franklin County program had a higher proportion of referrals than SCAN for other problems as well as for neglect, most notably physical abuse and adult substance abuse. Case objectives more often included increasing the family's use of counseling services.

Since each family in Franklin County was seen by a team, including an MSW worker and a paraprofessional, families received many more paraprofessional services than those in other programs, including family planning, transportation, homemaker and housekeeping services. Families also received more crisis intervention, more

recreational services and more psychiatric and psychological services of all kinds. With two workers assigned to each case, families in Franklin County had twice as many contacts in the first three months of family-based services as SCAN, more than in any other site.

Families in Franklin County also experienced a much higher rate of worker turnover than in other programs, and only 64% of the primary caretakers attended most or all of the sessions. This did not prevent Franklin County families from showing much higher rates of change in behavior, material resources, use of services, and family's perception of the problem, however; and cases were more likely to be closed because case goals had been achieved in this program than in others. All the families showed at least one area of positive change and only 7.3%, the lowest proportion in the study, showed any negative change. Although the highest risk children in each family were more likely to be placed temporarily during the service period, they were more likely to be placed with a friend or relative, both temporarily and at the end of services. Finally, the family-based worker was involved in long range planning for the child in nearly two-thirds of the placement cases.

Predictors of Placement in Franklin County

In the discriminant analysis, placement cases in Franklin County were distinguished by more psychological services (p=.00), more problems (p=.00), more directive interventions (p=.02), and older children (p=.04) (Table 6.4) (significance levels from bivariate t-tests). In addition, other social work services and the number of children at high risk of placement in the family helped to identify placement cases, although they were not significant at the bivariate level.

More than eighty percent of the cases which ended in placement received psychological testing and about half received other psychological services (see table 6.5

for a breakdown by site). Placement cases also received more directive interventions, which in Franklin County consisted primarily of accompanying clients to an appointment, advocacy, outreach, case management, recreational services, and group therapy. The oldest child in placement cases averaged 10.1 years ($p < .05$) and the total number of problem areas, 11.8 ($p < .05$). Sixty percent of placement cases received school social work services. There was no overall difference between placement and non-placement families in the number of children at imminent risk of placement. The characteristics which identified placement cases were correlated with larger family size, more services, fewer case objectives, fewer contacts in the first month of family-based services, and less financial assistance.

Predictors of Non-placement in Franklin County

Non-placement cases in Franklin County were distinguished by children who scored higher on the CWBS ($p=.00$) and by higher scoring caretakers ($p=.00$). The total number of supportive services given to the family (money management, homemaker services, public health nurse, mental retardation services, and support groups) and educational interventions (teaching and role modeling) also made small contributions to the discriminant model, differentiating non-placement cases (Table 6.6). These characteristics were found more often in families that had been known to the agency for a shorter period of time and reopened as cases less often. Together, 93% of the placement and 97% of the non-placement cases were correctly classified by the discriminating variables and 69% of the variance was explained.

Other variables significantly differed between placement and non-placement cases but were not included in the discriminant model because they explained the same variance as those that were included or because of unequal variances between placement and non-placement cases. In Franklin County, these variables included

higher levels of family stress; more child behavior, substance abuse, and status offense problems and longer services for placement cases. The highest risk child in the family was also more likely to have had a prior placement of more than three months, to be out of the home at the time of intake, and to be placed temporably in a residential facility or with a friend or relative. The family was more likely to have been reopened as a case and to have received services for a longer period of time before coming to the family-based unit. On the other hand, primary caretakers were significantly more likely to attend most or all the sessions in non-placement cases and more changes occurred in behavior, family dynamics, emotional climate, family's perception of the problem and the community's perception of the family. With regard to service delivery, placement cases received services for a longer time period, on average, and experienced a change of workers significantly more often.

SCAN

SCAN differed strikingly from Franklin County in the proportion of minority families served, with eighty percent of the primary caretakers being black compared to only fifteen percent in Franklin County. SCAN families were also more likely to be headed by single, unemployed caretakers. As a primary provider of child protective services, SCAN also dealt with younger children who were less likely to be at imminent risk of placement or to have experienced prior placements, and who scored higher on the CWBS.

In keeping with its origins, SCAN families were more often referred and treated for health and mental health problems, both of children and adults, and for problems involving poverty and housing. About a third of the cases were teamed with another worker, most of them other professionals. SCAN was much less likely to deal with adult relationship or child behavior problems and, due to the younger age of the

children none were referred for child substance abuse, status offenses or delinquency. In accordance with the nature of the families' problems, case objectives in SCAN were much more likely to involve increasing the family's use of concrete and supportive services. Objectives were also focused more on changing adult behavior.

Services distinguishing SCAN from Franklin County and the other sites included more role modeling, more accompanying of clients to appointments, more outreach, and more information and referral services. SCAN families were also more likely to receive general assistance, subsidized housing, legal services, and special education than those at any other site. They received services over a longer time period, averaging eleven months, the longest in the study. While SCAN families received less than half as many contacts in the first three months as Franklin County families, this was in part due to a high number of failed contacts, averaging two per family in the first three months.

At SCAN, primary caretakers were less likely to attend most or all of the family-based sessions and only one-third of the cases were closed because case goals were achieved. More families than in most sites, but fewer than in Franklin County, experienced changes in material resources, use of services, and the family's perception of the problem. Over three quarters improved and one quarter got worse in at least one area. More than 20% of the highest risk children were placed temporarily during service. However, only a third of the highest risk children in placement cases were placed in foster homes, group homes, or institutions by the end of service. Over a third were placed with relatives or friends. SCAN workers were not responsible for long-range planning for placed children.

Predictors of Placement at SCAN

A key factor in distinguishing placement cases in the SCAN discriminant analysis was a larger number of children in the family at imminent risk of placement (2.3 in

placement cases, .2 in non-placement cases) (p=.00), augmented slightly by a greater number of case objectives to increase the use of counseling services (Table 6.7). The characteristics identifying placement cases were correlated with larger family size, older children and lower child and caretaker CWBS scores. They were also correlated with more problems and more psychological/psychiatric and social work services (primarily school social work and family services). Although placement families had significantly lower child and caretaker CWBS scores, more problems, and more case objectives, these factors did not enter into the discriminant model.

Predictors of Non-placement at SCAN

Non-placement cases at SCAN were identified by more objectives to increase clients' use of concrete and supportive services (p=.00) and by a longer period of service (p=.03). These characteristics were found more often in families who received more financial assistance and supportive services (primarily money management counseling, support groups, and volunteer services). Altogether 79% of the placement and 97% of the non-placement cases were correctly classified by the discriminating variables and 62% of the variance was explained. Other differences between placement and non-placement cases included more referrals from public social services and fewer from medical personnel, more temporary placements, and more problems involving neglect and adult mental health among placement families.

IOWA SITES

The two programs in Iowa selected for the study were located in the same city and operated in a complementary fashion. The Ottumwa District Office of the Iowa Department of Human Services (IDHS) oversees the county offices in its district and offers special supportive services to the district including Family Therapy, the office-

based program included in this study. In 1980, the Department of Human Services contracted with Iowa Children and Family Services (ICFS) to provide a home-based family support program in the district. Since that time, the majority of the cases served by the In-Home Family Counseling Program have been referred by IDHS. Basically, the IDHS Family Therapy team served families who were able to come into the office once a week for therapy. Families who needed more intensive, in-home services were referred to ICFS and other in-home providers.

Because they served the same geographic area and IDHS set the guidelines for both programs directly or through its contract with ICFS, the two programs shared many characteristics. But because the services complemented each other in serving families with different needs and because one was a public, in-office program and the other a private, in-home program, there were also several differences. Although it is in a rural area, ICFS also shared certain characteristics with the urban programs, since, like them, it served primarily families with younger children.

Both Iowa programs saw mostly white families, about half of whom were married couples. About a quarter of the primary caretakers were divorced and about a third employed. About half received AFDC and food stamps, significantly more than in all but the urban sites. About 20% of the highest risk children had experienced a prior placement and half were considered to be at imminent risk of placement. Both agencies had a high proportion of families that were court ordered into family-based services, ICFS, 20% and IDHS 42%. In both agencies, about half the families were referred for either physical abuse, sexual abuse, or neglect and a quarter or more for couple or family relationship problems or parent-child conflict. Families were reported to have problems in significantly fewer areas than in most of the other agencies.

In over half the families in both Iowa programs, child abuse or neglect or parent-child conflict was a focus of treatment. Parenting skills were defined more often than

in the other programs as a treatment problem and case objective. Increasing the use of outside counseling services was cited less often as a treatment objective, perhaps because in rural districts fewer counseling services are available to families. Unlike many other programs, these rural ones did not team in treating families. Overall, families in the Iowa programs received fewer different kinds of family-based services than those in urban sites.

In terms of outcomes, over ten percent of the highest risk children experienced a temporary placement during family-based services. At the close of service, over half of the children at highest risk in placement cases went to foster homes, group homes, or institutions. Iowa workers were involved in long-range planning for placed children somewhat more often than in the study sample as a whole with plans recorded for one-third to one-half of the placement cases. Treatment sessions were well attended: at least eighty percent of the primary caretakers and 50% of the second adults who resided in the home attended most or all of the sessions. In addition to high attendance, over half of the primary caretakers fully cooperated with services. Iowa families experienced the most change in the areas of behavior and family relationships, but, compared to other sites, much less change in material resources, emotional climate, or their perception of the problem.

Iowa Children and Family Services

Due to its service population, the ICFS program was rather more like the urban sites, than like its neighbor, IDHS. The average age of the highest risk child in the family was 9.0 years, considerably lower than in most other sites, which averaged 11.5 or older. Because of their younger age, the highest risk children in each family scored higher on the CWBS and were more often the biological child of the primary caretaker and the other adult in the family, if there was one. At 30.9 years of age, the primary

caretakers were younger than those in all but the urban programs and were more frequently female, divorced, living in poverty, and receiving AFDC.

ICFS families were more often referred and treated for neglect, family relationship problems, and parenting skills than IDHS families. Fewer problem areas were reported for ICFS families but again, like urban sites, more case objectives were recorded, especially in the areas of adult behavior and relationship change and family relationship change. Families at ICFS received fewer individual counseling services but more services from other agencies. With the exception of Franklin County, they received more home visits than in any other agency, averaging 5.4 home visits a month over a seven and a half month service period. Workers also accompanied clients to appointments and provided transportation more often than in most other sites.

ICFS was more likely than other sites to have closed cases because objectives were fully or partially achieved. Positive change was demonstrated in 86% of the families, although nearly a quarter of families got worse in at least one area of functioning. Overall, 80% of case objectives were partially or completely achieved and 13% of the families required no continuing services after closure.

Predictors of Placement at ICFS

In the discriminant analysis, ICFS placement cases were distinguished by the number of children in the family at high risk of placement (p=.00) (Table 6.8), the age of the oldest child (p=.04), and a greater number of psychological services (mostly psychiatric assessment) (p=.02). Other factors which discriminated placement cases included: a greater number of case objectives relating to changing the family's perception of the problem and family relationships (p=.02) and, although they contributed less and were not significant at the bivariate level, social work services from other sources (school social work and public social services), more case objectives

relating to increased use of concrete and supportive services, more problems relating to child substance abuse, more stress, and more directive interventions.

Although the variables did not enter the discriminant model, placement cases had children with significantly lower CWBS scores and received significantly more financial aid. The characteristics identifying placement cases were correlated with lower caretaker and child CWBS scores, more contacts in the first month of service, and fewer services overall. Additional differences found in placement cases included a placement history of more than three months in a foster home, group homes, or institution; more referrals for child behavior, health, or mental health problems, more court orders for family-based services, more individual counseling and psychological assessment, more use of temporary placement with a friend or relative; and more problems with delinquency or status offences.

Predictors of Non-placement at ICFS

More educational interventions, primarily homework, marginally distinguished non-placement cases. Together 67% of the placement cases and 91% of the non-placement cases were correctly classified by the discriminating variables and 53% of the variance was explained. Additionally, non-placement families were more likely to be treated for physical abuse, to have a primary caretaker who attended most or all of the sessions, and show change in behavior and family dynamics.

Iowa Department of Human Services

The IDHS Family Therapy program was much more like the remaining agencies in the study than ICFS or the urban sites in that both the highest risk children in the family and the primary caretakers were older (average 13.2 and 36.4 years). Families were also more likely to be referred for delinquency, adult relationship problems, and

parent-child conflict. Unlike other agencies in the sample, over forty percent were court-ordered to family-based services and families were more often treated for adult relationship problems. IDHS families received more services from other units in the agency and fewer services directly from family-based workers. Although primarily an office-based program, there were fewer office contacts with families than in the other in-office programs, an average of two in the first month and seven over the average service period of five months. It should be noted that the median length of service in IDHS was three months, indicating that some cases with long service periods affected the mean length of service.

IDHS used temporary placements at about the same rate as final placements, twelve percent each in the weighted data. However, more of the children were placed in foster homes, group homes or institutions at the end of service than in the other sites. Only 60% of the case objectives were achieved or partially achieved, but 76% of the families showed positive change and only 12% became worse in any area. Less change in family functioning was noted for IDHS families in all areas except family hierarchy, but a relatively high 37% of families required no continuing services after termination.

Predictors of Placement in IDHS Family Therapy Program

Three factors discriminated placement cases in the IDHS analysis: interventions which were more directive (accompanying clients to appointments, advocacy, case management, recreational activities, information and referral, and therapeutic contracts) ($p=.02$); more children in the family at imminent risk of placement ($p=.01$); and the amount of stress experienced by the family in the year before the case was closed to family based services (Table 6.9). Placement cases had significantly lower child CWBS

scores and more services from other units in the agency, although these variables did not enter the discriminant model.

Characteristics which identified placement cases were correlated with younger children, cases open longer with the agency, and lower caretaker CWBS scores. They were also correlated with a number of other services, a longer period of family-based services, and more case objectives concerning parenting and increasing the family's use of outside concrete and supportive services. Additionally, placement cases were significantly more likely to have had a prior placement for parent-child conflict or in a foster home and to have a temporary placement, especially in a residential setting.

Predictors of Non-placement at IDHS Family Therapy Program

Three factors also distinguished non-placement cases in the discriminant model, although they contributed much less to the discriminating function and all were non-significant at the bivariate level: the total number of objectives for the case; objectives relating to changing the family's relationships and child's emotional well-being; and supportive services, primarily parent education. Non-placement families were also significantly more likely to be referred and treated for adult relationship problems, to have case objectives relating to adult individual change, to recieve employment and paraprofessional services, and to show change in the areas of behavior; family hierarchy, dynamics, and emotional climate; and informal support networks. Taken together, this group of factors was much less predictive of outcome than the models for ICFS and the urban sites, correctly classifying only 28% of the placement cases, but 96% of the non-placement cases, and explaining 40% of the variance.

MINNESOTA SITES

Unlike the sites in Iowa, the two study programs in Minnesota are in different parts of the state and both are home-based. Minnesota public social services are county-administered and the two programs grew under separate local initiatives. The Intensive Services program in Dakota County was begun by the Department of Human Services in 1979, while the Intensive In-Home Treatment Program of Lutheran Social Services was started with funding from two counties in western Minnesota in 1981. Being in a rural state like Iowa, the Minnesota programs had several characteristics in common with the Iowa programs, especially with IDHS. The Minnesota programs served older caretakers, over half of whom were married and nearly all of whom were white. Twice as many of the caretakers as in the Iowa programs were employed, however, and only about 40% were living in poverty.

As in IDHS, the children at highest risk in the Minnesota families were older and a quarter to a third had experienced a prior placement. Two thirds or more were considered at imminent risk of placement. More families than average were referred for delinquency, physical abuse, child substance abuse, or parent-child conflict and fewer for family relationship problems in both sites, although more were treated for family relationship problems. Case objectives more often included parenting skills and less often included increasing the family's use of outside counseling services.

Workers in Minnesota less often accompanied clients to appointments and families received financial aid less often. While families in Minnesota received a greater variety of interventions from the family-based programs themselves, they received fewer direct services, including concrete and supportive services, overall. Both programs provided services for a shorter period of time than in most other sites. The Minnesota agencies used temporary placements during service at about the same rate as in Iowa, involving 12% of the highest risk children in the families. Over 20% were in

placement at the end of the case, more than half in foster homes, group homes or institutions.

The proportion of families showing positive change in Minnesota was somewhat lower than the average for the study and the proportion showing negative change, somewhat higher. Change was more frequent in the area of family hierarchy and less frequent in the areas of family emotional climate and perception of the problem. More families than average required continuing services after closure.

Dakota County Intensive Services

Besides the Franklin County program, Dakota County IS was the only other public in-home program in the study. However, its location in a relatively wealthy suburban area and its treatment philosophy based on the Milan Model of family therapy, made it quite different from Franklin County. The IS program also received a higher proportion of referrals for status offenses, parent-child conflict, and adult relationships. Working primarily as co-therapists or as a treatment team, IS workers much more often employed interventions such as homework, therapeutic contracts, and therapeutic letters. IS families also received more services from other units in the agency.

Families were contacted less quickly after referral and seen for a shorter period than in other programs in the study. Direct contacts averaged of 9.5 over a three month service period. Only IDHS and the Oregon sites had fewer contacts in the first three months, but they saw families over a longer time period. Perhaps related to the shorter service period, IS families had also had fewer case objectives.

Although Dakota County had the shortest average length of service, only 18% of the cases were closed because of a time limit. On average, 68% of the case objectives were partially or completely achieved. Three quarters of the families demonstrated

positive change, but over a quarter grew worse in at least one area. In over half the cases, change was noted in the areas of behavior, family hierarchy, family relationships, and emotional climate. Change was least frequent in material resources and use of services, in keeping with the relative affluence of the service population. The IS unit was not responsible for long range planning for placed children and only 18% of the cases were closed with no continuing services.

Predictors of Non-placement in Dakota County

By far the most important factor in distinguishing non-placement cases in the Dakota County discriminant analysis was the CWBS score of the lowest functioning child in the family (p=.00) (Table 6.10). Children in non-placement cases scored an average of 12 points higher. A greater number of educational interventions (role modeling and homework assignments) (p=.04), and other social work services (child protective and family services), also distinguished non-placement cases, but the latter's contribution was small. Non-placement cases received significantly more services from other units in the agency and more supportive services from outside the agency. Characteristics identifying non-placement cases were correlated with younger children, less stress, and higher caretaker CWBS scores. In addition, although the highest risk children were more likely to be out of the home at the time of intake in non-placement cases, they were more often staying with friends or relatives. Non-placement cases more frequently were treated for and had case objectives relating to adult relationships and showed significantly more change in the areas of behavior, family hierarchy, and family dynamics.

Predictors of Placement at Dakota County

As in Iowa, placement cases were distinguished by more directive interventions, including accompanying clients to an appointment, case management, and information and referral which, except for the latter, were much more often delivered by another unit in the agency. Placement cases were also marginally distinguished by more contacts in the first month of service. Neither of these discriminating variables were significant at the bivariate level. However, placement cases were significantly more likely to contain children who had prior placements lasting longer than three months and to be under greater stress. They were also more likely to receive psychological testing or psychiatric assessment, but less likely to receive financial aid.

Characteristics which identified placement cases were correlated with lower caretaker CWBS scores, more problems, and more case objectives, especially relating to parenting. In addition placement cases were significantly more likely to have a temporary placement in shelter care and to have failed appointments. Together these factors correctly classified 44% of the placement cases and 95.5% of the non-placement cases, and 41% of the variance was explained.

Lutheran Social Services

LSS differed from Dakota County in a number of respects both because of its more rural location and because of program differences. There were more male primary caretakers (32%) than in any other site and all the primary caretakers were white. Nearly 70% were employed and only 18% received AFDC. Over a third of the highest risk children, who averaged 12.5 years of age, had experienced a prior placement and 80% were judged to be at imminent risk of placement, one of the highest rates among the study sites. Nearly twenty percent of the families were court-ordered into family-based services.

About a third of the families were referred to LSS for abuse or neglect, a third for delinquency, and nearly two-thirds for parent-child conflict (up to four referral problems could be coded). Substantial numbers of problems were reported in all areas except sexual abuse and child neglect. Family relationships, parenting skills, and child behavior were targeted more often as treatment problems. As in the other midwestern sites, there were fewer case objectives to increase families' use of counseling services and more to increase parenting skills. LSS families had an average of 9.5 case objectives which focused particularly on individual level change and adult and family relationship change. In keeping with the case objectives, LSS workers more often used individual counseling as an intervention, but they less often provided case management services or accompanied families to appointments.

Family-based workers provided an average of 4.7 interventions for each family, primarily family therapy, individual counseling, homework assignments, and adult relationship counseling. Families received an average of six contacts a month, mostly in their homes, over a five month period. Only Franklin County and ICFS provided more total contact in the first month or the first three months of service.

LSS made less use of temporary placements but more than 20% of the highest risk children in the families were placed by the end of service, over half in foster homes, group homes or institutions. The family based worker was involved in making long range plans for more than a third of the families who experienced placement. LSS enjoyed the same high level of participation as the Iowa sites, with eighty percent of the primary caretakers and two thirds of the second adults attending most or all of the sessions. However, only 32% of the highest risk children did likewise, the lowest level of participation in the study. At the termination of services, seventy percent of the case objectives had been achieved or partially achieved, and two-thirds of the families had improved in at least one area. However, more than a third grew worse.

Families changed the least in the area of material resources and only 14% required no further service after closing.

Predictors of Placement at LSS

One primary factor distinguished placement cases in the discriminant analysis, the presence of adolescent problems including child substance abuse, status offenses, delinquency, or child behavior problems (p=.00). The number of families with these problems was among the highest in the study (Table 6.11). Having more than one child at imminent risk of placement and case objectives to increase the use of concrete and supportive services also made substantial contributions to the discriminant model, although they were not significant at the bivariate level. The model was one of the two weakest in the study and correctly classified only 23% of the placement, but 91% of the non-placement cases and explained only 29% of the variance. The age of the child at highest risk in the family, and the total number of problems were significantly higher for placement cases, but did not enter into the discriminant model. Placement cases also received significantly more services from outside agencies.

The characteristics predicting placement were correlated with older children, lower caretaker CWBS scores, and more case objectives, but fewer relating to parental, adult behavior, and adult relationship change. They received more contacts in the first month of service and more directive interventions, mostly recreation and information and referral. Placement cases were also more likely to be referred by the court rather than a social service agency, less likely to be referred or treated for physical abuse, more likely to be receiving public social services and attending a domestic violence or child abuse support group. Non-placement cases were more likely to show changes in the areas of family hierarchy, relationships, and perception of the problem.

COLORADO SITES

The two Colorado programs resulted directly from the state's Senate Bill 26 which in 1979 capped the money available for foster care and residential programs, redirecting it to placement prevention and reunification. Both Adams and Boulder County were among the first to fund such programs. The Boulder County Intensive Family Therapy Team, established to keep children out of residential placements, is dispersed among three district offices. The Adams County Adolescent Day Treatment Program is funded by contracts with the Department of Social Services and the school district through the Adams County Community Mental Health Center. It provides an alternative to residential placement of adolescents who can no longer be maintained in public school. Both programs are primarily office-based.

To a certain extent, family characteristics are similar in the two agencies because they both target adolescents and the prevention of residential placement. The highest risk child in the families is, on average, 13-15 years old and the primary caretaker, 39-40. Over a quarter of the primary caretakers were males, a characteristic shared with other programs serving a high proportion of adolescents. Only about a third of the highest risk children in the families were the biological children of the second adult.

As in the Minnesota programs, Colorado families were frequently referred for problems related to adolescence, especially parent-child conflict. Parenting skills were less of a focus. Families in both programs had fewer case objectives and received more case management services. They were less likely to receive AFDC.

Families in the Colorado sites received more different kinds of interventions from the family-based program than those in the Mid-west or in Oregon. The programs also used teaming more in providing services. In Boulder, one third of the families were seen by co-therapists or by a single worker with team consultation. At ADT, over half

the cases had team consultation and another 20%, co-therapy. Colorado families received fewer services from outside the agency, but had among the longest service periods in the study, averaging about 10 months in both sites. Because of the length of service, the families received the most direct contacts, averaging one contact a week. It should be noted that in Boulder County, the median length of service was eight months, indicating that some cases with long service periods affected the mean length of service.

Boulder County Department of Social Services

The families in Boulder County differed in many respects from those seen by ADT. The primary caretakers were more often married and less likely to be from a minority group, divorced, or employed. Most strikingly, none of the families were reported to have incomes below the poverty level or to receive AFDC. Only 26% of the highest risk children in the families were at imminent risk of placement, although a quarter had been placed before and 28% were court-ordered into service.

A high proportion of families were referred for parent-child conflict or child abuse. Fewer were referred for delinquency, status offenses, and substance abuse. Treatment focused on parent-child conflict and family dysfunction more often than in other sites and families in Boulder County had more case objectives to change parenting or adult and family relationships. The Boulder County family-based unit used more different interventions with their cases than many other sites, especially individual counseling, couple counseling, role modeling, homework, and therapeutic contracts. The families received an average of 5.8 different interventions.

More than 40% of the children at highest risk in each family experienced a temporary placement, many in group and residential settings. Only eight percent of the cases ended in placement, mostly in foster homes, group homes or institutions.

Almost all the placement cases had a long range plan. Although both the primary caretakers and the second adults attended fewer of the sessions than average, more than 80% of the primary caretakers were seen as cooperating fully with services, the highest rate in the study. More than 90% of the families showed positive change and, on average, 90% of the case objectives were achieved or partially achieved. Only 20% of the families got worse in at least one area and more than half required no further services at closing, the second highest proportion in the study.

Predictors of Placement in Boulder County

Three factors identified placement cases in the Boulder County discriminant analysis (Table 6.12): at least one child in the family at imminent risk of placement (p=.00), more psychological services (p=.00), and more educational interventions (role modeling, homework, and teaching) (p=.02). Not only were educational interventions used more in Boulder County than in other sites, but they had the opposite effect, being associated with placement rather than non-placement. Although they did not enter into the discriminant model, many of the other variables tested differed significantly between placement and non-placement cases. Especially noteworthy in placement cases were higher averages for directive interventions, stress, total number of problems, adolescent problems, and number of services, variables which appeared in the discriminant models for other agencies.

Characteristics which identified placement cases were correlated with cases that had been known to the agency longer and lower child CWBS scores. They were also correlated with more stress, more problems (especially status offenses, delinquency and child substance abuse), and more services over a longer period of time. In addition, placement cases had received services for a longer period of time before being referred

to family-based services, had been reopened more often by the agency, and more often had a temporary placement, especially in foster or residential care.

Predictors of Non-placement in Boulder County

A higher scoring caretaker (p=.00) was the only variable that predicted non-placement in the discriminant model. The lowest child's CWBS score, parenting and adult relationship change objectives, and number of case objectives were also significantly higher for non-placement cases. Non-placement cases were also referred more often for child abuse and more often had case objectives relating to adult relationships. Both the highest risk child and the second adult in the family more often attended most or all the family-based treatment sessions in non-placement cases. Non-placement families showed significantly more improvement in the areas of behavior, family dynamics, emotional climate, perception of the problem by the family, and perception of the family by the community. Together the variables in the model correctly classified 65% of the placement cases and 96% of the non-placement cases, and explained 67% of the variance.

Adams County Adolescent Day Treatment Program

ADT is quite different from other programs in the study. A daily program, it includes education as a primary component. Its semi-residential nature is reflected in much greater involvement in services of the highest risk children and much lower involvement of the primary caretaker and second adult in the family. ADT served a high proportion of employed primary caretakers, over a quarter of whom were Hispanic. Despite the high level of employment, a quarter of the families were living in poverty.

ADT was the only program in which the highest risk children in the family were disproportionately male (over two-thirds). Although more than three quarters were

considered at imminent risk of placement, less than one-quarter had experienced prior placement. Over a third of the families were court-ordered into treatment.

Most families were referred for delinquency, status offenses, child substance abuse, or parent-child conflict. These were recorded as problems for more than one half of the families, more often than in any of the other sites. Treatment often focused on status offenses and child behavior with objectives to change the child's behavior or peer relations.

ADT used group therapy and coercive interventions (threat of court, police or other negative sanction to affect family's behavior) more often than other sites. Next to the urban sites, ADT delivered the most services directly, often accompanying clients to appointments and providing case management and recreational services. Services also lasted the longest, over 10 months on average, with families seen weekly at the day treatment center. Although less than a quarter of the highest risk children were placed temporarily during service, nearly two-thirds of those in placement cases ended up in foster homes, group homes or institutions. The family based workers were involved in long range planning for more than a quarter of the placement cases. ADT recorded the lowest level of caretaker cooperation with services, not surprising since caretakers were more often requesting placement. Overall 62% of the case objectives were achieved or partially achieved and more than three-quarters of the families showed positive change. Nearly half, however, got worse in at least one area. The least change was noted in material resources, family hierarchy, and the family's perception of the problem. Twenty percent of the families required no further services after termination.

Predictors of Non-placement at ADT

Non-placement cases were differentiated in the ADT discriminant analysis by three variables, none of which were significant at the bivariate level (Table 6.13). Non-placement cases had longer service, more objectives relating to parenting, and more objectives to increase use of counseling. Non-placement cases also received significantly more financial aid. Characteristics predicting non-placement were correlated with less stress, less imminent risk of placement, and more objectives to change family relationships and the child's emotional functioning. In addition, non-placement cases had received services for a longer period of time before being referred to ADT. Non-placement cases had also been opened longer and reopened more often by the Community Mental Health Center and received more recreational services and more co-therapy from ADT.

Predictors of Placement at ADT

Placement cases received more different types of services from the ADT program ($p=.05$), which correlated with children scoring lower on the CWBS. Psychological services were also found significantly more often in placement cases. In addition, a higher proportion of second adults in placement cases were unskilled laborers; more of the highest risk children were male and enrolled in special education classes, and fewer were the biological child of the second adult. Significantly more placement cases were court-ordered into family-based services, and couple counseling, were accompanied to an appointment, and had a temporary placement, especially in an emergency shelter. Second adults were more often involved in treatment in placement cases. Together the four variables in the model correctly classified 68% of the placement and 76% of the non-placement cases, but explained only 25% of the variance, the lowest of any of the models.

OREGON SITES

Three Oregon programs were selected for this study. Two provided services under the governance of the Department of Human Resources' Children's Services Division, the state-administered public child welfare agency in Oregon. The Children's Services Division (CSD) created Intensive Family Services in 1979 and diverted money from foster care into placement prevention. The third program in Oregon, the Albertina Kerr Center, is a private agency providing residential treatment and services to families in eastern Multnomah County.

The majority of the 16 CSD Intensive Family Service (IFS) projects were contracted to private agencies, including Catholic Family Services in Multnomah County, which is one of the three Oregon agencies in the study. In five counties, however, there were no suitable agencies to contract with, so in 1981-1982 CSD established its own IFS projects in Salem, Medford, Roseburg, Klamath Falls and St. Helens. These five "in-house" programs constitute the CSD sample. All the IFS programs operate under the same program standards and emphasize time-limited (90 days) family therapy to families facing imminent placement of a child. In all the Oregon sites, the highest risk children were older than the study average and the primary caretakers were more likely to be divorced. Only about a tenth of the families were court-ordered into service.

The primary reasons for referral to family-based services in the Oregon sites were parent-child conflict, delinquency, or status offenses. In the CSD and Multnomah County programs, families were two to three times more likely to have been referred for sexual abuse as in other sites. Overall, a higher proportion of families had problems with sexual abuse, delinquency, status offenses, child and adult substance abuse, and parent-child conflict in at least two of the three Oregon agencies.

Treatment was focused more on family dysfunction and less on parenting skill than in the other agencies in the study, while case objectives more frequently included increasing the use of counseling services. Since an average of only three or four objectives were established for each family, they covered a narrower range than in other sites. A third to a half of the families were seen primarily by two workers in co-therapy. Service delivery included less accompanying of clients to appointments and and less advocacy and, in CSD and Multnomah County, less individual counseling and fewer homework assignments than in other programs. Fewer families received financial aid or Medicaid.

On average, Oregon families received fewer different kinds of service from family-based service workers, from other agencies, and overall. They also received the fewest direct contacts in the first three months of service, less than three a month, or, in the case of the Kerr Center, less than two a month.

The Oregon sites had among the lowest placement rates in the study, although both Multnomah County and Kerr made moderate use of temporary placements. Over eighty percent of the families showed positive change in at least one area with high rates of change in behavior, family hierarchy, family relationships, emotional climate, and perception of the problem. Despite these high rates of change, a lower than average proportion of case objectives were achieved. In Multnomah and CSD this was partially explained by the number of cases closed because the time limit had been reached. The family based workers were not responsible for long-range planning for the children in placement cases in the Oregon sites.

Children's Services Division

Primarily located in smaller towns and cities, the five CSD projects served fewer minorities and fewer children with prior placements than the Multnomah County

program. The highest risk child in the family was more likely to be the biological child of both the primary caretaker and the other adult in the family and the primary caretaker, more likely to be employed. Seventy percent of the highest risk children were considered at imminent risk of placement at intake. Families were more often referred for sexual abuse, delinquency, and parent-child conflict than in other programs. Adult substance abuse was also much more often cited as family problem. Although individual counseling and homework assignments were used less, case management services and interventions from other units in the agency were more frequent.

The majority of the contacts in the CSD projects were in the office, although home visits were frequently made. In the first three months of service families received an average of eight contacts. Services continued for an average of four months. Only two percent of the highest risk children were placed temporarily during treatment, and only 11% of the cases ended in placement. An unusually high 79% of the highest risk children and 92% of the primary caretakers participated in most or all the sessions and over half the caretakers cooperated fully with services. Nearly 90% of the families experienced positive change, mostly in behavior, family hierarchy, emotional climate, and perception of problems. Only 12% of the families became worse in one or more areas. Despite this high level of change, case objectives were partially or completely met in less than a third of the cases and over a third were closed due to a time limit rather than goal achievement.

Predictors of Non-Placement at CSD

Non-placement cases were more clearly identified than placement cases in the CSD discriminant analysis, primarily by longer services (p=.01), more objectives to increase the use of counseling (p=.02) and of supportive services, and more educational

interventions -- mainly homework and teaching (Table 6.14). Caretaker scores on the CWBS and the total number of case objectives were significantly higher in non-placement cases. These characteristics were correlated with less imminent risk of placement, higher child CWBS scores, more financial assistance, and more contacts in the first month of service.

Predictors of Placement at CSD

Counseling services from outside agencies (p=.02) -- primarily school social work, psychological testing, and substance abuse counseling -- and older children distinguished placement cases. These characteristics were correlated with more problems and imminent risk of placement. Together these factors correctly classified 96% of the non-placement cases, but only 36% of the placement cases and explained 46% of the variance. The only other variables which differed significantly in placement cases were a prior or temporary placement of the highest risk child, referral for substance abuse, and greater involvement in services of the other adult in the family.

Multnomah County

In most respects the program in Multnomah County was very like that in the CSD projects, with a somewhat different client population. Serving the Portland metropolitan area, the Multnomah County program had more minority group families and fewer employed caretakers than the other Oregon sites. Over two-thirds of the highest risk children had prior placements and 79% were judged to be at imminent risk of placement. Multnomah families had the lowest child CWBS scores and the second lowest caretaker CWBS scores and were referred more often for sexual abuse and child substance abuse than in other sites. Referral rates for delinquency, status offenses, adult substance abuse, family relationship problems and parent-child conflict were also

higher than average. In averaging nine different problems, Multnomah families were comparable to the other urban sites in the study.

Multnomah workers used teaching or case management less often than the CSD projects but, otherwise, the services were very similar, although they were more often delivered in the families' homes. Contacts were somewhat less frequent, averaging 6.3 in the first three months of service and services lasted an average of five months, one month longer than in the CSD projects. It should be noted that the median length of service was three and one-half months, indicating that some cases with long service periods affected the mean length of service.

The Multnomah program placed 17% of the highest risk children temporarily and 15% at the end of service, mostly in foster homes, group homes, or institutions. Caretaker's cooperated with services less, but goal achievement was higher than in the CSD sites. Over 80% of the families showed positive changes, mostly in behavior, family hierarchy, relationships, emotional climate, and perception of problem. A fifth of the families became worse in at least one area and two-thirds required continuing service after closing.

Predictors of Placement in Multnomah County

In the discriminant analyses, CSD and Multnomah shared more discriminating variables than any other two sites, not surprising since they both operated under the same guidelines from the state of Oregon. The order and weighting of the variables differed, however. In Multnomah, the most important factors distinguishing placement cases were the number of outside counseling services received (p=.05) -- primarily family services, community mental health services, psychological testing, or substance abuse counseling -- and the presence of a child at imminent risk of placement (Table 6.15). These characteristics were correlated with stress, more problems, and being

reopened more times. They were also correlated with being seen more rapidly after referral, and more family-based services. Placements tended to occur more often in families with problems involving physical abuse and in which adult change was a case objective.

Predictors of Non-Placement in Multnomah County

Factors identifying non-placement cases included older children (p=.05), longer services (p=.02), caretakers who scored higher on the CWBS, and more objectives to increase the use of counseling. These characteristics were correlated with more services in the first month, lower child CWBS scores, more supportive services, and more objectives to increase use of concrete and supportive services. Again, similar to CSD, these variables distinguished all the non-placement cases, but only 33% of the placement cases and explained 36% of the variance. The only other variable which differed significantly between placement and non-placement cases was the number of contacts in the first three months which was higher for non-placement cases.

Albertina Kerr Center

The Kerr Center was very different from the other sites in Oregon in a number of respects. Two-thirds of the highest risk children were boys and only twenty percent were the biological child of the second adult in the family. Few had had a prior placement or were considered at imminent risk of placement. The most referrals came from the schools and were for status offenses and parent-child conflict, although the latter was less often a referral problem than in the other Oregon sites. Over forty percent of the families were reported to have problems with child substance abuse, considerably higher than the second highest site, Multnomah.

Kerr made more use of individual counseling than most of the other sites, and much more than the other Oregon sites. As in the other Oregon sites, Kerr families received fewer services both directly from the family-based worker and from outside agencies. The families received an average of 8.3 contacts in the first three months of service; the average service period was eight months, much longer than in the other Oregon sites.

Perhaps due in part to its service population, Kerr had the lowest estimated placement rate in the study, four percent, even though 13% of the highest risk children were placed temporarily. Most of the placements made at the end of service were with relatives or neighbors. Kerr had one of the lower rates of participation by the primary caretaker, but high rates of participation of other adults in the family and of the highest risk children. A very high 95% of families showed positive change, mostly in the areas of behavior, family hierarchy, relationships, emotional climate, and perception of problem. However, a third became worse in at least one area. A little over half of the case objectives were achieved or partially achieved. Nearly 60% of the cases were closed without need of further service.

Predictors of Placement at Kerr

Placement cases in the Kerr program were distinguished by three equally weighted factors: more parenting objectives (p=.01); older children (p=.01), and more problems (p=.01) with a small additional contribution by the total number of support services received (Table 6.16). These characteristics were correlated with more stress and lower functioning caretakers and children. They were also related to being seen more quickly and to having more contact in the first month of family-based service. The other variables that were significantly different for placement cases, were a greater likelihood that a child was at imminent risk of placement (although this was still only

.5 per family in placement cases); more public social services; lower caretaker CWBS scores; and a higher number of case objectives. Sexual abuse was involved significantly more often in placement cases as well.

Predictors of Non-Placement at Kerr

Educational interventions -- mostly homework and teaching -- made a only small contribution to identifying non-placement cases. Altogether these variables accounted for only 17% of the placement cases but all of the non-placement cases and explained 38% of the variance. In non-placement cases primary caretakers were more likely to attend most or all of the sessions.

CHAPTER 7

PREDICTORS OF OUTCOME: SUMMARY OF FINDINGS AND DISCUSSION

A number of variables that distinguish placement from non-placement cases have been identified in this study, both in bivariate and multivariate analyses. This chapter will summarize the findings on predictors of outcome. First, the variables common to a number of the discriminant models for individual sites are identified. Then, these discriminant predictors are grouped with variables that differed significantly between placement and non-placement cases at the bivariate level, so as to identify service and family characteristics related to outcome in the overall data set. Finally, eleven of the most important variables are displayed schematically to illustrate the interdependence of family characteristics, service characteristics, and outcomes.

PREDICTORS OF PLACEMENT IN THE DISCRIMINANT MODELS

Although predictors of placement varied from site to site, in part due to the population served and differences in how services were delivered, several predictors were common to more than one site (Table 7.1). First among these common predictors was the imminent risk of placement of one or more children in the family. This indicator appeared in seven of the discriminant models and explained from 4% to 48% of the variance between placement and non-placement cases at the bivariate level (Table 7.2). In five sites, imminence of risk at intake was significantly higher in placement cases: the placement cases had an average of .5 to 2.3 children at imminent risk while the non-placement cases had .1 to 1.5. Only in Franklin County and ADT were there more children at imminent risk in non-placement cases.

Second among the common predictors of placement was the number of problems reported for families in placement cases. This was a distinguishing characteristic of

placement cases in two sites and differed significantly between placement and non-placement cases in five sites, with means of from 1.1 to 11.8 problems in placement cases and 1 to 8.9 problems in non-placement cases. At the bivariate level, the total number of problems explained from 4% to 26% of the variance between placement and non-placement in the sites in which it was significant.

A third predictor was the average age of the oldest child, which was significantly higher for placement cases in four sites and entered into the discriminant model in five sites. The average age of the oldest child in placement cases ranged from 6.7 to 16.2 and in non-placement cases, from 5.2 to 15.9, but explained less than 10% of the variance between placement and non-placement cases. In only one site, Multnomah County, was this relationship reversed; families with older children had fewer placements.

A fourth predictor of placement was a the number of psychological and psychiatric outpatient services received by a family. In all sites more placement than non-placement cases received these services. This variable entered into the discriminant models in five sites (in two as part of a more general variable measuring the number of counseling services received from outside the agency), and was significantly higher for placement cases in six sites. On its own, it explained from 4% to 26% of the variance between placement and non-placement cases.

Several other variables appeared in the models as discriminating placement cases, although they were not as consistently significant at the bivariate level as the four mentioned above. More directive interventions were associated with placement in four of the discriminant models, but were significant at the bivariate level in only three sites. The level of stress experienced by the family appeared in two of the models and was also significant at the bivariate level in three sites. Problems with adolescents such as status offenses, delinquency, substance abuse and behavior problems were

associated with placement in two models, and significant in three sites, two of which served primarily adolescents. The receipt of other social work services entered into three models and was significant in one sites. Other variables either entered into only one equation, were significantly different between placement and non-placement cases in only one site, or were contradictory in direction between sites.

PREDICTORS OF NON-PLACEMENT IN THE DISCRIMINANT MODELS

Turning to commonalities between non-placement cases across the sites, fewer factors emerge, even though non-placement cases were consistently more accurately classified by the discriminant models. First among the common factors is a primary caretaker who scored higher on the CWBS. This factor distinguished non-placement cases in three models and was significantly different from placement case caretakers in five sites. Caretakers in non-placement cases scored higher in all but one of the sites, with averages ranging from 58.4 to 79.9, and from 54 to 76.2 in placement cases. The caretaker CWBS score explained between 4% and 35% of the variance between placement and non-placement cases (Table 7.3).

A second common factor in non-placement cases was a higher CWBS score of the lowest scoring child. This score differentiated placement from non-placement cases in two models, was higher for non-placement cases in all but one of the sites, and was significantly higher in six sites. On its own, it explained between 8% and 30% of the variance between placement and non-placement cases.

Finally, non-placement cases received services for a longer period of time in seven of the sites and length of service differentiated non-placement cases in four of the models. The average length of service ranged from 96 to 288 days in placement cases and from 84 to 363 days in non-placement cases, but was significantly different in only four sites. In one of these four, Franklin County, the general direction of the

relationship was reversed so that placement cases received services for a longer time. The direction was also reversed in three other sites, although the difference was not significant. Alone, length of service explained from 4% to 12% of the variance between placement and non-placement cases. Again, the other variables discriminanting non-placement cases either appeared in only one model, were significant in only one site, or appeared in contradictory directions.

SIMILARITIES AMONG SITES SERVING YOUNGER AND OLDER CHILDREN

As already indicated by the order of site presentation in the last chapter, the differences between placement and non-placement cases were more accurately predicted in the three sites which served younger children and their families--Franklin County, SCAN, and ICFS. These programs shared more features than any others, except for those sites within the same state. In all three programs serving younger children, the families more often received financial aid and were more often referred for neglect and family relationship problems. The programs all delivered services primarily in the home and saw families over a relatively long period of time, seven to ten months. Both Franklin County and ICFS workers saw families an average of twice a week. Treatment focused more on neglect and parenting and families received more services than in the other sites, especially concrete services from other agencies, school social work services, and public social services. In terms of outcomes, all three programs had higher placement rates than the study average, 19% to 25%, but a third to half of the placements were with friends or relatives. The programs were also very successful in helping families achieve their case objectives, 80% being at least partially achieved.

The remaining eight programs were alike in not serving as many younger children, but beyond that had little in common in terms of their structure or treatment approach. Some were in-home, others in-office programs; some were in public

agencies, others in private. For the most part, these programs were less comprehensive and intensive than those serving younger children, providing fewer services from within the family-based program. Only in LSS were services as intensive as in the programs serving younger children. In the other programs, families averaged one direct contact a week or less in the first three months of service. With the exception of Boulder County, however, the programs in public agencies used more services from other units in the agency, but in all the programs families received less financial aid and fewer concrete services.

FAMILY CHARACTERISTICS RELATED TO OUTCOME

In both the bivariate and multivariate analyses, family characteristics had a somewhat stronger relationship to outcome than service characteristics, although, as will be discussed later, the two were really inseparable. Among the variables related to outcome at the bivariate level, the age of the highest risk child, a history of prior placement, certain types of problems, the level of stress, and child and caretaker CWBS scores all differed significantly between placement and non-placement cases.

The highest risk children in placement cases were, on average, a year older than those in non-placement cases and over 40% had experienced a prior placement. Less than a quarter of those in non-placement cases had been placed before. The most difference between placement and non-placement cases, however, was among children who had prior placements of three months or more in group homes or institutions. This group comprised less than 10% of the children at highest risk. Little difference in placement rates was found among children placed for less than three months or those placed in less restrictive settings. Children with prior placement due to parent-child conflict, child behavior problems, status offenses, delinquency, neglect, or adult

relationship problems were also more likely to be placed again than children with no previous placements or children placed for other reasons.

Placement and non-placement cases were also referred and treated for different problems. Families referred for delinquency or treated for status offenses or child behavior problems more often experienced placement. Overall, placement families had significantly more problems with delinquency, status offenses, child substance abuse, parent-child conflict, child behavior, child's peer relations, child's health or mental health, and adult substance abuse. Most of these problems were found more often in families with adolescent children at risk of placement. Placement families were also reported to be under more stress in the year prior to the termination of family-based services and to have both caretakers and children who scored lower on the Child Well-Being Scales.

Although motivation is usually seen as a client characteristic, it is a product of both the inclination of the family and the success of the worker in engaging them in services. Placement cases had more failed contacts, an indicator of lack of engagement. Although there was a high level of participation in services by the primary caretaker, the second adult in the household, and the highest risk child in both placement and non-placement cases, less participation by both the primary caretaker and the highest risk child meant more likelihood that a placement would occur. Reflecting the difficulty of these cases, a little over half of the primary caretakers were recorded as cooperating fully with services, but only 10% of the families dropped out, moved away, or were closed because a child ran away.

Children's age, number of problem areas in the family, and child and caretaker CWBS scores were found to be the most important predictors in the discriminant analyses of several sites, suggesting that families with older children, more problems, and lower functioning children and caretakers face an increased risk of placement.

Prior research has also identified older children, children with prior residential placements, and families with more severe problems as at greater risk for placement (Haapala, 1983; Rzepnicki, 1987; Heying, 1985; Hinckley, 1984; Szykula and Fleischman, 1985; Jones, 1981 and 1985; Turner, 1984; Kagan, 1987). Family motivation and cooperation with services have also been found to be related to placement in prior studies (Kinney, 1977 & 1978; Jones, 1981; DeWitt, 1980; and AuClaire and Schwartz, 1986).

SERVICE CHARACTERISTICS RELATED TO OUTCOME

At intake, imminent risk of placement reflects both the severity of the family's problems and the eligibility criteria of the program which regulate the timing of service. Of the cases that terminated in placement, 88.6% had children who were at imminent risk of placement at the time of intake, compared to 49.7% of the non-placement cases. Agency practices regarding temporary placement of children also influence outcome. Nearly half the highest risk children in placement cases experienced a temporary placement. Only 13% of the non-placement cases involved a temporary placement.

Programs, therefore, were more likely to place children who came to them at imminent risk of placement, who were already in placement at the time of intake, or who went into a temporary placement. Many programs restrict their services to families in which a child is on the verge of placement and exclude families for whom placement is an issue, but not imminent. Thus, they make their task of averting a placement more difficult by the timing of services. However, only 28.5% of families with a child at imminent risk experienced placement; over 70% remained together.

These two factors just discussed, timing of services and family motivation, were also thought by the social workers to be the most important causes of failure with

families. Caretaker motivation, an important element in the Child Well Being Score, and imminence of risk were both predictive of outcomes in the discriminant models of several sites.

Other service characteristics also differed significantly between placement and non-placement cases. Placement cases were less likely than non-placement cases to have adult relationship change and community change identified as case objectives. They were also less likely to receive paraprofessional services directed toward increasing self-esteem, although fewer than 20% of the families received concurrent services from a paraprofessional worker. In multiservice agencies, placement cases had been known to the agency longer before being referred for family-based services. In many agencies, placement families were accompanied to appointments more and received more case management, advocacy, substance abuse treatment, transportation, and psychological, psychiatric, and mental health services. Placement cases also received more protective services, crisis intervention and substance abuse treatment from the family-based unit as well as from outside agencies, and more different kinds of service overall.

The only service characteristics to emerge across several sites as predictors of outcome in the discriminant analyses were more psychological and psychiatric out-patient services for placement cases and a longer service period for non-placement cases. In many agencies, however, a mental health evaluation is routine before placement plans are finalized and since the sequence of services cannot be identified in this study, these may have followed a decision to place. Both longer services and more different types of services, however, have been found by previous researchers to be associated with maintenance of the family (Turner, 1984; Jones, 1981 and 1985).

INTERDEPENDENCE OF FAMILY, SERVICE, AND OUTCOME

Although no single set of variables emerged which predicted placement for all types of families in all types of agencies, a pattern can be discerned by looking at key variables and examining their ranking in agencies with lower and higher placement rates. (Table 7.4). Six family characteristics and six service characteristics were selected for comparison. All agencies were assigned a plus or a minus for the variable according to whether the agency average was in the lower or upper 50% of the range. The value for the agency in the middle of the range was left blank. Agencies are listed in order of their estimated placement rates with ADT last, since its placement rate could not be calculated. The proportion of placement and non-placement cases in the sample was used as the best available estimate for ADT.

Five of the six family characteristics in the table were significantly related to outcome. The sixth, the social workers' estimate of how many low income families they served, was included to account for differences in socio-economic characteristics. Similarly, five of the six service characteristics were also significantly related to outcome. The sixth, service delivery primarily in the home, was added to account for structural differences among the programs and because of its prominence in the literature on family-based services.

In looking at the five programs with placement rates in the lower half of the range, it can be seen that four programs served families with higher caretaker CWBS scores, fewer children at imminent risk of placement and higher incomes, and three programs served families with fewer prior placements, fewer problems, and children with lower CWBS scores. Only Multnomah County, which had the highest rate of placement in the lower range, served families which were above the median in most of the areas. Clearly, it is more possible to avert placement in a population with fewer risk factors.

The nature of the client population may also condition the service pattern observed in the programs with lower placement rates. Four of the five programs that made fewer placements also provided fewer different kinds of services directly (mostly confined to family therapy, individual counseling and information and referral services), made fewer temporary placements, and used directive interventions less. Three also made less use of psychological/psychiatric services and provided services over a shorter time period. It is, perhaps, significant that of the programs with lower placement rates, only Multnomah County, which had the highest risk population, provided services primarily in the home, although the in-office programs also made home visits to one fifth to three quarters of the families in the first month of service. That family-based services are directed toward preventing residential placement in Boulder County may account for the otherwise anomolous situation of a program with a low risk population providing more services, making more temporary placements, and using more directive interventions over a longer time period than is characteristic of the other agencies in this group.

At the median in placement rates, ICFS proved to be more similar in its client and service pattern to the agencies with higher placement rates, so will be considered with them. Four of these six agencies served higher risk families in terms of caretaker CWBS scores, imminence of risk of placement, income level, and prior placements, and three served families with more problems than the median. Only two served children with CWBS scores below the median. Lutheran Social Services and Franklin County, the two agencies with the highest estimated placement rates (22% and 25% respectively) served the families with the most risk factors. Again, service delivery appears to be related to family characteristics since five of the six agencies with higher placement rates delivered services primarily in the family's home; four of the six provided more services directly and made more use of temporary placements,

directive interventions, and psychological services; and three delivered services over a longer period of time.

While most of the family and service characteristics followed the expected pattern, with no more than one or two deviations in either the high or low placement group, the lowest child's Child Well-Being Score and length of service both presented a more complicated picture. The programs with the lowest scoring children all primarily served families with adolescents. In two of the agencies with lower placement rates, the severity of the child's problems was the only risk factor. All three programs with higher placement rates and higher Child Well-being Scores served families with younger children who were more likely to be referred for problems in parenting than problems related to the child's behavior, and thus less likely to have low child CWBS scores.

With the exception of IDHS, all of the programs with lower placement rates served non-placement cases for a longer period of time. This difference was significant in CSD and Multnomah County (averaging 1 to 2 months more of service) and was identified in the discriminant models for those sites as an important predictor of non-placement. Among the agencies with higher placement rates, non-placement cases in ICFS, SCAN, and ADT, also received services over a longer period of time. The difference was statistically significant, however, only in SCAN where length of service was also a predictor of non-placement in the discriminant model, and averaged nearly three months longer for non-placement cases. Only in Franklin County were longer services significantly associated with placement, but they were not predictive of placement in the discriminant model.

SUMMARY

This review of the factors related to placement and non-placement has identified both family and service characteristics that predict outcome at the bivariate and

multivariate levels. Family characteristics which are most predictive of placement in multivariate analysis include the age of the oldest child, the total number of problems, and child and caretaker CWBS scores. Families with older children, more problems, and lower functioning caretakers and children are more at risk of placement. Additional risk factors identified in bivariate analysis include prior residential or group home placement; problems associated with adolescence-such as status offenses, child substance abuse, parent-child conflict, child peer relationships, and child behavior; higher stress; and less caretaker motivation, cooperation, and engagement. Prior research has also identified older children, children with prior residential placements, and families with more severe problems and less motivation as at higher risk of placement.

Of the service characteristics, imminence of risk at intake and psychological or psychiatric outpatient services consistently predicted placement in the discriminent analysis. However, services of longer duration were associated with non-placement in several sites. Other service characteristics associated with placement in the bivariate analysis included more directive interventions and a longer period between referral to the agency and referral to family-based services. Placement cases also were less likely to have adult relationship change and community change objectives, or to receive paraprofessional services to build self-esteem. Prior research has identified longer service periods and a greater variety of services as predictive of placement prevention.

On their own, these predictors of placement provide important clues about the reasons for failure in family-based services. In their responses to the social worker questionnaire, workers identified families who had been in the service system longer and who were less motivated as benefiting less from family-based services. They had more optimism than the case review data indicate about their success with adolescents. It should come as no surprise, though, that families with more problems, both in

numbers and severity (as measured by the Child Well-Being Scales) experience more placements. What is surprising is the degree to which service characteristics are related to family characteristics. For the most part, programs that offer more focused, shorter term services primarily delivered in the office to families with fewer risk factors prevent placement in a higher proportion of cases. Programs offering more comprehensive, in-home services to families with more risk factors have higher placement rates. This interdependence of family characteristics, service characteristics, and outcomes may suggest an efficient division of labor among family-based programs: in-office programs may want to treat families who have fewer risk factors over a shorter period of time while in-home programs might focus their attention on families with multiple problems, offering them more comprehensive services, but expecting somewhat lower success rates.

CHAPTER 8

CONCLUSIONS AND RECOMMENDATIONS

This study has provided data on a wide range of family-based programs in the United States. While the diversity among programs has imposed some limitations on statistical analysis of the data, it has also provided a rich array of examples of family-based programs and their environments. This concluding chapter will briefly summarize the study's findings, outline its major implications, and suggest areas in which further research might be directed.

CHARACTERISTICS OF FAMILY-BASED PROGRAMS

Both the social worker and case review data clearly indicate that all eleven programs follow a model that can be called family-based with reference to philosophy and focus. Social workers in these programs almost universally believed in the importance of maintaining children in their own homes and in empowering families to bring this goal about by setting their own treatment objectives. While their treatment approaches were not identical in terms of strategy or technique, all family-based workers focused their efforts on the entire family as the unit of service. When the data are weighted to reflect the actual frequency to placement and non-placement they show that over eighty percent of the families received some form of family therapy. In nearly three-quarters, the primary caretaker participated in most or all of the contacts with the family-based worker; in half, the highest risk child and another adult in the household attended most or all of the sessions.

Family-based programs can be defined not only by their focus on the whole family, but also by the intensity and the duration of their services. Families in these programs were seen, on average, about once a week for two hours during the first

three months of service and services continued for about six and one-half months. In-home programs with lower caseloads generally offered more intensive services, whereas in-office programs had higher caseloads and offered less intensive services, with the exception of the Oregon Children's Services Division.

The study found the family-based programs were very successful in meeting their primary goal of keeping children out of placement. Overall, 84% of the families were estimated to be together when services were terminated (ranging from a high of 96% to a low of 75%). During family-based services, only 19% of the highest risk children had experienced a temporary placement. On average, two-thirds of the case objectives were achieved or partially achieved and over eighty percent of the families experienced positive changes, with a majority showing improvement in behavior, family relationships, emotional climate, perception of the problem, and hierarchy.

Some critics have argued that the only families who are kept together by preventive services are those with few problems (Magura, 1981). Magura's study indicated that children from families with more severe problems more often ended up in placement. In fact, this point of view is not supported by our study. On average, non-placement families had more severe problems on all ten items in the Parental Disposition subscale of the Child Well-Being Scales than the protective services populations studied by the scales' authors (Magura and Moses, 1981, pp. 171, 187). In this study, non-placement families registered nearly twice as many problems on six of the scale items as the protective services cases did (Table 8.1). Similar results were found for the oldest child's scores on the Child Well-being Scales (Table 8.2).

A Typology of Family-Based Programs

Despite the diversity among the programs in terms of location, structure, service approaches, and client populations, four general program types emerged based on their auspices--public or private--and the delivery of their services--primarily in the home or in the office. The question of program auspices was found to relate largely to staffing issues, including experience, turnover, and salary; location related more directly to program issues, including service approach, use of time, and coordination of service. By identifying these structural characteristics, we are more able to anticipate the staffing and service issues they raise and to plan and assess programs according to the type they represent.

Definitions of Success and Failure in Family-Based Services

The analysis of extensive interview and social worker survey data has confirmed that family-based workers view their cases as successful if placement has been averted and as failures if a placement is necessary. However, workers made more refined discriminations in this study that help to define other, intermediate measures of success and failure related to placement or non-placement: family change, stabilization, goal achievement, meeting of children's needs, and independence from service. These findings confirm that the central purpose of family-based services is to keep families together while recognizing that other objectives contribute to this larger goal.

Factors Associated with and Predictive of Success or Failure in Family-Based Services

While several family and service characteristics that predict outcome have been identified in previous research, this study validates and highlights their importance, especially of predictors such as the age of the child, prior group or residential

placement, severity of problems, lower motivation in placement cases, and longer, more comprehensive services in non-placement cases. In addition to these, this study has identified both the timing and type of services as important predictors of outcome. Perhaps most importantly, this research highlights the interdependence of family characteristics, service, and outcomes. This interdependence reaffirms the need to evaluate each program's success on its own terms, rather on the basis of some pre-established, universal criteria.

POLICY AND PRACTICE IMPLICATIONS

The findings of this research have strong implications for the way in which family-based services are structured, for service delivery, and for expectations of success with particular types of families.

STRUCTURAL IMPLICATIONS

Family-based services can be successfully delivered by public agencies.

The five public agency programs in this study employed a range of family-based models, delivered a variety of services, and had success rates comparable to other programs in the study. Despite the popular perception that public social service staff suffer from low morale, high caseloads, and high turnover, public family-based programs appear to be quite successful in attracting and maintaining an experienced staff who enjoy high morale, high job satisfaction and low turnover. Though it is not possible in this study to account for this phenomenon with total certainty, it may be that lower caseloads and the feeling of success that comes from effectively delivering services to a challenging client population make the family-based approach a highly satisfying one to social workers in public agencies.

Family-based services can be successfully delivered in the office for some client populations.

Although family-based services first developed as an in-home service within private agencies, this research demonstrates that the family-based approach can be successfully delivered in office settings, especially with particular client populations. Indeed, in-office programs generally demonstrated lower placement rates, but it is important to note that they were likely to treat families who had older children and more focused problems and to use in-home contacts for assessment. Families with younger children where problems were related more to abuse and neglect were treated more frequently in comprehensive, in-home programs.

Low salaries and lack of training opportunities create worker dissatisfaction.

Although the workers in this study generally expressed high levels of job satisfaction and morale, higher turnover and lower morale did show up in private agencies that paid lower than average salaries. Workers also expressed dissatisfaction over cutbacks in training and not receiving training from their own supervisors, and, in office programs, reported less access to funds for professional development. These findings imply both a need for careful attention to salary levels in purchase of service arrangements and the need for appropriate and on-going training for workers involved in the delivery of these highly complex services.

SERVICE DELIVERY IMPLICATIONS

Services must be matched to the client population served.

It is apparent from the range of successful programs represented in this study that no single model of family-based service is appropriate to all agencies and all families. Service delivery must be tailored to the needs of the families in the targeted

population, to the capabilities of the agency, and to resources and needs of the community.

Delay of family-based services increases the risk of placement.

In several agencies, cases that were open longer before being referred for family-based services and cases that were reopened more times were more likely to experience placement. This, and the importance of imminence of risk as a predictor of placement, indicates that timing is a critical factor and that delays in getting family-based services to clients can have a negative impact on outcome. In addition, the social workers viewed inappropriate timing of family-based services as one of the two most important causes of failure.

Directive services may not help families avoid placement.

One study finding is that more directive services--such as accompanying a client to an appointment, advocacy, case management, coercion, and recreational services--were predictive of placement in a number of sites. More often provided to higher risk families, these services may indicate a poor prognosis, may come too late or may somehow fail to build the family's own coping skills.

Other concurrent mental health and social work services may not help families avoid placement.

Families who received more mental health and in some sites, more social work services from outside the family-based program were more likely to experience placement. The involvement of many service providers may create problems in coordination that hinder case progress or may signal a situation in which services are not being effective. One recent study found that contrary to their expectations greater participation of other service providers was related to placement (Berd et al, 1988).

Family-based workers are not recording long-range plans for placed children.

The study found that only 28% of placement cases had a long-range plan for the child in the case record. In some programs, placement and long range planning are the responsibility of another unit in the agency, or, in the case of private programs, of the referring agency. However, since it is generally accepted that permanency planning involves planning for a placed child's potential return home, as well as for the provision of a stable home if reunification is not possible, family-based workers could play a crucial part in planning for the child's future. Workers need to use their knowledge of the family and maintain their commitment to the child until permanency planning has been accomplished.

Families may benefit from longer periods of service.

The study found that in several sites, families who received services from the family-based unit over a longer period of time had more successful outcomes. This may reflect the early identification and termination of families that are not benefiting from services or the continuation of support for families that are making progress. But the finding should also make programs wary of terminating services prematurely due to externally imposed time limitations. While short term services are often effective and it is important to use resources efficiently, the decision to terminate services should be made on a case-by-case basis.

Families benefit from education and supportive services.

In several sites, families who received educational interventions such as role modeling, homework, or teaching were more likely to avoid placement, as were families who received more supportive services -- parent education, support groups, volunteer services, or money management counseling. Families with case objectives to increase their use of concrete or support services also had better outcomes in several sites. This finding underlines the importance of a comprehensive approach to family

needs, whether the actual services are provided by family-based workers themselves, by other units in the same agency, or by other agencies.

Most families will continue to receive services after the termination of family-based services.

Overall, only 26% of the families were expected to receive no additional services after their cases were closed to family-based services. Placement requires continuing service, of course, but two-thirds of non-placement families were also expected to receive continued services from another unit in the agency or another provider. Given the severity of the problems facing these families, and the eligibility criteria in many programs that families must have exhausted all other services and be on the verge of placement to be accepted for services, it is perhaps unrealistic to expect that these families will be able to function without further help after a short period of intensive intervention. Intervention would perhaps best be seen as an attempt to avert placement, not a panacea capable of solving all of a family's problems.

IMPLICATIONS REGARDING CLIENT POPULATION

Children with prior group or institutional placements are at increased risk of placement.

These study findings confirm other research that shows that children with a history of prior placement, especially longer term and group or residential placement, are at higher risk of repeated placement. Furthermore, a temporary placement made during the course of family-based services increases the likelihood that the case will terminate in placement. This finding held true for all types of temporary placements, including those with friends or relatives, with the exception of respite care which occurred too infrequently to assess.

Families with more severe problems are at higher risk of placement.

Our findings confirm the claim of prior research that families with more problems and more severe problems are more likely to experience placement. All three aggregate measures of problems--the total number of problems in the family and the child and caretaker's Child Well-Being Scores which indicate severity--were predictive of placement in at least five sites. However, the number of problems identified and the average CWBS scores were very different among the sites, indicating that it is not possible to identify a level of severity that renders a family untreatable by these methods.

Families with problems relating to adolescence are at higher risk of placement.

In many sites, the study findings indicate that problems of delinquency, status offenses, child behavior, parent-child conflict, or child substance abuse are more likely to lead to placement. This was true whether the problem was the cause of a prior placement, the reason for the current referral, the focus of treatment, or simply reported to be present. Paired with the finding that older children are more likely to be placed, this strongly indicates that the life cycle crisis of adolescence may precipitate placement in troubled families and that family preservation may be made more difficult by the anticipated departure of the child.

Families who are not motivated to receive services are at higher risk of placement.

The relationship of motivation to case outcome found in prior research was confirmed in this study. Lower levels of caretaker and child participation in services and the caretaker's Child Well-being Score, which included ratings of cooperation and motivation, predicted placement. Furthermore, family-based workers saw lack of motivation as the primary reason for failure. This indicates that a family's willingness

to change may be as important to success as the particular problems they bring and the services they receive.

AREAS FOR FURTHER RESEARCH

This study highlights the importance of life cycle issues in the etiology of placement. Young families with many problems are referred for child abuse and neglect; families facing the crisis of adolescence come in with problems of delinquency, status offenses, parent-child conflict, and child behavior; both stepmothers and stepfathers have problems in parenting their new spouse's children. Our research suggests that different life cycle crises may require different services and different modes of service delivery. Further research is needed to explore these possibilities.

In addition to a more careful matching between intervention and family, further research should help identify both the effectiveness of different interventions and the longer term effectiveness of family-based services as a whole. These pressing questions, which concern all social service and counseling professions, can only be answered through studies with scientifically selected comparison or control groups and longer term follow-ups.

Several questions which relate to program structure need further research. Studies should seek to determine the relationship of staff morale and turnover to salary, training, supervision, and opportunities for advancement. While family-based workers seem to be more content with their work than public social service workers generally, such complex and demanding services cannot be successfully delivered without continuing support, training, and positive reinforcement. More in-depth study of these issues may offer suggestions for resolving these chronic problems in public social services.

Staffing patterns also deserve further study. Though a number of combinations of professional and paraprofessional services are currently utilized within family-based services, the relative merits of co-therapy, professional-paraprofessional teaming, and team consultation are unknown. It is widely believed that peer support is essential to delivering effective family-based services, but this, too, needs to be validated by further research, as does the contribution of paraprofessionals to delivering effective services. Since fewer than twenty percent of the families received paraprofessional services, this study was not able to determine their effect, though the use of paraprofessionals to help raise self-esteem showed a relationship to outcome and suggests the utility of a broader use of paraprofessional services with some types of problems.

Other questions which remain unanswered regarding program structure concern location, intensity and duration of services. The relative effectiveness of in-home versus in-office services for different client populations needs to be tested. Currently, intensity of services ranges from ten or more hours a week of direct contact to one hour a week and length of service from a few weeks to nearly a year in different family-based programs. Since all these dimensions have serious cost implications it is imperative to study the cost-effectiveness of different service delivery formats.

Further definition and elaboration of family-based program types according to structural and service characteristics would help the field more effectively match services to client needs. If we could reduce the bewildering array of services and models currently found under the rubric of family-based services to a few prototypical models, it would give coherence to the field and aid planners, administrators, and evaluators in identifying those characteristics and issues key to family-based services.

Finally, research is needed that will expand the family-based model from its protective service context to families that face placement because of health, mental

health or disability problems. Only a few families in this study were referred for these reasons, so we could not assess the relationship between the services they received and the ultimate case outcome. It is our view that while family based services are currently most frequently employed in child welfare settings, this approach need not be restricted to one category of service or one client population. Unlike protective services or foster care, family-based services are not yet another categorical service, but an innovative and systemic way to understand and intervene in families and their communities.

While further research is certainly needed to refine the practice of family-based services and to identify which practice models work best with which populations, it is already clear from this study that family characteristics, services, and outcomes are interdependent. Despite the preference for short term, in-home services that has been reflected in the literature on family-based services (Kinney, 1977 & 1978; Besharov, 1986), no simple formulation of service length or location can ensure high success rates. Just as direct service workers must consider each family's unique combination of strengths and problems, so administrators and program planners must patiently assess the unique circumstances in which their family-based programs must survive and flourish.

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TABLES

Table 2.1
Response Rate for
Social Worker Questionnaire

AGENCY	# SENT	# VALID	# RETURNED	%
IDHS	5	5	5	100
ICFS	19	18	16	89
Dakota County	11	10	9	90
LSS	23	17	16	94
Franklin Cnty	3	3	1	33
ADT	6	6	5	83
Boulder County	6	6	5	83
SCAN	30	19	16	84
Kerr	7	7	7	100
CSD	16	15	14	93
Multnomah	8	8	8	100
	134	114	102*	89.5

*Only 90% of the eligible social workers had cases selected for the sample.

Table 2.2
Study Period for Each Site

Site #/Name	Defined Study Period	Actual Study Period: Placement	Actual Study Period: Nonplacement
1. IDHS	7/84-9/85	10/83-7/85	1/84-7/85
2. ICFS	7/82-9/85	9/82-7/86	9/82-4/85
3. Dakota County	1/82-6/84	2/82-6/84	9/81-5/84
4. LSS	1/83-9/85	1/83-6/85	2/83-9/85
5. Franklin County	6/83-12/85	6/83-10/85	7/83-12/85
6. ADT	10/82-9/85	10/82-1085	11/82-8/85
7. Boulder County	10/1/82-9/30/85	4/81-7/85	10/81-4/85
8. SCAN	7/84-9/85	6/83-9/85	9/83-3/85
10. Kerr Center	10/82-12/85	4/82-2/86	9/83-12/85
11. CSD	7/83-9/85	8/84-1/86	8/83-2/86
12. Multnomah County	7/83-9/85	7/84-10/85	7/84-3/86

Table 2.3
Total Case Sample in Each Site

	Placement	Non-Placement	Total
1. IDHS	25	25	50
2. ICFS	26	24	50
3. Dakota County	25	25	50
4. LSS	17	33	50
5. Franklin County	15	33	48
6. ADT	19	17	36
7. Boulder County	25	24	49
8. SCAN	19	31	50
10. Kerr Center	25	25	50
11. CSD	24	26	50
12. Multnomah County	25	25	50
TOTAL	245	288	533

Table 3.1
Proportion of Time Spent in Various Activities and Average Caseload Size by Site

	SCAN	ICFS	IDHS	Dakota County	LSS	Boulder County	ADT	CSD	Multinomah County	Kerr	Total
In-person Contacts	44.17	40.47	39.00	28.57	48.9	44.78	40.83	48.25	52.62	53.33	44.39
Travel	11.25	25.60	13.00	17.86	18.70	4.78	3.33	8.75	11.87	.50	13.17
Administration Tasks	10.33	12.67	31.00	10.00	7.30	13.11	20.83	10.50	10.75	15.5	12.90
Staffings	6.83	7.27	5.20	19.28	8.90	10.22	15.00	9.25	5.75	12.00	9.40
Phone calls	8.92	3.60	4.40	7.29	4.90	8.89	7.83	7.37	5.62	4.17	6.45
Collaboration	8.08	4.80	5.40	3.86	4.70	6.75	7.50	4.38	5.12	2.83	5.33
Peer Support	3.25	2.80	2.00	7.14	2.50	4.14	3.17	6.25	4.12	7.50	4.02
Other	3.00	3.07	4.00	7.43	4.50	3.57	3.17	6.50	4.12	4.17	4.13
Avg Caseload	12.92	6.60	25.6	4.71	5.60	12.83	6.00	10.87	10.00	14.67	10.10

Table 3.2
Percentage of Social Workers Who Team With Another Person in at least One-Quarter of Their Cases By Site

	SCAN	ICFS	IDHS	Dakota County	LSS	Boulder County	ADT	CSD	Multinomah County	Kerr	Tot
Individual Teamed With											
Paraprofes-sional in same agency	23.1	20.0	0.0	66.7	0.0	0.0	16.7	16.7	25.0	0.0	19.5
Paraprofes-sional in another agency	8.3	26.7	0.0	0.0	10.0	0.0	0.0	0.0	12.5	0.0	2.2
Professional in same unit	25.0	13.3	0.0	100.0	0.0	33.3	73.3	50.0	75.0	16.7	34.1
Professional in another unit	50.0	0.0	20.0	66.7	0.0	11.1	0.0	42.9	62.5	16.7	24.2
Professional in another agency	76.9	46.7	0.0	16.7	10.0	22.2	16.7	28.6	50.0	33.4	34.1
Supervisor	50.0	13.3	0.0	0.0	10.0	11.1	16.7	0.0	50.0	16.7	20.6

Table 3.3
Reasons Social Workers Terminate Family Based Services, Other by Site
con't

	SCAN	ICFS	IDHS Dakota County	LSS	Boulder County	ADT	CSD	Multinomah County	Kerr	Total
j. the time limit for services set by the agency or the purchase agency was reached	16.7	13.3	0.0	14.3	0.0	0.0	20.0	62.5	62.5	33.4	22.8
k. the time limit set in a contract with the family was reached	7.7	0.0	0.0	57.2	0.0	0.0	25.0	37.5	62.5	16.7	20.4
l. the family was ready and able to accept needed services from another source	25.0	13.3	0.0	28.6	10.0	11.1	0.0	0.0	12.5	0.0	14.9
m. the family had a support system in the community	23.1	6.7	20.0	28.6	10.0	11.1	25.0	0.0	12.5	33.3	17.1
n. you were "burnt out" with the family	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
o. the child at risk was no longer in the family	30.8	26.7	0.0	0.0	0.0	11.1	20.0	0.0	0.0	33.3	15.8
p. other (please specify):	8.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	12.5	0.0	4.7

Table 3.3
Reasons Social Workers Often Terminate Family Based Services by Site

	SCAN	ICFS	IDHS	Dakota County	LSS	Boulder County	ADT	CSD	Multinomah County	Kerr	Total
a. case objectives were completely met	46.2	40.0	40.0	100.0	30.0	33.3	40.0	62.5	14.3	0.0	43.1
b. case objectives were partially met	77.0	53.4	60.0	100.0	90.0	88.9	80.0	100.0	87.5	83.3	78.7
c. the family was stabilized and no longer in crisis	69.2	53.3	100.0	85.7	90.0	77.8	50.0	100.0	100.0	66.7	78.4
d. the family was capable of functioning without services	53.9	66.7	80.0	100.0	80.0	88.9	60.0	100.0	100.0	83.3	79.8
e. a child was no longer at risk of placement	46.2	66.7	60.0	100.0	90.0	88.9	40.0	100.0	100.0	50.0	74.2
f. no change or movement occurred within a reasonable time period	38.5	13.3	20.0	0.0	50.0	0.0	20.0	25.0	12.5	0.0	22.4
g. no further change was possible at the time	61.6	20.0	20.0	28.6	50.0	22.2	20.0	28.6	37.5	16.7	34.1
h. the family decided to withdraw from services	0.0	0.0	40.0	14.3	0.0	0.0	0.0	25.0	25.0	50.0	27.0
i. the family reached a level of functioning comparable to most families in the community	38.5	20.0	0.0	85.7	0.0	11.1	0.0	25.0	25.0	50.0	27.0

Table 3.4
Characteristics of Public/Private and In-Home/In-Office Programs by Type

	Public		Private		Total
	In-Office	In-Home	In-Home	In-Office	
Worker's education in years $\bar{x}$	18.2	17.2	17.7	18.3	17.9
Number of years in agency $\bar{x}$	6.2	4.0	2.7	3.3	3.9
Hands-on Approach to Family Based Services $\bar{x}$	7.1	10.7	11.5	7.9	9.5
Too many referrals %	14.1	10.2	30.3	45.1	22.2
Frequency of Case Coordination Score $\bar{x}$	4.7	2.8	3.4	4.5	3.9
Time spent on Travel %	8.0	17.7	16.1	1.7	11.3
Salary $\bar{x}$	22,674	25,329	18,309	17,443	20,033
Turnover %					
Low	66.2	60.0	35.2	7.0	42.3
Moderate	18.9	40.0	33.5	34.9	29.9
High	14.9	0.0	31.3	58.1	27.8*
Community Resources Score $\bar{x}$	9.2	11.4	7.8	5.4	8.2
Morale %					
Low	7.4	10.0	25.5	33.7	19.8
Average	48.3	40.0	26.0	47.7	38.1*
High	44.3	50.0	48.5	18.6	42.1*
Cases Often Terminated with Successful Outcome %	83.9	100.0	63.1	45.9	71.0*

*$p<.05$

Table 4.1
Relation of Other Outcome Variables to Placement/Non-Placement[a]
(Percents)

	Placement	Non-Placement	Total
Temporary Placement of Highest Risk Child	45.2	13.2	19.2***
Goals Achieved			
None	16.5	13.9	14.4
1-50%	22.5	18.8	19.5
51-75%	22.2	12.9	14.6
76-100%	38.8	54.3	51.5*
Positive Change in Family Functioning			
None	40.3	11.9	17.2
Moderate	44.2	40.9	41.5
High	15.5	47.2	41.3***
Negative Change in Family Functioning			
None	48.6	82.7	76.4
Worse	51.4	17.3	23.6***
No Additional Services After Closing	7.4	30.0	25.8***

*p<.05
***p<.001
a. Data weighted to represent estimated incidence of placement and non-placement based on sampling lists.

TABLE 5.1
Demographic Characteristics at Intake
Primary Caretaker and Other Significant Adult

	Primary Caretaker			Other Adult		
	% Not Placed n=266	% Placed n=269	% Total n=535	% Not Placed n=203	% Placed n=197	% Total n=400
Sex						
Male	13.2	14.6	13.9	78.9	81.7	80.3
Female	86.8	85.4	86.1	21.1	18.3	19.7
Age						
$\bar{x}$	35.1	35.6	35.6	37.5	38.7	38.1
sd	7.6	8.7	8.1	9.2	10.3	9.8
Marital Status						
Never	7.4	8.3	7.9	6.6	2.2	4.5
Married	46.4	48.6	47.5	63.6	72.3	67.9
Cohab	5.3	9.0	7.2	7.2	9.3	8.2
Sep/Div	39.5	33.0	36.1	22.6	16.2	19.5
Widowed	1.4	1.1	1.3	0.0	0.0	0.0
Race						
White	83.8	83.8	83.8	82.1	85.5	83.8
Other	16.2	16.2	16.2	17.9	14.5	16.2
Intelligence						
Normal IQ	95.7	95.0	95.4	97.7	98.7	98.2
Low Func	4.3	5.0	4.6	2.3	1.3	1.8
Education						
$\bar{x}$	11.8	11.4	11.6	11.7	11.1	11.4
sd	2.1	1.8	2.0	2.4	2.9	2.7
Employment Status						
Not Employ But Avail	16.6	11.8	14.2	18.5	13.9	16.2
Not Employ Not Avail	36.9	37.9	37.2	20.8	26.1	23.4
Part Time Seasonal	7.1	13.0	10.1	6.5	4.3	5.3
Full Time	25.3	29.4	27.3	36.3	44.3	40.2
Unknown	14.1	7.7	10.9	18.0	11.4	14.7

TABLE 5.1 (cont.)
Demographic Characteristics at Intake
Primary Caretaker and Other Significant Adult

	Primary Caretaker			Other Adult		
	% Not Placed n=200	% Placed n=209	% Total n=409	% Not Placed n=121	% Placed n=116	% Total n=237
Occupation						
Homemaker	46.8	42.2	44.5	8.5	14.0	11.3
Unskilled	5.5	11.8	8.8	34.5	29.2	31.8
Personal Service	11.9	16.5	14.3	8.1	9.1	8.6
Skilled Clerical/ Sales	25.0	21.0	22.9	33.0	30.9	31.9
Tech/Prof	10.7	8.4	9.5	13.8	16.1	15.0
Military	0.0	0.0	0.0	2.2	.8	1.5
Unknown	0.0	0.0	0.0	0.0	0.0	0.0
Residence						
Household	98.9	99.1	99.0	74.5	79.1	76.8
Separate Household	1.1	.9	1.0	25.5	20.9	23.2

TABLE 5.2

Economic Characteristics

	% Not Placed	% of Placed	% of Total
	n=105	n=100	n=205
Monthly Income			
$\bar{x}$	$1062.83	$1374.15	$1264.96
	% Not Placed	**% of Placed**	**% of Total**
	n=253	n=260	n=513
Number Supported			
1	0.0	1.2	.6
2	13.4	12.2	12.8
3	26.4	20.8	23.5
4	28.2	37.0	32.7
5	18.6	17.5	18.0
6	8.5	7.2	7.8
$\bar{x}$	4.0	4.0	4.0
Estimated Income Level			
Below Poverty or AFDC	55.2	51.1	53.2
$10,000-$20,000	24.5	29.0	26.7
$20,000-$40,000	18.2	18.8	18.5
Over $40,000	2.0	1.1	1.6

TABLE 5.3
Demographic Characteristics at Intake
Highest Risk Child

	% Not Placed n=262	% Placed n=260	% Total n=522
Sex			
Male	50.3	51.4	50.8
Female	49.7	48.6	49.2
Age			
x	11.4*	12.3*	11.9
sd	4.8	4.5	4.6
Race			
White	81.9	82.8	82.3
Other	18.1	17.2	17.7
Intelligence			
Normal IQ	94.0	92.6	93.3
Low Func	6.0	7.4	6.7
Education			
x	5.3**	6.3**	5.8
sd	3.9	3.6	3.8
Not in School	12.9	14.1	13.5
PreSchool	3.2	.4	1.8
K-12	64.0	55.8	59.9
Spec K-12	12.0	17.5	14.8
Other	7.9	12.2	10.0
Residence			
Household	87.6	79.7	83.6
Separate Household	4.4	5.8	5.1
Foster Home	5.2	9.5	7.4
Adopt Home	2.8	5.1	3.9
Risk			
Low	20.4	3.0	11.7
Moderate	28.3	11.3	19.9
High	44.7***	70.3***	57.4
In Temp.	6.6	15.3	11.0

* p<.05
** p<.01
*** p<.001

TABLE 5.3 (cont.)
Demographic Characteristics at Intake
Highest Risk Child

	% Not Placed n=266	% Placed n=269	% Total n=535
Relation to PC			
Biological Child	88.5	85.9	87.1
Adopted Child	4.3	6.4	5.3
Stepchild	3.0	3.6	3.3
Other	4.2	4.1	4.1
Relation to Adult 1			
Biological Child	49.7	41.8	45.8
Adopted Child	9.8	9.2	9.5
Stepchild	21.7	31.3	26.5
Unrelated/ Other	18.8	17.7	18.2
Previous Placements			
None	76.5	58.9	67.7
Less than 3 Months	10.6	13.9	12.2
More than 3 months	12.9***	27.1***	20.1
Previous Placements			
None	76.5	58.9	67.7
Emergency	10.6	13.9	12.2
Foster Home	7.6	9.6	8.6
Group/Inst	3.2	11.6	7.5
Both Foster & Group/ Inst	2.0	6.0	4.0

***p<.001

TABLE 5.4
Summary of Prior Services

	% Not Placed n=187	% Placed n=198	% Total n=384
Contacts one month	19.1	16.5	17.8
Contacts less than 6 months	25.2	21.7	23.4
Contacts more than 6 months	25.9	38.0	32.1
Unknown	29.9	23.8	26.8

TABLE 5.5
Times Case Reopened

	% Not Placed n=217	% Placed n=224	% Total n=441
Never reopened	72.1	65.1	68.5
Reopened once	14.9	17.4	16.2
Reopened 2 or more times	13.0	17.5	15.3

TABLE 5.6
Reasons for Placement

	Prior Placements			Final Placement
	% Not Placed n=260	% Placed n=269	% Total n=535	% Placed n=535
Abuse	17.7	17.8	17.8	8.4
Neglect	3.3	7.4	5.3	12.4
Delinquency	3.5	7.8	5.6	17.5
Adult Substance Abuse	.8	2.6	1.7	4.9
Adult Relationships	.8	3.6	2.2	2.6
Parent-Child Conflict	4.3	13.0	8.7	33.4
Family Dysfunction	.8	.4	.6	7.9
Child Behavior	3.9	10.3	7.1	18.0
Child Health	1.7	3.7	2.7	10.5
Economic Deprivation	.8	2.2	1.5	.5
Sexual Abuse	6.0	7.1	6.5	5.4
Staus Offense	2.6	7.2	4.9	18.7
Child Substance Abuse	1.4	2.2	1.8	4.4
Adult Health	2.6	3.6	3.1	8.8

TABLE 5.7
Identified Problems in Family

	By Referral Source			By HBFC as Treatment Basis			By All Sources		
	% Not Placed	% Placed	% Total	% Not Placed	% Placed	% Total	% Not Placed	% Placed	% Total
.buse	21.7	17.8	19.8	26.2	23.3	24.7	22.6	28.3	25.5
exual Abse	11.0	10.6	10.8	8.8	12.0	10.4	17.2	22.2	19.7
leglect	13.8	17.5	15.7	14.2	13.8	14.0	20.5	22.6	21.6
)eliquency	16.4***	30.2***	23.3	7.8	11.2	9.5	21.7***	37.8***	29.8
tatus)ffense	19.8	25.6	22.8	8.7**	18.3**	13.5	26.5***	44.9***	35.7
'hild ubstance .buse	6.5	11.5	9.0	4.2	6.7	5.5	14.4**	25.3**	19.9
.dult ubstance .buse	10.5	12.3	11.4	5.7	7.1	6.4	20.8*	29.2*	25.0
.dult Relation- hips	21.4	18.7	20.0	25.3**	15.2**	20.2	52.8	52.7	52.7
'arent- 'hild 'onflict	47.3	54.2	50.8	22.0	27.7	24.9	59.9**	72.9**	66.4
'amily Relation- hips	20.2	19.0	19.6	32.2	27.4	29.8	52.4	56.1	54.2
.dult Health/ Mental Health	11.2	13.6	12.4	16.5	13.5	15.0	32.1	34.5	33.3
'hild Behavior	35.8	41.5	38.7	19.1*	27.1*	23.1	61.7*	70.3*	66.0
'hild Health/ Mental Health	12.3	13.4	12.9	11.6	10.7	11.1	31.8*	40.9*	36.4
'hild Relation- hips	17.8	17.2	17.5	9.9	10.9	10.4	48.3**	62.1**	55.2
'conomic)epriva- ion	8.4	5.5	6.9	11.9	8.4	10.1	34.8	28.2	31.5
'arenting kills	-	-	-	30.7	32.9	31.8	-	-	-

'p<.05
'*p<.01
'**p<.001

TABLE 5.8
HBFC Service Objectives

	% Not Placed n=266	% Placed n=269	% Total n=535
Counseling	39.2	34.5	36.8
Support Services	26.8	22.1	24.4
Parenting	56.7	59.4	58.0
Concrete Services	24.0	26.0	25.0
Adult Behavior	18.5	20.8	19.7
Adult Individual	25.5	20.0	22.7
Adult Relationship	28.6*	19.4*	24.0
Adult-Child Relationship	24.8	28.5	26.6
Child Behavior	28.1	35.0	31.6
Child Individual	18.4	18.3	18.4
Family Relationship	38.4	38.4	38.4
Community	14.9*	8.6*	11.7

*p<.05

TABLE 5.9
Type of Service Received

	% Not Placed n=266	% Placed n=269	% Total n=535
Interventions			
Individual Counseling	67.0	69.5	68.3
Marital Counseling	28.8	28.6	28.7
Group Therapy	16.4	20.0	18.2
Family Therapy	91.2	96.8	94.0
Role Modeling	26.4	22.1	24.2
Therapeutic Contract	18.4	21.6	20.0
Teaching	40.9	39.0	39.9
Homework	37.5	37.6	37.6
Therapeutic Letters	6.3	7.1	6.7
Play Therapy	5.3	4.7	6.7
Accompany to Appointment	21.5**	32.7**	27.1
Advocacy	27.4*	36.5*	32.0
Case Management	48.3**	60.9**	54.6
Information/Referral	48.9	55.1	52.0
Recreation	11.6	15.9	13.7
Outreach	8.7	11.3	10.0
Coercion	3.1	11.0	7.1
Counseling Services			
Child Protective Services	35.2	42.5	38.9
Other Public Social Services	21.9	26.5	24.2
Family Services	6.6	10.7	8.7
School Social Work	26.2	29.6	27.9
Community Mental Health	15.4**	24.7**	20.1
Psychiatric	6.6	11.7	4.2
Crisis Intervention	11.2	16.7	14.0
Psychological Testing/ Evalution	15.8***	32.4***	24.1
Psychiatric Assessment/ Diagnosis	6.9***	19.8***	13.4
Day Treatment	7.8	12.0	9.9
Inpatient Mental Health	3.9	10.9	7.4
Substance Abuse Counseling	10.0*	15.6*	12.8
Other In-House Counseling Services	15.3	17.5	16.4
Substance Abuse Inpatient	2.4	5.2	3.8

*p<.05; **p<.01; p<.001

TABLE 5.9 (cont.)
Type of Service Received

	% Not Placed n=266	% Placed n=269	% Total n=535
Support Services			
Homemaker	7.8	7.8	7.8
Public Health/Visiting Nurse	5.4	4.1	4.8
Parent Education	23.4	18.0	20.7
Substance Abuse Support Group	7.5	7.0	7.3
Other Support Group	6.8	8.6	7.7
Volunteer Services	4.1	2.1	3.1
Mental Retardation Services	3.0	4.6	3.8
Money Management Counseling	13.2	9.7	11.5
Other In-house Support Services	4.2	3.3	3.8
Concrete Services			
AFDC	31.7	27.2	29.4
Food Stamps	26.7	23.1	24.9
Medicaid	22.0	22.4	22.2
SSI	14.8	14.5	14.7
General Assistance	6.1	7.3	6.7
Emergency Family Housing	2.2	3.8	3.0
Subsidized Housing	6.7	7.5	7.1
Emergency Cash or Goods	7.4	5.3	6.4
Day Care	4.9	3.5	4.2
Family Planning	2.9	2.6	2.8
Housekeeper/Chore Service	3.3	3.3	3.3
Legal Services	7.5	8.2	7.8
Employment Assistance	9.1	6.3	7.7
Transportation	11.8*	18.0*	14.9
Medical	17.8	19.6	18.7
Remedial Education	6.5	10.5	8.5
Other Concrete Services	2.8	3.3	3.1

TABLE 5.10
Source of Service by Mean Number of Services Received

Source of Service	x Not Placed n=266	x Placed n=269	Overall x n=535
FBS Intervention	4.4	4.8	4.6
Other In-house Interventions	.4	.4	.4
FBS Counseling Services	.4*	.6*	.5
Counseling Services Out of Agency	1.2***	1.8***	1.5
FBS Support Services	.2	.2	.3
Support Services Out of Agency	.3	.3	.3
FBS Concrete Services	.2	.3	.3
Other In-house Concrete Services	.2	.2	.2
Concrete Service Out of Agency	1.4	1.3	1.3
Total In-house Services	5.5	6.1	5.8
Total Other In-house Services	.8	.9	.9
Total Services Out of Agency	3.4*	4.2*	3.8
Total Psychiatric/ Psychological Services	.3***	.6***	.5
Total all Services	9.7*	11.2*	10.5

*p<.05
***p<.001

TABLE 5.11
Paraprofessional Services

	% Not Placed n=47	% Placed n=50	% Total n=97
Service			
Counseling	62.8	46.7	54.5
Building Self Esteem	59.4*	36.7*	47.7
Parent Education	64.0	68.0	66.1
Household Skills Development	40.6	40.0	40.3
Housekeeping	16.1	11.0	13.5
Child Care	51.6	44.0	47.7
Respite Care	8.9	3.5	6.1
Emergency Care	6.6	6.9	6.8
Recreation	13.1	28.3	20.9
Role Modeling	33.7	30.3	32.0
Health Care	27.9	16.7	22.1
Transportation	31.0	44.7	38.1
Money Management	37.9	23.3	30.4

TABLE 5.12
Brief Out-of-Home Placement
of Highest Risk Child After Intake

	% Not Placed n=266	% Placed n=269	% Total n=535
Type of Placement			
Emergency Shelter	2.8	14.5	8.7
Respite Care	2.7	3.6	3.1
Foster Home	6.5***	21.6***	14.1
Group Home	4.2	11.3	7.8
Residential Tx	2.2	16.6	9.4
Friend or Relative	4.8	14.8	9.8
Any Placements	13.1***	48.0***	30.6

***p<.001

TABLE 5.13
Well Being Scores

	x Not Placed n=264	x Placed n=266	Overall x n=530
Combined Caretaker and Children			
x	74.06***	66.53***	70.28
Target Child			
	n=242	n=198	n=440
x	72.99***	66.79***	69.59
Lowest Child			
	n=246	n=199	n=445
x	72.39***	65.64***	68.66

***p<.001

TABLE 5.14
Involvement in Family-Based Services

	Primary Caretaker			Other Adult*			Highest Risk Child		
	% Not Placed n=263	% Placed n=267	% Total n=531	% Not Placed n=192	% Placed n=190	% Total n=382	% Not Placed n=255	% Placed n=248	% Total n=503
Not Involved	.4	.4	.4	10.6	8.4	9.5	4.5	6.1	5.3
Attended a few sessions	5.2	7.4	6.3	6.0	11.2	8.7	5.8	10.6	8.1
Attended less than half	2.6	2.7	2.7	5.6	8.5	7.1	3.5	3.0	3.3
Attended about half	4.9	11.9	8.4	11.1	10.3	10.7	11.2	15.6	13.4
Attended more than half	12.5	22.4	17.5	16.0	22.3	19.3	16.1	27.3	21.6
Attended most or all	74.4***	55.2***	64.8	50.7	39.2	44.7	59.0***	37.4***	48.3

***p<.001
*Only includes families in which the other adult resides in the household.

TABLE 5.15
Reason for Termination of Services

	% Not Placed n=265	% Placed n=267	% Total n=532
Children Placed or Family Dropped Out	10.0***	50.7***	30.5
Service No Longer Effective	13.3	13.3	13.3
Family Requested Termination	10.9	10.6	10.7
Family No Longer Eligible/Time Limit	13.6	8.8	11.2
Service Completed/ Goals Met	52.2***	16.7***	34.3

***p<.001

TABLE 5.16
Case Disposition After Termination

	% Not Placed n=266	% Placed n=269	% Total n=535
Transferred to Another Unit	16.2**	27.3**	21.8
Continued Service w/One Agency	31.2	30.3	30.7
Continued Service w/More Than One	34.7***	49.1***	42.0
Started Service w/One Agency	8.5***	23.3***	15.9
Started Service w/More Than One	3.2	5.7	4.5

**p<.01; ***p<.001

TABLE 5.17
Summary of Changes in Families During Family Based Services

	Positive Change			Negative Change		
	% Not Placed n=266	% Placed n=269	% Total n=535	% Not Placed n=266	% Placed n=269	% Total n=535
Behavior	77.1***	37.3***	57.1	5.4***	23.4***	74.4
Material Resources	23.5***	7.5***	15.7	7.8	11.9	9.8
Family Structure/ Hierarchy	56.2***	26.2***	40.9	4.0	13.6	8.9
Family Dynamics/ Relationships	72.3***	34.4***	53.3	4.3***	23.4***	13.9
Use of Services	49.3	41.4	45.5	5.2	12.1	8.6
Affect/ Emotional Climate	70.3***	29.8***	50.1	4.8***	28.5***	16.6
Perception of Problem	66.4***	31.0***	49.0	2.6	10.5	6.5
Community Perception of Family	32.1***	9.1***	20.3	3.6***	18.9***	11.5
Informal Support Network	30.9**	15.6**	23.7	.6	4.7	2.5
Community Involvement	36.5***	18.4***	26.8	4.6***	29.2***	17.9

**p<.01
***p<.001

TABLE 5.18
Restrictiveness of Final Placement in Placement Cases

	Child #1 n=267	Child #2 n=217	Child #3 n=137	Target Child n=259
In-Home	39.0	57.3	65.5	29.1
Informal Placement	24.0	10.0	12.2	17.9
Foster/Group Home	24.7	21.4	14.7	32.0
Institution	12.3	11.3	7.7	21.0

Table 6.1
Demographic Characteristics of Families by Site[a]

	Franklin County	SCAN	ICFS	IDHS	Dakota County	LSS	Boulder County	ADT	CSD	Multinomah County	Kerr	Total
	n=48	n=50	n=50	n=50	n=50	n=50	n=49	n=36	n=50	n=50	n=50	n=533
Primary Caretaker												
Age x	29.3	26.8	30.9	36.4	39.4	36.8	38.5	39.8	38.4	37.5	36.9	35.3
Sex Female %	89.8	95.1	96.6	88.0	97.5	67.9	72.1	72.2	87.5	79.4	95.8	86.0
Married %	33.0	11.8	49.6	53.0	52.8	63.2	75.1	51.4	39.5	45.1	35.2	46.5
Divorced %	20.8	10.3	28.3	26.6	31.8	19.8	16.6	25.7	42.9	39.6	34.4	26.9
Non-white %	17.3	82.2	5.0	8.3	1.7	0.0	4.2	33.3	4.1	17.2	3.9	16.4
Employed %	20.9	6.3	27.5	35.5	69.3	68.9	64.1	76.0	69.8	33.1	51.3	46.3
Below Poverty Level %	82.4	90.0	75.6	56.2	38.1	38.6	0.0	25.0	N/A	N/A	52.1	54.6
AFDC %	75.7	83.9	59.5	50.6	3.2	18.1	0.0	8.3	16.0	6.8	8.0	30.9
Highest Risk Child[b]												
Age x	7.7	5.2	9.0	13.2	13.2	12.5	13.0	14.7	12.3	14.1	12.9	11.5
Sex Female %	50.9	50.7	47.3	53.2	49.5	51.8	42.7	32.4	56.5	57.7	36.0	48.5
Regular K-12 Class %	56.5	35.1	61.4	76.8	75.7	78.3	78.4	6.5	78.3	54.1	68.1	62.3
Biological Child of Caretaker %	93.7	87.6	97.9	93.1	84.8	84.6	70.3	88.2	98.9	81.0	88.3	88.0
Biological Child of 2nd Adult %	56.7	57.9	55.0	47.8	50.9	46.4	35.1	33.3	65.6	48.1	21.1	48.1
Prior Placement %	27.0	6.1	17.5	22.8	26.7	35.1	22.2	22.6	28.5	68.1	12.2	26.2
At High Risk of Placement %	87.3	25.7	48.8	56.8	65.9	80.0	25.7	76.4	70.3	79.3	16.2	56.8
Court-Ordered into Family-Based Serv. %	17.7	3.8	20.3	42.1	4.0	17.8	27.9	34.4	8.0	12.0	7.9	17.0

a Data weighted to represent estimated incidence of placement and non-placement based on sampling lists.
b Oldest Child at Highest Risk
c n=18

Table 6.2
Problems Identified by Referral Source and by all Sources By Site[a]

	Franklin County	SCAN	ICFS	IDHS	Dakota County	LSS	Boulder County	ADT	CSD	Multinomah County	Kerr	T
Reason for Referral %												
Abuse	39.0	27.2	23.3	25.4	32.0	25.7	27.3	2.8	5.0	16.0	.3	20
Sexual Abuse	10.7	6.2	7.5	16.5	8.8	3.7	8.3	8.3	20.0	29.6	3.9	11.
Neglect	55.9	44.3	13.0	7.5	7.2	8.4	.9	0.0	8.5	10.2	0.0	14.
Delinquency	6.2	0.0	6.9	23.5	21.0	34.8	18.1	44.4	36.5	24.2	7.4	19.
Status Offense	3.9	0.0	4.8	8.0	53.0	16.1	13.3	44.4	11.5	45.8	34.6	20.
Child Substance Abuse	0.0	0.0	0.0	.5	12.8	12.4	5.3	19.4	2.1	20.6	7.7	7.
Adult Substance Abuse	23.7	12.4	15.0	18.1	11.2	8.4	4.4	8.3	3.1	16.0	0.0	11.
Adult Relationships	20.9	12.3	27.4	40.6	44.6	9.7	16.3	19.4	12.5	19.4	11.7	21.
Parent-Child Conflict	14.7	8.7	24.7	46.4	88.8	63.5	75.4	61.1	52.5	65.2	28.2	47.
Family Relationships	29.4	39.5	34.3	21.0	10.3	6.4	23.8	5.6	8.0	28.4	12.0	20.
% With Problem												
Abuse	49.7	29.6	28.8	24.5	5.7	26.1	28.2	11.1	13.0	24.8	12.7	23.
Sexual Abuse	14.7	11.1	10.9	17.0	12.0	8.7	8.3	11.1	37.0	50.8	12.8	17.
Neglect	64.4	56.7	19.8	8.5	6.3	16.7	5.0	8.3	5.0	22.2	7.9	20.
Delinquency	19.7	3.7	12.4	16.5	2.5	36.2	19.2	58.3	42.5	52.0	19.4	24.
Status Offense	14.6	2.5	13.1	24.0	5.7	29.8	36.1	69.4	30.6	64.6	47.2	29.
Child Substance Abuse	5.6	0.0	3.5	5.4	3.2	15.4	18.9	52.8	14.0	25.8	41.8	16.0
Adult Substance Abuse	37.8	21.0	21.9	15.0	0.0	26.4	8.6	27.8	31.2	37.8	19.9	22.4
Adult Relationships	50.2	33.3	61.6	49.1	31.2	60.8	73.3	61.1	59.5	57.4	50.3	53.1
Parent-Child Conflict	51.3	22.2	44.6	59.8	8.0	89.0	84.0	100.0	71.5	62.0	81.8	62.0
Family Relationships	69.5	88.9	63.7	40.5	12.0	31.1	58.2	41.7	36.8	80.0	54.2	52.8

a. Data weighted to represent estimated incidence of placement and non-placement based on sampling lists.

Table 6.3
Case Outcomes by Site[a]
(Percents)

	Franklin County	SCAN	ICFS	IDHS	Dakota County	LSS	Boulder County	ADT	CSD	Multinomah County	Kerr	Total
Highest Risk Child Placed Temporarily	46.3	22.0	11.8	12.8	12.2	12.4	40.6	22.2	2.1	16.8	13.4	19.2
Estimated Placement Rate[a]	25.0	22.2	19.0	11.8	20.7	22.3	8.1	N/A	11.3	15.4	4.0	16.0
Restrictiveness of Final Placement[b]												
Relatives	50.0	38.9	30.8	4.2	0.0	17.6	12.0	11.8	8.7	4.3	16.7	20.0
Foster Home	7.1	33.3	34.6	75.0	40.0	29.4	32.0	17.6	13.0	52.2	12.5	29.8
Institution	0.0	0.0	23.1	12.5	24.0	29.4	44.0	47.1	21.7	21.7	12.5	22.3
% Attending most or all Sessions												
Caretaker	64.0	59.7	90.9	83.0	69.7	81.9	60.3	19.4	92.3	79.4	65.3	70.8
Other Adult[c]	30.9	26.8	39.3	70.3	62.5	66.4	40.1	14.3	59.3	58.6	62.0	49.3
Highest Risk Child	52.8	40.7	36.1	47.3	55.2	32.1	68.0	76.5	79.0	55.3	75.5	55.4
% of Caretakers Cooperating Fully with Services	58.9	47.0	60.7	52.9	59.2	54.5	83.3	26.7	60.9	40.6	61.1	55.7
% Positive Change in												
Behavior	88.5	48.8	67.2	63.2	67.6	54.6	78.0	60.0	86.9	71.6	83.0	70.2
Material Resources	53.7	30.2	8.6	8.7	4.3	35.7	32.5	0.0	0.0	18.7	15.1	20.5
Family Hierarchy	47.5	19.1	34.0	56.2	66.5	58.2	57.6	17.1	76.3	62.0	60.3	51.0
Family Relationships	62.8	46.8	62.8	54.3	62.8	66.0	71.1	58.8	85.8	69.4	75.6	65.4
Use of Services	92.1	72.1	41.6	18.1	11.5	52.4	53.9	48.6	45.1	52.2	21.2	47.2
Emotional Climate	71.3	62.4	44.7	49.4	56.4	47.2	95.5	54.3	80.5	68.1	82.9	64.3
Perception of Problem	81.5	71.6	34.0	39.0	49.7	51.4	74.4	29.0	88.7	62.9	76.4	60.1

Case Outcomes by Site (cont.)

	Franklin County	SCAN	ICFS	IDHS	Dakota County	LSS	Boulder County	ADT	CSD	Multinomah County	Kerr	To
% With Positive Change	100.0	76.6	86.2	75.8	73.3	65.5	92.1	77.8	88.4	80.8	95.5	82.
% Worse in at Least One Area	7.3	25.8	23.4	11.8	27.6	36.8	20.1	47.2	12.0	19.2	33.7	23.
Case Closed Because												
Goals Achieved	75.5	34.7	58.1	37.0	47.0	47.5	63.0	44.4	32.9	35.8	29.9	45.
Time limit reached	8.2	19.8	0.0	4.6	18.3	3.7	15.7	0.0	39.0	28.4	0.0	12.
Overall % of Goals Achieved	89.6	85.5	80.2	60.2	68.2	73.8	88.6	62.3	27.1	47.8	51.9	67.
% With a Long Range Plan[b]	66.7	10.5	34.6	48.0	0.0	35.3	88.0	26.3	0.0	0.0	16.7	28.
% With no Additional Services after closing	4.3	5.1	13.3	37.5	18.1	14.4	54.7	20.6	23.8	32.3	58.7	25.8

a) By family; estimated from sampling lists of placement prevention cases provided by agencies. Does not include assessment or reunification cases.

b) Placement cases only.

c) Includes only adult living in household.

Table 6.4
FRANKLIN COUNTY
Discriminant Analysis of Placement/Non-Placement
N=43

Variable	Standardized Discriminant Coefficient	Within Group Correlation	Univariate F	Significance
Psychological Services	-.42	-.46	20.86	.00
Total Number of Problems	-.73	-.43	17.90	.00
Lowest Child CWBS Score	.66	.39	14.84	.00
Directive Interventions	-1.26	-.27	7.28	.01
Caretaker CWBS Score	-.28	.26	6.60	.01
Age of Oldest Child	.53	-.19	3.33	.07
Total Number of Support Services	.63	.12	1.46	.23
Other Social Work Services	.37	-.08	.68	.41
Educational Interventions	1.10	.01	.66	.93
Number of Children at High Risk in Family	.36	-.00	.25	.96

Canonical Correlation	.83	Wilks' Lambda	.31
Chi-Squared	44.9 D.F. 10	Significance	.00
Correctly Classified:	94.9%		
Placement	92.9%		
Non-Placement	96.9%		

Table 6.5
Incidence of Variables Predictive of Placement/Non-Placement by Site

Placement Cases (Percent Receiving Services) [a]

	Franklin County	SCAN	ICFS	IDHS	Dakota County	LSS	Boulder County	ADT	CSD	Multinomah County	Kerr
Psychological Services											
Psychological Testing	81.7	53.0	11.5	20.0	32.0	29.4	60.0	15.8	21.0	12.0	16.0
Psychiatric Assessment	60.0	21.0	38.5	24.0	8.0	0.0	20.0	21.1	8.0	12.0	4.0
Psychiatric Counseling	46.7	32.0	11.5	8.0	0.0	11.8	4.0	5.3	0.0	4.0	4.0
Directive Interventions											
Accompany to an Appointment	33.3	84.0	50.0	36.0	16.0	17.6	36.0	73.7	4.0	8.0	8.0
Advocacy	46.7	84.0	42.3	52.0	4.0	17.6	68.0	68.4	75.0	4.0	12.0
Outreach	26.7	53.0	3.8	0.0	0.0	5.9	20.0	10.5	4.0	4.0	0.0
Case Management	73.3	100.0	50.0	76.0	96.0	5.9	68.0	100.0	75.0	20.0	8.0
Coercion	13.3	32.0	0.0	0.0	0.0	5.9	8.0	68.4	4.0	0.0	4.0
Recreation	53.3	16.0	7.7	8.0	0.0	29.4	40.0	15.8	0.0	0.0	0.0
Information and Referral	60.0	100.0	50.0	44.0	84.0	41.2	60.0	42.1	46.0	20.0	48.0
Therapeutic Contract	20.0	21.0	3.8	12.0	36.0	23.5	80.0	26.3	0.0	0.0	8.0
Group Therapy	46.7	11.0	0.0	0.0	8.0	17.6	36.0	94.1	13.0	0.0	8.0
Adolescent Problems											
Child Behavior	46.7	10.5	19.2	36.0	20.0	70.6	36.0	57.9	0.0	0.0	8.3
Child Substance Abuse	6.7	0.0	7.7	8.0	4.0	17.6	16.0	10.5	0.0	0.0	4.2
Status Offense	13.3	0.0	3.8	16.0	28.0	23.5	40.0	52.6	12.0	4.0	16.7
Delinquency	0.0	5.0	3.8	0.0	4.0	35.3	24.0	42.1	0.0	0.0	16.7
Family Change Objectives											
Perception of Problem	6.7	5.3	15.4	12.0	16.0	47.1	12.0	0.0	4.0	20.0	8.3
Relationships	13.3	0.0	73.1*	44.0	88.0	76.5	52.0	42.1	12.0	8.0	12.5
Child Emotional Well-being	26.7	5.3	19.2	20.0	28.0	41.2	20.0	31.6	4.0	0.0	8.3

a Percents underlined are higher for placement than non-placement cases.

Table 6.5
Incidence of Variables Predictive of Placement/Non Placement by Site

Placement Cases (cont.)
(Percent Receiving Services) [a]

	Franklin County	SCAN	ICFS	IDHS	Dakota County	LSS	Boulder County	ADT	CSD	Multinomah County	Kerr
Other Social Work Services											
School Social Work	60.0	37.0	38.5	20.0	32.0	17.6	32.0	5.3	25.0	28.0	32.0
Public Social Services	66.7	53.0	38.5	36.0	0.0	29.4	4.0	10.5	0.0	12.0	20.0
Child Protective Services	93.3	0.0	30.8	36.0	44.0	11.8	32.0	57.9	13.0	0.0	0.0
Family Services	20.0	21.0	0.0	12.0	0.0	5.9	8.0	0.0	4.0	20.0	16.0
Adult Change Objectives											
Parenting	80.0	79.0	92.3	92.0	88.0	88.2	56.0	47.3	13.0	0.0	8.0
Behavior	26.7	79.0	38.5	16.0	12.0	5.9	8.0	5.3	0.0	0.0	8.0
Relationships	20.0	5.0	50.0	24.0	20.0	54.5	20.0	10.5	4.0	8.0	8.0
					(Means)[b]						
Total Number of Problems	11.8*	10.7*	6.7	5.2	1.1	7.8*	7.6*	8.5	7.4	9.9	9.5*
Number of Children at High Risk	1.4	2.3*	1.5*	1.4*	1.0	1.1	1.0*	.7	.9	1.3	.5*
Age of Oldest Child	10.1*	6.7	13.1*	13.8	14.4	15.9	15.6*	16.2	14.7	13.5*	15.2*
Level of Stress	266*	62	170	125	110*	116	133	100	115	96	119
Total Number of Family Based Services	12.8	11.3	5.0	2.6	4.6	5.4	7.7*	10.1*	2.4	2.1	3.9
Total Number of Contacts in 1st Month	9.6	4.2	8.0	2.8	4.1	8.1	5.7	4.6	2.9	2.2	3.8

* One-tail T-test $p<.05$

a Percents underlined are higher for placement than non-placement cases.

b Means underlined are higher for placement than non-placement cases.

Table 6.6
Incidence of Variables Predictive of Placement/Non Placement by Site

Non-Placement Cases (Percent Receiving Services) [a]

	Franklin County	SCAN	ICFS	IDHS	Dakota County	LSS	Boulder County	ADT	CSD	Multinomah County	Kerr
Educational Interventions											
Role Modeling	39.4	68.0	33.3	20.0	24.0	21.2	54.2	23.5	0.0	0.0	0.0
Homework	36.4	29.0	50.0	52.0	64.0	57.6	58.4	23.5	12.0	0.0	16.0
Teaching	63.6	87.0	25.0	28.0	64.0	36.2	45.8	11.8	65.0	4.0	8.0
Use of Counseling Objectives	51.5	51.6	12.5	20.0	12.0	6.1	16.7	52.9	84.0	60.0	65.4
Use of Services Objectives											
Concrete	24.2	100.0	16.7	4.0	8.0	3.0	8.3	11.8	24.0	24.0	34.6
Support	42.4	58.1	16.7	16.0	12.0	12.1	8.3	5.9	36.0	44.0	34.6
					(Means) [b]						
Lowest Child CWBS Score	76.7*	82.9*	86.5*	75.9*	76.5*	74.4	67.5*	67.0	65.7	51.2	78.6
Caretaker CWBS Score	75.5*	74.0*	79.9	76.3	73.6	72.7	75.7*	58.4	79.1*	65.4	78.7*
Total Number of Objectives	6.8	10.5*	9.1	6.2	4.8	9.5	6.3*	5.4	4.1*	3.4	4.1*
Total Number of Support Services	2.9	1.6	.6	.6	.4*	.3	.2	.3	.2	.4	.2
Length of Service	199*	363*	238	152	84.4	142	322	341	132	169	248

* One-tail T-test $p<.05$

a Percents underlined are higher for non-placement than placement cases.

b Means underlined are higher for non-placement than placement cases.

Table 6.7
SCAN
Discriminant Analysis of Placement/Non-Placement
N=50

Variable	Standardized Discriminant Coefficient	Within Group Correlation	Univariate F	Significance
Number of Children at High Risk in Family	-1.01	-.73	43.57	.00
Use of Service Objectives	.51	.40	13.03	.00
Length of Services	.33	.22	3.94	.05
Use of Counseling Objectives	.38	-.04	.11	.74

Canonical Correlation	.79	Wilks' Lambda	.37
Chi-Squared	46.08	D.F. 4	Significance .00
Correctly Classified:	87.9%		
Placement	78.9%		
Non-Placement	96.8%		

Table 6.8
IOWA CHILDREN AND FAMILY SERVICES
Discriminant Analysis of Placement/Non-Placement
N=44

Variable	Standardized Discriminant Coefficient	Within Group Correlation	Univariate F	Significance
Number of Children at High Risk in Family	-1.04	-.51	12.66	.00
Age of Oldest Child	-.88	-.28	3.85	.06
Psychological Services	-.90	-.23	2.53	.12
Family Change Objectives	-.30	-.21	2.16	.15
Other Social Work Services	-.28	-.19	1.70	.20
Use of Service Objectives	-.66	-.12	.67	.42
Adolescent Problems	.61	-.11	.59	.45
Level of Stress	.84	-.08	.28	.60
Educational Interventions	-.41	.05	.13	.72
Directive Interventions	.56	-.03	.53	.82

Canonical Correlation	.73		Wilks' Lambda	.46
Chi-Squared	28.71	D.F. 10	Significance	.00
Correctly Classified:	78.7%			
Placement	66.7%			
Non-Placement	91.3%			

Table 6.9
IOWA DEPARTMENT OF HUMAN SERVICES
Discriminant Analysis of Placement/Non-Placement
N=38

Variable	Standardized Discriminant Coefficient	Within Group Correlation	Univariate F	Significance
Directive Interventions	-1.03	-.36	3.09	.09
Number of Children at High Risk in Family	-.90	-.34	2.72	.11
Level of Stress	-.34	-.26	1.54	.22
Total Number of Objectives	1.16	.19	.82	.37
Family Change Objectives	.48	.07	.12	.73
Total Number of Support Services	.84	.06	.84	.77

Canonical Correlation	.63		Wilks' Lambda	.61
Chi-Squared	16.52	D.F. 6	Significance	.01
Correctly Classified:	62.0%			
Placement	28.0%			
Non-Placement	96.0%			

Table 6.10
DAKOTA COUNTY
Discriminant Analysis of Placement/Non-Placement
N=46

Variable	Standardized Discriminant Coefficient	Within Group Correlation	Univariate F	Significance
Lowest Child CWBS Score	.93	.70	14.99	.00
Educational Interventions	.51	.28	2.42	.13
Directive Interventions	-.44	-.18	1.03	.32
Total Contacts in First Month	-.57	-.14	.62	.44
Other Social Work Services	.50	.08	.17	.68

Canonical Correlation	.64	Wilks' Lambda	.59
Chi-Squared	21.81	D.F. 5	Significance .00
Correctly Classified:	68.1%		
Placement	44.0%		
Non-Placement	95.5%		

Table 6.11
LUTHERAN SOCIAL SERVICES
Discriminant Analysis of Placement/Non-Placement
N=41

Variable	Standardized Discriminant Coefficient	Within Group Correlation	Univariate F	Significance
Adolescent Problems	-.91	-.63	6.25	.02
Number of Children at High Risk in Family	-.74	-.42	2.85	.10
Use of Service Objectives	-.39	-.29	1.37	.25

Canonical Correlation	.54	Wilks' Lambda	.71
Chi-Squared	12.83	D.F. 3	Significance .00
Correctly Classified:	57.3%		
Placement	23.5%		
Non-Placement	90.9%		

Table 6.12
BOULDER COUNTY
Discriminant Analysis of Placement/Non-Placement
N=36

Variable	Standardized Discriminant Coefficient	Within Group Correlation	Univariate F	Significance
Number of Children at High Risk in Family	-.56	-.59	25.14	.00
Caretaker CWBS Score	.55	.57	23.68	.00
Psychological Services	-.43	-.46	15.43	.00
Educational Interventions	-.52	-.29	6.15	.02

Canonical Correlation	.82	Wilks' Lambda	.32
Chi-Squared	36.29	D.F. 4	Significance .00
Correctly Classified:	80.8%		
Placement	65.2%		
Non-Placement	95.8%		

Table 6.13
ADOLESCENT DAY TREATMENT PROGRAM
Discriminant Analysis of Placement/Non-Placement
N=30

Variable	Standardized Discriminant Coefficient	Within Group Correlation	Univariate F	Significance
Length of Services	.62	.55	2.83	.10
Adult Change Objectives	.45	.51	2.37	.13
Number of Family Based Services	-.46	-.48	2.10	.16
Use of Counseling Objectives	.50	.41	1.56	.22

Canonical Correlation	.50	Wilks' Lambda	.75
Chi-Squared	7.40	D.F. 4	Significance .12
Correctly Classified:	72.2%		
Placement	68.4%		
Non-Placement	76.5%		

Table 6.14
CSD
Discriminant Analysis of Placement/Non-Placement
N=41

Variable	Standardized Discriminant Coefficient	Within Group Correlation	Univariate F	Significance
Length of Services	.75	.53	9.40	.00
Use of Counseling Services	.38	.37	4.60	.04
Outside Counseling Services	-.73	-.33	3.70	.06
Use of Service Objectives	.39	.20	1.31	.26
Educational Interventions	.52	.15	.77	.38
Age of Oldest Child	-.41	-.14	.63	.43

Canonical Correlation	.68	Wilks' Lambda	.54
Chi-Squared	25.07	D.F. 6	Significance .00
Correctly Classified:	65.3%		
Placement	36.0%		
Non-Placement	95.8%		

Table 6.15
CATHOLIC SOCIAL SERVICES
MULTNOMAH COUNTY
Discriminant Analysis of Placement/Non-Placement
N=43

Variable	Standardized Discriminant Coefficient	Within Group Correlation	Univariate F	Significance
Outside Counseling Services	-.84	-.45	4.66	.04
Age of Oldest Child	.36	.36	2.95	.09
Length of Services	.59	.31	2.28	.14
Number of Children at High Risk in Family	-.52	-.30	2.14	.15
Caretaker CWBS Score	.45	.24	1.35	.25
Use of Counseling Objectives	.32	.12	.31	.58

Canonical Correlation	.60	Wilks' Lambda	.64
Chi-Squared	16.89	D.F. 6 Significance	.01
Correctly Classified:	66.7%		
Placement	33.3%		
Non-Placement	100.0%		

Table 6.16
KERR CENTER
Discriminant Analysis of Placement/Non-Placement
N=49

Variable	Standardized Discriminant Coefficient	Within Group Correlation	Univariate F	Significance
Adult Change Objectives	-.79	-.41	5.08	.03
Age of Oldest Child	-.75	-.41	5.03	.03
Total Number of Problems	-.72	-.41	5.03	.03
Educational Interventions	.72	.09	.23	.63
Total Number of Support Services	-.43	-.03	.30	.86

Canonical Correlation	.62	Wilks' Lambda	.61
Chi-Squared	22.03	D.F. 5	Significance .00
Correctly Classified:	60.0%		
Placement	16.7%		
Non-Placement	100.0%		

Table 7.1
Main Predictors of Placement/Non-Placement By Site
Means

	Franklin County	SCAN	ICFS	IDHS	Dakota County	LSS	Boulder County	ADT	CSD	Multinomah County	Kerr	Total
Number of Children at High Risk												
Placement	1.4	2.3***	1.5***	1.4**	1.0	1.1	1.0***	.7	.9	1.3	.5*	1.2*
Non-Placement	1.5	.2	.6	.7	.8	.9	.2	.8	.7	1.0	.1	.7
Total Number of Problems												
Placement	11.8***	10.7***	6.6	5.2	1.1	7.8*	7.6***	8.5	7.4	9.9	9.5*	8.0*
Non-Placement	7.8	8.1	6.0	4.4	1.0	6.7	6.0	7.9	6.7	8.9	7.5	6.4
Age of Oldest Child												
Placement	10.1*	6.7	13.1*	13.8	14.4	15.9	15.6*	16.2	14.7	13.6*	15.2**	13.3
Non-Placement	7.2	5.2	9.6	13.3	14.5	14.1	14.0	15.9	14.2	15.6	12.9	12.3
Number of Psychological Services												
Placement	1.9***	1.0	.6*	.5	.4*	.4	.8***	.4*	.3*	.3	.2	.7*
Non-Placement	.8	.7	.2	.4	.2	.3	.2	.1	.1	.2	.1	.3
Caretaker CWBS Score												
Placement	65.4**	56.7***	76.2	71.4	72.5*	69.5	54.0***	61.0	68.8**	61.2	72.9*	65.7*
Non-Placement	75.7	74.0	79.9	76.3	73.6	72.7	75.7	58.4	79.1	65.4	78.7	74.5
Lowest Child CWBS Score												
Placement	66.8**	72.3**	78.6**	68.7*	64.8***	72.5	49.4***	67.1	60.7	47.9	74.5	66.9*
Non-Placement	76.7	82.9	86.5	75.9	76.5	74.4	67.5	67.0	65.7	51.2	78.6	72.4
Length of Services (days)												
Placement	288*	251*	204	173	96	175	254	283	102**	107*	226	199
Non-Placement	199	363	238	152	84	142	321	341	132	168	248	211

* p<.05 One-tail T-test
** p<.01
*** p<.001

Table 7.2
Significant Bivariate Correlations* Between Discriminant Analysis Predictors and Placement/Non-Placement

Predictors of Placement Cases

	Franklin County	SCAN	ICFS	IDHS	Dakota County	LSS	Boulder County	ADT	CSD	Multinomah County	Kerr
Number of Children at High Risk in Family	(.05)	-.69	-.46	-.33		-.21	-.66			-.21	
Psychological Services	-.51		-.29				-.49		-.33[a]	-.24[a]	-.21[a]
Directive Interventions	-.31		(-.05)	-.30	(-.15)	-.20	-.42				-.21
Age of Oldest Child	-.25		-.26			-.26[b]			(-.08)	.24	-.32
Level of Stress			(-.12)	(-.12)	-.25		-.28		-.22		
Total number of problems	-.51	-.42				-.23	-.36				-.32
Adolescent Problems			(-.12)			-.43	-.27				
Family Change Objectives			-.28	(-.10)							
Other Social Work Services	(-.13)		(-.15)		(.10)						
Adult Change Objectives							.30	(.13)			-.33
Total Number of Family Based Services								-.28			
Total Number of Contacts in First Month					(-.07)						

* All correlations are significant at a level of .10 or less (one-tailed test) except those in parentheses, which are with variables included in the discriminant model although not significant at the bivariate level. Variables included in the discriminant model for each site are underlined.

a Number of counseling services from other agencies

b Age of highest risk child

Table 7.3
Significant Bivariate Correlations* Between Discriminant Analysis Predictors and Placement/Non-Placement

Predictors of Non-Placement

	Franklin County	SCAN	ICFS	IDHS	Dakota County	LSS	Boulder County	ADT	CSD	Multinomah County	Kerr
Length of Services	-.39	.27						(.20)	.35	.30	
Caretaker CBWS Score	.40	.57		.22			.59		.33	.19	.26
Lowest Child CWBS Score	.42	.40		.29	.50		.55				
Educational Interventions	(.11)		(-.01)		.25		-.30		(.10)		(.08)
Use of Counseling Objectives		(-.05)						.23	.30	(-.03)	
Use of Services Objectives		.46	(.04)			(-.11)			(.14)		
Total Number of Objectives		.31		(.08)					.29		-.23
Total Number of Support Services	(.13)			(.08)							(-.06)

* All correlations are significant at a level of .10 or less (one-tailed test) except those in parentheses which are with variables included in the discriminant model although not significant at the bivariate level. Variables included in the discriminant model for each site are underlined.

Table 7.4
Patterning of Rate of Placement and Predictors of Placement[a]

	Family Characteristics						Service Characteristics						
	Low Caretaker CWBS	High Risk of Placement	Low Income	Prior Placement	Total Problems	Low Child CWBS	In-Home Services	Total Family Based Services	Temporary Placement	Directive Services	Psychological Services	Length of Service	Placement R...
Kerr	-	-	-	-	+	-	-	-	-	-	-	+	-
Boulder	-	-	-		-	+	-	+	+	+		+	-
CSD	-	-	-	-	-	+	-	-	-	-	-	-	-
IDHS	-	-	+	-	-	-	-	-	-	-	+	-	-
Multnomah	+	+	-	+	+	+	+	-	-	-	-	-	-
ICFS	-	+	+	+	-	-	+	-			+	+	
Dakota		+	-	+	-	+	+		-	+	-	-	+
SCAN	+	-	+	-	+	-	+	+	+	+	+	+	+
LSS	+	+	+	+			+	+	+	-	+	-	+
Franklin	+	+	+	+	+	-	+	+	+	+	+		+
ADT	+			-	+	+	-	+	+	+	-	+	+

a) Minuses indicate weighted average for site is in lower 50%, pluses indicate weighted averages in top 50%. Median value is left blank. Weights are based on estimated placement rates is left blank.

Table 8.1
Distribution of Items in Parental Disposition Subscale of the Child Well-Being Scale in Placement and Non-Placement Cases
N=535
(Percents)

Scale Name	Levels of Scale[a] 1	2	3	4	5
Caretaker Capacity N=469					
Placement	41.9	31.1	21.7	5.4	
Non-Placement	49.1	36.4	14.5		
CWLA	61	27	8	4	
Acceptance N=288					
Placement	13.5	48.4	25.9	12.2	
Non-Placement	33.0	42.8	19.5	4.6	
CWLA	59	29	12	4	
Approval N=265					
Placement	11.0	31.2	48.5	9.2	
Non-Placement	18.3	45.6	27.7	8.4	
CWLA	41	35	17	7	
Motivation N=495					
Placement	16.4	37.9	32.5	10.2	3.0
Non-Placement	29.6	38.1	25.9	6.1	.3
CWLA	54	14	17	11	4
Expectations N=353					
Placement	5.1	59.2	24.6	11.1	
Non-Placement	11.3	66.8	15.9	6.0	
CWLA	44	37	11	8	
Cooperation N=512					
Placement	42.4	31.5	22.8	3.3	
Non-Placement	57.6	28.4	12.6	1.3	
CWLA	60	23	11	6	
Recognition of Problems N=470					
Placement	18.6	46.6	34.8		
Non-Placement	28.8	48.0	23.1		
CWLA	47	30	15	8	
Child's Family Relations N=466					
Placement	5.1	33.3	25.8	36.0	
Non-Placement	20.2	47.2	17.1	15.4	
CWLA	70	18	8	2	2

[a]=indicates no problem.

Table 8.2
Distribution of Items for Oldest Child in Child Well-Being Scale in Placement and Non-Placement Cases
N=535
(Percents)

Scale Name	Levels of Scale[a] 1	2	3	4	5	6
Disabling Conditions N=378						
Placement	65.8	8.2	9.1	12.5	3.3	1.1
Non-Placement	69.4	11.8	8.1	9.8	.5	.4
Protection from Abuse N=113						
Placement	44.3	40.3	15.4			
Non-Placement	53.2	31.5	15.3			
Physical Needs of Child N=300						
Placement	65.0	22.6	9.0	3.4		
Non-Placement	66.2	21.7	9.7	2.3		
School Attendance N=128						
Placement	40.3	11.8	20.0	22.4	5.5	
Non-Placement	44.8	18.4	14.0	16.2	6.6	
Academic Performance N=233						
Placement	29.2	29.0	23.6	18.2		
Non-Placement	28.2	34.1	24.8	12.9		
Physical Discipline N=234						
Placement	35.8	21.4	23.8	17.0	2.1	0.0
Non-Placement	43.9	21.3	21.2	12.4	.6	.6
Child's Misconduct N=366						
Placement	36.2	15.6	13.5	20.3	24.0	10.8
Non-Placement	25.9	23.4	16.3	14.2	15.1	5.0
Child's Family Relations N=374						
Placement	9.5	33.1	16.1	41.2		
Non-Placement	23.7	40.8	15.0	20.6		
Child's Cooperation W/Agency N=320						
Placement	27.2	45.4	23.1	4.3		
Non-Placement	48.9	34.3	16.3	.5		
Deliberate Locking Out N=244						
Placement	95.2	3.9	.8			
Non-Placement	96.2	3.2	.6			
Sexual Abuse N=254						
Placement	76.2	.9	12.7	10.2		
Non-Placement	84.9	0.0	9.1	6.		

[a]=indicates no problem

APPENDIX 1: FAMILY BASED SERVICES INVENTORY

FAMILY-BASED SERVICES INVENTORY

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FAMILY-BASED SERVICES INVENTORY

National Resource Center on Family Based Services
The University of Iowa
Iowa City, Iowa 52242

March 25, 1986

GENERAL INSTRUCTIONS

This questionnaire deals with your experiences as a family-based services worker in (agency name). For the purposes of this questionnaire, family-based services are defined as intensive (once a week or more) services in which the family is the unit of service and which provide an alternative to out-of-home placement of a child or children.

The attached questionnaire is organized into eight sections which ask about you as an individual; the agency; the supervision you received; the families you worked with; referrals, community services and case management; your practice; case outcomes; and your opinions on a variety of issues regarding families and the agency.

The questions refer to a specific period of time which is under study. To the best of your ability, you should answer the questions with reference to the time period (dates).

If you were only employed by the agency or doing family-based services for part of the time period, your answers should refer to the time you were employed and doing family-based services. It is important that you do your best to reflect the situation in the agency during that time period, since we will be studying cases from that time period and need to know what the environment was like then.

Please return the completed questionnaire in the attached self-addressed, stamped envelope by _____ _____.

Once again, thank you for your participation in this important research.

Identification # _____

I. First we would like to know some things about you. Please circle or fill in the most appropriate response. Circle only one number unless otherwise indicated.

1. Age: _____ years

2. Sex: 1. male
   2. female

3. Ethnocultural background:
   1. Native American
   2. Black
   3. Caucasian
   4. Chinese
   5. Philippino
   6. Japanese
   7. Indochinese
   8. Other Asian
   9. Hispanic
   10. Other (Please specify: _____)

4. During the study period, were you: (Circle all that apply)
   1. married
   2. separated/divorced
   3. widowed
   4. never married

5. How many children did you have? _____

6. How many years of formal education have you completed? (elementary through graduate school) _____ years

7. At the beginning of the study period, what educational levels had you completed? (Circle and complete <u>all</u> that apply.)
   1. no education past high school
   2. community college or some college education (subject: _____)
   3. bachelor's degree (subject: _____)
   4. some graduate work (subject: _____)
   5. master's degree (subject: _____)
   6. some post-master's work (subject: _____)
   7. doctoral degree (subject: _____)
   8. some post-doctoral work (subject: _____)

8. Did you have any professional certification? (Circle all that apply.)

   1. AAMFT
   2. ACSW
   3. state social work or counseling license
   4. other (please specify: _____)
   5. none

9. How long has it been since you completed your last degree? _____ years

In completing questions 10-13, please enter 0 if you have less than 6 months experience, 1 if you have 6 months to 1 year's experience, and the nearest whole number for over 1 year's experience. ("a"-"d" may add up to more than "e" if your job covered more than one category, or "e" may be greater if you had related experience not covered in "a"-"d".)

10. At the beginning of the study period, how many years of <u>paid</u> experience did you have in the following?

    a. child welfare services _____ years
    b. other public social services _____ years
    c. individual counseling or therapy _____ years
    d. family counseling or therapy _____ years
    e. total <u>paid</u> professional experience _____ years

11. At the beginning of the study period, how many years of <u>volunteer</u> experience did you have in the following?

    a. child welfare services _____ years
    b. other public social services _____ years
    c. individual counseling or therapy _____ years
    d. family counseling or therapy _____ years
    e. total <u>volunteer</u> experience _____ years

12. How many years have you been (were you) employed by this agency?

    _____ years

13. How many years have you been doing (did you do) family-based services in this agency? _____ years

II. Now we would like to know some things about your agency.

14. During the study period, how supportive of family-based services were the following? (Please use the following scale:)

0 = not supportive
1 = slightly supportive
2 = moderately supportive
3 = strongly supportive
4 = not applicable or don't know

____ state legislature

____ local government

____ agency board of directors

____ agency administration

____ unit supervisor

____ in-house support services

____ other units in the agency

15. During the study period, how much pressure was your program under by the following groups to achieve results? (Please use the following scale:)

0 = no pressure
1 = slight pressure
2 = moderate pressure
3 = strong pressure
4 = not applicable or don't know

____ news media

____ advocacy groups

____ legislators

____ ad hoc committees/task forces

____ court

____ state social services department

____ county social services agency

____ other (please specify: _____)

16. During the study period, how much input did you have in developing the part of the agency budget which most affects your work?

1. none
2. a little
3. a moderate amount
4. a great deal

17. Did the agency's financial resources change during the study period?

1. decreased
2. no change
3. increased
4. don't know

18. During the study period, did the family-based program experience any of the following? (Circle all that apply.)

1. layoffs of professional staff
2. layoffs of clerical or support staff
3. wage or salary freezes
4. wage or salary reductions
5. abolition of professional positions
6. abolition of clerical or support staff positions
7. reductions in benefits for professionals
8. reductions in benefits for clerical or support staff
9. turnover among professional staff
10. turnover among clerical or support staff
11. cost-of-living increases for professional staff
12. cost-of-living increases for clerical or support staff
13. merit increases for professional staff
14. merit increases for clerical or support staff
15. addition of professional positions
16. addition of clerical or support staff positions

19. During the study period, were salaries for professional staff in the family-based services program generally: (Circle all that apply.)

1. lower than most private agencies in the area?
2. lower than most public agencies in the area?
3. about the same as most private agencies in the area?
4. about the same as most public agencies in the area?
5. higher than most private agencies in the area?
6. higher than most public agencies in the area?
7. don't know

20. It is important to know how family-based services compare in salary to other social services. Could you tell us how much your annual salary before deductions was during the study period? $_____

Approximately how many hours a week did you work during the study period? _____

21. Would you say the turnover in the family-based services program during the study period was:

0. no turnover
1. low
2. moderate
3. high
4. very high

22. If any professional staff left the family-based services program during the study period, how important were the following factors in their decision to leave? (Please use the following scale:)

1 = not important
2 = somewhat important
3 = important
4 = very important
5 = don't know or not applicable

____ low pay

____ opportunities for advancement

____ stress related to the demands of family-based services

____ personal or family reasons (unrelated to the job)

____ stress due to the structure or policies of the agency

____ layoffs or reductions in staff

____ reassignment by agency

____ need for a change

____ personality conflict

____ other (please specify:_____)

23. Were any professional staff hired in the family-based program during the study period?

0. no
1. yes

If yes, how difficult was it to find people with the following qualifications? (Use the following scale:)

1 = very difficult
2 = somewhat difficult
3 = not difficult
4 = easy
5 = don't know

___ people with the education or formal training required
___ people with the personal characteristics required
___ people with the experience required
___ people with the counseling skills required
___ people with the practical skills required
___ people willing to accept the salary offered
___ people willing to work nights or weekends
___ people willing to work in the families' homes

24. Would you say morale in the family-based program during the study period was:

1. very low
2. low
3. average
4. high
5. very high

25. Would you say morale in the family-based program during the study period was:

1. declining
2. remaining stable
3. increasing

26. How long do you see yourself doing family-based services?

1. I am no longer doing family-based services.
2. I am looking for a job in another area now.
3. I am looking for another job in family-based services.
4. I plan to stay in my present job for another year or two.
5. I plan to stay in my present job indefinitely.
6. I plan to stay in family-based services but may change jobs.
7. I plan to look for a job in another area.
8. I don't know.

27. Here are some statements that describe the work situation. Please indicate <u>how true</u> you feel each statement was of <u>your job</u> during the study period. (Check one box per statement.)

		Very True	Somewhat True	A Little True	Not at All True
a.	I was given a lot of chances to make friends.	___	___	___	___
b.	The chances for promotion were good.	___	___	___	___
c.	I had the opportunity to develop my own special abilities.	___	___	___	___
d.	Travel to and from work was convenient.	___	___	___	___
e.	I never seemed to have enough time to get everything done on my job.	___	___	___	___
f.	I was not asked to do excessive amounts of work.	___	___	___	___
g.	The work was interesting.	___	___	___	___
h.	The pay was good.	___	___	___	___
i.	I had the freedom to decide what I did on my job.	___	___	___	___
j.	I was given a chance to do the things I do best.	___	___	___	___
k.	The job security was good.	___	___	___	___
l.	The problems I was expected to solve were hard enough.	___	___	___	___
m.	On my job, I couldn't satisfy everybody at once.	___	___	___	___
n.	My fringe benefits were good.	___	___	___	___
o.	The physical surroundings were pleasant.	___	___	___	___
p.	I could see the results of my work.	___	___	___	___
q.	I could forget about my personal problems.	___	___	___	___
r.	I had enough time to get the job done.	___	___	___	___
s.	I was free from conflicting demands.	___	___	___	___
t.	The hours were good.	___	___	___	___
u.	Promotions were handled fairly.	___	___	___	___
v.	The people I worked with took a personal interest in me.	___	___	___	___
w.	I had too much work to do everything well.	___	___	___	___
x.	My employer was concerned about giving everybody a chance to get ahead.	___	___	___	___
y.	To satisfy some people on my job, I had to upset others.	___	___	___	___
z.	The people I worked with were friendly.	___	___	___	___
aa.	I had a lot to say about what happened on my job.	___	___	___	___
bb.	I decided the speed with which I worked.	___	___	___	___
cc.	It was basically my own responsibility to decide how my job got done.	___	___	___	___
dd.	I decided who I worked with on the job.	___	___	___	___

28. How adequate, in general, was the clerical support available to you during the study period?

0. no clerical support available
1. clerical support available but not enough time
2. clerical support available but of poor quality
3. adequate clerical support
4. very good clerical support

29. Was clerical support available to you for the following tasks? (Circle all that apply.)

1. typing letters
2. typing reports
3. typing handwritten case narratives
4. typing dictated case narratives
5. completing case-related forms
6. typing case-related forms
7. filing case materials
8. answering telephones
9. taking telephone messages
10. making appointments
11. billing hours to contracting agency
12. preparing statistical reports

30. How adequate, in general, was the office space available to you during the study period?

1. had no office space
2. very inadequate
3. inadequate
4. adequate
5. very adequate

31. Was office space available for the following activities? (Circle all that apply.)

1. interviewing families in the central office
2. interviewing families in satellite offices
3. doing your paperwork
4. making telephone calls
5. taking breaks
6. agency meetings
7. meetings with community people
8. storing client records

32. In the space to the left, please check the events that occurred during the study period. For those that occurred, please rate the impact on the family-based program using the scale on the right.

		Very Negative	Negative	Neutral	Positive	Very Positive
___	agency reorganization	___	___	___	___	___
___	change in agency director	___	___	___	___	___
___	change in program administrator	___	___	___	___	___
___	change in supervisor	___	___	___	___	___
___	staff transfers or reassignments	___	___	___	___	___
___	change in program treatment methods/ philosophy	___	___	___	___	___
___	lawsuit against this or another agency	___	___	___	___	___
___	new state law regarding placement prevention services	___	___	___	___	___
___	new regulations regarding placement prevention services	___	___	___	___	___
___	outside consultant	___	___	___	___	___
___	grant award	___	___	___	___	___
___	worker strike	___	___	___	___	___
___	collective bargaining issues	___	___	___	___	___
___	reduction in staff	___	___	___	___	___
___	increase in staff	___	___	___	___	___
___	reduction in training resources	___	___	___	___	___
___	increase in training resources	___	___	___	___	___
___	general program reduction	___	___	___	___	___
___	general program expansion	___	___	___	___	___
___	increase in number of family-based service providers	___	___	___	___	___
___	change in purchase-of-service contract	___	___	___	___	___
___	other	___	___	___	___	___
	please specify: _____	___	___	___	___	___
	_____	___	___	___	___	___

33. Here are some items which deal with <u>different aspects</u> of the work situation. Please indicate <u>how often</u> these aspects appeared in <u>your job</u> during the study period. (Check one answer per statement.)

	Very Often	Fairly Often	Some-times	Occasion-ally	Rarely
a. How often were you clear on what your job responsibilities were?	___	___	___	___	___
b. How often did your job require you to work very fast?	___	___	___	___	___
c. How often could you predict what others expected of you on the job?	___	___	___	___	___
d. How often did your job require you to work very hard?	___	___	___	___	___
e. How much of the time were your work objectives well defined?	___	___	___	___	___
f. How often did your work leave you with little time to get things done?	___	___	___	___	___
g. How often were you clear about what others expected of you on the job?	___	___	___	___	___
h. How often was there a great deal to be done?	___	___	___	___	___
i. How often did you feel professional values conflicted with what you had to do on the job?	___	___	___	___	___

34. All in all, how <u>satisfied</u> would you say you were with your job?

1. very satisfied
2. somewhat satisfied
3. not too satisfied
4. not at all satisfied

III. Next we would like to know some things about the kind of supervision and consultation you received on your cases during the study period.

35. On average, how many hours of the following kinds of supervision or consultation did you receive in a month? (Enter 0 if not applicable to your program.)

___ hours per month of individual supervision

___ hours per month of supervision in a group

___ hours per month of peer supervision

___ hours per month of individual consultation with an agency person other than your supervisor

___ hours per month of consultation in a group with an agency person other than your supervisor

___ hours per month of individual consultation with an external consultant

___ hours per month of consultation in a group with an external consultant

___ hours per month of informal discussion about your cases with other workers

36. How many times a year did you receive supervision or consultation using the following methods? (Please use the following scale:)

0 = never
1 = once or twice a year
2 = every other month
3 = monthly
4 = twice a month
5 = weekly
6 = daily

___ videotaping

___ live supervision with one-way mirror

___ audiotaping

___ supervisor or consultant sitting in on a session

___ supervisor or consultant teaming with you

___ role playing

37. In your opinion, how much time did your supervisor spend on the following activities? (Please use the following scale:)

0 = no time
1 = too little time
2 = about the right amount of time
3 = too much time
4 = not applicable

___ consulting about your unit's cases

___ training and staff development for family-based services

___ agency meetings

___ paperwork

___ providing direct service

___ developing new services

___ community meetings

___ teaching or consulting with others

___ supervising other family-based service units or programs

___ supervising other, non-family-based service units or programs

38. How often did you have regular staff meetings?

1. daily
2. weekly
3. every two weeks
4. monthly
5. no regular staff meetings

39. If you had staff meetings, how often was the time used for the following?

	Never	Not Very Often	Some-times	Often	Very Often
a. getting information about agency policy and procedures	___	___	___	___	___
b. giving feedback from staff to administration	___	___	___	___	___
c. discussing cases and interventions	___	___	___	___	___
d. mutual support	___	___	___	___	___
e. staff development and training	___	___	___	___	___
f. meeting with other agency staff involved in cases	___	___	___	___	___
g. meeting with other service providers	___	___	___	___	___
h. providing information on services available	___	___	___	___	___
i. socializing	___	___	___	___	___
j. recommending changes in agency policy and procedures	___	___	___	___	___

40. Approximately how many professional workshops or courses relevant to family-based services did you attend each year? ____

41. Was agency funding available during the study period for the following activities or materials? (Please use the following scale.)

1 = never available
2 = infrequently available
3 = sometimes available
4 = generally available
5 = always available

___ attending conferences

___ continuing education

___ books, journals

___ purchasing films

___ professional consultation

42. How many professional journals did you read regularly? ____

43. Did your agency maintain a library of professional journals and books relevant to your work?

1. yes
2. no

If yes, approximately how many times a year did you use it? (If weekly, enter 52, etc.) ____

IV. **Next we would like to know some things about the families you saw during the study period. For questions 44-53, estimate how many of the families you saw fell into each category. Please check the closest category.**

	None	Only a Few	About a Quarter	About Half	About Three Quarters	Most or All
44. Structure of client families:						
a. single-parent families	___	___	___	___	___	___
b. two-parent families (birth or adoptive)	___	___	___	___	___	___
c. blended (step-parent) families	___	___	___	___	___	___
d. other family compositions	___	___	___	___	___	___
45. Residence of client families:						
a. farm or rural (0-50 population)	___	___	___	___	___	___
b. small towns (51-2,500)	___	___	___	___	___	___
c. larger towns (2,501-25,000)	___	___	___	___	___	___
d. small cities (25,001-100,000)	___	___	___	___	___	___
e. medium-sized cities (100,001-500,000)	___	___	___	___	___	___
f. large cities (500,001-1,000,000)	___	___	___	___	___	___
g. large metropolitan area (over 1,000,000)	___	___	___	___	___	___
46. Ethnocultural background of client families:						
a. Native American	___	___	___	___	___	___
b. Black	___	___	___	___	___	___
c. Caucasian	___	___	___	___	___	___
d. Chinese	___	___	___	___	___	___
e. Philippino	___	___	___	___	___	___
f. Japanese	___	___	___	___	___	___
g. Indochinese	___	___	___	___	___	___
h. Other Asian	___	___	___	___	___	___
i. Hispanic	___	___	___	___	___	___
j. Other--please specify: _____	___	___	___	___	___	___
_____	___	___	___	___	___	___

	None	Only a Few	About a Quarter	About Half	About Three Quarters	Most or All
47. Income of client families:						
a. low income	___	___	___	___	___	___
b. middle income	___	___	___	___	___	___
c. high income	___	___	___	___	___	___
48. Age of child(ren) at risk of placement:						
a. infants	___	___	___	___	___	___
b. preschool (1-5)	___	___	___	___	___	___
c. elementary school (6-12)	___	___	___	___	___	___
d. adolescents (13-18)	___	___	___	___	___	___
49. Service history:						
a. new to services	___	___	___	___	___	___
b. 1 or 2 prior service periods	___	___	___	___	___	___
c. more than 2 prior service periods	___	___	___	___	___	___
50. Family problems:						
a. physical abuse	___	___	___	___	___	___
b. emotional abuse	___	___	___	___	___	___
c. sexual abuse	___	___	___	___	___	___
d. neglect	___	___	___	___	___	___
e. chronic neglect	___	___	___	___	___	___
f. status offense (truancy, runaway)	___	___	___	___	___	___
g. delinquency	___	___	___	___	___	___
h. adult-child conflict	___	___	___	___	___	___
i. domestic violence	___	___	___	___	___	___
j. inadequate housing	___	___	___	___	___	___
k. homeless	___	___	___	___	___	___
l. child behavior problems	___	___	___	___	___	___
m. mental retardation	___	___	___	___	___	___
n. substance abuse/chemical dependency	___	___	___	___	___	___
o. unemployment/underemployment	___	___	___	___	___	___
p. depression	___	___	___	___	___	___
q. chronic mental illness	___	___	___	___	___	___
r. marital or other problems between adults	___	___	___	___	___	___

	None	Only a Few	About a Quarter	About Half	About Three Quarters	Most or All
s. death of a family member	___	___	___	___	___	___
t. desertion or unresolved divorce	___	___	___	___	___	___
u. teen pregnancy or marriage	___	___	___	___	___	___
v. disrupted adoption	___	___	___	___	___	___
w. dysfunctional family relationships	___	___	___	___	___	___
x. poverty	___	___	___	___	___	___
y. multiple problems	___	___	___	___	___	___
z. multigenerational problems	___	___	___	___	___	___
aa. social isolation	___	___	___	___	___	___
bb. physical handicap	___	___	___	___	___	___
cc. other (please specify: _____	___	___	___	___	___	___
51. Appointment times:						
a. Monday-Friday, daytime	___	___	___	___	___	___
b. Monday-Friday, evenings	___	___	___	___	___	___
c. weekends	___	___	___	___	___	___
52. Appointment location:						
a. in family home	___	___	___	___	___	___
b. in office	___	___	___	___	___	___
c. other	___	___	___	___	___	___
53. During the study period, about how many of the referrals for family-based services came from the following <u>sources</u> <u>outside</u> your agency?						
a. public social service agency	___	___	___	___	___	___
b. family service agency	___	___	___	___	___	___
c. community mental health center	___	___	___	___	___	___
d. probation or police	___	___	___	___	___	___
e. court referral	___	___	___	___	___	___
f. court order	___	___	___	___	___	___
g. school	___	___	___	___	___	___
h. medical personnel or hospital	___	___	___	___	___	___
i. self-referral	___	___	___	___	___	___
j. family or friend	___	___	___	___	___	___
k. neighbor	___	___	___	___	___	___

V. Now we would like to know something about how families got into your program during the study period.

54. As far as you know, how important were the following factors in determining clients' eligibility for family-based services? (Please check the appropriate category for each item.)

	Not Important	Somewhat Important	Important	Very Important	Don't Know or Not Applicable
a. income	___	___	___	___	___
b. age of child	___	___	___	___	___
c. family composition	___	___	___	___	___
d. residence in a specific catchment area	___	___	___	___	___
e. child at risk of abuse, neglect, exploitation	___	___	___	___	___
f. child at risk of substitute care	___	___	___	___	___
g. child in substitute care with goal of reunification	___	___	___	___	___
h. all other available services exhausted	___	___	___	___	___
i. department of social services referral	___	___	___	___	___

55. As far as you know, how important were the following factors in making a family ineligible for the family based service program:

	Not Important	Somewhat Important	Important	Very Important	Don't Know or Not Applicable
a. seriously emotionally disturbed family member refused treatment	___	___	___	___	___
b. chemically dependent family member refused treatment	___	___	___	___	___
c. one or more family members refused to participate	___	___	___	___	___
d. family was too chaotic	___	___	___	___	___
e. violent family member posed danger to worker	___	___	___	___	___
f. one or more adults were too low functioning	___	___	___	___	___
g. sexual abuse perpetrator was in the home and denied responsibility	___	___	___	___	___
h. no child at imminent risk for out-of-home placement	___	___	___	___	___
i. high risk to child if remained in home	___	___	___	___	___

56. Did you "specialize" in any particular kind of case?

0. no
1. yes

If yes, what kind? _____

57. For the following list, please put a "1" next to the kinds of cases you worked best with and a "0" next to the kinds of cases you found the hardest to work with, leaving the others blank.

___ physical abuse
___ emotional abuse
___ sexual abuse
___ neglect
___ chronic neglect
___ status offense (truancy, runaway)
___ delinquency
___ adult-child conflict
___ domestic violence
___ inadequate housing
___ homeless
___ child behavior problems
___ mental retardation
___ physical handicap
___ substance abuse/chemical dependency
___ unemployment/underemployment
___ depression
___ chronic mental illness
___ death of a family member
___ marital problems or other problems between adults
___ desertion or unresolved divorce
___ teen pregnancy or marriage
___ disrupted adoption
___ dysfunctional family relationships
___ poverty
___ multiple problems
___ multigenerational problems
___ social isolation
___ other (please specify:_____)

58. Do you feel that referrals to your program during the study period were:

1. never enough
2. usually not enough
3. about the right number
4. usually too many to handle
5. always too many to handle
6. don't know

59. In general, how often did you coordinate with the referring worker/agency on a case using the following methods? (Please use the following scale:)

0 = never
1 = once a week
2 = once every 2 weeks
3 = once a month
4 = once a quarter
5 = once every 6 months
6 = once a year
7 = one time only

___ written initial or updated case plan
___ written progress report
___ in-person conference/staffing
___ telephone conference
___ other (please specify: _____)

60. How much do you think families with the following characteristics benefit from family-based services?

1 = do not benefit
2 = little benefit
3 = some benefit
4 = moderate benefit
5 = most benefit

___ families with little motivation or desire for services

___ families who have had children placed before

___ families new to the service system

___ families who have an extensive service history

___ families who are court-ordered

___ families who seek services voluntarily

___ families who are facing imminent placement

___ families whose problems are not yet at the crisis stage

___ families in crisis

___ families in which substance abuse is a problem

___ families in which chronic mental illness is a problem

___ families in which incest is a problem

___ families in which adolescent rebellion is a problem

___ families in which chronic neglect is a problem

___ families with children who have physical or developmental handicaps

___ families with housing problems in addition to other problems

61. During the study period, were cases assigned to family-based services workers on the basis of the following criteria? (Circle all that apply.)

1. geographic areas
2. worker expertise with particular kinds of cases
3. worker preference
4. in rotation
5. opening in caseload
6. opening for night or weekend
7. other (please specify: _____)

62. During the study period, how many families did you usually have on your caseload? ____

63. What is the highest number of families you had on your caseload? ____

64. What is the lowest number of families you had on your caseload? ____

65. Do you think it is most effective to work with families:

1. in their own homes
2. in the office
3. either, depending on the case

66. If you used office interviews with families, how often did you do so for the following reasons? (Please use the following scale:)

0 = never used office interviews
1 = never for this reason
2 = not very often
3 = sometimes
4 = often
5 = very often
6 = always

___ assessment

___ family's preference

___ structure or control

___ for safety of worker

___ to reduce driving time to appointments

___ to test family's motivation

___ for a change of setting

___ to use a one-way mirror or videotaping

67. How much influence did each of the following have in setting goals/objectives for a case? Please use the following scale:

1 = no influence
2 = some influence
3 = a great deal of influence
4 = set goals/objectives unilaterally
5 = not applicable

___ the referring worker/agency

___ your agency's intake unit

___ a placement review committee

___ a committee that screened referrals

___ the supervisor of your unit

___ the team assigned to the case

___ the worker assigned the case

___ the adult(s) in the family

___ the child(ren) in the family

___ other members of the community (e.g., school officials)

___ the court

68. Family-based service workers often consult others in assessing and planning interventions for cases. Please rank the following sources as to how valuable they were to you using the following scale:

0 = never consulted or not applicable
1 = of little value
2 = of some value
3 = of great value

___ team members

___ other workers in your unit

___ unit supervisor

___ workers in other units in your agency

___ division supervisor

___ agency director

___ consultant in your agency

___ outside consultant

___ workers in other agencies

69. Of your total work time in an average week during the study period, indicate approximately what percentage of your time was spent in:

___% in-person contact with your clients

___% phone contact with your clients

___% travel to see clients or for other agency-related work

___% direct contact with other agency staff (staff meetings, supervision)

___% peer support group/activities (self-management skills)

___% collaborative work with other community services (planning, arranging services, etc.)

___% administrative duties (paperwork)

___% other activities (staff training, professional reading, etc.)

100% total

70. Did you supervise any other staff?

1. yes
2. no

If yes, about what percent of your time was spent supervising? ____%

71. In an average case, about how many hours a week did you spend in face-to-face contact with the family?

____ hours

For the following questions, please give your best guess as to how many of your families during the study period received the service. (Please check the closest category.)

72. How many of your families received the following services <u>before</u> being referred for family-based services?	None	Only a Few	About a Quarter	About Half	About Three Quarters	Most or All	Don't Know
a. community mental health services	___	___	___	___	___	___	___
b. protective services	___	___	___	___	___	___	___
c. emergency family housing	___	___	___	___	___	___	___
d. homemaker	___	___	___	___	___	___	___
e. parent education	___	___	___	___	___	___	___
f. support groups (e.g., AA, Parents Anonymous, Al Anon)	___	___	___	___	___	___	___
g. substance abuse treatment	___	___	___	___	___	___	___
h. public financial aid (AFDC, food stamps, SSI, Medicaid)	___	___	___	___	___	___	___
i. private therapy or counseling	___	___	___	___	___	___	___
j. school social work services	___	___	___	___	___	___	___
k. subsidized or public housing	___	___	___	___	___	___	___
l. protective day care	___	___	___	___	___	___	___
m. out-of-home placement of child (foster or group home, or institution)	___	___	___	___	___	___	___

73. How many of your families received the following services <u>at the same time</u> they received family-based services?							
a. community mental health services	___	___	___	___	___	___	___
b. protective services	___	___	___	___	___	___	___
c. emergency family housing	___	___	___	___	___	___	___
d. homemaker	___	___	___	___	___	___	___
e. parent education	___	___	___	___	___	___	___
f. support groups (e.g., AA, Parents Anonymous, Al Anon)	___	___	___	___	___	___	___
g. substance abuse treatment	___	___	___	___	___	___	___
h. public financial aid (AFDC, food stamps, SSI, Medicaid)	___	___	___	___	___	___	___
i. private therapy or counseling	___	___	___	___	___	___	___
j. school social work services	___	___	___	___	___	___	___
k. subsidized or public housing	___	___	___	___	___	___	___
l. protective day care	___	___	___	___	___	___	___
m. out-of-home placement of child (foster or group home, or institution)	___	___	___	___	___	___	___

74. How many of your families were receiving the following services <u>at the time their case was closed</u> with family-based services.

	None	Only a Few	About a Quarter	About Half	About Three Quarters	Most or All	Don't Know
a. community mental health services	___	___	___	___	___	___	___
b. protective services	___	___	___	___	___	___	___
c. emergency family housing	___	___	___	___	___	___	___
d. homemaker	___	___	___	___	___	___	___
e. parent education	___	___	___	___	___	___	___
f. support groups (e.g., AA, Parents Anonymous, Al Anon)	___	___	___	___	___	___	___
g. substance abuse treatment	___	___	___	___	___	___	___
h. public financial aid (AFDC, food stamps, SSI, Medicaid)	___	___	___	___	___	___	___
i. private therapy or counseling	___	___	___	___	___	___	___
j. school social work services	___	___	___	___	___	___	___
k. subsidized or public housing	___	___	___	___	___	___	___
l. protective day care	___	___	___	___	___	___	___
m. out-of-home placement of child (foster or group home, or institution)	___	___	___	___	___	___	___

75. During the study period, how available were the following services to your clients? (Please use the following scale.)

0 = not available in this community
1 = available only to families in greatest need or who met strict eligibility requirements
2 = available to most families who needed the service
3 = available to all in need, but had a waiting list
4 = immediately available to all who needed the service
5 = don't know

___ community mental health services
___ protective services
___ emergency family housing
___ homemaker
___ parent education
___ support groups (e.g., AA, Parents Anonymous, Al Anon)
___ substance abuse treatment
___ public financial aid (AFDC, food stamps, SSI, Medicaid)
___ private therapy or counseling
___ school social work services
___ subsidized or public housing
___ protective day care
___ out-of-home placement of child (foster home, group home, or institution)

76. If families you were working with during the study period were receiving other services, how often were the following persons responsible for coordinating them? (Please use the following scale:)

0 = not applicable
1 = never
2 = sometimes
3 = frequently
4 = always
5 = don't know

____ you

____ a team member

____ your supervisor

____ an on-going worker in another unit

____ an on-going worker in another agency

____ everyone involved met together to coordinate

____ family coordinated

77. How adequate would you say were the efforts to coordinate services for families on your caseload?

1. very inadequate
2. inadequate
3. adequate
4. more than adequate

78. Please rate the working relationships during the study period between the family-based service program and other service providers:

0 = not applicable
1 = poor
2 = fair
3 = good
4 = excellent

___ public social service agencies

___ family service agencies

___ community mental health centers

___ probation

___ police

___ court

___ medical personnel or hospital

___ other family-based service providers

___ other service units in your agency

___ other (please specify: _____)

79. During the study period, in how many of your cases did you team with another person who also worked with the family? (Please use the following scale:)

0 = none
1 = only a few
2 = about a quarter
3 = about half
4 = about three quarters
5 = most or all

___ a paraprofessional in your agency (homemaker, parent aide, volunteer, etc.)

___ a paraprofessional in another agency

___ a professional person in your unit

___ a professional person in another unit in your agency

___ a professional person in another agency

___ your supervisor

80. When you teamed with another person in working with a family, did you usually:

1. have clearly different roles and responsibilities
2. exchange roles and responsibilities on a planned basis
3. exchange roles and responsibilities on a more spontaneous basis
4. have essentially the same roles and responsibilities
5. did not team

81. If paraprofessionals (homemakers, parent aides, volunteers, etc.) were involved with your cases during the study period, how often did they provide the following kinds of service? Please use the following scale:

1 = never
2 = not very often
3 = sometimes
4 = often
5 = very often
6 = don't know

___ counseling

___ building self-esteem

___ parent education/skills development

___ household skills development

___ housekeeping services

___ child care

___ respite care

___ emergency care

___ recreational activities

___ role modeling

___ health care

___ transportation

___ other (please specify: _____)

82. How would you describe your working relationship with the paraprofessionals on your cases?

0. Paraprofessionals were never used.
1. We worked independently.
2. We met only at the beginning of a case for case planning.
3. We met regularly for case planning.
4. We worked as a team.

VI. Now we would like to know some things about the way you practice family-based services.

83. Please rate each item for its importance in reaching case goals. Rate each item generally, not with regard to one specific client.

	Extremely Important	Important	Relatively Unimportant	Extremely Unimportant
a. sympathetic listening, expression of concern, understanding and acceptance, helping clients ventilate	___	___	___	___
b. general encouragement (expressions of confidence in clients' abilities, recognition of clients' achievements, etc.)	___	___	___	___
c. reassurance in relation to feelings of anxiety and/or guilt	___	___	___	___
d. outreach (continuing to help despite client resistance)	___	___	___	___
e. escorting clients to appointments to provide support and encouragement (not for advocacy only) and to teach clients to negotiate with systems	___	___	___	___
f. promoting or discouraging certain behavior by suggestion or advice	___	___	___	___
g. educating by giving information, reading material, etc.	___	___	___	___
h. role modeling or role playing to teach parenting or other skills	___	___	___	___
i. setting mutually-agreed-upon goals	___	___	___	___
j. discussing alternative solutions and consequences to identified problems	___	___	___	___
k. using authority to make suggestions or recommendations about clients' decisions or behavior	___	___	___	___
l. intervention in or coercion to affect clients' behavior (use of court, police, etc.)	___	___	___	___
m. encouraging examination of current behavior and its effect on self and others	___	___	___	___

	Extremely Important	Important	Relatively Unimportant	Extremely Unimportant
n. encouraging exploration of current feelings and how they are affecting current behavior	___	___	___	___
o. helping clients recognize patterns of behavior and how these help or hinder achievement of expressed goals	___	___	___	___
p. exploring clients' reactions to the treatment relationship	___	___	___	___
q. giving information about available resources	___	___	___	___
r. making referrals to agencies for other needed services	___	___	___	___
s. advocating for clients with other agencies or persons through mail or phone	___	___	___	___
t. accompanying clients to other agencies or persons to advocate for the clients or to make certain clients receive needed services and assistance	___	___	___	___
u. encouraging discussion of early life of clients	___	___	___	___
v. helping clients understand connections between early life events or reactions and present behavior, reactions, feelings, etc.	___	___	___	___
w. helping clients understand responses to treatment process in light of clients' own developmental history and similar response patterns outside the treatment relationship	___	___	___	___
x. shopping with or for clients for furniture, food, etc.	___	___	___	___
y. providing other concrete services	___	___	___	___

Following are six incomplete statements. Directly underneath are seven possible endings to each statement. Please put a "1" next to the <u>two</u> endings you agree with <u>most</u> and a "0" next to the <u>two</u> endings you agree with <u>least</u>.

84. A family can become dysfunctional when:

___ one or more family members are not differentiated from the family of origin

___ symptomatic behavior is reinforced by family attention

___ family members are unable to give or receive clear messages

___ a symptom develops because of the intrapsychic conflict of at least one family member

___ attempted solutions to a problem maintain or enlarge it

___ family boundaries are either too rigid or too diffused

___ family members have failed to realize their potential as family members and as individuals

85. The goal of family-based services is to:

___ help family members learn to give clear messages with a minimum of hidden meanings

___ increase family members' sense of belonging while concurrently increasing individual freedom

___ make the smallest change necessary to resolve the presenting problem

___ reconstruct the basic personalities of family members

___ teach family members more positive ways of changing another member's behavior

___ help at least one member be more objective in relation to the family

___ reorganize the family structure

86. As a family-based services worker I try to:

___ introduce different views of reality into the family

___ help at least one family member see the part he/she plays in the family's dynamic

___ design a particular approach for each problem

___ teach family members new skills

___ model effective communication

___ expand a family's options rather than teach specific skills

___ be aware of my own countertransference responses and utilize the family's transference

87. I find it effective in family-based services to:

___ use techniques based on the principles of learning theory

___ analyze the dreams of family members

___ explore the family's failed solutions

___ periodically change the location of family members in a session

___ point out family and individual assets often

___ obtain a multigenerational history of the family

___ remain spontaneous in a session by not deciding in advance what to do

88. Concerning participation in sessions, I believe:

___ attendance by as many family members and other persons significant to the family as possible is beneficial

___ it is usually better to treat family members individually

___ the best unit for treatment is those persons immediately involved with the problem

___ successful family treatment can occur even if only one family member participates

___ if a family is seen together initially, treatment can then be conducted with any subgroup of the family

___ it is important to include the family members who live together

___ since one family member can change the behavior of another, sessions may involve any subgroup of a family

89. In order to change, a client family must:

___ understand the underlying reasons for the dysfunctional behavior

___ find new ways of interacting which achieve the same goals but do not require the symptom

___ learn to check out the meanings of the communication between family members

___ grow as individuals while increasing its sense of family

___ understand the emotional processes which have occurred through several generations

___ change its current organization

___ learn new skills

90. In thinking about family-focused treatment programs that are designed to prevent child placement, to what degree are the following program characteristics important in delivering an <u>effective</u> service to clients?

	Not at All Important	Slightly Important	Moderately Important	Quite Important	Extremely Important
a. delivery of "hard" services like moving, cleaning, grocery shopping with clients	___	___	___	___	___
b. asking clients to identify/determine and prioritize their own treatment goals	___	___	___	___	___
c. workers are available 24 hours a day for emergency visits or calls	___	___	___	___	___
d. referring family to other counseling services	___	___	___	___	___
e. services are routinely provided in the home	___	___	___	___	___
f. services are routinely provided at night or on weekends	___	___	___	___	___
g. client appointments are at the convenience of the families	___	___	___	___	___
h. initial contact with clients is made within 24 hours of the referral	___	___	___	___	___
i. services are brief in duration, lasting no more than 90 days	___	___	___	___	___
j. services are intense, provided two or three times a week for 1-4 hours per time	___	___	___	___	___
k. accepting "non-motivated" clients for service	___	___	___	___	___

	Not at all Important	Slightly Important	Moderately Important	Quite Important	Extremely Important
l. the philosophy of service providers is that most kids are better off in their own homes	___	___	___	___	___
m. service providers encourage families to assume greater responsibility and self-determination over their own lives (family empowerment)	___	___	___	___	___
n. services are focused on goal-oriented case plans	___	___	___	___	___

VII. Now we would like to know some things about how cases were closed during the study period and how you assessed outcomes.

91. What was the usual role of the following persons in the decision to terminate with a family? (Please use the following scale:)

0 = no influence
1 = some pressure to keep open
2 = some pressure to close
3 = a great deal of pressure to keep open
4 = a great deal of pressure to close
5 = controlled when case was closed
6 = not applicable

___ family

___ unit supervisor

___ agency administrator

___ court

___ public social services worker

___ team

92. Who was involved in the decision to place a child? (Please use the following scale:)

0 = no involvement
1 = some involvement
2 = a great deal of involvement
3 = controlled placement
4 = not applicable

___ family

___ unit supervisor

___ agency administrator

___ court

___ public social services worker

___ worker

___ team

93. Please estimate how often you terminated services for the following reasons during the study period. (Please check the closest category.)

	Never	Not Very Often	Sometimes	Often	Very Often	Always
a. case objectives were completely met	—	—	—	—	—	—
b. case objectives were partially met	—	—	—	—	—	—
c. the family was stabilized and no longer in crisis	—	—	—	—	—	—
d. the family was capable of functioning without services	—	—	—	—	—	—
e. a child was no longer at risk of placement	—	—	—	—	—	—
f. no change or movement occurred within a reasonable time period	—	—	—	—	—	—
g. no further change was possible at the time	—	—	—	—	—	—
h. the family decided to withdraw from services	—	—	—	—	—	—
i. the family reached a level of functioning comparable to most families in the community	—	—	—	—	—	—
j. the time limit for services set by the agency or the purchase agency was reached	—	—	—	—	—	—
k. the time limit set in a contract with the family was reached	—	—	—	—	—	—
l. the family was ready and able to accept needed services from another source	—	—	—	—	—	—
m. the family had a support system in the community	—	—	—	—	—	—
n. you were "burnt out" with the family	—	—	—	—	—	—
o. the child at risk was no longer in the family	—	—	—	—	—	—
p. family moved away	—	—	—	—	—	—
q. other (please specify:						
_____	—	—	—	—	—	—
_____	—	—	—	—	—	—

94. During the study period, in approximately what percent of your cases did you recommend placement? ____%

95. How often under the following circumstances did you recommend placing a child in a foster home, group home or institution? (Leave blank if not applicable.)

	Never	Not Very Often	Sometimes	Often	Very Often	Always
a. the child was at risk of serious physical harm due to the parent's, caretaker's or another adult's behavior	—	—	—	—	—	—
b. the child was at risk of serious emotional harm due to the parent's, caretaker's or another adult's behavior	—	—	—	—	—	—
c. the child was at risk of serious physical or emotional harm due to his/her own behavior	—	—	—	—	—	—
d. parenting was not appropriate to child's needs	—	—	—	—	—	—
e. mental, emotional or physical disability of child	—	—	—	—	—	—
f. community rejection of child	—	—	—	—	—	—
g. family rejection of child	—	—	—	—	—	—
h. school rejection of child	—	—	—	—	—	—
i. family, school and community rejected child	—	—	—	—	—	—
j. all other services had been exhausted	—	—	—	—	—	—
k. placement was part of a permanency plan for the child	—	—	—	—	—	—

96. During the study period, how often did you have follow-up contact with your families after services were terminated?

	Never	Not Very Often	Sometimes	Often	Very Often	Always
a. in person	—	—	—	—	—	—
b. by telephone	—	—	—	—	—	—
c. in writing	—	—	—	—	—	—
d. in the first 3 months after termination	—	—	—	—	—	—
e. in the first 6 months after termination	—	—	—	—	—	—
f. in the first year after termination	—	—	—	—	—	—

97. During the study period, about what percent of your cases did you regard as successes? ____%

98. Thinking about the cases you regarded as successes, how often did the families have the following outcomes?

	Never	Not Very Often	Sometimes	Often	Very Often	Always
a. the family was together at the time services were terminated	—	—	—	—	—	—
b. the family stayed together one year after services were terminated	—	—	—	—	—	—
c. the family was able to solve its own problems without further outside help	—	—	—	—	—	—
d. the family felt better about themselves	—	—	—	—	—	—
e. the family told you they no longer needed your services	—	—	—	—	—	—
f. the family stopped keeping appointments	—	—	—	—	—	—
g. all or most case objectives were met	—	—	—	—	—	—
h. positive change in the family's interactions, behavior or communication occurred	—	—	—	—	—	—
i. the family achieved its own goals	—	—	—	—	—	—
j. the adults felt more competent in their roles	—	—	—	—	—	—
k. the family was stabilized and no longer in crisis	—	—	—	—	—	—
l. the children's needs were being appropriately met	—	—	—	—	—	—
m. parental rights were terminated	—	—	—	—	—	—
n. the child at risk was placed but other children were maintained in the home	—	—	—	—	—	—
o. a permanent plan was achieved for the child	—	—	—	—	—	—
p. the child was placed with a relative	—	—	—	—	—	—
q. the family participated in the decision to place the child	—	—	—	—	—	—
r. the child was protected from further harm by placement	—	—	—	—	—	—
s. the presenting problem was resolved	—	—	—	—	—	—

In general, what family outcomes do you think best indicate success?

_____

_____

_____

_____

99. During the study period about what percent of your cases did you regard as failures? ____%

100. Thinking about the cases you regarded as failures, how often did the families have the following outcomes?	Never	Not Very Often	Sometimes	Often	Very Often	Always
a. there was no change in the family	—	—	—	—	—	—
b. a permanent plan was not achieved for the child at risk	—	—	—	—	—	—
c. a child was placed with a relative	—	—	—	—	—	—
d. the family stopped keeping appointments	—	—	—	—	—	—
e. case objectives were not met	—	—	—	—	—	—
f. a child was placed for time-limited or respite care	—	—	—	—	—	—
g. a child was placed in a foster home	—	—	—	—	—	—
h. a child was placed in a group home	—	—	—	—	—	—
i. a child was placed in an institution	—	—	—	—	—	—
j. parental rights were terminated	—	—	—	—	—	—
k. the family told you they no longer needed your services	—	—	—	—	—	—
l. the child at risk was placed but other children were maintained in the home	—	—	—	—	—	—
m. the family still needed outside help to deal with its problems	—	—	—	—	—	—
n. parenting was still not appropriate to the child's needs	—	—	—	—	—	—
o. the family was not stabilized	—	—	—	—	—	—

In general, what family outcomes do you think indicate failure?

_____

_____

_____

_____

101. In cases which you regarded as failures, how often were the following contributing factors?	Never	Not Very Often	Sometimes	Often	Very Often	Always
a. the family was referred for family-based services too late	—	—	—	—	—	—
b. the family was not ready for family-based services	—	—	—	—	—	—
c. the family refused services	—	—	—	—	—	—
d. the family was not capable of change	—	—	—	—	—	—
e. the family was not motivated to change	—	—	—	—	—	—
f. services were too intensive	—	—	—	—	—	—
g. services were not intensive enough	—	—	—	—	—	—

	Never	Not Very Often	Sometimes	Often	Very Often	Always
h. the family's basic needs for food, shelter and clothing were not being met	—	—	—	—	—	—
i. supportive services were not available	—	—	—	—	—	—
j. community pressure, standards, or discrimination blocked change	—	—	—	—	—	—
k. services were terminated too soon because of a time limit	—	—	—	—	—	—
l. case goals/objectives were not appropriate	—	—	—	—	—	—
m. the initial case assessment was not accurate	—	—	—	—	—	—

VIII. The following questions ask for your opinions about the families you worked with and about your agency. Please check the appropriate category.

102. Different programs deal with different kinds of people and problems. We would like to know what most of your cases were like.	Strongly Disagree	Disagree	No Opinion	Agree	Strongly Agree
a. Most of the problems the families I worked with had were of their own making.	—	—	—	—	—
b. Most of the families I worked with never had a chance to make a decent life.	—	—	—	—	—
c. The families I worked with had a lot of strengths.	—	—	—	—	—
d. Most of the adults I worked with didn't know much about parenting skills.	—	—	—	—	—
e. The families I worked with were discriminated against in the community.	—	—	—	—	—
f. Most of the time the mother in the family was the most important person to work with.	—	—	—	—	—
g. The families I worked with were misunderstood by other service providers.	—	—	—	—	—
h. Most of the families I worked with had different values from the majority of the community.	—	—	—	—	—
i. Child welfare services created as many problems as they solved for the families I worked with.	—	—	—	—	—
j. If there was no progress in a case, it was usually because the family lacked the motivation to change.	—	—	—	—	—
k. Most of the adults I worked with came from troubled families themselves.	—	—	—	—	—

	Strongly Disagree	Disagree	No Opinion	Agree	Strongly Agree
l. Most of the school-age children in the families were not making it in regular classes.	___	___	___	___	___
m. Most of the problems the families I worked with had were due to poverty.	___	___	___	___	___
n. Most of the families I worked with were very disorganized.	___	___	___	___	___
o. It is important for family-based service workers to go to court with families to give them support.	___	___	___	___	___
p. Mental health services created as many problems as they solved for the families I worked with.	___	___	___	___	___
q. If there was no progress in a case, it was usually because the right intervention had not been hit upon.	___	___	___	___	___
r. Most of the adults I worked with didn't know much about household skills.	___	___	___	___	___
s. The schools created as many problems as they solved for the families I worked with.	___	___	___	___	___
t. Families who were sophisticated about mental health or social services were harder to work with.	___	___	___	___	___
u. Family-based services should be a last resort for families before placement.	___	___	___	___	___
v. Most of the families I worked with had a decent place to live.	___	___	___	___	___
w. The court created as many problems as it solved for the families I worked with.	___	___	___	___	___
x. It is important for family-based service workers to participate in social and recreational activities with families.	___	___	___	___	___
y. Sometimes you had to stick with families that were resistant to change for several months until they trusted you.	___	___	___	___	___
z. I would rather work with families who have not had services before.	___	___	___	___	___
aa. Most of the families I worked with had problems finding housing.	___	___	___	___	___
bb. Sometimes placement of children out of the home was in the family's best interests.	___	___	___	___	___
cc. Families referred to the program were those for whom the services were best suited.	___	___	___	___	___
dd. Most of the families referred to this program were too dysfunctional to benefit from the services.	___	___	___	___	___

103. The following questions ask for your perception of your family-based service program:	Strongly Disagree	Disagree	No Opinion	Agree	Strongly Agree
a. It was difficult to gain community support for the program.	___	___	___	___	___
b. Record-keeping was stressed in the program.	___	___	___	___	___
c. Staff meetings were held regularly.	___	___	___	___	___
d. Paperwork in the agency was too heavy.	___	___	___	___	___
e. The program had too many meetings.	___	___	___	___	___
f. I would have liked to talk with my colleagues more frequently.	___	___	___	___	___
g. Information about the program was well publicized in the service community.	___	___	___	___	___
h. The program had a clear treatment approach which distinguished its service from that of other agencies.	___	___	___	___	___
i. Orientation adequately prepared new workers in agency policies and procedures.	___	___	___	___	___
j. In-service training was provided on a regular basis.	___	___	___	___	___
k. Active client cases were regularly reviewed by supervisors.	___	___	___	___	___
l. In-service training was consistent in its approach to treatment.	___	___	___	___	___
m. Caseloads were too high to fully implement the family-based approach.	___	___	___	___	___
n. Inflexible work hours made it hard to provide family-based services in this agency.	___	___	___	___	___
o. New personnel were trained in case recording procedures before assuming a caseload.	___	___	___	___	___
p. Statistical information generated about the program was shared with the workers.	___	___	___	___	___
q. In-service training met the needs of workers.	___	___	___	___	___
r. Treatment plans and progress towards their accomplishment were regularly reviewed with all professionals involved with the family.	___	___	___	___	___
s. Orientation adequately prepared new workers in the program's treatment approach.	___	___	___	___	___
t. The agency regarded success as prevention of child placement--no matter what the circumstances.	___	___	___	___	___
u. The policies of the program screened out the most needy families from services.	___	___	___	___	___

104. How many days of work did you miss last month because of not feeling well (including mental health days)? _____ days

105. Here are some statements of job-related <u>feelings</u> in direct work with clients. Please read each statement carefully and decide <u>how</u> <u>strongly</u> you agree or disagree with each statement. Check the number on the scale that comes closest to <u>your</u> feelings.*

	Strongly Disagree 1	2	3	4	5	6	Strongly Agree 7
a. I can easily understand how my clients feel about things.	—	—	—	—	—	—	—
b. I feel I treat some of my clients as if they were "impersonal" objects.	—	—	—	—	—	—	—
c. I deal very effectively with the problems of my clients.	—	—	—	—	—	—	—
d. I have become more callous toward people since I took this job.	—	—	—	—	—	—	—
e. I feel I am positively influencing people's lives through my work.	—	—	—	—	—	—	—
f. I don't really care what happens to some of my clients.	—	—	—	—	—	—	—
g. I feel that this job is hardening me emotionally.	—	—	—	—	—	—	—
h. I feel very energetic.	—	—	—	—	—	—	—
i. I can easily create a relaxed atmosphere with my clients.	—	—	—	—	—	—	—
j. I feel exhilarated after working closely with my clients.	—	—	—	—	—	—	—
k. Many clients cannot be helped no matter what I do.	—	—	—	—	—	—	—
l. I feel clients blame me for some of their problems.	—	—	—	—	—	—	—
m. I have accomplished many worthwhile things in this job.	—	—	—	—	—	—	—
n. In my job, I deal with emotional problems very calmly.	—	—	—	—	—	—	—
o. I feel "burned out" from my work.	—	—	—	—	—	—	—
p. I find that my personal values and those of my clients differ greatly.	—	—	—	—	—	—	—
q. I find it difficult to get useful feedback from my clients.	—	—	—	—	—	—	—

APPENDIX 2: CASE REVIEW INSTRUMENT AND GENERAL INSTRUCTIONS

CASE REVIEW INSTRUMENT - OUTCOMES RESEARCH PROJECT

GENERAL INSTRUCTIONS

Unless otherwise specified:

1. For all yes/no questions, code **0=NO 1=YES**

2. Use the following codes as necessary; however, a reasonable estimate is usually preferable to a missing data code.

   a. For missing data (i.e. information that is supposed to be in case record but is not, e.g., it is requested on a form but not completed and not indicated elsewhere in case record): code **99** in each space

   b. For information that is not available and not routinely recorded in case record (e.g., not required on a form), leave blank. Do not use blanks in the demographics matrix.

   c. For questions that are not applicable to a particular agency or case, code **88** in each space.

3. If the case has been opened to family-based services unit more than once during the study period, code time-specific data from:

   a. the service period that terminated with a placement, or

   b. the most recent opening during the study period, unless the case remains open. If so, use service period that ended in a termination.

4. Enter demographic and income information from the following sources in order of preference:

   a. Intake to family-based services unit
   b. Referral to family-based services unit
   c. Intake to agency, if a multi-unit agency
   d. Referral to agency, if a multi-unit agency
   e. Case narrative or other sources

5. Boldface terms are defined in code book.

6. DO NOI WRITE ANY NAMES OR IDENTIFYING INFORMATION ON THE CASE REVIEW INSTRUMENT

National Resource Center on Family Based Services
The University of Iowa

I. INTAKE

Variable Number	Variable Name	Coding	Special Directions/Definitions
1	Project case number	Enter identification number assigned to the case on the log of sample cases. Do not use agency identification number.	
2	Worker number	Code from agency list attached.	If more than one worker during service period beir coded, code the worker who had the most influence the outcome of the case (usually the worker with t longest involvement or the last worker). Make a n on the instrument of why this worker was selected.
3	Population	Do not code. Enter name of community listed as 1) primary residence or 2) mailing address of family on log of sample cases.	
4	SMSA	Do not code.	
5	Sex	0. Male 1. Female	Family Members: Usually family members are relate by birth, adoption or marriage, but may include li in boyfriends or girlfriends or surrogate kin (unrelated "aunt" or "grandmother," "spouse" of sa sex, etc.). Do not include individuals who live in the household but have no involvement with the fam or the case (e.g., boarders).
6	Age	Write in age in years at time of intake or referral (see general instructions), e.g., 06, 23, 36. Write in 00 for infant of less than 1 year. If birthdate only is given, subtract year of birth from year of intake/referral.	Significant others may include adult children, relatives or friends who play an important role in the family but do not live in the household. The primary caretaker is a person who has legal or major responsibility for all or most of the childr in the family and with whom the children primarily reside.
7	Marital Status	Code status current at time of intake: 0. Never married (use for unmarried child) 1. Married (living with spouse) 2. Living with boyfriend or girl-friend 3. Separated (married, living apart) 4. Divorced 5. Widowed	If children reside with different primary caretake in different households, code the primary caretake for the children at risk of placement. List children in order of age, beginning with chil as oldest. If there are more than 6 children in th family, attach an additional page, renumbering chil 1 as child 7, child 2 as child 8, etc., on the second page.
8	Race/Ethnicity	For mixed race, code lowest number, 1-6. 0. White/non-Hispanic 1. Black/non-Hispanic 2. Hispanic 3. Asian or Pacific Islander 4. Indochinese 5. American Indian or Alaskan native 6. Other	
9	Mental retard-ation	0. None, intelligence in normal range 1. Borderline intelligence, retard-ation, or low level of function-ing indicated in case record.	

Table Number	Variable Name	Coding	Special Directions/Definitions
1	Years of Education	Write in 00 for infant, preschool, kindergarten, or attending first grade. Write in number of years completed, starting with first grade (e.g., 12 for high school graduate or GED, 16 for college graduate). Number will correspond to last grade completed for 1-12.	Count only formal education, not vocational or technical training, unless in a 2-year community college program. Do not estimate based on age. Code 99 if there is no mention of education in the case record.
11	Educational Status	0. Not in school, over school-leaving age, or under 6 and not in day care. 1. Preschool or day care 2. K-12, regular class 3. K-12, special class for mentally, emotionally or physically disabled. 4. Alternative school or GED courses 5. Vocational or technical school or community college 6. 4-year college or university or graduate school 7. School-age but dropped out, suspended, or expelled	
12	Paid employment	If no mention of employment or possible employment in case record, code 0. Code 0 for child under 16 and not working. Code 1 for child 16 and over who is not in school and not working unless not able to work. 0. Not employed, not available for work 1. Unemployed, available for work 2. Seasonal or irregular employment 3. Employed part-time (less than 35 hours) but available for more work 4. Employed part-time, not available for more work 5. Employed full-time (35 hours a week or more) 6. Employed, no indication of hours 7. Retired	
13	Occupation	Code current or usual 0. Homemaker (not otherwise employed) 1. Sheltered employment 2. Unskilled labor 3. Personal service worker (e.g. waitress, domestic, janitorial) 4. Skilled labor, crafts 5. Clerical, sales, small business 6. Technical, professional, managerial 7. Military 8. Not applicable-never worked outside home or as homemaker	

Variable Number	Variable Name	Coding	Special Directions/Definitions
14	Relation to Primary Caretaker	01. Legal spouse 02. Girlfriend or boyfriend 03. Parent 04. Former spouse (divorced) 05. Biological child 06. Biological child-parental rights terminated/relinquished 07. Adopted child 08. Stepchild 09. Grandchild 10. Ward (caretaker is legal guardian) 11. Sibling 12. Step-sibling 13. Other relative 14. Unrelated 15. Other	
15-17	Relation to Adults 1-3	Use same codes as above (14).	
18	Previous Placement Experience	1. No previous out-of-home placements for this child. 2. Previous placement(s) in emergency foster home or shelter care only (for less than 3 months at a time). 3. Previous placement(s) in foster home care only (at least once for 3 months or more). 4. Previous placement(s) in group, residential treatment or institutional care only (at least once for more than 3 months). 5. Previous placement(s) in both foster home and group/institutional care (at least once for more than 3 months in each type).	Do <u>not</u> count the out-of-home placement a child mi have been in at referral to the family-based serv program. County only placements <u>previous</u> to that one.
19	At Risk of Substitute Placement	Code for each child: 1. Low risk 2. Moderate risk 3. High risk 4. In temporary placement	<u>Low risk</u>: no indication of possible placement in record. <u>Moderate risk</u>: discussion of possible placement, not imminent. <u>High risk</u>: placement imminent without family-base services, or just returned from placement. <u>Temporary placement</u>: code only if placement is expected to be short-term, e.g., if child is expe to be returned to family within 30 days of intake family-based services. Include relative placement it is a response to the family problems and not a routine visit, e.g., during holiday, or with non-custodial parent.

iable mber	Variable Name	Coding	Special Directions/Definitions
0	Residence	00. Living in household 01. Adult maintaining a separate household 02. Foster family home 03. Adoptive home 04. Emergency shelter care 05. Respite care 06. Group care/halfway house 07. Residential treatment facility or psychiatric hospitalization 08. Incarcerated (jail, prison, reform school, detention facility) 09. Hospital or nursing home (non-psychiatric) 10. Institution for mentally retarded/developmentally disabled/other handicap 11. Other institution 12. Military 13. Runaway/whereabouts unknown 14. Minor living with biological parent in another household 15. Minor living with other relative or guardian 16. Minor living with non-relative 17. Minor living alone or in supervised independent living 18. Child placed out of home: location unknown. 19. Other	Code residence at intake/referral for each individual.
21	Gross monthly income	If available, enter total household monthly income before deductions to the nearest dollar.	
22	Number of persons	Enter total number of persons residing in household who are wholly or in part dependent on the income.	If child support or alimony is paid to another household or a member away from home (e.g., in college) is still being supported by the family, count them as well.
23	Estimate of income level	From financial and other case information, estimate whether the overall income and resources of the family indicate that it is: 1. below poverty level or on AFDC 2. low income family (e.g., $10,000 to $20,000 for family of 4) 3. middle income family (e.g., $20-$40,000 for family of 4) 4. high income family (e.g., above $40,000 for family of 4)	
24	External referral source	If more than one source, code the one that seemed to have the most influence on goals, process and outcome. 01. public social service agency 02. private social service/family agency 03. emergency shelter facility 04. school 05. day care center or provider 06. community mental health center 07. private counselor or therapist 08. police or other law enforcement 09. court/probation/parole 10. medical (hospital, physician, clinic)	External referral source: an agency or individual independent of the central administrative structure in which family-based program is located. Code other units in a multi-unit agency as an internal referral. If all referrals are from the same public agency, code the source of referral to the public agency if known.

Variable Number	Variable Name	Coding	Special Directions/Definitions
24	External referral source (cont.)	11. public health or visiting nurse 12. other professional 13. self-referral (family member) 14. other individual not in family (friend, neighbor, relative) 15. other 16. unknown	
25	Internal referral source	1. intake unit 2. child protective services unit 3. on-going social service unit 4. financial or medical assistance unit 5. child placement unit (e.g., foster care unit) 6. case or placement review committee 7. other 88. not applicable—direct referral to family-based service from an external source	Internal referral source: unit or individual withi the same central administrative structure/agency a the family-based program. Applies only to multi-unit agencies in which referral does not come directly to family-based unit.
26	Reason for referral	00. no statutory problem 01. physical abuse-suspected 02. physical abuse-founded 03. sexual abuse-suspected 04. sexual abuse-founded 05. emotional abuse-suspected 06. emotional abuse-founded 08. chronic neglect-suspected 09. chronic neglect-founded 10. neglect-suspected 11. neglect-founded 12. delinquency 13. status offense 14. chronic mental illness of adult 15. drug or alcohol abuse by adult 16. adult criminal offenses 17. drug or alcohol abuse by child 18. domestic violence 19. marital or other problems between adults 20. desertion or unresolved divorce 21. parent/child conflict 22. other dysfunctional family interaction 23. social isolation 24. adult depression or emotional problems 25. health problems, physical or developmental disability (mental retardation) of adult 26. child behavior problems 27. chronic mental illness of child 28. health problem, physical or developmental disability (mental retardation) of child 29. child depression or emotional problems 30. child relationships problems with peers or siblings 31. school problems other than truancy 32. teenage pregnancy or marriage 33. death of a family member 34. disrupted adoption 35. inadequate housing 36. unemployment/underemployment 37. poverty/financial need 38. homelessness 39. other	Code only problems mentioned by referral sources o as part of referral information. Do not code problems first identified during assessment or treatment. STATUTORY PROBLEM: code 0 to 13. If more than one code the problem most emphasized in the referral. there are problems of equal importance or importan is unclear, code lowest number. Founded means 1) an admission by the person(s) responsible; or 2) a court finding; or 3) any othe confirmation deemed valid by the agency. Physical Abuse: non-accidental physical injury to child by a caretaker. Sexual Abuse: using or allowing a child to be use for sexual gratification. Emotional Abuse: failure to meet emotional needs child necessary for normal development; habitual verbal assault, scapegoating, close confinement. Chronic neglect: a history of more than two episo of substantiated or highly probable neglect. Neglect: failure to provide minimally adequate or essential food, shelter, clothing, health care, supervision. Delinquency: child has committed an offense which would be a crime if committed by an adult. Status offense: child has committed an offense whi would not be a crime if committed by an adult (e.g. runaway, truant, ungovernable). OTHER PROBLEMS: Code 01 to 39. Code the 3 proble most emphasized in the referral. If there are more than 3 of equal importance, code lowest numbers.

iable mber	Variable Name	Coding	Special Directions/Definitions
7	Court-ordered	0. Services were not court-ordered. 1. Services were court-ordered.	
8	Reason for placement	Leave blank if no prior placement. Code reasons for up to 3 placements, coding most recent as 1, etc. Code most important reason for placement. Use problem numbers from [26]; if more than three, code most recent.	
9	Out-of-home placement	Code number of placements of each type for each child. Leave blank if there is no indication of a prior placement.	
0	Times reopened	Write in number of times case was reopened following a formal termination of services, i.e., 0=no prior service; 1=one prior period of service followed by a termination.	Code total number of reopenings to agency, not family-based unit.
1	Year first opened	Enter last two digits of year case first opened by agency (e.g., 83 for 1983).	
2	Prior service summary	1. Family experienced contacts lasting no more than one month or less with one source, generally for diagnostic study. 2. Family received service for a short period of time (less than 6 months) from one agency or source. 3. Family received service for a short period of time (less than 6 months) from two or more agencies or sources. 4. Family received prior service for a significant period of time (6 months or more) from one agency or source. 5. Family received prior service for a significant period of time (6 months or more) from at least two different agencies or sources. 6. Family received prior service from one agency or source—time period unknown. 7. Family received prior services from at least two different agencies or sources—time period unknown.	Do not include concrete services (e.g., AFDC, food stamps, medicare, public housing) in this assessment.

II. PROBLEMS AND CASE OBJECTIVES

Time Period: Family Based Services Assessment to FBS termination for service period being coded.

Variable Number	Variable Name	Coding	Special Directions/Definitions
33	Initial assessment	Summarize the 3 primary problems identified in the initial assessment within the family-based unit for which service objectives were established.	Do not include problems identified by referral sources or others which were not taken up as servi objectives.
34	Seen as a problem by	Code 1 according to who expressed or agreed that this was a problem for the family. Code 0 if all family members specifically disagreed.	Code "whole family" if there is an indication in t case record that 1) the issue was discussed with t family members involved in service, and 2) there w no disagreements or divisions among these family members about the problem, and 3) all family membe cooperated with attempts to address the problem, i.e., there is no behavioral evidence of resistanc or attempts to sabotage problem resolution. If som family members agreed that it was a problem and others disagreed, code "subset of family." If no indication of discussion with family, leave blank. Disregard children who are too young to have an opinion.
35	Case objectives	List up to 4 objectives for each identified problem.	Do not include standard goals, e.g., Title XX goal List the most specific statements of what is to be achieved during service, according to the case or service plan. If more than 4 for a problem, list most relevant and specific.
36	Seen as objective by	Code as 34.	
37	Specificity	Rate specificity of each objective: 0. Vague or global-not clear what family could do to achieve it. 1. Behaviorally specific-what family needed to do was clear.	
38	Achievability	Rate each objective according to your assessment of how likely the family was to achieve it, given the family's history, current level of functioning, and resources: 0. Unlikely that this family could achieve this objective while the case was open with family-based services. 1. Likely that this family could achieve this objective before termination with family-based services.	
39	Level of achievement	Leave blank if level of achievement not indicated in case record. 0. Changed, no longer an objective. 1. Not achieved. 2. Partially achieved. 3. Substantially achieved.	
40-46	Subsequent assessment	Code as 33 through 39.	
47-51	Unrelated objectives	Code as 35 through 39.	

. **SERVICES**

ime Period: Family-based services intake to FBS termination for service period being coded.

iable mber	Variable Name	Coding	Special Directions/Definitions
2	Interventions	Code 1 if service was received by any family member involved with family-based services, according to source. FBS Unit: provided by family based services unit within agency. Other Unit: provided by another unit within agency. Other Provider/Agency: provided by another agency. Unknown: code if case record indicates service received but does not indicate source. Service needed but not available: code if service was part of case plan or sought after but not available to family. Do not code if family failed to follow up on service that would have been available to them.	Role modeling: demonstrating parenting, household or interpersonal skills by doing with family member present in an actual or simulated situation as part of intervention plan. Therapeutic contract: specific written contract with one or more family members; do not count routine case plan. Teaching: presentation of material or information on parenting, budgeting, coping, social or self-help skills. Homework assignments: specific assigned activities between appointments or face-to-face contacts for one or more family members. Therapeutic letter: a letter written to family as part of intervention to achieve a specific effect. Do not count routine appointment or eligibility letters. Play therapy: use of games, toys or other play with younger children to elicit feelings and perceptions or to resolve problems. Accompanying family member(s) to meetings or appointments to provide support and encouragement, to make sure appointment is kept, or to teach family member to negotiate with systems. Advocacy: intervening in the community or agency on behalf of the family (family member(s) may or may not be present). Case management: arranging for and coordinating services to family. Information and referral: giving information about available resources or making referrals for needed services with no continuing responsibility for coordination. Recreation: accompanying family member(s) on recreational or social outing or providing fun experiences. Outreach: continuing to contact family and trying to build a relationship despite resistance, e.g., missed appointments, hostility, apathy or indifference. Coercion: use of or threat of court, police or other negative sanction to affect family's behavior.

Variable Number	Variable Name	Coding	Special Directions/Definitions
53	Counseling received	Code 1 if service was received by any family member involved with family-based services, according to source.	
54	Support services received	Code 1 if service was received by any family member involved with FBS, according to source.	
55	Concrete services received	Code 1 if service was received by any family member involved with FBS, according to source.	
56	Out-of-home placement	Code 1 only if a brief placement was used during the service period being coded, e.g., if a child was placed after intake to FBS and returned to the home or was moved to another placement before the case was closed. If in effect at time of closing, code only as a change in residence [question 71].	
57	Para-professional	Code 1 if any type of paraprofessional [homemaker, parent aide, volunteer] was involved].	Counseling: discussion/advice, interventions aroun feelings or perceptions about parenting, self, relationships, etc. Building self esteem: planned use of positive experiences or statements to increase family membe confidence, positive self-image, feelings of self-worth. Parent education/skills development: formal traini such as STEP or PET program or work on discipline, physical care, age-appropriate care, nurturance, e Household skills development: teaching or modelin skills in cleaning, shopping, cooking, etc. Housekeeping services: cleaning, shopping, cooking, etc., with no teaching or modeling function. Child care: supervision or maintenance of child due to caretaker's planned absence for reason other tha respite or emergency. Respite care: provision of child care to give caretaker recreational time away from child, may be during day or overnight. Emergency care: provision of child care due to caretaker's unplanned or unexpected absence, may be during day or overnight. Recreational activities: accompanying family member(s) on recreational or social outing or providing fun experiences. Role modeling: demonstrating parenting, household o interpersonal skills by doing with family member present in an actual or simulated situation. Health care: providion of services related to a diagnosed medical condition, e.g., change of dressing, exercise, etc. Transportation: taking a family member to an appointment or other destination with no purpose other than providing transport. Money management: arranging or providing assistance in developing effective budgets and managing indebtedness.

CONTACTS

ıme Period: Agency intake to termination of family-based services.

iable mber	Variable Name	Coding	Special Directions/Definitions
8	Agency referral date	Month/day/last 2 digits of year most recent referral during study period was received by agency (or, if a placement case, date of referral for service which resulted in placement).	If date received not available, use date referral made. Agency referral date may be months or years before referral to family-based services if case has been open to the agency for a long time. Use earliest date if several conflicting dates are recorded.
9	FBS referral date	Code as 58.	
0	Closing date	Date case closed to family-based services.	May be date transferred to another unit in a multi-unit agency. Use latest date if several conflicting dates are recorded.
1	Last follow-up	Date of last follow-up contact (in person or by telephone). Leave blank if no follow-up.	
2	Primary model	Code one: 0. single worker 1. co-therapy face-to-face with at least one community professional 2. co-therapy face-to-face with another professional in this agency 3. co-therapy face-to-face with supervisor 4. single worker with another worker behind mirror 5. single worker with team consultation 6. single worker with agency para-professional(s) 7. single worker with community paraprofessional(s)	
3	Attempted Contacts	Write in date of attempted service contacts starting with day of first face-to-face contact with family-based worker on case (may be before case is officially opened to FBS). Code 1 in appropriate box if failed to make contact. If successful, code 1 for location. Do not count casual contacts or drop-ins with no service content, chance encounters in community, etc. If contact dates not recorded in case record or other agency form, estimate total number of contacts in each category.	Failed: family or member(s) failed to keep scheduled appointment. In home: face-to-face contact in the family's home with family or any subset of family. In office: face-to-face contact in the central or auxiliary office with family or any subset of family. Elsewhere: face-to-face contact outside the home or office with family or any subset (e.g., restaurant, court, community agency, recreation).

V. LIFE EVENTS

Time Period: From one year prior to termination with FBS for service period being coded, to termination or placeme of a child in effect at time of termination. Do not count final placement.

Variable Number	Variable Name	Coding	Special Directions/Definitions
64	Life Events	Enter number of times event has occurred in year prior to termination with FBS or placement. Leave blank if event did not occur. Code each event in only one category; if more than one category applies, code the one that appears first on the list.	Estimate frequency only if case record indicates t event has occurred and the best guess is that it i within the year prior to termination with FBS or placement.

. TERMINATION OF FAMILY-BASED SERVICES

Time Period: From intake to family-based services to closing for this service period.

riable umber	Variable Name	Coding	Special Directions/Definitions
65	Worker change	Code number of times the family based service worker changed during this period, e.g., 0=one primary worker throughout; 1=two primary workers, etc. Include only workers for service period being coded, if more than one service period.	
66	Worker months	Answer only if there was a change in primary workers. Round up from .5 months to nearest whole number. Code 0 for under .5 months.	
67	Child abuse reports	If any child abuse reports were recorded during the period between intake and termination to family-based services for this service period, enter the number of reports recorded. Code 0 if no reports in case record.	
68	Court involvement	Code 1 if there was a court hearing, petition, or pending action during the time the case was open to family-based services during this service period.	
69	Reason for termination	If more than one, code primary reason. 01. By request - family terminated service because they believed goals had been met or were satisfied with progress 02. By request - family terminated service for other reasons 03. Dropped out - family failed to keep appointments 04. Family moved or unable to locate 05. Child[ren] removed from home 06. Child[ren] ran away 07. Child[ren] emancipated 08. Service completed; no further service needed 09. Services no longer effective/ applicable 10. Family ineligible - no longer meets income or other eligibility criteria 11. Time limit reached 12. Court order for services terminated 13. Other	
70	Degree of involvement	Code for each person listed in demographics section. 0. Not involved with family-based services. 1. Attended only a few sessions. 2. Attended less than half the sessions. 3. Attended about half the sessions. 4. Attended more than half the sessions. 5. Attended most or all of the sessions.	

Variable Number	Variable Name	Coding	Special Directions/Definitions
71	Residence at termination	Code only if there is a change from question 20 (intake to family-based services); otherwise, leave blank. 00. Living in household 01. Adult maintaining a separate household 02. Foster family home 03. Adoptive home 04. Emergency shelter care 05. Respite care 06. Group care/halfway house 07. Residential treatment facility or psychiatric hospitalization 08. Incarcerated (jail, prison, reform school, detention facility) 09. Hospital or nursing home (non-psychiatric) 10. Institution for mentally retarded/developmentally disabled/ other handicap 11. Other institution 12. Military 13. Runaway/whereabouts unknown 14. Minor living with biological parent in another household. 15. Minor living with other relative or guardian 16. Minor living with non-relative 17. Minor living alone or in supervised independent living 18. Child place out-of-home, location unknown 19. Other	
72	Follow-up residence	Code as for question 71. If no follow-up, leave blank.	
73	Disposition	Code 0 or 1 in each space.	Do not include concrete services such as AFDC, food stamps, medicaid, etc.
74	Reason for placement	01. physical abuse-suspected 02. physical abuse-founded 03. sexual abuse-suspected 04. sexual abuse-founded 05. emotional abuse-suspected 06. emotional abuse-founded 08. chronic neglect-suspected 09. chronic neglect-founded 10. neglect-suspected 11. neglect-founded 12. delinquency 13. status offense 14. chronic mental illness of adult 15. drug or alcohol abuse by adult 16. adult criminal offenses 17. drug or alcohol abuse by child 18. domestic violence 19. marital or other problems between adults 20. desertion or unresolved divorce 21. parent/child conflict 22. other dysfunctional family interaction 23. social isolation 24. adult depression or emotional problems	Code up to 3 problems with most important first or lowest number first.

riable umber	Variable Name	Coding	Special Directions/Definitions
74	Reason for placement (cont.)	25. health problems, physical or developmental disability (mental retardation) of adult 26. child behavior problems 27. chronic mental illness of child 28. health problem, physical or developmental disability (mental retardation) of child 29. child depression or emotional problems 30. child relationship problems with peers or siblings 31. school problems other than truancy 32. teenage pregnancy or marriage 33. death of a family member 34. disrupted adoption 35. inadequate housing 36. unemployment/underemployment 37. poverty/financial need 38. homelessness 39. other	
75	Permanency plan	Circle the number of any child for whom placement was part of a permanency plan.	Permanency Plan: a specific, written plan that takes into account the long-term needs and interests of the child as he/she grows for a permanent home.
76	Summary of changes	Code from memory. Do not refer back to case record. Leave blank if no information in case record. 1. Has become worse since intake (or time problem was identified) 2. No change-remains the same. 3. Has improved since intake (or time problem was identified)	Behavior: e.g., for adult: discipline, physical care, age-appropriate care, nurturance, drug/alcohol use, home or financial management, etc. For child: destructive, violent, uncooperative withdrawn; truancy, poor grades, conflict with adults, disruption, delinquency, status offense, petty offenses and misdemeanors, etc. Material resources: e.g., housing, income, employment, household furnishings, etc. Family structure/hierarchy: e.g., age and generational boundaries, coalition between parents, "parenting" child, etc.; addition or loss of members prior to child placement. Dynamics/relationships: e.g., clear messages, open communication, reduction of blame, constructive problem solving, conflict, sexual relationship between adults (prior to child placement). Services: appropriate use of, e.g., medical care, day care, counseling, homemaker, transportation, etc. Affect or emotional climate: e.g., self-esteem, depression, anger, separation, differentiation, guilt, blame, feelings of powerlessness vs. personal growth, fun, enjoyment. Perception/definition of problem: definition as family problem rather than identified patient's problem; reframing as positive rather than negative. Community's perception of/reaction to family: understanding, acceptance, tolerance on part of neighbors, officials, agencies, etc. Informal support network: friends, neighbors, community persons other than agency representatives, officials, etc. Community involvement: reports, complaints, number of persons, agencies involved in family.

VII. CHILD WELL-BEING/FAMILY MEASUREMENT SCALES

Time Period: Family-based services intake to termination of family-based services for this service period.
Code from memory; do not refer back to case record.

Variable Number	Variable Name	Coding	Special Directions/Definitions
77-105	**CHILD WELL-BEING/FAMILY MEASUREMENT SCALES**	For the codes for these scales, refer to the Manual for Child Well-Being/Family Measurement Scales appended to this code list.	Select a code according to your general impression the adult's or child's situation. Do not place to much weight on the presence or absence of any particular behavior. Listed behaviors are example of behaviors that might apply to this family, but specific behaviors present need not be listed or m be included in more than one category. The scale items are meant to evoke a certain level of functioning, not to describe the family exactly. If two categories seem to apply equally well, code the lowest number.
	INTAKE	Rate each scale at Intake to FBS or when problem was identified. Leave blank if insufficient information to rate. Code 88 if not applicable.	
	CLOSING	Code scales according to situation at the time of the last contact with family. 1. Situation has worsened since intake (or since time problem was identified). 2. No change-situation is the same. 3. Situation has improved.	Leave blank if no further information about situation.
106	Summary of problems	Code 1 for each problem identified during this service period. Leave others blank.	

CHILD WELFARE LEAGUE OF AMERICA, INC.

67 Irving Place, New York, NY 10003 (212) 254-7410

MANUAL FOR

CHILD WELL-BEING/

FAMILY MEASUREMENT SCALES

Adapted from the Child Well-Being Scales and
The Family Measurement Scales

77. HABITABILITY OF FAMILY RESIDENCE

The scale measures the actual interior and exterior physical condition of the family's home. The scale does not consider the reason[s] for or cause[s] of poor conditions.

1. Adequate

Reasonably maintained and structurally safe inside and outside. No obvious physical hazards. Proper waste disposal. Utilities working and reliable.

Habitability should not be judged by poor appearance, inconvenience, or obsolescence.

2. Some problem[s], posing no immediate threat, and correctable

Physical, structural, or sanitation problems exist in home or buildings. Utilities may be inoperative on occasion. Family can avoid hazards by being careful.

Problem[s] are fairly routine and could be repaired or corrected by family if necessary. But if ignored, problem[s] would deteriorate.

3. Some problems, posing immediate threat, but correctable

Physical, structural problems, non-working utilities, safety hazards or sanitation problems exist that need immediate remediation to prevent accidents or illness. Could be repaired or corrected in short time at reasonable expense, though not by family.

4. Problems pose immediate and continuing threat, difficult to correct

Home or building is hazardous, dilapidated, and poorly maintained. Structural problems, safety hazards, non-working utilities or poor sanitation exist in home or building. Due to this, there is a significant, continuous threat of accident or illness to family member[s].

Problems are major and pervasive and require large investments of time and money to correct. Out of family's control.

5. Family member sustained injury or illness

Accident or illness due to poor maintenance, structural problems safety hazards, non-working utilities, or poor sanitation, in home or building. Medical treatment was required.

88. Not applicable.

Blank: insufficient information.

78. SUITABILITY OF LIVING CONDITIONS

This scale does not consider type of residence [e.g., hotel, apartment, doubling up], but only measures how adequate the living conditions are for family life.

1. Adequate for performance of all essential household functions

Living conditions [e.g., furnishings, size and condition of home, appliances and fixtures, utilities maintenance services] are adequate to pursue all essential household functions and to meet personal needs of family members [e.g., preparing and serving meals, food storage, bathing and other personal hygiene, sleeping, privacy needs, physical comfort—warmth, ventilation, light, etc.]

Problems, if any, are temporary and minimal.

2. All essential household functions performable, but with some delays and difficulties

Household routines are performed under difficulties, but family members manage to adjust and cope [e.g., some overcrowding; must cook on hot plate limited furnishings; breakdowns of old but repairable appliances].

Basic personal needs are being met, but conditions may be uncomfortable and unpleasant. [Include temporary breaks in utility service.]

3. Conditions compromise performance of one or several essential household function[s], on long-term basis

At least one essential household function can't be performed, or several functions can be performed only at a minimal or unsatisfactory level.

Problems in living conditions are long-term, and/or not easily resolved.

Causes strains and disrupts normal family life, [e.g., meals often can't be prepared at home; plumbing chronically defective].

4. Family has housing, but most household functions cannot be performed

Living conditions barely suitable for providing shelter or refuge from street. E.g., one-room home; no appliances; no furnishings; one or more utilities always off; extremely filthy or rodent-infested.

Family members may spend as little time home as possible.

Family life may be almost completely disorganized.

5. Family lacks housing

Family has no residence; or is habitating a structure that cannot be termed housing [e.g., burned-out building; in a car]; or will immediately lose residence [condemned, evicted, etc.]

88. Not applicable.

Blank: insufficient information.

79. MONEY MANAGEMENT

1. Adequate

Caretaker spends available money wisely, putting needs of the children first. Food, rent, essential clothing have priority.

Is able to budget funds over a period of time; when necessary, manages to stretch money to avoid running short. Rarely has to borrow money.

May buy things other than necessities, but rarely at the expense of necessities.

Tries to maintain some reserve money for unexpected but important needs.

If family is economically deprived, or if no reserve can be kept, that is because of insufficient income, not poor money management.

2. Mildly Inadequate

Caretaker spends money appropriately, putting needs of children first. Food, rent, essential clothing have priority.

Has a problem budgeting funds over a period of time; tends to run short. This is not due to insufficient income.

Has to borrow often from friends and relations, but usually manages to pay it back eventually.

Never has reserve funds; spends all that comes in, even if income would allow a small reserve.

Sometimes wastes money buying poor quality items, or overspends for items that are available cheaper at same quality, or buys too many perishable goods at one time.

3. Moderately Inadequate

Caretaker sometimes displays poor judgment regarding spending priorities, e.g., dips into rent money to buy non-essentials, or buys toys for children instead of food.

Sometimes spends money on non-essentials for self, while children lack an essential.

But these things do not happen regularly.

Budgeting poor; sometimes has to put off important expenditures because of lack of planning and impulse buying.

Borrows regularly from friends and relatives; finds it difficult to get out of debt, or sees no necessity for doing so.

4. Seriously Inadequate

Family has constant of frequently recurring monetary crises. This is not primarily due to insufficient income.

Constant exercise of poor judgment in expenditures leads to children being regularly and seriously deprived of necessities. There may be threatened loss of housing due to non-payment of rent.

Caretaker may be unable to hold on to money. E.g., "drinks the money up," spends it on others, loans it to others with no hope of recovery, "gambles it away," etc. This is chronic situation.

Buys non-essentials on credit, usually without prospect of being able to pay the money back. Bill collectors are in constant contact.

Is heavily in debt. May borrow money from disreputable sources at high interest.

88. Not applicable

Blank: insufficient information.

80. ADULT RELATIONSHIPS

For this scale, "adult relations" should be defined as including relations between unmarried, regularly cohabiting adults.

1. No significant discord

Relations are good; only infrequent, normal arguments occur.

There is mutual tolerance and conflicts are resolved quickly; channels of communication kept open.

Adults have close, positive emotional ties.

Child[ren] are never drawn into arguments between adults.

There is never any physical violence between adults, and never any talk of separation.

2. Moderate discord

Adults have more than usual amount of arguments.

There are attempts at problem-solving, but these are not always successful; channels of communication may temporarily close.

Threats of separation or divorce are sometimes made, but not carried out.

Children are sometimes drawn into arguments between adults.

Nevertheless, there seems to be a close emotional tie between adults and they usually support each other in serious matters [e.g., involving their children].

Rare instances of fighting [hitting, slapping] may occur. [If there is a pattern of violence, or if a serious injury occurred, always code "3" or "4" instead.]

3. Serious discord

Adults seem to have more periods of arguments than of peace and harmony.

Since contacts between adults tend to result in conflict, contacts on all except essential matters tend to be avoided.

There is little tolerance and "grudges" are harbored for long periods of time.

Adults may have a diminished emotional tie and may seek satisfaction outside the marital relationship.

Children may not only be drawn into arguments, but may be the focus of arguments.

Parents have talked about separation and one may have stayed away from home for several days on several occasions. But no legal separations or long periods of separation have occurred, and no legal action is pending.

There may also be some hitting and slapping, but no injuries have occurred.

4. Severe discord

There is a pattern of serious discord as described in [3] above.

In addition, physical violence resulting in injury has occurred and there are threats of more violence.

Family income may be disrupted.

Separations are occurring and divorce proceedings may be imminent or may have begun.

88. Not applicable

Blank: insufficient information

81. FAMILY'S SOCIAL SUPPORT

1. Well-supported

Caretakers have frequent and regular contact with several relatives and/or close friends who do not live in household.

Can count on these others, both for emotional support during stressful times and for concrete, tangible support when needed, e.g., babysitting, transportation, assistance with shopping or household, small loans etc. Always have someone to turn to when needed.

Relatives or friends don't "drift away" when there are problems; don't leave impression of being "imposed upon." Others are genuinely concerned about parents; able to empathize with them. Caretakers feel valued and respected by others.

Caretakers have support available in crisis as well as for lesser problems in everyday living.

2. Marginally supported

Caretakers have frequent and regular contact with only one or two relatives or close friends who do not live in the household.

Can count on these persons for emotional support and concrete help, but have no one to turn to when these persons are unavailable.

Because of few persons for support, these may become overburdened quickly.

Caretakers feel need to spend more time w. people.

Caretakers have support available in a crisis, but there are few people available for everyday activities or regular socializing.

3. Partially isolated

Caretakers have no close friends or relatives that can be counted on or turned to regularly.

Caretakers are acquainted with others (at work, neighbors), but cannot go to them with important personal problems. (Or, there is no one the caretaker trusts enough for this.)

Can ask for and receive help sometimes with the lesser problems of everyday life.

Caretakers feel lonely much of the time and are hesitant to "impose" on people, though others are generally friendly to caretakers. People sometimes willing to "lend a hand".

Close relatives may live too distantly to offer regular support, though parent may be in touch by phone or letter.

Caretakers display some distress with isolation.

4. Completely isolated

Caretakers have virtually no relations or contacts with other people, other than on the "hello-goodbye" level. Closest contacts are very superficial ones with, e.g., storekeeper or building superintendent.

There is no person that can be called on regularly for substantial help or assistance, or no one who takes a genuine interest in the caretaker (other than perhaps a spouse, child, or professional helper). There is never anyone to talk with, share problems with, or to lend a hand.

Neighbors and others might tend to avoid the caretakers. Help is never offered and might be rejected if caretakers requested it.

Caretakers do not know how to establish relations with others, or have characteristics that cause others to avoid closer interaction.

Caretakers usually must confront crises alone, or only w. public aid (hospital, police, social wkr etc.)

Caretakers may have become accustomed to persistent isolation and may not express any distress with it (or distress may be well-repressed).

88. Not applicable

Blank: insufficient information

82. CARETAKER'S CAPACITY FOR CHILD CARE

1. Adequate

No personal limitations on capacity for child c

Caretaker has no significant physical, mental-e
tional or behavioral limitations that interfere wi
his/her ability to care for the children.

2. Marginally adequate

Caretaker has a physical, mental-emotional or b
vioral problem that threatens to interfere with hi
her child caring ability (or that has already caus
some erraticism in child care quality).

Examples are chronic physical illnesses, physic
disabilities, mental or emotional illnesses, subst
abuse, criminal activity.

Caretaker requires and may be receiving help or
treatment for this problem, but there is no curren
necessity or plan for hospitalization, institution-
alization or incarceration of the caretaker.

Problem is not of long duration, or if it is of
long duration, has recently improved. Supportive
services (counseling, medical care, etc.) seem suf
cient to stabilize the situation or further improv
it.

3. Moderately inadequate

Caretaker has a physical, mental-emotional, or
behavioral problem that is of long duration, or if
is of short duration, has recently deteriorated.
Problem may be recurring and not be completely cur-
able.

Caretaker will be, is now, or recently was hospi
lized, institutionalized or incarcerated.

Caretaker will resume (or is resuming) at least
partial child care responsibilities, but longer-ter
provisions for supplementary child care (day care,
homemaker, etc.) may be required.

Temporary substitute care for the children will
is now, or was used during caretaker's absence, or
used as a respite service, but long-term substitute
care not necessary.

4. Severely inadequate

Owing to a physical, mental-emotional or behavio
problem, caretaker has no current capacity to care
the children, even with supplementary child care se
vices, and no change is expected in the near future

If caretaker is or is due to be hospitalized, in
stitutionalized or incarcerated, this is expected t
be long-term.

If caretaker is at home, he/she is not capable o
more than personal self-care tasks, perhaps requiri
assistance.

In either case, long-term arrangements for subst
tute care of children are required.

88. Not applicable

Blank: insufficient information.

83. CONTINUITY OF PARENTING

1. Continuous parenting

No breaks in parenting for the children for at least one year (at intake) or since referral (at closing). If there are two caretakers, they have remained together without separation. If one caretaker, he/she has maintained primary responsibility for the children. If parenting is shared with relatives, this is part of an extended family network and children are well-acquainted with and completely comfortable with these relatives. No permanent or extended absence of a parenting figure has occurred.

2. Marginal stability

One of the caretakers has provided continuous, stable care for the children in the past year (at intake) or since referral (at closing).

The other caretaker has not been in the household consistently or was away an extended period of time (due to marital difficulties, institutionalization, etc.). Or the caretakers may have separated and the other caretaker now only makes visits.

This has required adjustments in the lives of family members.

3. Moderate instability

One or two unexpected (but temporary) breaks in parenting have occurred in the last year (at intake) or since referral (at closing).

Children had to receive care for an extended period of time by a person who does not normally care for them. But caretaker(s) did not leave abruptly. Caretaker(s) maintained some contact during the absence.

Caretaker has returned to resume caretaking (or is expected to return shortly).

4. Serious instability

Children have experienced a series of breaks in parenting during the last year (at intake) or since referral (at closing). Caretaker(s) left children for extended periods of time on short notice with persons who are unfamiliar to the children and do not normally care for them.

Caretaker(s) has (have) left abruptly, without preparing the children for this. Children have been shifted from one home to another. However, the caretaker(s) has always returned to resume caretaking responsibility; children have not been deserted.

5. Desertion/abandonment

Children have been deserted or abandoned by their caretaker(s). This was abrupt and there is no indication that caretaker(s) intends to return.

Children have been shifted from one home to another. Future plans for them are uncertain at this time.

88. Not applicable

Blank: insufficient information.

84. SUPERVISION OF YOUNGER CHILDREN (UNDER AGE 13)

1. Adequate supervision and substitute care arrangements

Children supervised properly inside and outside of home. Caretaker knows children's whereabouts and activities.

Makes safe and appropriate substitute child care arrangements when needed (e.g., babysitting).

2. Some difficulties with supervising children in or around home or with substitute care arrangements, but no identifiable danger

Caretaker sometimes doesn't know what children are doing, doesn't check on them often enough.

Children may be "getting into" things or wandering off too far from home.

Caretaker makes substitute care arrangements, but not always suitable (e.g., babysitter may be too young or immature).

Or caretaker gives too much responsibility to children for self-care (e.g., "latch-key" child).

But children have not been in danger or injured as a result.

3. Difficulties with supervision or substitute care leading to identifiable danger (but no harm or injury)

Children may have been found playing at home with dangerous objects or appliances.

Children may have been found playing in unsafe circumstances (e.g., leaning over fire escape, in middle of busy street, in a dump, or with older strangers).

Children may be left alone at home, or in the care of an incapable person (e.g., another young child, intoxicated adult) with no ability to obtain help in an emergency.

There was clear danger, but child not actually harmed or injured.

4. Harm or injury resulting from improper supervision or lack or substitute care

Child has been injured, requiring medical treatment; or victimized (e.g., robbed, molested); or became emotionally distraught (e.g., hysterical) with symptoms lasting more than one day.

88. Not applicable

Blank: insufficient information

85. SUPERVISION OF TEENAGE CHILDREN

1. Adequate

Caretaker provides proper and timely supervision of teenage children's activities inside and outside of the home.

Caretaker knows children's whereabouts and activities, whom they are with, and when they return.

Definite and reasonable limits are set on children's activities.

2. Marginal

Caretaker makes rules for the older children and generally enforces them. But children sometimes persuade caretaker to allow or to tolerate certain activities that are against caretaker's better judgment (e.g., staying out too late, attending an unchaperoned party).

Caretaker does try keeping track of children's activities and uses discipline when things get "out of hand." Children respect caretakers for the most part.

3. Moderately inadequate

Caretaker makes rules for older children, but has difficulty enforcing them. Children often engage in inappropriate activities without caretaker's knowledge.

Caretaker sometimes does not make enough effort to find out what children are up to, or does not react with necessary sanctions when rules are broken.

Caretaker has difficulty getting children's respect but has not lost it entirely.

4. Seriously inadequate

Caretaker has few, if any, rules for the older children, and rarely enforces any. Children often stay out all night without caretaker knowing where they are or when they may return.

Caretaker usually has no idea what children are doing and makes no attempt to find out. Children are known to be "wild."

Caretaker shows little or no interest in children's activities, as long as caretaker is not inconvenienced by them. Caretaker may say he/she is helpless to control children, or may defend children's independence ("they have to find out what the world is like for themselves.")

88. Not applicable

Blank: insufficient information

86. ACCEPTANCE OF/AFFECTION FOR CHILDREN

1. Very accepting and affectionate

Caretaker is accepting and affectionate toward th children (e.g., frequently uses spontaneous expressions or gestures of affection for children).

Encourages and warmly responds to children's overtures for physical contact and emotional respons

Often speaks about children's accomplishments and good behavior.

2. Fairly accepting and affectionate, but with reservations

Few if any spontaneous expressions or gestures of affection, but will describe child positively if asked.

Rarely initiates physical contact, but will usual allow children to initiate contact and will respond. Places limits on type, time or length of contact.

May sometimes prefer some children over others, b doesn't exclude any.

3. Not affectionate, but not openly rejecting or hostile

Caretaker tends to describe and speak to children in matter-of-fact or objective terms.

Does not appear to like physical contact with children (e.g., will allow contact, doesn't push awa but rarely responds warmly).

Tries to restrict contacts to functional ones (e.g., feeding, dressing).

Seems uncomfortable when children express affection; may complain that children demand too muc want to be kissed, etc.

May show persistent favoritism (e.g., affectionate to some children, cool or indifferent to others.

Seems confused about feelings toward children.

4. Openly rejecting or hostile

Consistently speaks to or about children in deprecating, resentful, or angry ways.

Usually does not allow children physical contact, and tries to minimize or avoid even functional contacts (e.g., feeding, dressing).

May punish children's requests for affection.

Declines to help and support children when they ar in trouble.

May sometimes show affection to one child for sole purpose of making another envious, or to enhance effects of subsequent rejection.

88. Not applicable

Blank: insufficient information

87. APPROVAL OF CHILDREN

1. Approval is primary way of guiding children

Caretaker prefers to guide child by rewarding behavior rather than by punishing misbehavior.
Praise may sometimes be spontaneous.
Criticism is limited and constructive.
Caretaker does not have retributive attitude.

2. Approval and disapproval both used conditionally

Punishment and disapproval are used as readily as rewards and praise, depending on children's behavior.
Approval given for specific acts, but not as general encouragement and not spontaneously.
Caretaker values "eye for an eye" or "giving just dues."

3. Disapproval is primary way of guiding children

Children rarely praised or rewarded for appropriate behavior, but often tend to be punished or criticized for misconduct.
But tends to be "fair," in that punishment and disapproval are linked to behavior in consistent way.
Caretaker is very retributive; may believe "goodness is its own reward" or that rewards are actually "bribes."

4. Excessive and severe disapproval used

Children's faults and shortcomings are clearly overemphasized.
Criticism/disapproval are disproportionate to actual behavior (children called "stupid," worthless, etc.).
Criticism/disapproval are not used in a fair and consistent way.
Caretaker gives rewards only to compensate or "atone" for his/her own unfairness or overreaction.

88. Not applicable

Blank: insufficient information

88. CARETAKER'S MOTIVATION TO SOLVE PROBLEMS

1. Adequate; shows concern and has realistic confidence

Caretaker is concerned about children's welfare; want to meet their physical, social, and emotional needs to the extent he/she understands them.
Has realistic confidence that he/she can overcome problems and is willing to ask for help when needed (e.g., to negotiate the "system" or to acquire knowledge).

2. Marginally adequate: shows concern, but lacks confidence

Caretaker is concerned about children's welfare and wants to meet their needs.
Lacks confidence that he/she can overcome problems (feeling of futility), making failure a self-fulfilling prophecy. May be unwilling for some reason to ask for help when needed.
But uses good judgment whenever he/she takes some action to solve problems.

3. Moderately inadequate; seems concerned, but impulsive or careless

Caretaker seems concerned about children's welfare and claims he/she wants to meet their needs.
But has problems with carelessness, mistakes, and accidents in trying to meet those needs.
May be disorganized, not take enough time, or pay insufficient attention; may misread "signals" from children; may exercise poor judgment.
But does not seem to intentionally violate proper parental role; shows remorse.

4. Seriously inadequate; indifferent or apathetic about problems

Caretaker is not concerned enough about children's needs to resist "temptations," e.g., competing demands on time and money. This leads to one or more important physical, social, or emotional needs of the children not being met.
Caretaker does not have the right "priorities" when it comes to child care; may take a "cavalier" or indifferent attitude. There may be a lack of interest in children and their welfare and development.
But caretaker does not actively reject the parental role.

5. Severely inadequate; rejection of parental role

Caretaker actively rejects parental role, taking a hostile attitude toward child care responsibilities.
Believes that child care is an "imposition" and may ask to be relieved of that responsibility.
May take the attitude that it isn't his/her "job."

88. Not applicable

Blank: insufficient information

89. CARETAKER'S ATTITUDE TO PREVENTING PLACEMENT

1. Caretaker is not considering, or is opposed to, out-of-home placement for any child

Has expressed no inability to care for the children. Wants children to remain in the home and is willing to do everything necessary to make this possible.

Is optimistic that children should and will remain home. Doesn't see any reason to place.

May be angry at any suggestion that child should be [or must be] placed. Or may become very anxious or depressed at the prospect.

2. Is considering placement, but wants to explore alternatives

Caretaker has asked that out-of-home placement for a child be considered, but desires to explore alternatives to placement. Caretaker is willing to utilize services and to work on correcting the conditions or situation leading to need for placement.

Caretaker wants child[ren] to remain in home, but request for placement is precipitated by feeling that placement may be the only solution, sees no other way, at her/his limit, etc.

Caretaker seems open to suggestions, services, and support to maintain child[ren] in home.

3. Prefers to place child, but willing to delay

Caretaker has requested out-of-home placement for child[ren]. Firmly believes this is necessary or desirable, or that he/she can't continue to care for child[ren].

Willing to try alternative to placement only at strong urging of caseworker. Doesn't believe alternative plan will be successful and may not be making [or may not make] whole-hearted efforts to prevent placement.

4. Asks for immediate placement

Caretaker wants child[ren] to be placed. Refuses to consider services or help that might enable child[ren] to remain in home, even temporarily.

Caretaker is adamantly against keeping children. May feel there is no hope for change, that all kinds of efforts have been made, e.g., "just can't do any more," or "this is the last straw."

May have threatened to do something "drastic" if child[ren] not removed. Or may say "not responsible for what might happen."

88. Not applicable

Blank: insufficient information

90. EXPECTATIONS OF CHILDREN

1. Very Realistic

Caretaker has good knowledge of [or good feelings for] age-appropriate behaviors.

Gradually encourages increasingly mature behavior, but takes care not to frustrate children.

Helps children on tasks as needed, but doesn't allow them to give up on own efforts too soon.

Displays flexibility in demands and offers options to children.

May make some mistakes, but those are readily acknowledged and corrected.

2. Somewhat unrealistic, but open to improvement

Caretaker has fair knowledge of age-appropriate behaviors, but children sometimes held to too high or too low a standard.

Sometimes makes demands that frustrate both child and caretaker; or alternatively, sometimes doesn't allow child to practice new behaviors.

But only rarely punishes children for inability to comply with demands, or for trying new behavior; caretaker is more confused than angry.

Is open to advice and guidance; wants to be realistic with children and understand their needs and capacities.

3. Somewhat unrealistic, and not open to improvement

Same as description for [2] above, except that caretaker is indifferent or angry when children cannot comply with demands, or when they attempt exploratory behaviors.

Caretaker is not very flexible and not open to advice.

4. Very unrealistic

Caretaker either has very poor understanding of age-appropriate behaviors, or makes unrealistic demands of children despite some understanding.

Often punishes children for inability to comply with demands, or for attempting more mature behavior; rarely tries to help children to comply.

There may be daily conflicts about expectations regarding children's behavior; children have become reluctant to explore or innovate.

Caretaker may refuse to acknowledge the concept of age-appropriate behavior, or may believe that her/his expectations are, in fact, appropriate; is hostile on this subject.

Child may exhibit some developmental delays or emotional stress due to this situation.

88. Not applicable

Blank: insufficient information

81. CARETAKER COOPERATION WITH CASE PLANNING/SERVICES

1. Adequate

Parent fully and actively involved in case planning, services and/or treatment. This holds both for services directed toward the children and toward self.

Accepts and actively uses suitable services; including following through on referrals to other agencies or providers.

Keeps appointments, makes self available as needed, and follows directions to best of his/her ability.

Shows concern about impact of services or treatment; complains about inadequate service when warranted.

May not agree with everything suggested, but tries to be constructive in proposing alternatives. When problems in cooperation develop, there tend to be extenuating circumstances.

2. Mildly inadequate

Not as fully or actively involved in case planning/services as could be, maybe because he/she is rather disorganized or somewhat ambivalent about services.

Accepts and uses suitable services, but doesn't always make best use of them or drops them too early; follows through on referrals, but sometimes not in a timely manner.

Makes appointments, but often postpones them and sometimes doesn't keep them with no extenuating circumstances.

May cooperate satisfactorily with services for children, but may cooperate less well with personal services believed to reflect poorly on self.

Tends to wait for caseworker to suggest and act; may complain without proposing alternative, but does accept advice.

3. Moderately inadequate

Caretaker is only minimally involved in case planning, services, and/or treatment. There is a pattern of passive resistance to service providers.

Accepts services verbally, but doesn't use them or follow through on referrals without constant prodding and direct assistance (e.g., has to be taken there every time, even though own transportation can be arranged).

Often has to be cajoled, coerced, or "chased after."

Makes appointments but rarely keeps them; doesn't reschedule in advance, even if there are extenuating circumstances.

When services used, participates without much enthusiasm or at the minimal acceptable level.

Generally doesn't refuse to accept services, doesn't act consistently hostile, and doesn't actively sabotage services.

Agency able to remain in contact with family.

4. Seriously inadequate

Actively resists any agency contact or involvement.

Caretaker refuses to accept any service, or actively sabotages services when persuaded or coerced into using any.

May threaten service providers, or otherwise discourage them from attempting to engage client in service.

Family may be very difficult to contact or remain in contact with; may relocate mainly to avoid agency contact.

88. Not applicable

Blank: insufficient information

82. PARENTAL RECOGNITION OF PROBLEMS

1. Adequate: good understanding and recognizes responsibility

Caretaker understands the types of problems the family has and generally agrees with others about the severity of those problems.

Is aware of the degree to which children's physical, social and/or emotional needs are not being met.

Caretaker understands own part in or contribution to the problems (to the extent that she/he is responsible for their existence at all). Accepts full responsibility (if warranted).

2. Mildly inadequate: partial understanding, recognizes only limited responsibility

Caretaker understands the types of problems existing, but does not agree with others about their severity (believes problems less severe).

May lack adequate knowledge about child development and parenting.

Consequently, accepts only limited responsibility for existence of the problems (to the extent that she/he is responsible for their existence at all).

Fuller understanding of the problems might lead to greater acceptance of responsibility (if warranted).

3. Moderately inadequate: at least partial understanding, but recognizes no responsibility

Caretaker has at least some understanding of family's problems, but entirely fails to recognize own part in or contribution to those problems.

Accepts no responsibility for children's unmet needs, even though some responsibility should be taken.

Is adamant that other family members, society, etc., are solely to blame.

4. Seriously inadequate: no understanding

Caretaker does not understand that the family has problems; denies there are any problems at all. Consequently does not understand search for "causes" or need for "help."

May bring up question of cultural bias, even though most members of client's cultural group would not agree.

This lack of awareness may be real, or a ploy masking poor motivation to deal with problems.

88. Not applicable

Blank: insufficient information

93. CARETAKER'S SUBSTANCE ABUSE

1. No abusive or socially unacceptable use of alcohol; no use of drugs

Caretaker may drink alcohol in moderation; does not usually become more than mildly intoxicated. No problems with deviant behavior or everyday functioning as a result. No use of any drugs, including marijuana.

2. Moderate use of marijuana

Caretaker may regularly smoke a "joint" in social settings or at home. May become mildly intoxicated, but not incompetent or out of control. Does not affect everyday activities. No other use of drugs.

3. Some substance abuse but no serious consequences yet

Caretaker experiments with or uses drugs/substances other than alcohol or marijuana (e.g., narcotics, barbituates). Or may go on alcohol "binges" or smoke pot until in a stupor.

Heavy use tends to be episodic and has not had very serious consequences for the caretaker. But it may be causing arguments at home, some job absenteeism, dangerous driving situations.

Caretaker realizes that excessive use can be unhealthy or dangerous. Is not physically or psychologically addicted. Continues to function in normal daily routine.

4. Considerable substance abuse, with some serious consequences

Caretaker uses a wide variety of substances regularly and heavily, or abuses one substance (alcohol or other specific drug) very heavily.

This has affected ability to meet social role expectations. E.g., in danger of losing job or goes from one job to another; job performance poor; spouse threatens separation; financial problems occur; child care is suffering.

Shows signs of physical and/or psychological dependence on alcohol and/or drugs.

But continues to pursue normal activities and social relations on a minimal level and seems to care about "drying up" or "getting unhooked."

5. Considerable substance abuse, with severe consequences

Substance abuse same as "4," except that caretaker has "dropped out" of or is unable to pursue one or more important social roles. E.g., unemployment with no prospects; spouse has left caretaker, or caretaker "on the skids." Life has become completely organized around using/obtaining drugs.

Caretaker may be involved in illegal activities to support habit. May be ill as a result of substance abuse. May be confused much of the time.

Caretaker does not seem concerned about his/her future. Behavior/attitudes are extreme, i.e., either very aggressive or very passive.

88. Not applicable

Blank: insufficient information

. CHILDREN'S DISABLING CONDITIONS—DEGREE OF IMPAIRMENT

No symptoms observed or reported

Mild symptoms, no impairment, no difficulty

Symptoms exist, but there is no impairment in rrying out daily activities or in meeting role quirements.
This may be because the symptoms are very mild, or cause the child is being provided with services ich enable her/him to overcome more serious symptoms d function in the normal range. (E.g., medicines, erapy, physical aid, etc.)
Child has no more difficulty in functioning than do her children.

Moderate symptoms, no significant impairment, performs with difficulty

Symptoms exist, and child maintains a normal level functioning in daily activities and major roles ly with difficulty and with increased effort. ajor social roles are family member, student, iend, and citizen.)
There may be definite impairment in ability to rform secondary roles (e.g., recreational tivities).
This may be because the symptoms are moderate in rength, or because the services or therapy provided ius far have not fully compensated for the effects of ire severe symptoms.
The condition may be causing some pain, discomfort, ress or loss of time during child's activities. The ndition may require others to make minor adjustments relations with the child to accommodate him/her.
However, the end products of the child's rformances are in the normal range quantitatively id qualitatively. (E.g., child in wheelchair who is ainstreamed," some epileptic children with ackouts.)
(If symptoms impair child's effectiveness in inctioning, use one of codes below.)

. Fairly severe symptoms, definite impairment, but can perform major roles at minimal level

Symptoms exist and there is definite impairment loss of effectiveness) in carrying out daily ctivities or in performing major roles.
This may be because the symptoms are fairly severe, r because the services or therapy provided thus far aven't enabled the child to perform in the normal ange, even with difficulty.
Child is able to function only at a minimal level n his/her normal environment, but would be able to erform (or does perform) some roles better in a pecialized, supportive environment (e.g., special chool).
Child's relations with others are outside the ormal range (e.g., tends to be a disruptive influence n others, is often punished or sanctioned by others, ay be isolated).
But symptoms are not severe enough to warrant nstitutionalization or to exclude child involuntarily rom any major role activities. Child is not a danger o self or others.

. Symptoms very severe, unable to perform one or more major roles at any level, temporary placement

Symptoms exist, and child is unable to perform one r more major roles.
This may be because the symptoms are very severe, r because the services or therapy provided thus far ave not significantly improved those symptoms. Child ill not be (or is not) allowed to remain in one or more of her/his major roles (because remaining is of no benefit or even harmful to him/her; and/or because child makes it impossible for others to carry out their activities, even with difficulty; and/or because severe sanctions are threatened against child; and/or because child represents danger to self or others).
Child will be (or is) temporarily institutionalized, hospitalized, or placed in a residential setting. Long-term placement is not expected.

6. Symptoms very severe, long-term or permanent placement anticipated

Same as (5) above, except that symptoms are so chronic and pervasive, or have such a poor prognosis, that long-term or permanent institutionalization, hospitalization, or placement in a residential setting is anticipated.

88. Not applicable

Blank: insufficient information

EXAMPLES OF TYPE OF CONDITION:

A. Chronic physical illness/handicap
B. Developmental disability/retardation
C. Diagnosed emotional illness (not misconduct or social maladjustment unless accompanied by diagnosed emotional illness)
D. Specific learning disability
E. Hearing, speech, sight impairment
F. Undiagnosed disabling symptoms present

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95. PROTECTION FROM ABUSE

This scale applies only if a "third party," i.e., someone other than the child[ren]'s caretaker has, or had previously abused or threatened to abuse any of the children. Otherwise, code 88 [not applicable].

1. Adequate

At Intake: Child was abused by third party despite the fact that caretaker used good judgment, i.e., did not give third party unlimited or unrestricted access to the child[ren].

There did not seem to be any prior indications that abuse would occur and/or caretaker exercised reasonable precautions in attempting to protect children from any potential abuse.

At Closing: 3rd party who previously abused [or threatened to abuse child[ren] no longer resides in household; **AND/OR** caretaker has severed relationship with this person, or maintains only perfunctory relationship.

Potential for further abuse seems virtually eliminated.

2. Somewhat inadequate

At Intake: Child was abused by third party and caretaker did not use good judgment in protecting child[ren] from potential abuse. I.e., third party was allowed unrestricted or unlimited access to children.

Parent was too "trusting" or did not pick up on signals for potential abuse. But was not aware of abuse.

Caretaker reacted rapidly and reasonably to the incident[s], e.g., reported abuser or requested help.

At Closing: Third party who previously abused [or threatened to abuse] children is still in household; **AND/OR** caretaker has not severed his/her relationship with this person.

But caretaker has now restricted or limited third party's access to children; is aware of potential danger.

This has reduced but not eliminated the danger of repeated abuse.

3. Seriously inadequate

At Intake: Child was abused by third party and caretaker took no steps to stop it or to stop repeat incidents.

May have passively stood by without protesting or pretended not to know it was happening.

Did not immediately report it or seek help.

At Closing: 3rd party who previously abused [or threatened to abuse] children is still in household **AND/OR** caretaker has not severed his/her relationship with this person.

3rd party still has unlimited or unrestricted access to child[ren]. Caretaker may say she/he is worried, but has taken no action to reduce danger of repeated abuse. OR caretaker says there is no cause for worry.

Caretaker shows little or no ability or inclination to stand up to 3rd party and prevent repeated abuse.

88. Not applicable

Blank: insufficient information

96. PHYSICAL NEEDS OF CHILD

1. Adequately met

Needs for food, clothing, hygiene, and medical car are being met. Meals are regular and ample. Clothin sufficient and appropriate. Child clean and washed. Needed medical treatment being received.

2. Physical needs marginally or inconsistently met, but little or no effect on child's functioning

Meals may be irregular or nutritionally unbalanced but child not usually hungry or listless as a result.

Enough clothing, but may be in poor condition.

More regular bathing or increased attention to hygiene needed [but child is not filthy].

Better preventive health care [e.g., immunizations check-ups] may be needed.

But situation doesn't appear to interfere with child's everyday functioning.

3. Physical needs not being met, effecting child's functioning, but no illness

Not enough food; as a result child is often hungry and may be listless.

Not enough or the wrong kind of clothes; e.g., lacl of protection from elements.

Hygiene so poor that child is uncomfortable and stigmatized by peers.

May not be receiving needed medical care [but illness or injury will probably clear up or heal by itself, e.g., sprain, bronchitis].

Child's functioning in some or all everyday activities [school, play, sleep, etc.] is impaired as a result [but child is not seriously ill or severely limited].

4. Physical needs not met, serious illness or injury involved

As a result of poor diet, clothing or hygiene, child has symptoms of such problems as: malnutrition, dehydration, food poisoning, pneumonia, serious gastric disorder, anemia, etc.

Or, child is not receiving medical care for an injury or illness that [if left untreated] is life-threatening, could result in some permanent disability, or is a threat to public health. [Include lack of treatment for a developmentally disabled child, or lack of diagnostic assessment when severe symptoms apparent.]

88. Not applicable

Blank: insufficient information

7. SCHOOL ATTENDANCE

. Average attendance

May have missed a number of days, but no more than ost other students.
Include child with above average attendance.

. Below average attendance

The child tends to be absent from school more requently than other students. But this does not eem to have affected the child's school performance. here has been one complaint to the caretaker from the chool about this, but no other action is ontemplated.

. Poor attendance, no strong school reaction

The child attends school irregularly. The child is bsent as often as he/she attends. This has adversely ffected the child's school performance.
There have been several complaints to the caretaker rom the school about this, but stronger action is not et considered indicated.

. Poor attendance, strong school reaction

The child does not attend school at all for weeks t a time and is absent more often than present [but s enrolled]. The child requires extensive remedial ork to catch up in school.
There have been many complaints to the caretaker rom the school and more serious action has now been hreatened [e.g., court action].

. No attendance—not enrolled

The child does not attend school at all because the aretaker has not enrolled the child.
The child is being left far behind his/her peers cademically.

88. Not applicable

Blank: insufficient information

98. ACADEMIC PERFORMANCE

1. Acceptable

Child receiving at least average grades in school.
OR
Child receiving below average grades, but it is believed child is performing up to her/his potential.

2. Marginal

This child's grades are below average but she/he is not failing any subjects. The child is believed to be performing below his/her potential.

3. Moderately unacceptable

The child is currently failing one or two major subjects in school. There is a risk that the child will not be promoted to the next grade. Remedial work and increased effort will be necessary to prevent this.

4. Very unacceptable

The child is failing so many subjects in school that he/she will not be promoted to the next grade or will be transferred to an alternate school or remedial program. [If scheduled for graduation, the child could not graduate.]

88. Not applicable

Blank: insufficient information

98. PHYSICAL DISCIPLINE

1. No physical discipline used with child.

Child never physically punished. Only non-physical, non-assaultive methods of discipline used (e.g., revoking privileges, verbal disapproval).
Caretaker does not allow others to physically punish child.

2. Physical discipline used, but not excessive or inappropriate (not abusive)

Only culturally acceptable mode(s) of physical punishment used, typically spanking on rear.
Punishment is not excessive and does not ordinarily leave physical marks or cause great pain.
Purpose of punishment is primarily to symbolize disapproval, not to hurt or inflict great pain on child.

3. Excessive or inappropriate discipline used, but no resulting injury

See definitions and examples of excessive or inappropriate force below.

Child experiences considerable temporary pain, but is not physically injured, though potential for some injury was there. (If actual injury did result, choose one of next codes.)

4. Excessive or inappropriate physical force used, resulting in superficial injury.

See definitions and examples of excessive or inappropriate force below.

Typical superficial injuries are bruises, welts, cuts, abrasions, or first-degree (mild) burns. Injuries are localized in one or two areas and involve no more than broken skin.
Superficial injuries do not ordinarily require medical attention; proper home remedies would suffice. (However, medical treatment may be received.)

5. Excessive or inappropriate physical force used, resulting in moderately serious injury

See definitions and examples of excessive or inappropriate force below.

Moderate injuries should usually receive medical attention to reduce risk of complications, substantially speed healing, or reduce pain. But such injuries are not life-threatening and not likely to cause crippling, even in the absence of medical treatment.
Examples are sprains, mild concussions, broken teeth, bruises all over body, cuts needing suture, 2nd degree (moderately severe) burns, minor (small bone) fractures, etc.
Moderate injuries do not ordinarily require hospitalization for medical reasons (however, child may be hospitalized for protection against repeat harm).

6. Excessive or inappropriate physical force used, resulting in severe injury

See definitions and examples of excessive or inappropriate force below.

Severe injuries always require prompt medical attention, often on an emergency basis (e.g., long bone fractures, internal injuries, 3rd degree (most severe) burns, brain or spinal cord injuries, deep wounds or punctures that could result in systemic infection).

Injury may be life-threatening; or could result i physical or mental crippling; or could cause serious disfigurement; or could cause deep, chronic pain.

Hospitalization is usually required for medical reasons.

88. Not applicable

Blank: insufficient information

DEFINITIONS OF EXCESSIVE OR INAPPROPRIATE FORCE:

a. Caretaker (or other) uses culturally acceptable mode(s) of punishment, but overdoes it, prolongs unduly, or uses excessive force.

OR

b. Culturally unacceptable or inappropriate mode(s) physical punishment used.

Examples:

Continuous or lengthy beating, slapping or whipping; hitting with fist; kicking, biting, twisting, shaking dropping, bludgeoning, burning, scalding, poisoning, suffocating, using weapon, etc.

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100. CHILD'S MISCONDUCT

For cases being rated at closing, consider only "serious consequences" that have followed recent misconduct, e.g., since referral to the agency.

1. Recent conduct generally acceptable at home, in school or work, and in community

Child's recent conduct is comparable to that characterizing other children of the same age.

2. Some recent oppositional behavior at home or school, but no serious consequences for child

See examples of "oppositional behavior" and "serious consequences" below.
Caretaker may be requesting help with child, but not placement. School may have complained to caretaker, but no threat of imminent suspension or expulsion. No police or court involvement.

3. One or two recent incidents of moderately serious misconduct at home, in school, or in community, but no serious consequences for the child

See examples of "moderately serious misconduct" and "serious consequences."
Caretaker may be requesting help with child, but not placement. School may have complained to caretaker, but no threat of imminent suspension or expulsion. Child may have been "picked up" by police, but no arrest. No court involvement.

4. Pattern of oppositional behavior at home or school that has resulted in some serious consequence(s) for child

See examples of "oppositional behavior" and "serious consequences."

5. Pattern of moderately serious misconduct that has resulted in some serious consequence(s) for child

See examples of "moderately serious misconduct" and "serious consequences."

6. At least one recent incident of very serious misconduct (violent or felonious behavior)

Examples: assault on caretaker or teacher; sexual assault; drug dealing; carrying weapon; burglary; hold-ups; arson, etc. Probably has (or will) result in serious consequences for child.

88. Not applicable

Blank: insufficient information

Examples of OPPOSITIONAL BEHAVIOR:
At home: argumentative, rude; refuses to do chores, clean up after self; comes home late; refuses to say where going.
At school: refuses to follow directions, to complete work; or cheats.
Excludes: property offenses, violent offenses, or behavior physically dangerous to the child.

Examples of MODERATELY SERIOUS MISCONDUCT:
Steals from family members or peers; petty theft or shoplifting; breaks things or vandalizes; makes threats; runs away; unapproved sexual activity; using drugs or alcohol; bullies siblings or peers.
Excludes: assaultive or felonious offenses.

Examples of SERIOUS CONSEQUENCES FOR CHILD:
Out-of-home placement is requested or received; imminent or actual suspension/expulsion from school; police arrest; court petition or appearance; any serious injury to child.

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101. CHILD'S FAMILY RELATIONS

1. Child's family relations generally positive with few conflicts

There is mutual tolerance and conflicts are resolved quickly.
Child participates adequately in family life.
Include child whose family relations were good, even though he/she may now be placed for other reason (e.g., misbehavior).

2. Child often in conflict with family members, but some contacts remain positive

There are attempts at problem-solving, though not always successful; some mutual tolerance exists.
Child may be temporarily excluded from some family activities, or have some privileges revoked.

3. Child's behavior very disruptive of family relations (but no requests for separation have been made)

Other family members tend to avoid contact with child (or child tends to avoid contact with them).
Some contacts attempted, but usually result in conflict.
There are few attempts to solve problems.

4. Child in danger of separation from family due to conflicts at home

For example, caretaker has made status offender complaint; or has asked for out-of-home placement; or child desires placement; or refuses to go home.

5. Child separated from family due to conflicts at home

For example, child is living with relative, in foster home, in residential treatment center, etc.

88. Not applicable

Blank: insufficient information

102. CHILD'S COOPERATION WITH AGENCY

1. Child is fully and actively involved in case planning, services and/or treatment

Accepts and actively uses suitable services, including following through on tasks, or on referrals to other service providers.

Keeps appointments, makes self available as needed, and follows directions to best of his/her ability.

Shows concern about impact of services or treatment; complains about inadequate service when warranted.

May not agree with everything suggested, but tries to be constructive in proposing alternatives.

When problems in cooperation develop, there tend to be extenuating circumstances.

2. Involved in planning and services, but lacks initiative and tends to hold back

Child is not as fully or actively involved in case planning and/or services as he/she could be. This may be because child is rather disorganized and/or somewhat ambivalent about services.

Accepts and uses suitable services, but doesn't always make best use of them, or drops them too early; follows through on referrals, but sometimes not in a timely manner.

Makes appointments, but often postpones them and sometimes doesn't keep them at all.

May cooperate satisfactorily with services for other family members, but cooperates less well with services focused on self.

Tends to wait for caseworker to suggest and act; may complain without proposing alternative, but does accept advice.

3. Only minimally involved in planning and services

Passively resists cooperating or is argumentative at every stage.

May accept services verbally, but doesn't use them or follow through on referrals or tasks without constant prodding and direct assistance (e.g., has to be taken there every time, even though own transportation can be arranged).

Often has to be cajoled, coerced, and/or "chased after."

Makes appointments, but rarely keeps them; doesn't reschedule in advance, even if there are extenuating circumstances.

When services used, participates without much enthusiasm or at the minimal acceptance level.

But generally doesn't refuse to accept services, doesn't act consistently hostile, and doesn't actively sabotage services.

Worker able to remain in touch with child.

4. Rejects any involvement with agency

Actively or passively rejects any agency contact or involvement.

May refuse to accept any service or actively sabotage services when persuaded or coerced into using any.

May threaten service providers, throwing tantrums, or otherwise discourage them from engaging child in service.

May not accept even being "led through" tasks; may have no reaction to admonitions or criticism at all. May display psychosomatic symptoms when confronted with need to act.

Child may be very difficult to find or remain in touch with.

88. Not applicable

Blank: insufficient information

103. DELIBERATE "LOCKING OUT"

1. No problem with locking out

Child never denied access to his/her home or expelled from home. This is never used as a deliberate means of punishment.

2. Some problem, low potential danger, no injury

Child was denied access to his/her home or expel from home. She/he had somewhere to go (relative, friend, neighbor) and was old enough or capable enc to go there.

If out-of-home overnight, child was in safe location (another home or shelter).

Includes runaway child whose caretaker refused t take her/him back and who came to police or social service agency for help.

Does not include any child who had to ask strang for help.

3. Moderate to high potential danger, possible superficial injury

Child was denied access to or expelled from home

Includes any child who had no safe place to go (relative/friend/neighbor) or who was not old enoug or capable enough to go there.

Includes any child who would not be able to cont the police or social service agency without help fr a stranger.

Includes any child who has been out several hour or more in very bad weather, or who is too young to cross streets safely.

As a result, child may have received some superficial injury (e.g., bruise) not requiring medical attention, or may have been scared or threatened. But there was no serious injury, accident, or crime victimization.

4. Serious consequences

As a result of being denied access to or expelle from his/her home, child sustains an injury or illn that usually requires medical attention, but not hospitalization.

Or, child is moderately victimized (e.g., robbed but not physically or sexually assaulted or kidnapp

Or, child commits a status offense during this time.

5. Severe consequences

As a result of being denied access to or expelle from her/his home, child sustains a severe injury o illness that usually requires hospitalization.

Or, child is seriously victimized (assaulted, kidnapped, etc.)

Or, child commits a delinquent offense during th time.

88. Not applicable

Blank: insufficient information

104. SEXUAL ABUSE

1. No sexual abuse or impropriety

Caretaker does not sexually abuse or provoke child in any of the ways below, nor allow anyone else to do so.

2. Sexual suggestiveness

Sexually provocative comments are made to a child, or child is shown pornographic photos.
But there have been no sexual approaches to the child, and no molestation is suspected.

3. Sexual harassment

Child is being harassed—encouraged, pressured, or propositioned—to perform sexually.
But no sexual activity has actually occurred.

4. Sexual exhibitionism

Person has exhibited him/herself sexually in front of the child (e.g., exposure of genitals, masturbation). The child was pressured to participate, but did not do so.

5. Sexual molestation

Person has sexually molested the child (e.g., fondled breasts or genitals; made child exhibit him/herself). But there was no sexual intercourse between them.

6. Sexual intercourse

Child was sexually abused—sexual intercourse occurred (oral, anal, genital).

88. Not applicable

Blank: insufficient information

105. PERPETRATOR

1. Caretaker or legal guardian of child

2. Adult acquaintance (caretaker was unaware of incident)

3. Adult acquaintance (caretaker was aware of incident and did nothing about it)

4. Other

88. Not applicable

Blank: insufficient information

NATIONAL RESOURCE CENTER ON FAMILY BASED SERVICES
CASE REVIEW INSTRUMENT

I. INTAKE

____ 1. Project case number

____ 2. Worker number

DO NOT CODE: Enter name of community on case log

_____ 3. Population of community in which family resides

____ 4. Is community part of a SMSA?

DEMOGRAPHICS:

Code all spaces for each **family member** and **significant other.** Code 88 in each blank if not applicable. Code 99 if missing (see coding instructions). Do not leave blanks.

	5. Sex	6. Age	7. Marital Status	8. Race/Ethnicity	9. Mental Retardation	10. Education (yrs)	11. Educational Status	12. Paid Employment	13. Occupation	14. Relation to Caretaker	15. Relation to Adult 1	16. Relation to Adult 2	17. Relation to Adult 3	18. Previous Placements	19. At Risk of Substitute Placement	20. Residence
Adults																
Primary Caretaker										XXXXXXXXXXXXXXXXXXXX						
Other Adult 1										XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX					
Other Adult 2											XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX				
Other Adult 3												XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX			
Children																
Child 1																
Child 2																
Child 3																
Child 4																
Child 5																
Child 6																

HOUSEHOLD RESOURCES:

_____ 21. Gross monthly income

____ 22. Number of persons in household supported by this income

____ 23. Estimate of income level

____ 24. Primary **source of referral external** to the agency

____ 25. Source of **referral** to family-based unit **from within the agency** (code 88 in single-purpose agency)

26. Reason for referral to family-based services:

____ **Statutory** problem

____ **Other problem**

____ **Other problem**

____ **Other problem**

____ 27. Were family-based services court-ordered? 0=no 1=yes

28. If children had been placed out of the family before referral to family-based services, what were the reasons for placement? (Most recent placement is #1.) <u>If no placements, go to 30</u>.

	Placement # 1	2	3
Child 1			
Child 2			
Child 3			
Child 4			
Child 5			
Child 6			

29. Number and type of prior out-of-home placements:

	Child # 1	2	3	4	5	6
a. emergency shelter						
b. respite care						
c. independent living						
d. foster family home						
e. group home/halfway house						
f. institution for mentally retarded/ developmentally disabled						
g. residential treatment or psychiatric hospitalization or assessment						
h. detention facility/incarceration						
i. adoptive home						
j. formal or informal placement with friend or relative						
k. other (specify:)						

____ 30. How many times has this family been reopened as a case by <u>this agency</u>?

____ 31. Year case first opened by <u>this agency</u>.

____ 32. Summary of prior services.

II. PROBLEMS AND CASE OBJECTIVES

33. Problems Identified in Initial Assessment:

34. Seen as a Problem By:

		Whole Family	Subset of Family
1.			
2.			
3.			

35. Case Objectives Related to Problems:

36. Seen as Objective by:

37. 38. 39.

Problem 1

		Whole Family	Subset of Family	Specificity of Objective	Achievability	Level of Achievement
1.						
2.						
3.						
4.						

Problem 2

1.						
2.						
3.						
4.						

Problem 3

1.						
2.						
3.						
4.						

40. Problems Identified after Initial Assessment:

41. Seen as a Problem By:

		Whole Family	Subset of Family
1.			
2.			
3.			

42. Case Objectives Related to Problems:

43. Seen as Objective by:

44. 45. 46.

Problem 1

		Whole Family	Subset of Family	Specificity of Objective	Achievability	Level of Achievement
1.						
2.						
3.						
4.						

Problem 2

1.						
2.						
3.						
4.						

Problem 3

1.						
2.						
3.						
4.						

47. Case Objectives Not Related to Identified Problems:	48. Seen as Objective by: Whole Family	Subset of Family	Specificity of Objective	49. Achievability	50. Level of Achievement	51.
1.						
2.						
3.						
4.						

III. SERVICES

What services did this family receive while the case was open with family based services? (Leave blank if did not receive.) See definitions in code book.

52. Interventions

	Direct: FBS Unit	Direct: Other Unit	Other Provider/Agency	Unknown	Needed but Not Available
a. individual therapy/counseling					
b. marital/couple therapy/counseling					
c. group therapy/counseling					
d. family based services/family therapy					
e. **role modeling**					
f. **therapeutic contract**					
g. **teaching**					
h. **homework assignments**					
i. **therapeutic letters**					
j. **play therapy**					
k. **accompanying family/member to appointment or meeting**					
l. **advocacy**					
m. **case management**					
n. **information/referral**					
o. **recreation**					
p. **outreach**					
q. **coercion**					

53. Counseling Services

	Direct: FBS Unit	Direct: Other Unit	Other Provider/Agency	Unknown	Needed but Not Available
a. child protective services					
b. other public social services					
c. private social or family services					
d. school social work services/counseling					
e. community mental health services					
f. psychiatric counslg/therapy-outpatient					
g. crisis intervention					
h. psychological testing/evaluation					
i. psychiatric assessment/diagnosis					
j. day treatment					
k. inpatient mental health services					
l. substance abuse counseling					
m. inpatient substance abuse treatment					
o. other (specify:)					

54. Support services

	Direct: FBS Unit	Direct: Other Unit	Other Provider/Agency	Unknown	Needed but Not Available
a. homemaker					
b. public health/visiting nurse service					
c. parent education					
d. substance abuse support group					
e. other support group (e.g. child abuse, domestic violence)					
f. Big Brothers/Sisters, Foster Grandparents/other volunteer services					
g. Mental retardation/developmental disability services					
h. financial/money management counseling					
i. other (specify:)					

55. Concrete services

	Direct: FBS Unit	Direct: Other Unit	Other Provider/Agency	Unknown	Needed but Not Available
a. AFDC					
b. food stamps					
c. Medicaid					
d. SSI					
e. general assistance/home relief					
f. emergency family housing					
g. subsidized or public housing					
h. emergency cash or goods					
i. day care					
j. family planning					
k. housekeeper/chore service					
l. legal services					
m. employment assistance (job trng, vocational rehab, sheltered employment)					
n. transportation					
o. medical					
p. remedial/special education					
q. other (specify:)					

56. Out-of-home placement of child(ren) during family-based services

	Child # 1	2	3	4	5	6
a. emergency shelter						
b. respite care						
c. independent living						
d. foster family home						
e. group home/halfway house						
f. institution for mentally retarded/ developmentally disabled						
g. residential treatment or psychiatric hospitalization or assessment						
h. detention facility/incarceration						
i. adoptive home						
j. formal or informal placement with friend or relative						
k. other (specify:)						

57. If paraprofessionals (e.g., homemaker, parent aide, volunteer) were used in this case, what kind of service did they provide? (See definitions in code book.) If no paraprofessionals were used, go to 58.

___ a. **counseling**
___ b. **building self-esteem**
___ c. **parent education/skills development**
___ d. **household skills development**
___ e. **housekeeping services**
___ f. **child care**
___ g. **respite care**
___ h. **emergency care**
___ i. **recreational activities**
___ j. **role modeling**
___ k. **health care**
___ l. **transportation**
___ m. **money management**
___ n. paraprofessional used but no other indication of type of service
___ p. other (specify: _____)

IV. CONTACTS

____ 58. Date referral received by agency in multi-unit agency (code 88 if single-purpose agency).

____ 59. Date of referral to family-based services

____ 60. Date case closed to family-based services.

____ 61. Date of last follow-up contact.

____ 62. Primary model employed in face-to-face contact with family.

63. Dates of <u>attempted</u> service contacts (if more than one in same day, list date twice):

	failed	in-home	in office	elsewhere	location unknown
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		failed	in-home	in office	elsewhere	Location unknown
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(Attach a third sheet if necessary)

V. LIFE EVENTS SECTION

64. Life events in year prior to termination with family-based services or placement of a child in effect at time of termination. Do not count final placement. (Leave blank if did not occur.) Code actual number for each event:

____ a. death of spouse

____ b. divorce

____ c. marital separation from mate

____ d. detention in jail or other institution (non-medical)

____ e. death of a close family member

____ f. major personal injury or illness

____ g. marriage

____ h. being fired at work

____ i. marital reconciliation with mate

____ j. retirement from work

____ k. major change in the health or behavior of a family member (extended or immediate)

____ l. pregnancy

____ m. sexual difficulties

____ n. gain of new family member (e.g., through birth, adoption, oldster moving in, etc.)

____ o. major business readjustment (e.g., merger, reorganization, bankruptcy, etc.)

____ p. major change in financial state (e.g., a lot worse off or a lot better off than usual)

____ q. death of close friend

____ r. changing to a different line of work

____ s. major change in number of arguments with spouse (e.g., either a lot more or a lot less than usual regarding child-rearing, personal habits, etc.)

____ t. taking out a mortgage or loan for a major purchase (e.g., for a home, business, etc.)

____ u. eviction or foreclosure of mortgage

____ v. major change of responsibilities at work (e.g., promotion demotion, lateral transfer)

____ w. son or daughter leaving home (e.g., marriage, attending college, etc.)

____ x. trouble with in-laws

____ y. outstanding personal achievement

____ z. primary caretaker beginning or ceasing work outside the home

____ aa. beginning or ceasing formal education

____ bb. major change in living conditions (e.g., building a new home, remodeling, deterioration of home or neighborhood)

____ cc. revision of personal habits (dress, manners, associations, etc.

____ dd. trouble with the boss

____ ee. change in working hours or conditions

____ ff. change in residence

____ gg. changing to a new school

____ hh. major change in usual type and/or amount of recreation

____ ii. major change in church activity (e.g., a lot more or a lot less than usual)

____ jj. major change in social activities (e.g., clubs, dancing, movies, visiting, etc.)

____ kk. taking out a mortgage or loan for a lesser purchase (e.g., for a car, TV, freezer, etc.)

____ ll. major change in sleeping habits (a lot more or a lot less sleep, or change in part of day when asleep)

____ mm. major change in number of extended family get-togethers (e.g., a lot more or a lot less than usual)

____ nn. major change in eating habits (a lot more or a lot less food intake, or very different meal hours or surroundings)

____ oo. vacation

____ pp. minor violations of the law (e.g., traffic tickets, jaywalking, disturbing the peace, etc.)

VI. TERMINATION OF FAMILY-BASED SERVICES

____ 65. How many times was there a change in the primary family-based services worker on the case?

66. If there was a change of workers, how many months was each worker on the case?

____ a. first worker

____ b. second worker

____ c. third worker

____ 67. Were there additional child abuse reports while this case was opened to family based services during this service period? 0=no 1=yes

____ 68. Was there court involvement in this case while it was open to family-based services during this service period? 0=no 1=yes

____ 69. Reason for termination of family-based services

70. Degree of involvement in family-based services

____ Primary Caretaker
____ Other Adult 1
____ Other Adult 2
____ Other Adult 3
____ Child 1
____ Child 2
____ Child 3
____ Child 4
____ Child 5
____ Child 6

Change in Family Members' Residence (code only if different from intake (item 20)):

71. At Termination	72. At Follow-up	
____	____	Primary Caretaker
____	____	Other Adult 1
____	____	Other Adult 2
____	____	Other Adult 3
____	____	Child 1
____	____	Child 2
____	____	Child 3
____	____	Child 4
____	____	Child 5
____	____	Child 6

73. Disposition of case after termination with family-based services. 0=no 1=yes

____ Transferred to another unit in this agency.
____ Continued to receive services from only one other agency.
____ Continued to receive services from more than one other agency.
____ Started services with only one new agency.
____ Started services with more than one new agency.

Code 74 and 75 only for cases in which a child was in placement o in which placement was planned or imminent at termination. If no placement, go on to question 76.

74. If children were placed out of the family at the time of termination, what were the reasons for placement?

	Reason # 1	2	3
Child 1			
Child 2			
Child 3			
Child 4			
Child 5			
Child 6			

75. Circle the child number(s) for which placement was part of a **permanency plan:**

Child #: 1 2 3 4 5 6

Code the following questions (76-105) from memory. Do not refer back to case record. See code book for codes and definitions.

76. Summary of changes from intake (or time problem identified) to termination:

____ a. changes in **behavior** of family members
____ b. changes in family's **material resources** or circumstances
____ c. changes in **family structure/hierarchy** (prior to placement)
____ d. changes in **dynamics/relationships** within family (prior to placement)
____ e. use of available **services**
____ f. changes in family's **affect or emotional climate**
____ g. changes in family's **perception/definition of problem**
____ h. changes in **community's perception of/reaction to family**
____ i. change in **informal support network** of family
____ j. change in degree of **community involvement** with family

VII. CHILD WELL-BEING/ FAMILY MEASUREMENT SCALES:

77.-105.

Code only persons who participated in services.

		77. habitability of residence	78. suitability of living conditions	79. money management	80. adult relationships in household	81. family social support/isolation	82. caretakers' capacity	83. continuity of parenting	84. supervision - younger (under 13)	85. supervision - teenagers	86. acceptance of children	87. approval of children	88. caretakers' motivation	89. attitude to placement	90. expectations of children	91. caretakers' cooperation	92. caretakers' recognition	93. substance abuse
PRIMARY CARETAKER	Intake																	
	Closing																	
OTHER ADULT 1	Intake																	
	Closing																	
OTHER ADULT 2	Intake																	
	Closing																	
OTHER ADULT 3	Intake																	
	Closing																	

		94. disabling conditions	95. protection from abuse	96. physical needs	97. school attendance	98. academic performance	99. physical discipline	100. child's misconduct	101. child's family relations	102. child's cooperation	103. locking out	104. sexual abuse	105. perpetrator
CHILD 1 -	Intake												
	Closing											XXX	XXX
CHILD 2 -	Intake												
	Closing											XXX	XXX
CHILD 3 -	Intake												
	Closing											XXX	XXX
CHILD 4 -	Intake												
	Closing											XXX	XXX
CHILD 5 -	Intake												
	Closing											XXX	XXX
CHILD 6 -	Intake												
	Closing											XXX	XXX

106. Summary of problems: Code 1 for each problem identified during this service period. Leave others blank.

____ a. physical abuse-suspected

____ b. physical abuse-founded

____ c. sexual abuse-suspected

____ d. sexual abuse-founded

____ e. emotional abuse-suspected

____ f. emotional abuse-founded

____ g. chronic neglect-suspected

____ h. chronic neglect-founded

____ i. neglect-suspected

____ j. neglect-founded

____ k. delinquency

____ l. status offense

____ m. chronic mental illness of adult

____ n. drug or alcohol abuse by adult

____ o. adult criminal offenses

____ p. drug or alcohol abuse by child

____ q. domestic violence

____ r. marital or other problems between adults

____ s. desertion or unresolved divorce or separation

____ t. parent/child conflict

____ u. other dysfunctional family interaction

____ v. social isolation

____ w. adult depression or emotional problems

____ x. health problems, physical or developmental disability (mental retardation) of adult

____ y. child behavior problems

____ z. chronic mental illness of child

____ aa. health problem, physical or developmental disability (mental retardation) of child

____ bb. child depression or emotional problems

____ cc. child relationship problems with peers or siblings

____ dd. school problems other than truancy

____ ee. teenage pregnancy or marriage

____ ff. death of a family member

____ gg. disrupted adoption

____ hh. inadequate housing

____ ii. unemployment/underemployment

____ jj. poverty/financial need

____ kk. homelessness

____ ll. other

Case Reader _____

Date Coded _____

Case Reader: Complete after coding is finished.

How long did it take you to code this case? ____ minutes

Did you get any additional information on the case from (circle one answer for each):

a. the worker? yes no

b. the supervisor? yes no

c. another person? yes no

(specify:)

In your opinion, how complete was the information in this case compared to the sample case you coded in training? (circle one)

much less complete		about the same		much more complete
1	2	3	4	5

APPENDIX 3: INSTRUCTIONS TO LIAISONS AND CONSENTS

(Project Liaisons, for Agency Administrators)

NATIONAL RESOURCE CENTER ON FAMILY BASED SERVICES

School of Social Work
The University of Iowa
Oakdale Hall, Room N118
Oakdale, Iowa 52319
(319) 353-5076

MEMORANDUM

To : Robert Roy, Manager, Kerr Center **Date:** 9/9/85
(through Julie Plekan, Project Liaison)

From: Kristine Nelson
Principal Investigator

Re : Outcomes Research Project

First, let us express our appreciation of your participation in the National Resource Center on Family Based Services research on success and failure in family-based services. Before we can proceed with data collection, we will need your written consent to use client case records in the research. This letter is to explain the procedures, risks and benefits involved in the study and to obtain your formal consent to participate.

As our proposal indicates, data collection will proceed in two stages, involving first a social-worker questionnaire to be administered early in 1986 and second the coding of information from 50 family-based cases by paid case readers to commence in July or August 1986. We will also be asking a few interested social workers to monitor one of their cases during this time period to gather information about the processes involved in providing family-based services.

At the conclusion of the study your agency will be provided with a report on the factors associated with success and failure of services in your cases and an overall analysis of the twelve project sites. The information gathered in this study will help program planners and administrators all over the country to establish and improve family-based services and prevent unnecessary out-of-home placements.

Social workers' participation in the research project will be voluntary, and each will receive a copy of the enclosed cover letter outlining the procedures, risks and benefits of the study and assuring the confidentiality of their responses. Since client families will not be contacted directly, we will not be able to obtain consent to participate in the research from each individual. As agency administrator, however, your consent to gather data from client case records is needed.

The data gathered from case records on each family will include demographic information on each family member, reason for referral, source of referral, identified problems, service goals, types of service delivered, units of service delivered, and outcome measures, including whether service goals were achieved and whether a family member was placed outside the home or otherwise left the home during the course of service.

The only risk involved in this study is the accidental disclosure of client information; however, we will take several steps to avoid such disclosure. The case readers will be employed by the project and supervised directly by your agency. They will be subject to all rules and regulations concerning confidentiality applied in the agency and will be thoroughly trained before handling cases. A copy of the "Affirmation of Confidentiality" which they will sign is attached. No names or identifying numbers will be recorded on the case review instruments. After case information has been coded, the case review instruments will be forwarded directly to responsible project staff at the National Resource Center. All identifying information will also be removed from the cases monitored by individual social workers before data are forwarded to project staff.

To facilitate follow-up of missing information and clarification of any questions that may arise later, project reference numbers will be coded on the case review instruments. A list of these numbers and the corresponding agency case numbers will be kept separately from the research instruments and forwarded to the National Resource Center as soon as data collection is completed. The lists and instruments will be kept separately under lock and key and destroyed upon completion of the study. Data will be reported only in aggregate and will include no information which would identify individual social workers, clients, or families.

Please sign the following certification of consent and return it to the National Resource Center as soon as possible. Your participation is very much appreciated. If you have any questions about the study, please call Janet Hutchinson, Project Director, or Kristine Nelson, Principal Investigator, at 319/353-5076.

Certification of Consent

I hereby agree to my agency's participation in the National Resource Center on Family Based Services research on success and failure in family-based services, described above. I further agree to provide case readers employed by the project access to agency case records for the purpose of recording data from them. I understand the possible risks and benefits of the research, the procedures to safeguard confidentiality, and that my agency's participation in this research is voluntary.

_____

Administrator's Signature

The University of Iowa

Iowa City, Iowa 52242

National Resource Center on Family Based Services
School of Social Work
Oakdale Campus, N118-OH
Oakdale, Iowa 52319

(319) 353-5076

Dear Family-Based Service Colleague:

The National Resource Center on Family Based Services and the Regional Research Institute for Human Services at Portland State University are conducting a federally-funded study of family-based pre-placement preventive services. The study will document program characteristics and service approaches in agencies across the nation and will identify factors which are related to success and failure in family-based services. As a family-based services worker in one of twelve programs selected for the study, your participation is extremely important to us. The information we are asking you to supply on your program and practice will help program planners and administrators establish and improve family-based preventive services and prevent unnecessary out-of-home placements.

We are asking you to complete the attached questionnaire and to return it in the enclosed self-addressed, stamped envelope. It will take about 30 minutes to complete. The confidentiality of your responses will be respected. They will be reported only in combination with the responses of many other social workers. No information on your individual answers will be given to your agency. The number on the questionnaire is to facilitate follow-up of unreturned questionnaires. It will also be used to identify you as the social worker for cases which may be selected as part of a random sample. You may be asked to supply missing or additional information on these cases at the time the random sample is studied.

The only risk to you in this study is accidental disclosure of the information you provide for us. This will be guarded against by keeping the completed questionnaires and the list of social workers' names and identifying numbers under lock and key and by destroying them when the study is completed. The benefit of this study will be improved services to families receiving preventive services across the nation.

Return of this questionnaire to the National Resource Center will be considered your consent to participate in the study. Your participation is voluntary and you may refuse to participate or to answer particular questions without negative consequences from your agency. If you have any questions about the study, please call Janet Hutchinson, Project Director, or Kristine Nelson, Principal Investigator, collect, at 319/353-5076.

Thank you very much for your participation in this important research.

Sincerely,

Kristine Nelson
Principal Investigator

The University of Iowa

Iowa City, Iowa 52242

National Resource Center on Family Based Services
School of Social Work
Oakdale Campus, N240 OH
Oakdale, Iowa 52319

(319) 353-5076

August 1, 1986

Val Broste
Lutheran Social Service of Minnesota
Intensive In-Home Treatment Program
Box 477
Fergus Falls, MN 56537

Re: Family Based Services Outcomes Research Project

Dear Mr. Broste,

We are about to enter our third phase of data collection and will need your assistance on the following activities:

1. Field-testing the Case Review Instrument. I have enclosed a draft of the case review instrument which we plan to use in the case reading, which will start in September. Please review it for items that could be added or deleted. It would be helpful if you or one of your associates would go through a closed prevention case and complete the case review instrument: a) to make sure the categories are applicable to your program; b) to determine what information is not available; and c) to see how long it takes to code from your records. We will need your feedback by August 15 so that the necessary revisions can be made. (Our data collection schedule for this phase is tight.)

2. Case Sampling. We also need to develop a list of cases from which to select the case reading sample. In order to make sure the sample is scientifically drawn, I will need a list of **all** cases opened for family-based services during the study period (Jan. 1983 to Sept. 1985).

   Alongside each case record designation, indicate the following: 1) an **"A"** if the case was opened for **assessment only** and never received services; 2) an **"R"** if it is a reunification case; 3) a **"P"** if one or more of the children were in a formal, non-relative placement at the time family-based services were terminated (family foster care, group home, institution) or if placement was planned or imminent; 4) and **"RAW"** if the child involved had run away and remained out-of-home at the time family-based services were terminated.

   If your program does not distinguish between reunification and placement prevention cases, please regard as a reunification case any case in which a child was out-of-home at the time of referral to family-based services and:

1) the child had been out-of-home for more than 30 days, or 2) the child stayed out of the home for more than 30 days after the referral was made. Thus, a temporary placement for sampling purposes is defined as a placement of less than 30 days before or after referral, a revision of our earlier instruction.

If you have problems with any part of this request, please call me or Miriam Landsman at the Resource Center.

3. Case Readers. We will be calling all of the sites except those in Iowa and Oregon in late August about hiring and training case readers. We will appreciate your assistance in suggesting resources (schools of social work, other units in your agency, etc.) that we can contact to identify readers. Resource Center staff will be training case readers on-site in September. We'll be requesting some dates from you, a room adequate to the task, and your participation or at least two people at your agency who will be supervising the case readers while on-site (a primary and back-up supervisor).

Thanks very much for your help in getting the third stage of this project underway.

Sincerely,

Kristine Nelson

Kristine Nelson
Principal Investigator

KN/mc
enclosures

PROTECTION OF HUMAN SUBJECTS

I. Client Families

A. Since research using case records does not involve contacting clients directly, consent to participate is not given by subjects.

B. Instead, the agency director has granted access to case records under conditions and rules relating to confidentiality in the state and agency.

C. There is a risk of accidental disclosure of information that would embarrass or disadvantage families.

D. Several measures protect against such disclosure.

1. No client names or case numbers appear on data collection instruments.

2. For security, instruments and records should not be taken out of the designated coding areas and should be kept locked up when not in use.

3. Coders should respect the confidentiality of information in the case records.

a. Don't code the case if you know someone in the family.

b. Don't discuss cases with anyone not involved in the research project or the agency.

II. Agencies

A. The agency is entitled to the same privileges of confidentiality as client families.

1. Don't discuss information that may be damaging or put agency in a poor light in the community.

2. The agency can withdraw consent to use case records at any time and terminate the research project.

B. It is the agency's responsibility to protect clients and the agency.

C. It is the case reader's responsibility to protect the confidentiality of the information obtained and to maintain the integrity of the research process so that researchers will continue to have access to agency data.

III. Sanctions

A. Each case reader will sign an Affirmation of Confidentiality agreeing to abide by agency rules and state laws concerning confidentiality of case record information.

B. If confidentiality is violated by a case reader, he or she will be terminated from the research project and may be prosecuted under the applicable laws.

The University of Iowa

Iowa City, Iowa 52242

National Resource Center on Family Based Services
School of Social Work
Oakdale Campus, N118-OH
Oakdale, Iowa 52319

(319) 353-5076

1847

Affirmation of Confidentiality

I, the undersigned, employed as a case reader on the study entitled "An Analysis of the Factors Contributing to the Failure of Family-Based Child Welfare Services in 12 Family-Based Service Agencies," affirm that I will abide by all rules and laws concerning confidentiality applicable to the agency providing cases, that I will not participate in recording information on any case in which any family members are known to me, and that under no circumstances will I discuss information from the case records with any individual not directly connected with the agency or the research project. I understand that any violation of the above conditions will result in the immediate termination of my employment.

Signed: _____

Date: _____

Witnessed: _____

The University of Iowa

Iowa City, Iowa 52242

National Resource Center on Family Based Services
School of Social Work
Oakdale Campus, N240 OH
Oakdale, Iowa 52319

(319) 353-5076

CASE READER AGREEMENT

1. The agency to which the case reader is assigned will be responsible for submitting an invoice to the National Resource Center on Family Based Services, School of Social Work, The University of Iowa, following the satisfactory completion of the case review instruments.

2. The agency will pay the case reader $20.00 per satisfactorily completed case review instrument and $2.50 per satisfactorily completed form for cases rejected from the sample (short case review instrument).

3. The agency will reimburse case reader for mileage to and from their home, school or place of business and the agency, when in performance of their case reading tasks. Mileage will be reimbursed at $.21 per mile.

4. All cases must be read and the instruments completed by December 15, 1986.

5. The case reader will not be paid for case review instruments which, in the view of the agency liaison and on-site trainer, are not satisfactorily completed. This includes partially completed instruments and haphazardly completed instruments.

6. Cases will be monitored, randomly, by the agency project liaison.

7. The case reader will abide by the conditions set forth in the Affirmation of Confidentiality.

8. The case reader may be terminated from the project at any time for failing to complete case reading in accordance with the schedule agreed upon with the agency liaison, for incomplete or inaccurate coding, or for violations of confidentiality.

_____

Case Reader Date

_____

Project Liaison Date

NATIONAL RESOURCE CENTER ON FAMILY BASED SERVICES
OUTCOMES RESEARCH PROJECT:

CASE READER INFORMATION SHEET

Name: _____

Please circle or fill in the most appropriate response. Circle only one number unless otherwise indicated.

1. Age: _____ years

2. Sex:
   1. male
   2. female

3. Race/ethnicity
   1. Native American
   2. Black
   3. White
   4. Asian or Pacific Islander
   5. Indochinese
   6. Hispanic
   7. Other (Please specify: _____)

4. Marital status:
   1. married
   2. separated/divorced
   3. widowed
   4. never married

5. List the ages of your children: _____

6. How many years of formal education have you completed? (elementary through graduate school) _____ years

7. What educational levels have you completed? (Circle and complete all that apply.)
   1. no education past high school
   2. community college or some college education (subject: _____)
   3. bachelor's degree (subject: _____)
   4. some graduate work (subject: _____)
   5. master's degree (subject: _____)
   6. some post-master's work (subject: _____)
   7. doctoral degree (subject: _____)
   8. some post-doctoral work (subject: _____)

8. Do you have any professional certification? (Circle all that apply.)

1. AAMFT
2. ACSW
3. state social work or counseling license
4. other (please specify: _____)
5. none

9. How long has it been since you completed your last degree? _____ years

In completing questions 10 and 11, please enter 0 if you have less than 6 months experience, 1 if you have 6 months to 1 year of experience, and the nearest whole number for over 1 year of experience. ("a"-"d" may add up to more than "e" if your job covered more than one category, or "e" may be greater if you had related experience not covered in "a"-"d".)

10. How many years of <u>paid</u> experience do you have in the following?

a. child welfare services _____ years
b. other public social services _____ years
c. individual counseling or therapy _____ years
d. family counseling or therapy _____ years
e. total <u>paid</u> professional experience _____ years

11. How many years of <u>volunteer</u> experience do you have in the following?

a. child welfare services _____ years
b. other public social services _____ years
c. individual counseling or therapy _____ years
d. family counseling or therapy _____ years
e. total <u>volunteer</u> experience _____ years

Case Reader Information

SITE	CASE READER	AGE	SEX	RACE	MARITAL STATUS	CHILDREN	AGES OF CHILDREN	#YEARS OF FORMAL EDUCATION	EDUCATIONAL STATUS	PRIMARY FIELD OF STUDY*	PROF. CERTIFICATION	YRS SINCE COMPLETION OF LAST DEGREE	#YEARS PAID EXPERIENCE*	#YRS VOLU... TEER ...
1,2	01	26	F	White	married	0	0	18	MA	3	-	1 1/2	1	2
1,2	02	32	F	White	married	1	2	18	MSW	1	-	4	7	2
1,2	03	45	F	White	divorced	4	14, 16 20, 21	16 1/2	BSW**	1	-	1/2	0	0
1,2	04	25	M	Asian	never married	0	0	16	BSW**	1	-	1/4	0	1
1,2	05	26	M	White	married	0	0	16	BA**	3	-	4	2	0
1,2	06	26	F	White	never married	0	0	16	BA**	3	-	1/2	2	0
3	07	31	F	White	divorced	0	0	17	BA**	3	-	5	4	5
4	08	33	F	White	married	0	0	16	BSW**	1	-	11	6	0
4	09	33	F	White	married	2	1, 5	16	BS	9	A	12	0	0
5	10	23	F	Black	never married	0	0	17	BSW***	1	-	-	2	0
5	11	22	F	White	never married	0	0	16	BSW***	1	-	-	0	1
5	12	34	M	White	never married	0	0	18		9	-	11	0	6
6	13	24	F	White	never married	0	0	16	BA**	1	-	2	2	0
6	14	39	M	White	married	0	0	18	MA	7	-	16	16	3
6	15	36	F	White	never married	0	0	19	MSW	1	B	12	12	1
6	16	28	M	White	married	0	0	17	BSW**	1	-	3	2	2
8	17	30	M	White	never married	0	0	22	PhD****	8	-	2	8	2
10	18	42	M	White	never married	0	0	18	MSW	1	-	1/3	21/2	1 1/2
12	19	30	F	White	married	2	8, 10	18	MSW	1	-	1/2	1	3
11	20	33	F	White	divorced	0	0	18	MSW	1	C	6	10	8
1	21	37	M	White	married	1	12	16	BA	3	-	14	15	0
7	22	44	F	White	married	3	20, 20, 23	16	BSW	1	-	0	0	1
7	23	29	F	White	never married	0	0	19	JD	9	-	3 1/2	0	1
7	24	27	F	White	married	2	3 1/2,7	15 1/2	BSW	1	-	0	0	7
7	25	34	M	White	married	3	5, 8, 11	18	MSW	1	D	10	10	3

* primary field of study=current field of study, if not the same as that of previous degrees.

* #years paid experience=the total #years of paid experience in: child welfare services, other public social experiences, individual counseling or therapy, family counseling or therapy.

* #years volunteer experiencse=the total #years of volunteer experience in the above categories.

** Denotes people who are currently working on advanced degrees in social work.

*** Denotes people who are currently working on bachelor's degrees in social work.

**** Denotes people working on doctoral degree.

A. RN

B. State social work or counseling license

C. ACSW

D. Certification to provide marital and family counseling.

INSTRUCTIONS FOR CASES REJECTED FROM SAMPLE

1. Record reason rejected on log, reasons may include:

   a. Assessment case mistakenly included in sample - no treatment involved. E.g., case referred for assessment only; case assessed as not suitable for family-based services and closed or transferred; sessions not continued past assessment period for other reasons.

   b. Reunification case mistakenly included in sample - only child at risk out of home at time of referral for more than 30 days or child remained out of home for more than 30 days after the referral was made. Do not count relative placements.

   c. Case not opened during study period.

   d. Case record missing or otherwise not available during coding period. State why.

   e. Case record too incomplete to code - state what is missing.

   f. Social worker questionnaire not completed by any of the workers involved in the case.

   g. Case still open; has been ongoing since it was opened during the study period.

2. Code short instrument for cases rejected for reasons e, f and g above.

   Code as much information as is readily available on face sheets, referral forms, etc and in a quick scan of record, e.g. for dates and change in residence. Try at least to get starred information.

3. Replace case with a new one from list of replacement cases after all cases in original sample have been coded.

Log of Sample Cases

Agency: ____________________

Project case	Agency case number	Name of Community	Date out	Date in	Case reader	Coding Complete	Rejected	Reason for rejection

Log of Sample Cases

Agency: ____________________

Project case	Agency case number	Name of Community	Date out	Date in	Case reader	Coding Complete	Rejected	Reason for rejection

APPENDIX 4: RELIABILITY ANALYSIS

RELIABILITY ANALYSIS

Two types of reliability were calculated in this study, the inter-rater reliability of key variables and the inter-item reliability (Cronbach's Alpha) of additive scales.

Inter-rater reliability was calculated from a sample of twenty cases, two cases in each of ten sites, which were coded by a second coder. A second coder was not available at the Adolescent Day Treatment Center. The reliability cases were selected at random from cases coded later in the sample to assure that coders were thoroughly familiar with the coding system. Reliability was calculated using Pearson Product Moment Correlations and, for variables in which a zero was frequently recorded, percent agreement between coders. Means of the variables in the original and re-coded sample were also compared.

Because the coders were working from lengthy case records using a complex instrument some unreliability was expected. Table 1 gives the Pearson's r and sample means for selected variables. Of the 25 variables tested, nine were correlated at .70 or above including a number of the variables that were found to be related to placement across sites. An additional six variables were correlated at .48 or better, again including several important predictors of placement. Ten of the variables were correlated at well below .50, the level considered acceptable for studies of this type (Magura & Moses, 1986: 185). Comparing means on the least reliable variables shows little substantive difference, however, so averages may be safely compared among sites for most variables.

The percentage of agreement between coders for variables for which a zero was frequently recorded shows some of them to be more reliable than the correlation coefficient indicates, including the number of psychological services received and the number of children at high risk of placement, both important predictors of placement (Table 2). Several variables have unacceptably low reliability by either method, including the percent of goals achieved, stress, the total number of family-based

services, and the factor-based scales aggregating family change objectives, adolescent problems, educational interventions, and directive interventions.

Clearly there was disagreement about what constituted goal achievement, a stressor, a family change objective, an adolescent problem, and a family-based service (both educational and directive interventions were primarily within the family-based unit). The coding of all of these involved identifying both the occurrence of the variable in the case narrative and the number of times it occurred. Since low reliability reduces the relationships and significance of the variables affected, it can be surmised that these would have shown more consistent relationships to outcome if they had been coded reliably (Magura & Moses, 1986: 192-3). They were probably coded more reliably at the few sites in which they were significantly related to placement.

Inter-item reliability was coded for the longer additive scales from both the case review and social worker data. Of the scales measuring job satisfaction, Maslach and Jackson's Human Services Survey proved the most reliable with an alpha of .82. The reliability coefficients of the subscales adapted from Jayartne and Chess' Professional Satisfaction Inventory ranged from .61 to .91 (Table 3). Of the scales measuring treatment orientation, the Halper and Jones (1984) treatment techniques scale was most reliable at .91. The Hamilton and Montayne subscales measuring family therapy orientation ranged in reliability from .

Of the scales computed from the case review data, the Family Systems Change Scale proved most reliable at .94. Both the Child Well-Being Scales for the oldest child and the Parental Disposition subscale also had high reliability at .84 and .73 respectively. The Holmes Schedule of Recent Experience (stress scale), which also had a low inter-rater reliability, was the least reliable with an alpha of .50, however it still meets the minimum criteria for reliability (Magura & Moses, 1986: 187).

Despite the problems of using case record data and multiple coders at multiple sites, both the inter-rater and inter-item reliability of most items tested were

relatively high. Only the Holmes scale seems unsuitable for this type of methodology. Particularly encouraging is the high reliability of the Family Systems Change Scale and the Child Well-being Scales. Both can be seen as promising measures of outcome in family-based services. The Family Systems Change Scale was developed for this study and needs to be tested in direct practice. The Child Well-being Scales were designed to be completed by workers and, although they proved their applicability to case record data in this study, they could be used only to assess the family's functioning at intake because there was too little information about the family at the time the case was closed to rate the scales and compute change scores.

Table 1
Interrater Reliability of Significant Variables
N=20

Variable	Correlation	Mean A	Mean B
Age of Oldest Child	.99	13.6	12.9
Total visits in 1st month	.89	5.8	4.5
Total Number of Support Services	.82	.7	.8
Use of Service Objectives	.81	.8	1.0
Adult Change Objectives	.79	2.2	2.1
Number of Areas of Positive	.78	2.6	2.8
Lowest Child CWBS	.75	69.1	72.4
Additional Services After Closing	.74	1.7	1.7
Length of Service	.73	169	146
Total Number of Objectives	.61	6.3	6.1
Number of Areas of Negative Services	.59	.9	.8
Long Range Plan	.55	.15	.05
Primary Caretaker CWBS	.51	62.0	63.9
Total Number of Problems	.49	7.4	6.7
Total Number of Psychological Services	.48	.4	.3
Percent of Goals Achieved	.44	38.0	25.0
Stress	.40	96.9	80.9
Number of Children at High Risk	.37	.6	.9
Counseling Services from Outside Agency	.34	1.4	1.3
Total Number of Family Based Services	.32	5.7	5.4
Family Change Objectives	.31	1.7	1.1
Adolescent Problems	.29	1.1	.6
Use of Counseling Objectives	.21	.2	.8
Educational Interventions	-.06	.8	1.1
Directive Interventions	-.14	2.6	1.9

Table 2
Percent Agreement Between Raters on Variables with a High Percent of O's
N=20

Variable	Percent Agreement
Long Range Plan	90
Number of Psychological Services	80
Number of Children at High Risk	75
Number of Areas of Negative Change	70
Use of Counseling Objectives	55
Counseling from Outside Agency	55
Adolescent Problems	40
Educational Interventions	40

SCALE RELIABILITIES

Scale	Cronbach's Alpha
Human Services Survey	.82
Professional Satisfaction Inventory Subscales	
Ambiguity of Expectations	.91
Workload	.84
Role Conflict	.79
Professional Autonomy	.76
Comfort with Work Conditions	.73
Financial Reward and Job Security	.70
Challenge	.68
Relations with Co-workers	.65
Opportunities for Promotion	.61
Treatment Techniques Scale	.91
Family Therapy Orientation Scales	
Psychodynamic	.72
Communications	.61
Behavioral	.59
Structural	.57
Strategic	.50
Family Systems Change Scale	.94
Child Well-Being Scales	
Oldest Child	.84
Parental Disposition	.73
Schedule of Recent Experience	.50