California Social Work Education Center

C A L S W E C

CHOICES:

A Child Welfare Curriculum Module on Voluntary Services and Court-Mandated Services

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2000

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CalSWEC PREFACE

The California Social Work Education Center (CalSWEC) is the nation's largest state coalition of social work educators and practitioners. It is a consortium of the state's 16 accredited schools of social work, the 58 county departments of social services and mental health, the California Department of Social Services, and the California Chapter of the National Association of Social Workers.

The primary purpose of CalSWEC is an educational one. Our central task is to provide specialized education and training for social workers who practice in the field of public child welfare. Our stated mission, in part, is "to facilitate the integration of education and practice." But this is not our ultimate goal. Our ultimate goal is to improve the lives of children and families who are the users and the purpose of the child welfare system. By educating others and ourselves, we intend a positive result for children: safety, a permanent home, and the opportunity to fulfill their developmental promise.

To achieve this challenging goal, the education and practice-related activities of CalSWEC are varied: recruitment of a diverse group of social workers, defining a continuum of education and training, engaging in research and evaluation of best practices, advocating for responsive social policy, and exploring other avenues to accomplish the CalSWEC mission. Education is a process, and necessarily an ongoing one involving interaction with a changing world. One who hopes to practice successfully in any field does not become "educated" and then cease to observe and learn.

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To foster continuing learning and evidence-based practice within the child welfare field, CalSWEC funds a series of curriculum sections that employ varied research methods to advance the knowledge of best practices in child welfare. These sections, on varied child welfare topics, are intended to enhance curriculum for Title IV-E graduate social work education programs and for continuing education of child welfare agency staff. To increase distribution and learning throughout the state, curriculum sections are made available through the CalSWEC Child Welfare Resource Library to all participating school and collaborating agencies.

The section that follows has been commissioned with your learning in mind. We at CalSWEC hope it serves you well.

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SUMMARY

The general objective of this research was to compare the relative effectiveness of court-mandated services versus voluntary service plans in preventing child maltreatment recidivism. Two groups were compared (a group given a mandated plan versus a group given a voluntary plan) on dependent variables derived from public policy notions of success in child protection. Four hundred and fifty children were selected at random from the 1,898 children for whom DSS filed a petition or gave a voluntary plan for child maltreatment reasons between January 1, and June 30, 1995. All children initially received services in their homes. Eighteen cases were eliminated from the sample because a review of their case files indicated they were not study eligible.

Files of study children were reviewed to identify child, parent(s), and family characteristics; characteristics of the alleged abuse; history of prior CPS involvement; service delivery history; and outcome variables.

Findings

Situations that would suggest heightened risk warranted a court-mandated plan. Children in families who had received court plans exhibited more problem characteristics than children in families who received voluntary plans. Significantly higher rates of severe behavior problems, mental illness, learning disabilities, developmental delay, runaway behavior, juvenile delinquency, and substance abuse were noted with this group. These problems may make it appear that parents need more intrusive and coercive supervision to deal with these problems. Parents and other significant adults of the children in the court-

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mandated group also had significantly more problems than the other parents. They were more likely to be perpetrators, have substance abuse problems, criminal histories, and mental illnesses. These parents may need the added stimulus of court intervention in order to bring about change in the family.

Hispanic families were more likely to receive voluntary plans. White families were more likely to have received court-mandated plans. Parents in families that received voluntary plans were more likely to be married to one another, which might suggest stability to social workers. Younger children in voluntary plan families were more likely to be enrolled in preschool or kindergarten than children in the court intervention families. Such findings may suggest that children are getting supervision outside the family. Siblings were also more likely to be in the home of voluntary plans. It is possible that siblings of children in court-mandated families are in placement in out-of-home settings already, which is another sign of risk.

Court-mandated families were more likely than families receiving voluntary plans to have been homeless and to have had the death of a child at some point. They were also more likely to have lived in unsafe housing. Such factors suggest court-mandated families are at greater risk than families receiving voluntary plans.

Children from families who have had a previous history of involvement with DSS received court plans. It is possible that they had received a voluntary plan in a previous contact with DSS and it was determined, as a result of the new referral, that more intensive and coercive supervision was needed. In cases where failure to protect was an issue and the mother was the perpetrator, families were more likely to receive court-ordered plans.

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Failure to protect results in situations where the caretaker is unable or unwilling to protect a child from an abusive situation. Added court intervention may be seen as needed to afford that protection. Finally, as expected, the higher the assessed risk by the social worker, the more likely the case will involve court intervention.

On average, court-mandated cases were open 16 months; voluntary cases 6 months. Court-mandated cases received more clinical, substance abuse, and residential services. These findings are consistent with greater risk found in court-mandated cases. The longer length of time a case was open, and the greater number of services supplied to this group relative to voluntary plan cases, is a reflection of the need to address risk. Court-mandated families were more likely to utilize the services they were provided than those with voluntary plans, which provides some evidence of the utility of court mandates. However, no differences were found between study groups on the completion of case plan conditions. Generally, court-mandated cases had more contacts with social workers. Social workers had more contact with collateral agencies and workers in court-mandated cases, and they had more contact with the friends and neighbors of those with voluntary plan cases.

The major finding of this research is that type of plan did not make a difference on case outcome. Children were more likely to remain in the home at the end of the service delivery period in families that received voluntary plans. However, when other factors are controlled, the advantage of a voluntary plan disappears. Moreover, similar rates of recidivism were noted between both types of plans after the case was closed. The mothers' characteristics and levels of functioning were strongly associated with case outcomes.

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Fathers' characteristics were not. Study children were more likely to live with their mothers than with their fathers, which made the mothers' functioning more important to the child. Only 36% of study children lived with their biological fathers, and 83% lived with their biological mothers. However, if the father is the perpetrator of abuse, a case is more likely to fail. Children who lived with their biological mothers fared better than children who did not. Fathers were also important in avoiding new referrals when they are married to the biological mother of the child. Marriage may be taken by social workers as an indicator of stability. Drug and alcohol abuse on the part of the mother seemed to be the most important problem characteristic associated with case failure. Over one half of the mothers in the sample had a drug problem at some point in their lives. Recycling these families in and out of the system will not end until effective means of addressing alcohol and drug problems is available for this population. Receiving public assistance such as AFDC, General Relief, SSI, social security, or unemployment insurance was associated with avoiding recidivism. These forms of public aid have at least guaranteed a minimum level of resources. Most of the study children lived in families that experienced high levels of deprivation. These findings have implications for welfare reform. The loss of benefits could result in more referrals and more children in out-of-home care.

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PROJECT STAFF

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We gratefully acknowledge the assistance given to us by Lynn Amabile, MSW, in helping the abstractors obtain cases.

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CHAPTER I

SPECIFIC AIMS OF THE STUDY

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CHAPTER I
SPECIFIC AIMS OF THE STUDY

The general objective of this research was to compare the relative effectiveness of court-mandated versus voluntary service plans in preventing recidivism in child maltreatment cases. Two groups were compared (a group given a mandated plan versus a group given a voluntary plan), on dependent variables derived from public policy notions of success in child protection. The research addressed the following specific aims:

- Identify the type of cases given either a voluntary or a court-mandated plan.
- Types of plans and case outcomes were used to describe different categories of case outcome at case closure.

The interest was to identify if the case penetrated the system any further, measured by children entering out-of-home care. Public policy would regard cases that entered foster care as failures. Figure 1 describes study groups and outcome variables.

Figure 1
Outcomes During Service Delivery

Dependent variable	Court-mandated	Voluntary
Successful	Child still with caretaker or relative	Child still with caretaker or relative
Unsuccessful	Child in-out-of-home care	Child in-out-of-home care

- Cases were also examined 6 months after case closure. The purpose of this analysis was to determine if there was a rereferral for abuse and/or system reentry as an additional measure of determining success or failure. See Figure 2 below.

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Figure 2 Outcomes 6 Months After Case Closure		
Dependent variable	**Court-mandated**	**Voluntary**
Successful	No referral or reentry	No referral or reentry
Partially successful	Referral to CPS but no reentry	Referral to CPS but no reentry
Unsuccessful	Reentry into CPS	Reentry into CPS

- Cases were differentiated by each outcome by: child, family, and service characteristics. This included identifying the level of compliance by the natural parent(s) with the service plan and identification of the type of services provided.

- Case characteristics of voluntary plan cases on system entry; including identifying reason for entry, family background, and level of risk

- Factors that determined success or failure of a plan were identified.

- The empirically-based findings of this research are discussed for the purpose of suggesting guidelines for practice and future research.

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CHAPTER II

BACKGROUND AND SIGNIFICANCE

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CHAPTER II
BACKGROUND AND SIGNIFICANCE

Society has given Child Protective Services (CPS) an enormous obligation to protect children and preserve families. This challenging task is carried out in the context of increasing reports of child maltreatment at a time when CPS has fewer resources to protect those children in need. Child welfare agency decisions to intervene with families have enormous implications for a democratic society. Errors by child welfare workers can threaten the integrity and privacy of families. Practice theory, social policies, and agency procedures have not yielded a consensus on the criteria to make decisions about intervention with families (Gleeson, 1987; Knitzer, Allen, & McGowan, 1978). The lack of clear guidelines has resulted in the failure to protect children and families.

In the late 1950s, the suggestion first emerged that research in child welfare ought to give great attention to decision-making processes. The purpose for doing so is that guidelines for decision making can be developed (Wolins, 1959). Fanshel (1962) suggested that research efforts should focus on the decision-making choice points found in child welfare.

This research focused on the decision to give a child's caretaker a court-mandated or a voluntary service plan. CPS workers must decide after substantiating a child abuse complaint, whether to request the court to mandate services with the caretaker, or to develop a voluntary plan. Court-ordered services are assumed to provide an element of social control that protects the child, and provides a stimulus that enhances the likelihood

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that families will get needed services. Proponents of voluntary plans assert that court intervention introduces an adversarial element into the worker-client relationship that works against the therapeutic change process (Wilk & McCarthy, 1986). However, one study that examined the difference between court intervention versus voluntary treatment for abusive and neglectful parents aimed at increasing parenting skills, found that court involvement did not necessarily make someone less amenable to treatment (Iruesta-Montes & Montes, 1988). This study found that court-ordered groups made comparable gains in parenting skills compared to persons receiving voluntarily services. They argue that compliance can be gained from court-ordered mandates in which the court spells out the nature of treatment, by whom, frequency, what behavioral changes are demanded, and expected length of intervention.

Court intervention may limit the number of families who voluntarily seek services because they see the court as punitive, and may fear legal consequences. DePanfilis (1982) claims that despite mandatory reporting laws, private agencies are equally concerned about referring their voluntary cases to a sometimes impersonal system of reporting and investigation. A voluntary option is assumed to increase the number of families receiving services, perhaps at earlier stages of risk, thus preventing the need for more expensive “after the fact” services. DePanfilis reports data from a small quasi-experimental study, which suggested that voluntary cases had lower placements rates, shorter stays in placement, and briefer periods of treatment. She suggests the two most important factors are the decision as to what type of plan is administered and the client’s motivation and self-awareness about the problem.

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Voluntary programs are attractive because they support the family structure, limit state intervention in private family matters, and meet the requirements of P.L.96-272. Some support these programs as cost-saving alternatives to out-of-home care. Others remain skeptical on how effectively in-home services prevent child maltreatment (Schuerman, 1991). Wells and Biegel (1992) assert that the empirical evidence is mixed on the effectiveness of family preservation services that are delivered in-home.

An additional concern of court intervention is the cost involved. In San Diego County, more money is spent in the dependency system on legal services than is spent on treatment services (Davis, English, & Landsverk, 1993). Presumably, if voluntary plans were just as effective in reducing child maltreatment they would be the cost efficient choice between the two options. On the other hand, voluntary plans may place children at more risk due to lowered ability by the worker to see that a caretaker utilizes services. Voluntary plans may be more costly because if they do not work, CPS workers must still file for court intervention.

Surprisingly, there is a paucity of direct empirical data utilizing child protective samples to help identify which choice would be the best for social workers to make. Wolfe, Aragona, Kaufman, and Sandler's (1980) report is one of the few published empirical studies on the role of the courts in child protective services. The report states that a court order was more likely than a voluntary plan to spur completion of a parenting skills program. However, they do not comment on whether treatment was effective. Other research is available from related fields of service, which examined whether voluntary or court-ordered treatment is effective. The following are studies from domestic violence,

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substance abuse, and mental health. All of these are settings in which CPS clients are likely to be found, so they do have some relevance.

Rosenfeld (1992) reviewed 25 studies that collectively cast doubt on the assumption that mandatory psychotherapeutic treatments are effective in reducing incidents of violence between spouses. In many of the studies he reviewed, the choice was between court-ordered therapy or arrest. Rosenfeld asserts the differences in the reoccurrence of intimate partner violence between subjects receiving court-ordered treatments, those arrested, and those persons who do not receive any treatment. He also reports that many subjects withdraw from court-ordered treatments, indicating that legal system involvement does not motivate unwilling clients. On the other hand, Dutton (1986) used a quasi-experimental design to examine post-conviction rates of 50 men who completed court-ordered treatment plans against those who received nothing at all. He found the treatment group had a 32% lower recidivism rate during a 3-year follow-up period. Dutton concludes that court orders improve the protection of women who opt to remain in a relationship with a husband who would not seek treatment voluntarily.

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

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Wells-Parker (1994) used meta-analysis to review literature on drinking and driving programs and asserts that rehabilitation is more effective than coercive interventions like license revocation. She argues for a combination of strategies such as sanctions combined with therapy, education, and monitoring. Schottenfeld (1989), in another review of the literature, found involuntary treatment for substance abuse to be an impediment to treatment. Those treated involuntarily tended to deny problems related to substance abuse. Voluntary clients were more likely to admit to problems of addiction and withdrawal. However, Schottenfeld did note that it is possible to be court-ordered to treatment but voluntarily accept services. Lipsky (1980) suggests court-mandated clients can be engaged by attaching client-centered goals to the court-mandated goals. Mandated goals consist of things like drug/alcohol abstinence, gainful employment, and avoidance of criminal activities. Client-centered goals include financial or economic betterment, improved housing, assistance in taking care of dependents, and relief from emotional distress.

Cournos, McKinnon, and Stanley (1991) compared the records of 51 involuntarily and 51 voluntarily medicated patients in a psychiatric hospital. They found that forced medication did not return a patient to the community more quickly, or get the patient to eventually comply with medication. No differences were found between groups in discharge rates, compliance with staff, or relapse. However, initial improvements in the patients' mental health were noted.

All of these studies suggest factors that are important in considering what type of plan to utilize, such as: (a) client's motivation to engage in treatment, (b) client's willingness to acknowledge a problem, and the idea that (c) court orders are useful to engage clients

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and protect victims; but unless client's motivation to engage in treatment develops during the early stages of treatment, clients are likely to withdraw from treatment.

The initial investigation and subsequent treatment in child maltreatment cases involves local law enforcement officers and social workers representing child protection agencies. These professionals are responsible for the initial decision-making stages, and the disposition of cases. One decision the worker makes is whether to leave the child in his or her home or remove him or her to out-of-home placement. Among children who have substantiated cases, but have been left in their homes, the social worker must decide whether to seek court intervention or develop a voluntary plan for services with the caretaker.

Studies suggest that there is a divergence of opinions on how one ought to act. Wilk and McCarthy (1986) and Craft and Clarkson (1985) find that the professional orientation of the decision maker is a key factor in the type of recommendation made. Researchers find police officers are in favor of court mandates. They speculate that police officers view perpetrators as criminals in need of punitive treatment rather than social services. Fridell (1991) suggests police are suspicious of any diversion schemes such as voluntary plans, and would like to use the courts because they believe that would increase compliance with treatment. Fridell unexpectedly found that mental health professionals providing services to families favored court intervention, possibly because they see the advantage that a court order provides in assuring attendance at counseling sessions. Craft and Clarkson found lawyers were more likely to urge court intervention than child welfare workers. Lawyers are comfortable with the adversarial nature of the courtroom, and they see the courts as the

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best guarantor of the rights of all the parties involved. All of the above researchers found social workers to favor voluntary plans. Finkelhor (1979) suggests social workers favor such plans because the treatment orientation of child welfare contains a belief in rehabilitation. Social work practitioners have educations, which stress the limits of coercion in bringing about therapeutic change. Social workers would prefer less adversarial approaches than the court provides. Social workers come from an atmosphere where there is a reliance on trust and cooperation. Social workers find the adversarial process of the courts to be foreign, uncomfortable, and in some instances unproductive (Duquette, 1980).

Finkelhor (1979) notes that this paradigm may not protect children from sexual abuse. He recognizes that there is an alternative view of treating sexual abuse as a criminal act, and like any other assault, uses the full weight of the justice system to punish the act rather than try to rehabilitate. Also as a society, we have been willing to be intrusive and coercive, perhaps risking the unwarranted invasion of family privacy to protect children. The point of these various studies is that comparative data on treatment effectiveness, that would aid social workers in making decisions in how they should proceed, does not exist.

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CHAPTER III

THE STUDY CONTEXT

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CHAPTER III
THE STUDY CONTEXT

Child abuse investigations in San Diego County are made by the Children's Service Bureau (CSB) of the Health and Human Services Agency. During fiscal year 1995-1996, a monthly average of 6,935 children was referred to the CSB for investigation. Of those reports, 3,900 were deemed high enough risk to warrant investigations. Three hundred and seventy-one cases were substantiated with a protective issue. It is also possible to have a case substantiated without a protective issue. An example of such a case would be the substantiation of a molest incident where the investigator discovered that either the perpetrator was deceased, or had no contact with the family; approximately 175 investigations fit this category. Cases could also be “unfounded.” In San Diego, this is defined by DSS when the social worker conducts a thorough investigation and finds the facts in the case to be unsubstantiated and/or not true. An example of this type of situation is when a worker finds that children do not live at the address on the referral/report.

Case Flow for Voluntary Cases

A social worker, known as the Court Intervention (CI) worker, is assigned to investigate allegations that a child has been abused or neglected. The social worker gathers information from a variety of sources to determine if the allegations are true and whether the child is at risk for further abuse and/or neglect (risk assessment). The social worker conducts a safety assessment, which makes a determination as to the immediate safety of the child. If the social worker believes that the child is at risk for further abuse or

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neglect, the case meets the requirement for court intervention, and requires services to reduce or eliminate the risk. The social worker must then determine if the child can be maintained safely in the home. The caretaker(s), who are usually the biological parent(s), sign a voluntary contract.

A voluntary contract outlines the following: (a) the current concerns regarding the child, (b) the steps that need to be taken in order to keep the child in the home, (c) the steps the families need to take in order to reduce the risk of abuse or neglect, and (d) the services that the family is to engage in, so that points a and b described above, can be accomplished.

The voluntary contract must be signed by the caretaker(s), the social worker, and the social work supervisor. The Court Intervention (CI) worker transfers the case to a Family Maintenance Voluntary (FMV) worker. The FMV worker monitors the family for compliance of the voluntary contract and is required to make face-to-face contact with the child and the caretaker a minimum of once a month. The FMV worker continually assesses the risk and safety issues regarding the child. If the social worker determines that the risk has been lowered and that the family meets the minimum standard of care, the family's case is closed. Should new allegations or new information be received by the agency regarding the child, the case is reactivated for another investigation. Generally, voluntary cases are opened for 3-6 months.

Case Flow for Court-Ordered Cases

A social worker may also determine that a child can be safely maintained in the

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home, but requires the intervention of Juvenile Court and Court orders for the caretakers(s) to increase compliance in order to reduce the risk of further abuse and neglect. The CI worker files a petition in Juvenile Court alleging the child falls under California's Welfare and Institutions Code 300 and that the child is in need of the protection of the Juvenile Court. Typically in San Diego County, each caretaker (i.e., the mother and father) and the child are assigned attorneys to represent them in Juvenile Court. There are several hearings to determine the validity of the allegations and the service plan that is needed to reduce the risk to the child. If the court finds that the child is in need of the Court's protection, due to the declaration of true findings on the allegations of abuse or neglect, in turn they make the child a dependent of the Juvenile Court. If the child is made a dependent, the service plan is presented to the Court and is signed by the caretaker(s), social worker, the social worker's supervisor, and the Juvenile Court Judge.

The Juvenile Court orders the caretaker(s) to comply with service plans that may include: (a) the concerns that have brought the child and family to the Court's attention; (b) the steps that need to be taken in order to keep the child in the home; (c) the steps the families need to take in order to reduce the risk of abuse or neglect; and (d) the services that the family is to engage in so that a, b, and c can be accomplished.

The CI worker transfers the case to a Family Maintenance Court (FMC) worker. The FMC worker monitors the family for compliance with the court-ordered service plan. The worker must make a face-to-face contact with the child and the caretaker a minimum of once a month. The FMC worker continually assesses the risk and safety issues regarding

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the child. Regular, periodic hearings are held in Juvenile Court in which the social worker presents information to the Court as to how the family is progressing on the service plan. If the social worker determines that the risk has been lowered and that the family meets the minimum standard of care, the social worker may make a recommendation to the Court that the family's case be closed. Should new allegations or new information be received by the agency regarding the child while the child is a dependent, and the social worker's assessment indicates continued or higher risk for the child, removal may be called for and another petition filed in Court. If the child is placed out of the home, a new service plan is formed to address the goal of reunification. Family maintenance cases are open for 6-12 months.

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CHAPTER IV

METHODOLOGY

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CHAPTER IV
METHODOLOGY

Overview

The study was a retrospective descriptive case record analysis. The specific aim of the analysis was to identify factors associated with giving either voluntary or court-mandated plans, and to identify predictors of success and failure under each type of plan. The potential population consisted of all 1,898 children for whom DSS filed a petition or gave a voluntary plan for child maltreatment reasons between January 1, and June 30, 1995 and who initially received services in their homes. The DSS Management Information System (MIS) was used to identify the potential sample. Four hundred and fifty children were selected at random with the additional rule that only one child per family could be included in the sample. Eighteen cases were eliminated from the sample. Twelve of these cases were excluded when a review of their case files indicated the services dates did not match the dates in the computerized MIS system, or there appeared to be no service activity during the observation period. Two cases were eliminated when the study children were found to be in placement during the observation period. Four files were never located.

Two study groups were available for comparison. The first group was a made up of children whose caretakers received voluntary service plans and the second group consisted of families who received court-mandated service plans. Study groups were compared on case outcomes. Data was collected on one child per family during the period the case was active for services. These cases are referred to by DSS as Voluntary Family

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Maintenance (VFM) and receive services for up to 6 months with an option to extend services for another 6 months. Children were followed for an additional 6 months after DSS closed their cases to determine if there was a referral or reentry.

The voluntary group consisted of 213 children and the court-mandated group consisted of 219 children. DSS case files are stored by child. Trained abstractors reviewed these files. The case files were abstracted to provide data on: (a) reasons a particular plan (voluntary versus mandated) was given; and (b) to gather data on the reasons for specific case outcomes which are described in Figures 1 and 2. Cases were differentiated by child, family, and service characteristics. The viewpoints of various professionals and caretakers on case decision making were ascertained from court documents. Reasons for case failure were identified as well as why those children received additional referrals or reentered protective services.

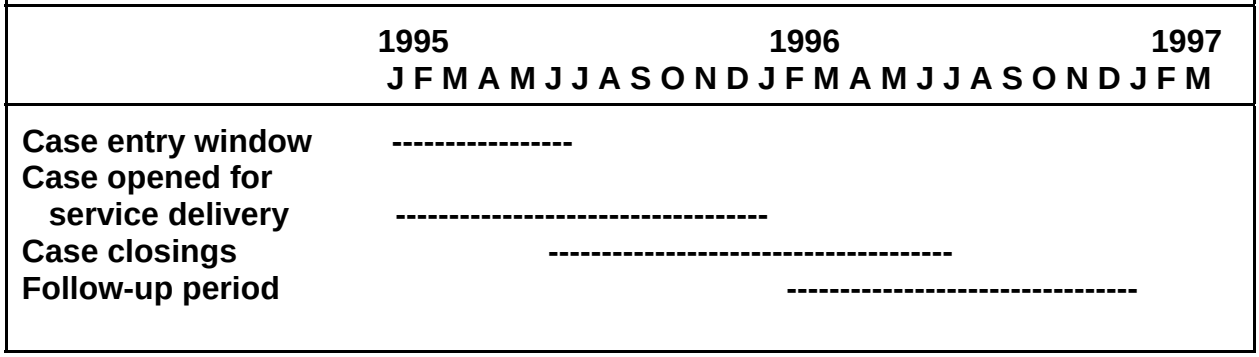
Design Subjects and Sources of Data

The design was a retrospective case review, with an embedded prospective study. This study was descriptive and contained no manipulation of variables.

- The following are the three conditions that needed to be met before a child was included in the sample:
    - Subjects must have had a case open between January 1, 1995 and June 30, 1995.
    - The family must have begun to receive services while the child was in their home.
    - The child could not have a sibling who was already included in the sample.
- The data was collected during the period of service delivery. Data was also collected on prior referral and placement history of the study child prior to service delivery. Families may have received services for 6 months with an option to extend for an

additional 6 months. Cases were followed for 6 months after case closure to gain outcome information. Study data was derived from case record review and from computerized data files at DSS. The archival data came from official documents prepared for the Dependency Court by DSS social workers, which increased confidence in the accuracy of the data. Furthermore, the quality of the data clearly was augmented by the membership of a former DSS staff person as part of the research team. Figure 3 describes the period of data collection.

Figure 3
Data Collection Timeline



- Additional file review included review of decision-making processes to learn reasons a particular plan (voluntary or mandated) was given, and to identify why a plan failed or succeeded. Court documents in a case file provided information on case assessment and planning.

- Additional data searches were completed during the follow-up period to identify if there were additional referrals or a system reentry. Data was also collected on prior referrals to the data collection windows. The research team has extensive experience using this system. Figure 4 provides a list of data collected from the DSS files.

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Figure 4
Data Collected from DSS Files:
Variable and Measure

Date of case opening Date of case closing Type of maltreatment Case plan goals Age of the child Child's gender Special needs of the child (medical, mental health, disability, injury are noted) Source of referral Reason case closed Risk assessment Direct services provided Parent cooperativeness Court actions Concordance of various professionals (legal, social work, etc.) with practice decisions. Nature of maltreatment Severity/Duration Perpetrator admission or denial Reporter Perpetrator's relationship to child Caretaker willingness to protect Non-abusing caretaker's response Worker level of education Family situational problems Homelessness Dangerous environment Domestic violence	Relationship of caretaker to the child Relationship of adult abuser to the child Language spoken in home Ethnicity of the child Reason for initial referral to DSS (type of abuse) Source of the report Reason for case closure Placement history Reentry Caretaker characteristics Marital status Employment status Drug and alcohol abuse Criminal history Other problems Religion Type of services provided Family composition Zip code Child characteristics Medical problems School problems Behavioral problems Mental health problems Child welfare outcomes Removal Reunification Termination of parental rights Social worker contacts Legal process Types of court action Who was involved

Data in these files described child and caretaker characteristics, the alleged abuse, and history of prior CPS involvement. These variables were independent variables in the study. Abstraction of a random sample of CPS case files provided data to identify what type

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of plan children received on system entry; identification of the case, child, family, and services characteristics associated with the decision to provide a specific plan to a family; and detection and evaluation of the outcome of that plan.

Files contained social studies, court reports, police reports, psychological evaluation, risk assessment, medical records, social work logs, service referrals, information about the specifics of the child maltreatment, service delivery, and information about problems impacting the family such as domestic violence.

The use of archival data always presents validity and reliability concerns. Data collection was completed by social work graduate-level research assistants. Abstractors were trained until they had basic knowledge of child protective services, the Dependency Court system, the organization of case record files, and the skills needed to apply variable definitions for the purpose of data abstraction. Abstractors demonstrated an inter-rater reliability of .94 on a common case. An experienced DSS worker who abstracted data from the common case using the study instrument set the initial "gold standard." New abstractors were not permitted to begin abstraction until they had obtained an inter-rater reliability of 90% or higher on the common case. A manual was developed to guide abstraction efforts. See Appendix A for the abstraction instrument and Appendix B for the manual. Abstractors required a mean of 1.71 hours to read and code a file, with a range of ½ to 5½ hours. Court-mandated cases took slightly more time to review (1.85 hours versus 1.58 hours).

The quality of the data was augmented by the membership of the San Diego CSB-DSS research staff person on the research team. This staff person helped in the

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clarification of discrepancies in the records, obtaining missing information, and in assisting case abstractors with questions or problems that they might have experienced.

Added confidence in the use of CPS service records as research data is found by Shireman et al. (1990) who compared the data derived from CPS case records and interviews with parents. Congruence was consistently high on concrete data such as the reason for referral. Similarly, preliminary cross-tabulation of record data on child behavioral problems and scores from some of the standardized child functioning, completed by an NIMH study on the same sample, found a high level of agreement between the two sources (Davis, English, & Landsverk, 1995).

Data Analysis

First, a general description of the whole sample was produced with a more detailed description of the study groups. The significance of differences on variables between groups were tested in bi-variate analysis of the data which was carried out in successive cross-tabulations dividing the sample into successive subgroupings as finely as seemed warranted according to differences among study groups.

Analysis then focused on testing explicit relationships. This approach incorporated two types of statistical techniques. Chi-square was used for nominal level data. Mann-Whitney U was used with ordinal level variables. T-Tests were used with interval level data. Pearson's r-tests were used to test correlations and the degree of association among variables. The outcome of this section was to categorize children, caretakers, and families by type of plan given (voluntary or court-mandated) and outcome (see Figures 1 and 2).

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Rationales for categorization were abstracted from case files and computer records. The second outcome of this section was to categorize children in the two plan types by successful, partially successful, and unsuccessful outcomes. Logistic regression analysis was used to identify study variables that predict accurate classification into plan type.

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CHAPTER V

DESCRIPTION OF THE SAMPLE

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CHAPTER V
DESCRIPTION OF THE SAMPLE

This chapter presents comparisons among the study groups in respect to characteristics of the children, caretakers, and their families; as well as the circumstances surrounding the referral to DSS. Families are distinguished by type of case plan given. This chapter addresses the following study questions:

(a) Identify the type of cases given either a voluntary or court-mandated plan.

(b) Identify case characteristics of voluntary plan cases on system entry.

Attributes of the Study Children

Tables 1, 2, and 3 describe the study children.

Table 1
Study Group Children Demographics

Variable	Total (N = 431)		Court-mandated (N = 213)		Voluntary (N = 219)		Signif. (p)
	N	%	N	%	N	%	
Child's age							
Less than a year	74	17.2	38	17.4	36	17.0	
1 to 4 years	127	29.5	62	28.3	65	30.7	
5 to 9 years	123	28.5	59	26.9	64	30.2	
10 to 14 years	79	18.3	41	19.2	37	17.5	
15+	28	6.5	18	8.2	10	4.7	.589
Child's gender							
Male	220	50.9	109	51.2	111	50.7	
Female	212	49.1	104	48.8	108	49.3	.919
Ethnicity							
White	179	41.4	80	37.6	99	45.2	
Mexican American	118	27.3	73	34.3	45	20.5	
Other Hispanic	9	2.1	5	2.3	4	1.8	
African American	95	22.0	42	19.7	53	24.3	
Native American	8	1.9	4	1.9	4	1.8	
Asian	10	2.3	4	1.9	6	2.8	
Other	12	2.8	7	3.2	5	2.3	.097

Percentages may equal more than 100% due to rounding.

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No significant differences were noted on age between study groups. The mean age of a child in the court-mandated group was 6.50; in the voluntary group it was 6.03. Slightly more males were found in the sample, but this difference was not significant. White children were more likely to have been given court-mandated plans, but only at a level approaching significance. Hispanics (Mexican American and other Hispanics) were more likely to have received voluntary plans. No statistical differences were found on the type of plan African Americans were given. Statistical tests were not completed with Asians or Native Americans because of their small numbers.

Table 2
Child Characteristics for Court-Mandated vs. Voluntary DSS Cases: Grade in School

Grade in school	Total		Court-mandated		Voluntary		Significance
	N	%	N	%	N	%	
Kindergarten/Early childhood	121	28.1	52	23.7	69	32.5	
First	23	5.3	10	4.6	13	6.1	
Second	23	5.3	12	5.5	11	5.2	
Third	15	3.5	9	4.1	6	2.8	
Fourth	25	5.8	17	7.8	8	3.8	
Fifth	18	4.2	10	4.6	8	3.8	
Sixth	19	4.4	9	4.1	10	4.7	
Seventh	14	3.3	4	1.8	10	4.7	
Eighth	9	2.1	5	2.3	4	1.9	
Ninth	11	2.6	7	3.2	4	1.9	
Tenth	7	1.6	6	2.7	1	0.5	
Eleventh	9	2.1	8	3.7	1	0.5	
Twelfth	2	0.5	2	0.9	0	0.0	
Not in school	115	26.7	62	28.3	53	25.0	
Unknown/Other	20	4.6	6	2.7	14	6.6	
TOTAL	**431**	**100.1**	**219**	**100**	**212**	**100**	**NS**

Totals may not equal 100% due to rounding.

The families in the voluntary sample appeared to be more likely to have a child in pre-school than families in the court-mandated group. It was not possible to determine

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whether they were in preschool prior to DSS involvement, or if the child was enrolled after CPS involvement. The age of the child was not significant in predicting what type of plan was given. Preschool enrollment of a child may be seen as a resource that allows a social worker to feel comfortable in offering a voluntary plan. The court-ordered group appeared to have slightly more children in the upper grades or who are not attending school.

Table 3
Special Characteristics of the Child

	Total		Court-mandated		Voluntary		Significance
Special characteristics	**N**	**%**	**N**	**%**	**N**	**%**	
School problems	68	15.8	41	18.7	27	12.7	.088
Severe behavior problems	62	14.4	41	18.7	21	9.9	.009
Mental illness	55	12.8	41	18.7	14	6.6	.0001
Learning disabled	43	12.0	28	12.8	15	7.0	.046
Medical problems	48	11.1	30	13.7	18	8.5	.083
Developmental delay	41	9.5	29	13.2	12	5.6	.007
Runaway	25	5.8	18	8.2	7	3.3	.028
Juvenile delinquency	22	5.1	17	7.8	5	2.4	.011
Substance abuse	16	3.7	13	5.9	3	1.4	.013
1 or more characteristic	227	52.5	135	61.6	92	43.2	.0001

The problem characteristics reported were assumed to represent risk factors that social workers considered in the decision to offer voluntary services, or in the decision to file for dependency. Children in families receiving court-mandated plans had significantly more (or at levels approaching significance) characteristics than voluntary plan children. School problems were the most common characteristic. Children who received court-ordered plans were more likely to have severe behavior problems, mental health difficulties,

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learning disabilities, and developmental delays than children from families receiving voluntary plans.

An example of how abstractors coded problems can be seen in the way in which medical problems were coded. Abstractors were told to use the medical problem code only if the teen had a *serious medical condition* that required time and energy on the part of the caretaker, social worker, or medical personnel. Normal childhood illnesses such as colds or sore throats were not coded as medical problems. Abstractors were looking for illnesses such as diabetes or asthma. A teen had to meet one of four conditions in order for a characteristic to be coded as present. These conditions were: (a) the teen was diagnosed by a professional as having the characteristic; (b) the teen received services for the characteristic; (c) the teen had a referral for services for the characteristic; (d) or someone in a position to know, such as a teacher or parent, made a statement to the workers that the problem was present. It is important to note that problems could exist at any time, not just during the period of service delivery. The special characteristic could have been part of the pre-DSS involvement history. A full definition of characteristics can be found in the case abstraction manual provided in Appendix B.

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Attributes of the Biological Mother

Table 4 describes the attributes of the biological mother of the child.

Table 4
Demographic Characteristics of the Biological Mother for Court-Mandated vs. Voluntary DSS Cases

Variable	Total		Court-mandated		Voluntary		Significance
	N = 432	%	N = 219	%	N = 213	%	
Age							
16-19 years	17	3.9	9	4.2	8	3.8	
20-29	156	36.6	74	34.3	82	39	
30-39	210	49.3	111	51.4	99	47.1	
40-49	41	9.6	22	10.2	19	9.0	
50+	2	.5	0	0.0	2	1.0	.510
Ethnicity							
White	210	50	118	53.9	92	43.2	
Hispanic	114	27.1	43	19.7	71	33.2	
African American	81	19.3	44	20.1	37	17.4	
Native American	4	1.0	3	1.4	1	0.5	
Asian	14	3.3	7	3.2	7	3.2	
Other	7	1.7	3	1.4	4	1.9	.120
Marital Status							
Married	139	32.6	59	27.2	80	37.7	.018
Separated**	39	9.1	18	8.3	21	9.9	
Divorced**	70	16.4	49	22.6	21	30.0	.009
Widow	10	2.3	5	2.3	5	2.4	
Single/Never married	104	24.4	53	24.4	51	24.1	
Single/uk/HX *	41	9.6	22	10.1	19	9.0	
Other	24	4.7	11	5.1	13	6.1	
Married to natural father	124	29.0	51	23.3	73	34.3	.019
Mother deceased	5	1.2	2	.9	3	1.4	

Responses may not equal 100% due to rounding
N may fluctuate in all tables due to missing data
* Single, marital history unknown
** Separated and divorced collapsed and tested with Chi-square together

No significant differences were noted between groups on age. About half of the mothers were between the ages of 30 and 39. The average age of the mothers was 31.32.

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No significant difference was found between groups. The same patterns that were found with children on ethnicity and group membership holds true for the mothers. Mothers in the voluntary group were more likely to have been married at some point, married to the child's father, and divorced; more so than mothers in the court-mandated group. Workers may view marriage as a protective factor that reduces risks in families.

Table 5
Special Characteristics of the Mother

Characteristic	Total		Court-mandated		Voluntary		Significance
	N	%	N	%	N	%	
Perpetrator	288	66.2	162	74.3	126	59.2	.001
Drug abuse	227	52.7	139	63.8	88	41.3	.0001
Domestic violence	185	42.9	90	41.5	95	44.6	.513
Alcohol abuse	172	39.9	110	50.5	62	29.1	.0001
Criminal hx	120	27.8	78	35.8	42	19.7	.0001
Abuse hx as child	105	24.4	60	27.5	45	21.1	.122
Mental illness	71	16.5	50	23.0	21	9.9	.0001
Medical problems	61	14.2	34	15.6	27	12.7	.395
Incarceration	60	13.9	42	19.3	18	8.5	.001
Non-English speaking	48	11.1	17	7.8	31	14.6	.025
Undocumented alien	16	3.7	8	3.7	8	3.8	.962
Cult/fanaticism	6	1.4	2	0.9	4	1.9	-----
Developmental delay	5	1.2	3	1.4	2	.9	**-----**

Mothers who received a court-mandated plan had significantly more problem characteristics than voluntary plan mothers. They also had a mean of 2.29 problem characteristics, while voluntary plan mothers had a mean of 2.91 problems. The mothers in the court-ordered group were significantly more likely to be a perpetrator of the abuse, have substance abuse problems, charged criminal histories including incarceration, and were less likely to be English speaking. The large numbers of problems noted in the court-

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ordered group might have been the reason they were seen as needing more intrusive and coercive interventions.

Table 6
Income Sources of the Biological Mother

Income source	Total		Court-mandated (N = 219)		Voluntary (N = 210)		Significance
	N	%	N	%	N	%	
AFDC/GR	213	51.6	102	46.6	111	52.9	.104
SSI/SSA/UI	30	5.8	19	8.7	11	5.2	.073
Employed	114	26.4	58	26.5	56	26.7	.987
Other	54	12.5	27	12.3	27	12.9	.987
Unknown	16	3.7	13	5.9	5	2.4	

The mothers in the sample are more likely to rely on public assistance than employment. The voluntary group is slightly more likely, but only at a level approaching significance, to rely on public assistance. Slightly more families in the court-mandated plan group received social security, Supplementary Security Income, or unemployment insurance, but the difference is only approaching significance.

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Attributes of the Biological Father:

The next series of tables refer to the biological father.

Table 7
Demographic Characteristics of the Biological Father for Court-Mandated vs. Voluntary DSS Cases

Variable	Total (N = 330)		Court-mandated (N=178)		Voluntary (N=152)		Significance
	N	%	N	%	N	%	
Age							
16-19 years	3	.9	3	1.7	0	0.0	
20-29	116	35.2	58	32.6	74	38.2	
30-39	148	44.9	84	47.2	111	42.1	
40-49	53	16.1	28	15.7	22	16.4	
50+	10	3.0	5	2.8	0	3.3	.427
Ethnicity							
White	174	52.7	95	43.6	79	40.5	
Hispanic	114	34.5	48	22.0	66	31.0	
African American	91	27.6	51	23.4	40	18.9	
Native American	6	1.8	4	1.8	2	0.9	
Asian	8	2.4	4	1.9	4	1.9	
Other	37	11.2	16	7.4	21	9.9	.162
Marital Status							
Married	117	32.6	58	26.7	59	27.8	.798
Separated	29	9.1	11	5.1	18	18.5	
Divorced	59	16.4	35	16.1	24	11.3	.722
Widow	1	2.3	1	0.5	0	0.0	
Single/never married	40	24.4	23	10.6	17	8.0	
Single/uk/HX *	59	9.6	33	15.2	26	12.3	
Other/uk	124	4.7	56	25.8	68	32.1	.420
Married to the natural mother	123	29.0	50	22.9	73	34.3	.002
Father deceased	16	1.2	6	.8	10	4.7	.286
Father unknown	42	12.7	19	8.7	23	10.8	.466

Percentages may not equal 100% due to rounding
Ns may fluctuate due to missing data
* Single, marital history unknown

Less data was available on fathers than mothers. About 25% of the children did not have any data recorded on their fathers. As expected, fathers were somewhat older than

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mothers. They were on average 32.79 years old. No differences were found on age or ethnicity between groups. Fathers in the voluntary group were more likely to be married to the study child's mother than fathers in the court-mandated group. Marriage may be seen as an indicator of stability for the worker.

Table 8
Special Characteristics of the Father

Characteristic	Total (N = 330)		Court-mandated (N = 178)		Voluntary (N = 152)		Significance
	N	%	N	%	N	%	
Drug abuse	150	45.5	91	51.1	59	38.8	.002
Domestic violence	149	45.2	76	42.7	73	48.0	.926
Alcohol abuse	146	44.2	88	49.4	58	38.2	.004
Criminal hx	143	43.3	98	55.1	45	29.6	.0001
Perpetrator	137	41.5	80	44.9	57	37.5	.029
Incarceration	86	26.6	42	23.6	18	8.5	.001
Non-English speaking	38	11.5	14	7.8	24	11.8	.074
Abuse hx as child	36	10.9	26	11.5	10	6.6	.007
Mental illness	24	7.3	19	10.6	5	1.5	.004
Medical problems	20	6.1	14	7.8	6	1.8	.077
Undocumented alien	14	4.2	6	3.4	8	2.4	.962
Cult/fanaticism	5	1.5	2	2.8	3	0.9	-----
Developmental delay	1	0.0	0	0.0	1	0.0	-----

Totals may equal more than 100% due to multiple responses.

As noted with the mothers, fathers in the court-mandated group had significantly more problem characteristics than fathers of children in the voluntary. This difference suggests significantly more risk with this group, which may account for why there was court intervention. Fathers in the court-mandated group were more likely than fathers in the voluntary group to have substance abuse problems; charged criminal histories, including

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incarcerations; be perpetrators of abuse; have abuse histories as children; have mental illnesses. High rates of domestic violence were noted in the study families, but are equally distributed between groups.

Table 9
Income Sources of the Biological Father

Income Source	Total (N = 271)		Court-mandated (N = 147)		Voluntary (N = 124)		Significance
	N	%	N	%	N	%	
AFDC/GR	26	9.6	14	9.5	12	9.7	.884
SSI/SSA	10	3.7	6	4.1	4	5.1	.763
Employed	170	62.7	82	55.8	88	71.0	.669
Other	17	6.3	13	8.9	4	12.7	.987
Economic* contributor to the child	147	34.3	71	32.6	76	36.0	.380

Payment of child support or employed and living in child's home; computed with N = 218 for the court group and N = 211 for the voluntary group.

Large amounts of data were missing on the income variable. The employed variable included fathers working full- and part-time, and those on active military duty. A father was considered an economic contributor to the child if he paid child support, or if he was employed and lived in the child's home. In only about a third of the children's households could it be established that fathers contributed financially.

Attributes of the Other Significant Adult

Abstractors were also instructed to review the case files for data on one additional adult with whom a social relationship to the child exists or existed (e.g., parent's boyfriend, stepmother, etc.). They were instructed to abstract data in the order listed: stepparent, boyfriend/girlfriend, or grandparent living in the home during the period of service delivery.

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If none of these persons existed, abstractors could collect data on an adult outside the home who appeared significant to the child. The next series of tables report on that effort. Abstractors identified 205 (46%) of these other significant adults.

Table 10
Demographic Characteristics of the Other Significant Adult
Court Mandated vs. Voluntary DSS Cases

Variable	Total		Court-mandated		Voluntary		Significance
	N	%	N	%	N	%	
Age	**(N = 83)**		**(N = 41)**		**(N = 42)**		
16-29 years	28	33.7	12	29.2	16	38.1	
30-39	33	39.8	16	39.0	17	40.5	
40-49	15	18.1	9	22.0	6	14.3	
50+	7	8.4	4	9.8	3	7.1	.848
Ethnicity	**(N = 190)**		**(N = 100)**		**(N = 105)**		
White	73	38.4	39	39	34	32.4	
Hispanic	39	20.5	12	12	27	25.8	
African American	18	9.5	18	18	15	14.3	
Other/UK	60	31.6	31	31	29	27.6	.258
Marital Status	**(N = 249)**		**(N = 122)**		**(N = 126)**		
Married and living w/spouse	64	25.7	34	27.9	30	23.8	
Other married	19	7.6	6	4.9	12	9.5	
Single/never married	11	4.4	4	3.3	7	5.6	
Single/uk/HX *	37	14.9	24	19.7	13	10.3	
Other/uk	73	29.3	31	25.4	42	33.3	.420
Married to the natural parent	45	18.1	23	18.9	22	17.5	.692
Employed	71	34.6	35	35	36	34.3	

* Single, marital history unknown
Differences from 100% due to rounding
Ns may fluctuate due to missing data

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Information on the significant other was often unavailable, as social workers do not always record data on this person. Patterns seem similar to data reported on the biological parents.

Table 11
Special Characteristics of the Other Significant Adult

Characteristic	Total		Court-mandated (N = 100)		Voluntary (N = 105)		Significance
	N	%	N	%	N	%	
Domestic violence	45	22.0	22	22.0	23	21.9	.987
Alcohol abuse	44	21.5	20	20.0	24	22.9	.618
Drug abuse	42	20.5	18	18.0	24	22.9	.389
Perpetrator	42	20.5	26	26.0	16	15.4	.056
Criminal hx	40	19.6	21	21.0	19	18.1	.600
Incarceration	20	9.8	7	7.0	13	12.4	.194
Non-English speaking	17	8.3	4	4.0	13	12.4	.030
Abuse hx as child	14	6.8	6	6.0	8	7.6	.646
Mental illness	10	7.3	9	9.0	1	1.0	.008
Medical problems	8	4.9	7	7.0	1	1.0	.025
Other	18	8.8	11	11.0	7	6.7	.495

Fewer differences were found between groups in regards to the special characteristics variables of the significant others than had been found with the parents. Nevertheless, in the court-mandated cases adults were more likely to have been a perpetrator of abuse and have physical and mental health problems, than adults in the voluntary group. Again, it is possible that these characteristics may have suggested more risk to the social worker, who as a result, then pursued a court order for the family.

Living Arrangements and Home Environment

The next series of tables refer to the child's living arrangements and home environment.

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Table 12
Who's Living in the Home

Characteristic	Total		Court-mandated (N = 219)		Voluntary (N = 213)		Significance
	N	%	N	%	N	%	
Both biological parents	120	27.8	55	25.3	65	30.8	.209
Mother	360	83.3	190	89.2	170	78.0	.002
Father	157	36.3	77	36.5	80	36.9	.936
Stepmother	12	2.8	4	1.9	8	3.7	.262
Stepfather	28	6.5	15	7.1	13	6.0	.640
Grandmother	53	12.3	27	12.8	26	12.0	.798
Grandfather	17	3.9	5	4.0	12	5.5	.094
Other relatives	40	9.3	23	6.0	17	7.9	.283
Boy/Girlfriend	43	20.1	19	9.0	24	11.1	.480
Siblings	320	74.1	146	66.7	174	81.7	.018
Other non-related children	47	10.9	25	11.4	22	10.3	.717
Other non-related adults	36	83.3	7	3.3	29	13.3	.001

The above table describes the number of individuals living in the home. Most children live in single parent families. Approximately 36% of the children live with their biological father. More children in the court-mandated group live with their biological mothers. Siblings and non-related adults are more likely to be present in the households of children receiving voluntary plans. From the data it is difficult to identify who the non-related adult is, but this person may be a paramour of the caretaking parent. This person was not coded as such because information on the relationship was not available in the file. A child in the voluntary group had a mean 2.06 siblings, and a mean of 1.79 siblings lived in the child's home. In the court-mandated group children have on average 2.16 siblings, but only

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1.48 of those siblings live in the home. A possible explanation for this difference is that the siblings not living in the home are in outside placements.

Table 13
Characteristics of the Family Environment

Characteristic	Total (N = 432)		Court-mandated (N = 219)		Voluntary (N = 213)		Significance
	N	%	N	%	N	%	
Environmental problems	**(N = 325)**		**(N = 184)**		**(N = 141)**		
Unsafe housing	106	32.6	64	34.8	42	29.8	.017
Inadequate housing	71	21.8	42	22.8	29	20.6	.109
Inadequate food	64	19.7	35	19.0	29	20.6	.452
Inadequate clothing	56	17.2	30	16.3	26	18.4	.618
Unsafe neighborhood	28	8.6	13	7.1	15	10.6	.659
Church membership	82		48		34		.109
Social support*	**(N = 461)**		**(N = 238)**		**(N = 223)**		
Extended family	294	63.8	159	66.8	135	60.5	.038
Church support	115	24.9	48	20.2	67	30.0	.031
Other support	52	11.3	31	13.0	21	9.4	.151

Percentage indicating received support from any of the following.

More children in the court-mandated group than the voluntary group lived in unsafe or inadequate housing. This difference is only approaching significance. “Inadequate housing” referred to conditions in the house such as overcrowding, shelter care, exposed electrical sockets, and non-working appliances. “Unsafe housing” referred to the behavior of the residents in the house, which placed the child at risk. Examples of this type of behavior included drug dealing, weapons in the house, or gang membership. “Unsafe neighborhood” referred to situations outside the house. The child’s house could be safe, but the neighborhood could present a danger. These situations would include gang activity, drug dealing, and high crime areas. Unsafe and inadequate housing were found in greater

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frequency in the court-mandated group, which may be another indicator of risk. This risk resulted in the social worker pursuing legal intervention.

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

Table 14
Family's Living Situation at Time of Service Delivery

	Total (N = 431)		Court-mandated (N = 218)		Voluntary (N = 213)		Significance
	N	%	N	%	N	%	
Owns home/condo	36	8.4	20	9.2	16	7.5	
Rents house	55	12.8	26	11.9	29	13.6	
Rentsapartment/trailer	254	59.0	127	58.3	127	59.6	
Living in home of another	86	20.0	45	20.6	41	19.2	.865

The above table is not only a description of the families' living arrangements, but is also another measure of socio-economic status. No differences are noted between groups. Approximately 8% of the sample was composed of homeowners, almost 60% were apartment or trailer renters, and about 20% lived in a shelter or the home of another. Seven court-mandated plan children and one voluntary plan child lived in a shelter. If housing data is considered in conjunction with the low rates of employment, and the high rates of

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reliance on public assistance reported earlier, one can observe the high levels of deprivation among families receiving protective services.

Table 15
Family and Social Changes During Service and the Period of Service Delivery Characteristics of the Significant Other Adult

Characteristic	Total		Court-mandated (N = 219)		Voluntary (N = 213)		Significance
	N	%	N	%	N	%	
Housing change	211	48.9	108	50.0	93	43.7	.188
Separation	111	25.7	57	26.5	54	25.5	.806
Criminal involvement/ father	87	20.1	51	23.6	36	16.9	.084
Incarceration/father	84	19.4	57	26.4	27	12.7	.0001
Pregnancy	82	19.0	43	19.9	39	18.3	.674
Criminal involvement/ mother	60	13.9	32	15.0	28	13.1	.591
Divorce	57	13.2	32	14.8	25	11.7	.348
Incarceration/mother	51	11.8	34	15.9	17	8.0	.064
Homelessness/eviction	44	10.2	30	13.9	14	6.6	.013
New job after unemployment/mother	38	8.8	23	10.6	15	7.0	.189
Loss of job/either parent	35	8.1	23	10.5	12	5.6	.064
Job change	31	7.2	22	10.0	9	4.2	.019
Loss of job/mother	27	6.3	16	7.4	11	5.2	.339
Household addition	23	5.3	7	3.2	16	7.5	.050
Major illness/child	19	4.4	11	5.1	8	3.8	.501
Major illness/mother	17	3.9	7	3.2	10	4.7	.440
Death of parent	17	3.9	8	3.7	9	4.2	.782
Death of child	13	3.1	10	4.7	3	1.4	.051
Marriage	11	2.5	10	4.7	1	0.5	.006
Major injury mother	10	2.3	5	2.3	5	2.3	.982
Other	35	21	21	9.5	14	6.5	.302

Most of the above events were recorded if they occurred during the period of service delivery or the prior year. Some events were coded if they occurred at any time. These

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events included divorce, deaths in the family, and incarcerations. The events are assumed to be stressors, and are risk factors that might cause a social worker to consider pursuing court intervention. Families with court-mandated plans had more stressful events relative to the voluntary group. The court-ordered group was more likely to have had an incarcerated parent, experienced homelessness, unemployment, the death of a child, and marriage by one of the child's parents or caretakers. The voluntary group was more likely to have had job changes, and an addition of a member to the household. The addition of a member does not include the birth of a child.

Summary

It would appear cases are assigned appropriately if court-mandated cases are those of higher risk. Children in families who had received court plans exhibited more problem characteristics than children in families receiving voluntary plans. Significantly higher rates of severe behavior problems, mental illness, learning disabilities, developmental delay, runaway behavior, juvenile delinquency, and substance abuse were noted with this group. These problems may make it appear that parents need more intrusive and coercive supervision to deal with these problems. Parents and other significant adults of the children in the court-mandated group also had significantly more problems than the other parents. They were more likely to be perpetrators, have substance abuse problems, criminal histories, and mental illness. These parents may need the added stimulus of court intervention in order to bring about change in the family.

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Hispanic families were more likely to receive voluntary plans; White families were more likely to have court-mandated plans. Explanations for this ethnic difference will be explored in future analysis. Parents in families that received voluntary plans were more likely to be married to one another, which might suggest stability to social workers. Younger children in voluntary plan families were more likely to be in preschool or kindergarten than the court intervention families. This finding may suggest the social worker's confidence that a mandated reporter will report any new incidences of maltreatment. Siblings were also more likely to be in the home of voluntary plans. It is possible that the siblings of children in court-mandated families are in out-of-placement settings already, which is another indicator of risk.

Court-mandated families were also more likely to have been homeless at some point and to have had a previous death of a child than families receiving voluntary plans. Court-mandated families were also more likely to have lived in unsafe housing. Again, these factors suggest that court-mandated families are at a greater risk than families receiving voluntary plans.

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CHAPTER VI

CASE MALTREATMENT CHARACTERISTICS

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CHAPTER VI
CASE MALTREATMENT CHARACTERISTICS

This chapter describes the maltreatment history of the child. Table 16 provides the child's history prior to the current referral. The remaining tables in this chapter describe case characteristics for the episode that brought the child into contact with DSS for the service period reviewed in the upcoming chapters. This chapter identifies the case characteristics of voluntary plan cases on system entry; including reason for entry, family background, and level of risk.

Table 16
Prior Protective Service History of the Child
Means and Percentages Reported

Variables	Total (N = 430)	Court-mandated (N = 218)	Voluntary (N = 212)	Significance
Previous referrals	**N %**	**N %**	**N %**	
% W/previous referrals	293 68.9	161 70.8	132 63.7	.011
Mean # of referral(s)	3.04	3.57 (sd=3.26)	2.41 (sd=2.80)	.0001
% W/previous placements	153 35.6	96 44.2	36 16.9	.0001

A large proportion of the children in the study were actually reentering the CPS system. Children in families who received court-ordered plans had more extensive histories of contact with protective services than did children in the voluntary plan group. They were far more likely to be in families that had previous referrals or where children had been in out-of-home placements. Some of the referrals could have been unfounded. The placement rates are a better determinant of previous child maltreatment since they indicate that a

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complaint was substantiated. The most frequent out-of-home placement was the County Receiving Home for Children. Families with CPS histories may be considered by social workers to be higher risk, and therefore needing court intervention. The voluntary cases had far fewer referrals and out-of-home placements. The next table examines the source of the referral for the maltreatment episode prior to the service episode examined in this research.

Table 17
Source of the Referral

Reporter	Total (N = 429)		Court-mandated (N = 217)		Voluntary (N = 212)		Significance
	N	%	N	%	N	%	
Medical professionals	92	21.4	46	21.4	46	22.0	
Law enforcement	88	20.5	53	24.7	35	16.7	
School personnel	55	12.8	32	14.9	48	23.0	
Relatives/Neighbors	49	11.4	25	11.6	30	14.4	
Self referral	25	5.8	11	5.1	14	6.7	
Anonymous	19	4.4	13	6.0	6	2.9	
Other	16	3.7	9	4.2	7	3.4	.209
Mandated	309	72.0	157	73.0	152	72.7	
Non-mandated	115	27.0	58	27.0	57	27.3	.945

No significant differences were noted between groups regarding who reported the abuse incident. A collapse into mandatory versus non-mandatory also did not reveal any differences between groups. Table 18 describes the type of the abuse and perpetrator. Table 19 presents perpetrator as a collapsed variable from the previous table.

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Table 18
Type of Abuse and Perpetrator

Abuse type and perpetrator	Total (N = 432)		Court-mandated (N = 219)		Voluntary (N = 213)		Significance
	N	%	N	%	N	%	
Physical abuse	153	35.4	81	37.3	72	34	.467
Mother	83	19.2	47	21.5	36	16.9	.229
Father	55	12.7	33	15.1	22	10.3	.140
Other*	37	8.6	15	6.8	22	10.3	.196
General neglect	126	29.2	61	28.1	65	30.8	.541
Mother	117	27.1	57	25.6	60	28.2	.484
Father	33	7.6	23	10.5	10	4.7	.023
Other**	8	1.9	3	1.4	5	2.3	.451
Caretaker incapacity	75	17.4	43	19.8	32	15.2	.206
Mother	49	11.3	39	17.4	30	14.1	.436
Father	15	3.5	11	5.0	4	1.9	.074
Other**	3	0.1	1	0.5	2	0.9	.546
Severe neglect	72	16.7	40	18.4	32	15.2	.366
Mother	68	15.8	38	17.4	30	14.1	.351
Father	9	2.1	6	2.7	3	1.4	.333
Other**	2	<1	2	0.9	0	0.0	.162
Sexual abuse	57	13.2	30	13.8	27	12.7	.740
Mother	1	<1	1	0.5	0	0.0	.323
Father	21	4.9	13	5.9	8	3.8	.292
Other**	34	7.9	16	7.3	19	8.9	.539
Failure to protect	56	13.0	36	16.6	20	9.4	.028
Mother	47	10.9	30	13.7	17	8.0	.056
Father	14	3.2	8	3.7	6	2.8	.624
Other**	4	.9	2	0.9	2	.1	.978

Can have more than one type of abuse or perpetrator
Other categories include: stepparents, parent's boyfriend/girlfriend, other relative, other non-related person.

Table 19
Overall Perpetrator of Abuse

Abuse type and perpetrator	Total (N = 432)		Court-mandated (N = 219)		Voluntary (N = 213)		Significance
	N	%	N	%	N	%	
Mother	323	74.8	171	78.1	152	71.4	.108
Father	133	30.1	78	35.6	55	25.8	.027
Other	88	20.4	40	18.3	48	22.5	.271

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

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"Failure to protect" was the only protective issue that distinguished groups. This protective issue was seen more frequently with plans given to court intervention groups. Failure to protect is an issue that occurs in conjunction with other forms of abuse. Mothers who were perpetrators of this form of abuse were also more likely to be found in the court-mandated plan group. Failure to protect is present when one caretaker is not the perpetrator of the abuse, but either acquiesces, or does not have the ability to shield the child from further abuse or neglect. This factor would suggest added risk to the safety of the child, which would require careful consideration in pursuing the protection of court oversight. Generally, court-mandated plans were used when the father was the perpetrator. This choice was especially true in cases of general neglect, and caretaker incapacity. The next table refers to the social workers' rating of risk during the investigations.

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Table 20
Social Workers' Rating of Risk

	Total (N = 359)		Court-mandated (N = 156)		Voluntary (N = 203)		Significance
	N	%	N	%	N	%	
Overall rating of risk							
No risk	2	0.6	0	0.0	2	10.1	
Low	97	27.0	46	29.5	51	25.1	
Moderate	175	48.7	53	34.0	122	60.1	
High	61	17.0	38	24.4	23	11.3	
Unknown	24	6.7	19	12.1	5	2.5	.0001
Severity/Frequency for abuse							
Low	167	48.3	59	39.1	108	55.4	
Moderate	74	21.4	25	16.6	49	25.1	
High	63	18.2	37	24.5	26	13.3	
Unknown	42	12.1	30	19.9	12	6.2	.0001
Severity/Frequency for neglect							
Low	137	42.0	46	32.2	91	49.7	
Moderate	94	28.8	37	25.9	57	31.1	
High	53	16.3	33	23.1	20	10.9	
Unknown	42	12.9	27	18.9	15	8.2	.0001
Child's age, physical, and mental abilities							
Low	89	26.1	30	20.3	59	30.6	
Moderate	93	27.3	38	25.7	55	28.5	
High	147	43.1	68	45.9	79	40.9	
Unknown	12	3.5	12	8.1	0	0.0	.001
Perpetrator access							
Low	126	36.7	55	37.2	71	36.4	
Moderate	49	14.3	15	10.1	34	17.4	
High	137	39.9	59	39.9	78	40	
Unknown	31	9.0	19	12.8	12	6.2	.001
Child-caretaker interaction							
Low	219	64.2	86	58.5	133	68.6	
Moderate	61	17.8	27	18.4	34	17.5	
High	15	4.4	9	6.1	6	3.1	
Unknown	46	13.5	25	17.1	21	10.8	.002

A large amount of data was missing on social work risk assessment forms. The missing data may have been embedded in the narratives of the case records, but was not

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abstracted. The unknown portion of the table refers to the determination by the social worker that there is insufficient information to make the assessment of risk. In most instances, high-risk cases were assigned court-mandated plans. Low-risk cases were assigned voluntary plans. The one exception where there is no difference on high risk is perpetrator access. Social workers indicated more often with the court-mandated group that there was insufficient data to make a judgment. Mandatory plans were given to cases where there was insufficient information, perhaps as a safety issue.

Summary

Findings in this chapter paralleled those of the previous chapter. Situations that would suggest heightened risk warranted a court-mandated plan. Children from families with a previous history of involvement with DSS received court plans. It is possible that they received a voluntary plan in a previous contact with DSS, and as a result of the new referral a determination was made that more intense and coercive supervision was needed. Also, in families where failure to protect was an issue, and where the mother was the perpetrator, there was a greater likelihood to receive court-mandated plans. Cases where the father was the perpetrator generally received court plans. Failure to protect results in situations where the caretaker is unable or unwilling to protect a child from an abusive situation. Additional court intervention may be seen as needed to afford that protection. Finally, as expected, the higher the assessed risk by the social worker, the more likely the case will involve court intervention.

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CHAPTER VII

SERVICES AND CONDITIONS

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CHAPTER VII
SERVICES AND CONDITIONS

This chapter reports on services and conditions provided during the 6-month to 1-year period of service delivery. The following research questions are partially addressed in this chapter: (the letters before the research questions correspond to those listed in Chapter 1):

(d) Cases are differentiated by each outcome by child, family, and service characteristics. This includes identifying the level of compliance of natural parent(s) with service plans and the type of services provided.

(e) The level of compliance of natural parent(s) with the service plan and outcome are identified. Court reports, service plans, and case summaries provided a list of services given to the child, caretaker, and family. These items were reviewed by abstractors to provide data for the tables reported below. Social workers also provided comment on utilization of services, which answered the compliance question. For example, if a parent completed a set of parenting classes, it was coded as completed, even if there were indications at some point that the parent was not attending classes. If she or he started classes, but never finished, it was coded as not utilizing the service.

Court-mandated cases were opened an average of 480.57 days and voluntary cases an average of 187.37. As expected, court-mandated cases were open for longer periods of time. The longer period of service is consistent with the higher level of risk identified in the preceding chapters. The large standard deviation with court-mandated cases suggests a wide variation among those cases in the amount of time they were open. Voluntary cases were expected to be open for 6 months. The following table provides a report of the mean number of services provided by case type. Also illustrated in the table is the percentage of

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clients given at least one service of the specific type. Table 22 reports why a recommended service was not used and reasons are collapsed into two categories: system or client fault.

Table 21
Service Type and Utilization

	Total (N = 432)		Court mandated (N = 219)		Voluntary (N = 213)		Significance
Service Type	**Mean (%)**	**SD**	**Mean (%)***	**SD**	**Mean (%)**	**SD**	
Mean # & % of concrete services provided	1.25 55.8%	1.54	1.36 59.8 %	1.51	1.10 51.2%	1.43	.08 .296
Mean # & % of concrete services utilized	1.17 53.7%	1.47	1.30 58%	1.50	1.03 49.3%	1.42	.048 .306
Mean # & % of clinical services provided	1.75 79.1%	1.36	.1.99 84.5%	1.40	1.48 75.4%	1.18	.126 .001
Mean # & % of clinical services utilized	1.46 69.4%	1.36	1.82 79.5%	1.45	1.10 60.1%	1.14	.001 .0001
Mean # & % of substance abuse services provided	.805 49.8%	.95	1.18 59.9%	1.15	.716 39.8%	.973	.0001 .0001
Mean # & % of substance abuse services utilized	.95 37.0%	1.03	.959 49.4%	1.14	.441 25.4%	.837	.0001 .0001
Mean # & % of residential services provided	.147 12.0%	.420	.215 17.4%	.502	------- 6.6%	--------	------ .002
Mean # & % of residential services utilized	.127 8.9%	.387	.192 15.6%	.479	-------- 4.7%	--------	.001 .001
Mean # & % of family services provided	1.17 76.9%	1.01	1.21 80.4%	.986	1.13 71.6%	1.04	.401 .033
Mean # of & % family services utilized	.979 63.7%	1.00	1.08 73.1%	.957	.878 71.6%	1.04	.021 .001
Mean # & % of other services provided	.433 34.5%	.629	.452 35.0%	.658	.379 32.2%	.592	.028 .375
Mean # & % of other services utilized	.378 29.7%	.667	.438 32.9%	.717	.315 26.2%	.591	.001 .154

* Percentage receiving at least one service.

1. Concrete services include travel related, recreation, employment/training for adult, income support/public assistance, childcare, medical dental, emergency shelter, housing, clothing, furniture, car repair, legal services, and food.
2. Clinical services include family therapy/counseling, psychiatric evaluation, individual counseling/therapy, domestic violence services, parent/teen/child support/counseling group.
3. Residential services include day treatment and residential services.
4. Family services include parent training, financial and budgeting, homemaker, parent/child conflict management, educational services for the child, family planning, independent living, and parent anonymous.
5. Other services include client advocacy and specified verbatim comments, which could not be coded in the above categories.

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Table 22
Reasons for Nonutilization

	Total (N = 286)		Court-mandated (N = 103)		Voluntary (N = 183)		Significance
Nonutilization reason	**N**	**%**	**N**	**%**	**N**	**%**	
System fault	20	7.0	8	7.8	12	6.6	
Client fault	219	76.6	82	79.6	137	74.9	
Unknown	47	16.4	13	12.6	34	18.6	.294

System fault included services unavailable, no transportation, and waiting list.
Client refusal, drug or alcohol problem
Unknown refers to no reason given in file.

Court-mandated cases were more heavily serviced than voluntary cases. Court cases received on average 6.46 services, while the voluntary group received a mean 4.91 services. Except for concrete services, the court-mandated group either received more services in each category, or the percentage of subjects in that group receiving the service category was larger. It would be expected that the court-mandated group would receive more services based on the amount of time opened, but the percentage receiving at least one service of a specific type adjusts (at least partially) for that difference. The provision of more services to persons with court-mandated plans is a reflection of the need to serve the greater risk identified earlier.

The impact of court-mandated supervision can be seen in the utilization of services. Consider the number of subjects receiving clinical services. Approximately 85% of the court-mandated group and 75% of the voluntary group received those services. Almost 60% of the court-mandated and about 40% of the voluntary group utilized those services. A service was considered utilized if the client completed the service. Similarly, 77% of the

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court-mandated group finished substance abuse treatment and only 59% of the voluntary group who received substance abuse treatment completed that service. Similar patterns were noted on most of the service categories. Most reasons for nonutilization were related to client resistance. No differences were found between groups on reasons why services were not used. This data suggests that court mandates provide the stimulus to complete services. Table 23 describes the number and type of contacts clients had with DSS and their social workers.

Table 23
Social Worker Contacts with Family

	Total (N = 427)		Court mandated (N = 215)		Voluntary (N = 212)		Significance
Contact type	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	
Office visits	1.36	2.65	1.56	3.15	1.16	2.01	.126
Home visits	7.50	6.40	6.73	6.41	8.29	6.31	.012
Phone visits	28.49	38.63	36.25	48.38	20.64	21.72	.0001
Field visits*	2.58	4.04	2.65	4.47	2.51	2.51	.736
Total contacts	82.92	91.51	97.58	114.24	68.04	56.81	.001
Visit with whom?							
Parent	17.15	17.87	19.00	21.98	15.29	12.14	.031
Family	3.20	6.00	3.88	7.35	2.51	7.35	.018
Child	6.61	5.48	6.45	5.68	6.79	5.28	.515
Provider	17.99	26.61	22.23	32.63	13.68	17.66	.001
Sibling	6.94	8.77	6.26	9.75	7.62	7.60	.109
Friend/Neighbor	1.03	2.90	.94	3.35	1.11	2.37	.537

Field visits include visits to other agencies on behalf of client. Along with contact with providers, it is a measure of the broker role.

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Contact information was gathered from case narratives and includes all recorded contacts between case openings and case closings. Home visits refer to social workers' contacts in the children's homes. Field visits refer to social workers contacts with schools, agency treatment programs, etc. Overall, the court-mandated group had more contacts. Surprisingly, voluntary cases received more home visits. It is possible that the demands of court cases made it more difficult for the worker to find the time to make home visits. With the exception of home contacts, court-ordered cases received more contacts of every type, and in particular, more phone contacts. The researchers had expected that court-mandated cases would have received significantly more contacts because of higher risk and because they were opened for longer periods of time. Table 24 describes the conditions in the case plan.

Table 24
Types of Conditions for Caretakers

	Total (N = 432)		Court-mandated (N = 219)		Voluntary (N = 213)		Significance
Condition	**N**	**%**	**N**	**%**	**N**	**%**	
No corporal punishment	206	47.7	99	45.2	107	50.2	.25
Household	184	42.6	87	39.7	97	45.5	.222
No drugs/alcohol	220	50.1	121	55.3	99	46.5	.068
Keep contact w/social worker	230	53.2	99	45.2	131	61.5	.001
No contact w/perpetrator	106	24.5	50	22.8	56	26.3	.403
Treatment	262	60.1	142	64.8	120	56.3	.071
Other	144	33.3	62	28.3	82	38.7	.023
Were conditions met							
Yes	357	82.6	181	82.6	176	82.6	
No	75	17.4	38	17.4	37	17.4	.996

Conditions Household: Includes keeping the home safe and clean, maintaining a stable residence, eliminating the threat posed to children's well-being by dangerous appliances and other objects in the home or yard, etc.

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Table 24 refers to court-ordered or CSB conditions for caretakers. Conditions were coded as met if the record indicated that all conditions were met, or an indication of failure to meet conditions was not found during the record review. No differences were found between study groups in meeting conditions. Voluntary cases were more likely to be required to keep contact with a social worker, and receive "other" conditions. Court-mandated cases were more likely, but only at a level approaching significance, to have treatment ordered and be told to have no contact with drugs or alcohol. Both groups had similar records of compliance with conditions.

Summary

Court-mandated cases were open on average 16 months, voluntary cases on average 6 months. Court-mandated cases received more clinical, substance abuse, and residential services. These findings are consistent with greater risk found in court-mandated cases. The longer length of time a case was open and the greater number of services supplied this group relative to the voluntary plan cases is a reflection of the need to address that risk. Court-mandated families were more likely to utilize services they were provided than those with voluntary plans, which provides some evidence of the utility of court mandates. However, no differences were found between study groups on the completion of case plan conditions. Generally, court-mandated cases had more contacts by social workers on their behalf. Social workers had more contact with collateral agencies and workers in court-ordered cases, and more contact with friends and neighbors of voluntary cases.

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CHAPTER VIII

OUTCOMES

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CHAPTER VIII
OUTCOMES

This chapter reports case outcomes by type of plan and addresses the following study aims and questions (letters in front of the research questions correspond to the questions listed in Chapter 1):

(b) Types of plans and case outcomes were used to describe different categories of case outcome at case closure. The variable interest of whether the case penetrated the system any further, such as entering out-of-home care. Figure 1, page 2, describes study groups and outcome variables.

(c) Cases were examined 6 months after case closure. The purpose of this analysis was to determine if there was a rereferral for abuse and/or system reentry as an additional measure of determining success or failure. See Figure 2, page 3. Analysis was a three-step process. First, cases were examined to determine if the child was still in the home at the end of the case closure period. Second, among remaining cases where the study child remained in the home, the case was followed for 6 months to determine if there was an additional referral. Finally, cases with referrals were subject to further observation to determine if they reentered the system.

(d) Cases are differentiated by each outcome by child, family, and service characteristics. This includes identifying the level of compliance by the natural parent(s) with the service plan. The type of services provided is identified.

(e) Reasons for case failure and success with voluntary plans are also identified. Table 25 describes outcomes at the end of the period of service delivery. Outcomes are based on location of the child at the end of the service delivery period.

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Table 25
Case Outcomes at the End of the Service Delivery Period

	Total (N = 429)		Court-mandated (N = 216)		Voluntary (N = 213)		Significance
Outcome	**N**	**%**	**N**	**%**	**N**	**%**	
In own home	356	82.9	168	77.8	188	88.3	
Placed with relatives	46	10.8	28	13.0	18	8.5	
In placement	27	6.3	20	9.3	7	3.3	.008

*Closure could have meant a change in program, such as moving to family reunification.

Children in voluntary cases were more likely to be at home at case closing; court-mandated cases were more likely to be in placement. Placement included foster care, group homes, the Polinsky Center (San Diego County's receiving home for children), and adoption. Three runaways were categorized as in placement since they were not in their own homes. Consistent with public policy, most children went to the home of relatives if they were removed from their parents' home.

Table 26 reports the correlations of variables previously found to be significant with type of case given with the three case outcomes. Because of space considerations, only those variables found to be significant with a case outcome are reported.

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Table 26
Correlation of Significant Variables with Case Outcomes
Pearson's R

Variable	In home at case closing	Referred in the follow-up period	Reentry in the follow-up period
Severe behavioral problem: Child	-.135**	-.009	.005
Mental illness: Child	-.141**	-.029	-.017
Runaway: Child	-.111**	-.042	-.034
Total characteristics: Child	-.143**	-.012	-.017
Married: Mother	-.037	-.114*	-.107*
Drug abuse: Mother	-.134**	.094*	.102*
Alcohol abuse: Mother	-.104*	.107*	.069
Incarcerated: Mother	-.129**	.028	.050
Total characteristics: Mother	-.131**	.098*	.100*
Married: Father	.039	-.121*	-.100*
Public assistance received: Family	.170**	-.224**	-.205**
Siblings in home	.068	.099*	.084
Number of siblings	.047	.093*	-.084
Church support: Family	.097*	-.023	.002
Church involvement	.006	-.055	-.104*
Change in family: Homelessness	-.216**	-.044	-.077
Living with mother	.287*	-.046	-.069
Number of previous referrals	-.024	.236**	.162**
Perpetrator of abuse: Father (1 = yes, 0 = no)	.038	-.119*	-.156**
Type of abuse: Neglect by father	.000	-.086	-.111*
Risk: Child/Caretaker interaction	.149**	.019	.031
Services provided: Substance abuse (1 = yes, 0 = no)	-.093	.174*	.071
Family services used	.188**	.045	.056
Perpetrator: Mother	.006	-.214**	-.039
Required condition: Keep contact with social worker (1 = yes, 0 = no)	.113*	.097*	.077
Required condition: No drugs/alcohol (1 = yes, 0 = no)	.020	.121*	.131**
Social work contacts: With parents	.159**	.105*	.084
Contacts: Home visits	.200**	.234**	.095*
Social work contacts by phone	-.179**	-.003	.088
Contacts: With friends/neighbors	-.092*	.095*	.015
Total contacts	-.144**	.015	.030

**P<. 01, * p<.05
1=in own home, 0=removed from home.
1=at least one new referral in the follow-up period, 0=no new referrals in the follow-up period.
1=reentered CPS, 0=did not reenter CPS.

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The total number of child problem characteristics is associated with whether a child remained in the home at the end of the service period. Children with mental illnesses, severe behavioral problems, or who were runaways at some point were less likely to be in the caretakers' homes at the end of service delivery periods. However, none of these characteristics predicted whether there was a family rereferral or case reentry. These characteristics may not predict rereferral or reentry because the child has already been removed and has not been returned. All of these characteristics present difficulty in parenting, which is why they predict removal.

Mother's drug and alcohol abuse, history of incarceration, and total number of characteristics are associated with removal at case closure. The total number of problems and drug abuse history are predictive of all three outcomes. The mother's alcohol abuse is associated with rereferral but not system reentry. None of the father's characteristics are associated with either being in the home at the end of the service delivery period or whether there was a rereferral. Living with both parents was associated with remaining in the home at the end of the service period, and with not receiving a referral or reentry during the follow-up period. Whether one lived with siblings did not predict removal, but was associated with whether a rereferral was received.

Children living with their biological mothers were not as likely to be removed as children living in other circumstances. Social workers may be reluctant to remove children from biological mothers because of attachment concerns. Living with a biological mother did not predict any of the other outcomes.

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The receipt of public assistance (AFDC, SS, SSI, GR, or unemployment compensation) was predictive of children remaining in their homes, and whether or not there was a new referral or reentry during the follow-up period. Public assistance was the most common source of income in the sample. The receipt of public assistance may mean that a family has basic minimum resources. Absence may mean deprivation. Similarly, having been homeless within a year of receiving services, or during the service delivery period, was predictive of the child being removed, but not of the other two outcomes.

Only two risk assessment factors predicted removal. The overall rating risk and the rating of the child/parent interaction were both associated with removal, but again these variables were not associated with the other two outcomes. Surprisingly, the type of abuse or who the perpetrator was, did not predict removal of the child at the conclusion of service delivery. If the father was the perpetrator it was more likely that there would be new referrals and a system reentry. “Mother as a perpetrator” was associated with new referrals but not system entry.

Utilizing family services (including parent training, financial and budgeting assistance, homemaker, parent/child conflict management, educational services for the child, family planning, independent living, and parents anonymous) were associated with a child remaining in the home at the end of the service delivery period. No other services were predictive of removal. These services, for the most part, strengthened the parental role. The condition of keeping contact with the social worker was associated with the child remaining in the home. The whole issue of contacts seems complex. Despite the condition

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to keep contact with the social worker, the more social work contacts an individual had, the more likely removal. Social workers may be spending more time on difficult cases. However, the number of home visits, child contacts, and parent contacts, were all positively correlated with the child remaining in the home. The number of phone contacts and contacts with family and neighbors was predictive of removal and a re-referral during the follow-up period. Perhaps social workers were spending more time with relatives of caretakers who were having difficulties since it might become necessary to remove those children. These findings support the importance of home visiting.

Ethnicity or race (Hispanic or White) did not predict any outcome; neither did the length of time a case was opened. Table 27 uses logistic regression to assess the relative importance of the variables that predicted child removal in the previous analysis. Not all variables could be entered because many were highly correlated with one another. For example, most of the contact variables were highly correlated. Therefore, only one, "total contacts," was chosen for entry since it was the strongest predictor of outcome at the end of the service delivery period.

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Table 27
Predicting Child Removal at the End of the Service Delivery Period: Logistic Regression

Variable	B	S.E.	Wald	Significance	Exp B
Type of case	-.2142	.3329	.4141	.5199	.8072
Total characteristics: Child	-.0938	.0707	1.7588	.1849	.9105
Total characteristics: Mother	-.1669	.0728	5.2550	.0219	-.0929
Living with mother: Child	1.8150	.3642	11.8447	.0006	3.2919
Public assistance received: Family	.9332	.3318	7.9107	.0049	2.5427
Church Support: Family	.4457	.3742	1.4183	.2337	1.5616
Family services used	.5855	.1950	9.0133	.0027	1.7959
Condition: Keep contact: With social workers	.4019	.3234	1.5436	.2141	1.4946
Total contacts by social worker	-.0075	.0531	5.9925	.0144	-.1029
Homelessness	-1.5517	.4661	11.0847	.0009	.2119
Constant	.9183	.4335	4.4871	.0342	

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

Whether one received a voluntary plan or court plan is no longer important when other significant variables are entered for control. The total number of problem characteristics the study children's mothers had, including: the receipt of public assistance, an experience with homelessness, the number of family services used, the number of social work contacts with the family, and if the children continue to live with their mothers, predicts whether the child(ren) remain in the home.

The number of problem characteristics a child has was no longer predictive of case outcome. What is important in determining outcome is the number of problem characteristics the mother has. The issue for social workers may be whether the mother can deal with the child's problems, and not whether the child has problems. The condition of remaining in contact with the social worker and receiving support from a church is no longer predictive of outcome. Table 28 examines whether a rereferral was received after

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services, and Table 29 examines if this referral came in the 6-month follow-up period. Table 28 provides a uniform measure of time after services. The tables delete the children removed from the home during the service period.

Table 28
Referrals After Services

	Total (N = 356)		Court-mandated (N = 168)		Voluntary (N = 188)		Significance
Outcome	**N**	**%**	**N**	**%**	**N**	**%**	
At least one referral	161	45.2	72	42.9	89	47.3	
No referrals	195	54.8	96	57.1	99	52.7	.229

Table 29
Referrals During the Follow-up Period

	Total (N = 356)		Court-mandated (N = 168)		Voluntary (N = 188)		Significance
Outcome	**N**	**%**	**N**	**%**	**N**	**%**	
At least one referral	83	23.3	36	21.4	47	25	
No referrals	273	76.7	132	78.6	141	75	.478

High rates of rereferrals were noted for both groups. No differences were found between groups on whether a referral for child maltreatment was received during the follow-up period. Receiving a court mandate for services does not protect against future referrals. Married parents, particularly those living together, are less likely to receive referrals or system reentry. Alcohol abuse predicts a referral but not the other two outcomes. The more siblings the study child has, the greater likelihood there will be a referral. More siblings may increase the chance that a reporter will observe child maltreatment in a family.

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The number of referrals for maltreatment, previous to the service period, predicts both whether there was a new referral and reentry. When either parent was the perpetrator, a referral was more likely. Receiving and using substance abuse services was associated with a rereferral but not reentry. A condition of no drugs or alcohol in the case plan was also associated with rereferrals and reentry. These characteristics suggest the difficulties clients have in successfully completing drug treatment. Table 30 describes whether or not a case reentered the system during the follow-up period. Only cases where there was a re-referral are included in the table.

Table 30
Reentry During the Follow-up Period

	Total (N = 161)		Court-mandated (N = 72)		Voluntary (N = 89)		Significance
Outcome	**N**	**%**	**N**	**%**	**N**	**%**	
Reentered system	128	79.5	56	77.8	72	80.9	
No entry	33	20.5	16	22.2	17	19.1	.384

Almost 80% of the cases with a referral entered the service system. Again, whether someone reentered the protective service system did not differ according to what type of plan given. Similar results were noted when entry rates were examined for referrals within 6 months of case closing.

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CHAPTER IX

SUMMARY OF FINDINGS AND IMPLICATIONS FOR PRACTICE AND RESEARCH

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CHAPTER IX
SUMMARY OF FINDINGS AND IMPLICATIONS FOR PRACTICE AND RESEARCH

The major finding of this research is that the type of plan did not make a difference on case outcome. Children were more likely to remain in their homes at the end of service delivery periods when their families received voluntary plans. However, when other factors are controlled, the advantage of voluntary plans disappears. Moreover, similar rates of recidivism were noted in the follow-up period between study groups. High rates of new referrals and system reentry were found for both study groups. Figure 5 summarizes the type of cases receiving court-mandated plans. Figure 6 describes the types of cases that received voluntary plans.

Figure 5
Summary of Characteristics of Cases Assigned a Court-Ordered Plan

- White children
- Children with school problems, behavioral problems, mental illness, learning disabilities, developmental disabilities, juvenile delinquency, substance abuse, and runaway behavior
- Unmarried mothers
- A parent or significant adult with drug and/or alcohol problems; criminal history; incarceration; mental illness; and/or was a perpetrator of abuse.
- A father with abuse history as a child
- Children living with their biological mother
- Families living in unsafe housing
- Families that had experienced homelessness
- Fathers who were the perpetrators of the current abuse episode, particularly in episodes of general neglect
- Failure to protect is an issue and the mother is the perpetrator
- Previous CPS referrals and placements
- Social workers judged the court-ordered cases to be high risk

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Figure 6
Summary of Characteristics of Cases Assigned a Voluntary Plan

- Hispanic children
- Child(ren) in preschool
- Families receiving public assistance
- Child(ren) whose biological parents are married
- Child(ren) whose other siblings are in the home

Workers are assigned cases according to the level of risk. Families having a high number of risk factors received court-ordered plans. All of the above characteristics could be found in either group, but were statistically more likely in the voluntary group. The ethnic difference in the assignment of cases is probably related to the family structure variables. For example, Hispanic children were more likely to live with both their biological parents. Factors associated with stability such as, family structure, marital status, source of income, and preschool were associated with receiving voluntary plans. Figure 7 summarizes differences in service delivery between groups.

Figure 7
Summary of Service Delivery Characteristics

- Court-ordered cases were open for longer periods of time
- Court-ordered cases received more social work contact; particularly contacts with parents and family, service providers, and contacts by phone
- Voluntary plans received more home contact by social workers
- Court-ordered plans were more heavily serviced
- Parents with court-ordered plans were more likely to utilize services provided
- Court-ordered plans were more likely to contain conditions for drug and alcohol treatment.
- Voluntary cases were more likely to have conditions to maintain contact with identified social workers
- No differences were found between groups in completing conditions in the service plan

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CPS clients who received court-ordered plans were more likely to utilize the services provided. This finding reaffirms one of the underlying rationales of court intervention; that it spurs individuals to use and complete services. On the other hand, differences were not found on whether conditions specified in the case plans were completed. The case contact findings are artifacts of the amount of time a case was open. Voluntary plans were assigned to low risk cases needing a relatively brief period of services. Court-ordered plans were meant to be open for longer periods of time. The amount of contact was predictive of outcome in an inverse manner, but the length a case was open was not associated with any outcome. The more contact, the more likely recidivism occurred. Social workers also may be providing more contact with difficult cases. Figure 8 describes those factors found to have empirical support in predicting outcomes (new rereferrals, system reentry, or out-of-home placement).

Figure 8
Summary of Factors Predicting Case Outcome

- Type of plan provided did not predict any case outcome.
- Mothers' characteristics, (particularly drug and alcohol abuse and incarceration at some point) were predictive of case failure.
- Children who lived with their biological mothers were less likely to be removed from their homes during service delivery than children who did not.
- Receipt of public assistance was associated with successful outcomes.
- Receipt of family services such as parent training, financial and budgeting, homemaker, parent/child conflict management, educational services for the child, family planning, independent living, and parents anonymous were all associated with successful outcomes.
- Study children whose biological parents were married to one another, were more likely to remain in the home and avoid new CPS referrals than children whose parents were not married to one another.
- If the father is the perpetrator of abuse, case outcomes are less successful.
- Records of previous referrals to CPS were associated with unsuccessful case outcomes.
- A condition of no drugs or alcohol in service plans was predictive of unsuccessful cases.
- An experience with homelessness was associated with childrens' removal at the end of the service delivery period.

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Mothers' characteristics were strongly associated with case outcomes. Fathers' characteristics were not. Study children were more likely to live with the mother and father, which made the mother's functioning more important to the child. Only 36% of study children lived with their biological fathers, whereas 83% lived with their biological mothers. However if the father is the perpetrator of abuse, the case is more likely to fail. Children who lived with their biological mothers fared better than children who did not. Fathers were also important in predicting success when they are married to the biological mother of the child. Marriage may be taken by social workers as an indicator of stability. Drug and alcohol abuse on the part of the mother seemed to be the most important problem characteristic associated with case failure. Over one half of the sample had a drug problem. Recycling these families in and out of the system will not end until effective means of addressing drug problems is available for this population. Receiving public assistance such as, AFDC, General Relief, SSI, social security, or unemployment insurance was associated with successful outcomes. These forms of public aid may have at least guaranteed a minimum level of resources for the families. Most of the study children lived in families that experienced high levels of deprivation. These findings have implications for welfare reform. The loss of benefits could result in more referrals and children in care.

Implications for Practice

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

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research with children remaining in their parents' homes at the end of service delivery.

- More effective means of assessing risk (particularly substance use) in caretakers are needed. Parents with drug problems appeared to be discharged from services only to receive additional referrals for services. Early discharge places children at risk. Children and caretakers could benefit from longer periods of supervision or movement into different approaches to intervention. In some cases, different approaches may mean terminating parents' rights.

- Families receiving public assistance are more likely to avoid recidivism than families without that aid. Provision of basic needs seem essential in keeping children with their families.

- The most important type of services in preventing recidivism were those that helped the parent(s) carry out parental or family functions; for example, parent training or homemaker services. Substance abuse or clinical services did not prevent recidivism. It may be that families that respond to family services are families whose major problem is a lack of competence that is addressed by family services. Substance abuse services go to families with more intractable problems and are also the type of problem where relapse is expected.

- An empirical indicator for low risk is the marital status of the biological parents. Married parents were less likely than unmarried parents to have new referrals or a child removal. Another indicator with empirical support is the child's living arrangements. Children who lived with their biological mothers were less likely than children in other situations to recidivate. One factor that was used in case assignment that can be discarded is the number of problem characteristics a child has. The findings of this research suggest it is the mother's functioning, and ability to deal with the child's difficulties that is the more relevant issue.

- Additional empirical indicators of risk of re-involvement and child removal with CPS include the number of previous CPS referrals and whether the father was a perpetrator of the abuse.

- An alternative would be to restrict court cases to a narrow range such as those where substance abuse is present; where previous referrals to CPS have been made; and where the father is the perpetrator. These characteristics seemed to be the greatest empirical indicators of risk.

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Implications for Research

This research utilized case review. One factor conspicuously absent from the research was a measure of the internal motivation of CPS clients and their reaction to service delivery. Both of these factors are important in determining utilization of services and outcomes. Research that collected data directly from clients might answer questions about type of plan not addressed in this research. Similarly, the outcomes used in this research were limited. Self-report or observational measures of family and caretaker change might reveal some benefit to a particular plan not measured in the outcomes used in this research.

Given the dangers child maltreatment poses, the utility of court ordered plans warrants further study. One method of investigation that would help clarify the specific effects of court and voluntary plans would involve random assignment. With equal amounts of recidivism found in the study groups, the ethical considerations inherent in random assignment are moot.

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

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Limitations of Data

This research was conducted at a single site. Contextual (both in the community and organization) may have influenced outcome. Single site research always raises issues about replication of study findings and the representativeness of the study data for other sites. Also, while most study data were available, a lack of specific data did make it difficult to examine some questions. For example, 74 (17%) cases did not have risk assessment data. Data on fathers and family income were often incomplete. Therefore, conclusions and implications about the effect of these variables should be regarded as tentative.

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APPENDIXES

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APPENDIX A

CASE ABSTRACTION INSTRUMENT

Jones, L. (2000). *Choices: A child welfare curriculum module on voluntary services and court-mandated services.* Berkeley: University of California at Berkeley, California Social Work Education Center.

THE EFFECTIVENESS OF COURT-MANDATED INTERVENTION VERSUS VOLUNTARY SERVICES IN CHILD PROTECTIVE SERVICES

ABSTRACTION FORM

RID_____(Code CASE NO)

Time to Complete Abstract___/___
hrs/min
Abstractor_____Abstract Date___/___/___

Case Open Date ___/___/___ Case Close Date ___/__/__ Transfer Date ___/___/___
(If applicable)

___Type of Case [1=FM Court-mandated, 2=FM Voluntary, 3=FR Out-of-Home, 4=ER in Home; 5=Other _____specify]

___Special Circumstances [1=Transfer case {Code transfer date}, 2=Open for investigation only, 3=No activity or nearly none in window, but considerable activity in prior periods]

I. CHARACTERISTICS OF CHILD *(See Face Sheet)*

1. ___/__/____ Date of birth
   mm/dd/yyyy

2. ___Gender (1=Male, 2= Female)

3. ___Race/Ethnicity

1=White	6=Filipino	11=Laotian	16=Middle Eastern
2=Mexican American	7=Cambodian	12=Vietnamese	17=Mixed race (Specify)
3=Other Hispanic	8=Pacific Islander	13=Chinese	_____/_____
4=African American	9=Japanese	14=African	18=Other (Specify)
5=Native American	10=Korean	15=African	_____
			77=Unknown

4. ___Grade in School at **case open date** *(Face sheet or Court Report Tab)*
   [0=Kindergarten/Early Education/Daycare, Actual grade=1 through 12, 66=Not in school, 77=Unknown, 88=Other_____]

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5. Special Characteristics (Child) [0=No, 1=Yes, 2=Suspected, 99=N/A, 77=Unk] *(See court reports, psych. eval., social studies, and medical records located on the left side.)*
   a.__ Developmentally delayed
   b.__ Diagnosed mental illness. Give DSM Code _____
   c.___ Learning disabled
   d.___ Physical disability
   e.___ Substance abuse/addicted (drugs)
   f.___ Substance abuser/addicted (alcohol)
   g.___ Substance addicted at birth
   h.___ Severe behavioral problems
   i.___ Medical problems
   j.___ Eating or sleeping disorders
   k.___ School problems
   l.___ Juvenile delinquency
   n.___ Runaway
   o.___ Conflict with parent or guardian
   p.___ Other
   q.___ Other

II. CHARACTERISTICS OF FAMILY/HOUSEHOLD *(See Face Sheet)*

A. Family *(See Face Sheet)*

1. All adults living in the home **where family began receiving services** [0=No, 1=Yes]

   1.1 ___Mother
   1.2 ___*Father
   1.3.___Stepmother
   1.4 ___Stepfather
   1.5 ___Grandmother
   1.6 ___Grandfather
   1.7 ___Other relatives. If yes, how many_____
   1.8.___Parent's girlfriend/boyfriend
   1.9 ___Other non-related adults. If yes, how many_____

   *Check here [ ] if paternity is in doubt.

2. _____Number of siblings (Include stepsiblings if living in the home).

3. _____Actual number of siblings living in home **where family began receiving services.**

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4. Sibling characteristics

	Birthdate	Sex (1=M, 2=F)		Birthdate	Sex (1=M, 2=F)
a. Sib 1	__/__/__	____	f. Sib 6	__/__/__	____
b. Sib 2	__/__/__	____	g. Sib 7	__/__/__	____
c. Sib 3	__/__/__	____	h. Sib 8	__/__/__	____
d. Sib 4	__/__/__	____	i. Sib 9	__/__/__	____
e. Sib 5	__/__/__	____	j. Sib 10	__/__/__	____

5. _____Number of other children living in home.

6. _____Living situation at time family began receiving services [1=owns home/ condo, 2=rent house, 3=rent apartment/trailer, 4=living in home of another, 5=shelter, 6=other_____, 77=unknown].

III. CHARACTERISTICS OF SIGNIFICANT ADULTS/FAMILY *(See Face Sheet, Court Reports, and Narratives).*
Check here [ ] if individual is deceased.

A. Natural Mother

1. Demographic Characteristics of Natural Mother

c. _____ Ethnicity [see codes on page 1]
d. ___/___/___ Date of birth
mm/ dd /yyyy
e. _____ Current marital status [1=Married, 2=Separated; 3=Divorced, 4=Widowed, 5=Single/Never been married, 6=Single/Unknown marital history, 8=Other_____, 9=Unknown]
ee. _____ Married to Natural Father? [0=No, 1=Yes, 7=N/A, 9=Unknown]
f. _____ Highest Grade Completed [0=None, Actual grade=1st through 12th, 13, 14, 15, 16=College, 17, 18, 19, 20=Graduate or Professional, 99=Unk]
g. _____ Highest Degree Completed [0=None; 1=HS or GED; 2 =AA, 3=BA, AB, BS; 4=MA, MS, MSW; 5=PhD, MD, JD; 77=Unk]
h. _____ Income Source [1=Full-time employed, 2=Part-time work, 3=Unemployed and looking for work, 4=Unemployed and no indication of looking for work, 5=Active military; 6=Retired, 7=Other_____, 9=Unknown]
i. _____Occupation/Profession

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Additional Income Source *(See Face Sheet).*
[0=No, 1=Yes, 2=Suspected, 9=Unknown/Not suspected]

j. ____AFDC ____SSI ____GR ____Unemp. Insurance ____Social Security
k, ____Additional Income: Legal (Specify_____)
m. ____Additional Income: Illegal (Specify_____)
n. ____Economic Contributor to Child's Home while receiving services?
[0=No, 1=Yes, 8=Other_____, 9=Unknown]

2. Special Characteristics **AT ANY TIME**
[0=No, 1=Yes, 2=Suspected, 7=N/A, 9=Unknown]
a. ____Developmentally delayed
b. ____Diagnosed mental illness (if Yes or Suspected, give DSM Codes_____
c. ____Physical disability
d. ____Other medical problem(s)
e. ____Domestic violence
f. ____Substance abuser/addicted (drugs)
g. ____Substance abuser/addicted (alcohol)
h. ____Charged criminal history
i. ____Abuse history as child
j. ____Cult activity/religious fanaticism
k. ____Incarcerated
l. ____Undocumented alien
m. ____Non-English speaking
n. ____Perpetrator of abuse on child
o. ____Other special characteristics:_____
p. ____Other special characteristics:_____

3. Caretaker Assessment Factors. See risk assessment form. Use code form or 99 for missing data.

a. ____Capacity for childcare
b. ____Child interaction
c. ____Parenting skills/knowledge
d. ____Substance abuse alcohol
e. ____Criminal behavior
f. ____Emotional and mental health

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B. Natural Father *[Abstractor note: Previous experience suggest there many not be much data on the father.]*
Check here [ ] if individual is deceased.
Check here [ ] if father is not known.

1. Demographic Characteristics of Natural Father

c. ___.___Ethnicity [see codes on page 1]
d. ____/____/____ Date of birth
mm / dd /yyyy
e. ____Marital status
[1=Married, 2=Separated, 3=Divorced, 4=Widowed, 5=Single/Never been married, 6=Single/Unknown marital history, 8=Other_____, 77=Unknown]
f. ____Married to natural mother?
g. ____Highest grade completed
[0=None; Actual grade=1st through 12th; 13, 14, 15, 16=College; 17, 18,19,20=Graduate of professional; 77=Unknown]
h. ____Highest degree completed
[0=None; 1=H.S. or GED; 2=AA, 3=BA, AB, BS; 4=MA, MS, MSW; 5=PhD, MD, JD; 99=Unknown]
i. Income source
[1=Full-time, 2=Part-time, 3=Unemployed and looking for work, 4=Unemployed and no indication of looking for work, 5=Active military, 6=Retired, 8=Other_____, 77=Unknown]
j. _____Occupation/Profession

Additional Income Source
[0=No, 1=Yes, 2=Suspected, 9=Unknown/Not suspected]

j. ____AFDC ____SSI ____GR ____Unemp. Insurance ____Social Security
k, ____Additional Income: Legal (Specify_____)
m. ____Additional Income: Illegal (Specify_____)
n. ____Economic Contributor to Child's Home while receiving services?
[0=No, 1=Yes, 8=Other_____, 9=Unknown]

2. Special Characteristics **AT ANY TIME**
[0=No, 1=Yes, 2=Suspected, 77=Unknown]
a. ____Developmentally delayed
b. ____Diagnosed mental illness (if Yes or Suspected, give DSM Codes_____
c. ____Physical disability

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d. ____Other medical problem(s)
e. ____Domestic violence
f. ____Substance abuser/addicted (drugs)
g. ____Substance abuser/addicted (alcohol)
h. ____Charged criminal history
i. ____Abuse history as child
j. ____Cult activity/religious fanaticism
k. ____Incarcerated
l. ____Undocumented alien
m. ____Non-English speaking
n. ____Perpetrator of abuse on child
o. ____Other special characteristics:_____
p. ____Other special characteristics:_____

3. Caretaker Assessment Factors. See risk assessment form. Use code form or 99 for missing data.

a. ____Capacity for childcare
b. ____Child interaction
c. ____Parenting skills/knowledge
d. ____Substance abuse alcohol
g. ____Criminal behavior
h. ____Emotional and mental health

II. CHARACTERISTICS OF SIGNIFICANT ADULTS/FAMILY RID_____

Abstractor note: Collect data on stepparent, guardian, boyfriend/girlfriend, or grandparent living in the home during the period of service delivery. Collect on one in order listed.

Check here [ ] if individual is deceased.

1. Demographic Characteristics of Significant Adult

c. ___.___Ethnicity [see codes on page 1]
d. ____/____/____ Date of birth
mm / dd /yyyy
e. ____Marital status
[1=Married, 2=Separated, 3=Divorced, 4=Widowed, 5=Single/Never been married, 6=Single/Unknown marital history, 8=Other_____, 9=Unknown]

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f. ____Married to natural parent?
[0=No, 1=Yes, 99=N/A, 77=Unknown]

g. ____Highest grade completed
[0=None; Actual grade=1st through 12th; 13, 14, 15, 16=College; 17, 18,19,20=Graduate of professional; 77=Unknown]

h. ____Highest degree completed
[0=None; 1=HS or GED; 2=AA, 3=BA, AB, BS; 4=MA, MS, MSW; 5=PhD, MD, JD; 99=Unknown]

i. Income source
[1=Full-time, 2=Part-time, 3=Unemployed and looking for work, 4=Unemployed and no indication of looking for work, 5=Active military, 6=Retired, 8=Other_____, 77=Unknown]

j. _____Occupation/Profession

Additional Income Source
[0=No, 1=Yes, 2=Suspected, 9=Unknown/Not suspected]

j. ____AFDC ____SSI ____GR ____Unemp. Insurance ____Social Security

k, ____Additional Income: Legal (Specify_____)

m. ____Additional Income: Illegal (Specify_____)

n. ____Economic Contributor to Child's Home while receiving services?
[0=No, 1=Yes, 8=Other_____, 9=Unknown]

2. Special Characteristics **AT ANY TIME**
[0=No, 1=Yes, 2=Suspected, 77=Unknown]

a. ____Developmentally delayed
b. ____Diagnosed mental illness (if Yes or Suspected, give DSM Codes_____
c. ____Physical disability
d. ____Other medical problem(s)
e. ____Domestic violence
f. ____Substance abuser/addicted (drugs)
g. ____Substance abuser/addicted (alcohol)
h. ____Charged criminal history
i. ____Abuse history as child
j. ____Cult activity/religious fanaticism
k. ____Incarcerated
l. ____Undocumented alien
m. ____Non-English speaking
n. ____Other special characteristics:_____
o. ____Perpetrator of abuse on child

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3. Caretaker Assessment Factors. See risk assessment form. Use code form or 99 for missing data.

   a. ____Capacity for childcare
   b. ____Child interaction
   c. ____Parenting skills/knowledge
   d. ____Substance abuse alcohol
   k. ____Criminal behavior
   l. ____Emotional and mental health

III. FAMILY Environment RID_____

1. Situational Problems
   [0=No, 1=Yes; suspected]

   a. ____In adequate housing (homelessness, physical crowding, non-working major appliances, danger due to electrical wiring, gas leaks)
   b. ____Unsafe house (weapons, drugs, violence)
   c. ____Food (rotting or inadequate food, malnutrition)
   d. ____Clothing (dirty or inadequate clothing)
   e. ____Unsafe neighborhood (crime area, gangs, street violence, drugs)
   f. ____Other (Specify_____)
   g. ____Other (Specify_____)

2. Does the family belong to any of the following? [1=Yes, 0=No, 7=Unknown]

   a. ____Church. If yes, indicate what denomination_____
   b. ____Union
   c. ____Service organization, club. If yes, what_____
   d. ____Neighborhood organization. If yes_____

3. Is there mention in files of family receiving support from any of the following? Support refers to the provision of concrete help (childcare, loan, food, etc.), and the provision of emotional support (advice, counseling, consoling, visitation). [1=Yes, 0=No]

   a. ____Extended family
   b. ____Neighbor/Friends
   c. ____Church. If yes, indicate what denomination_____
   d. ____Union
   e. ____Neighborhood organization

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4. Family Assessment Factors. Use codes from risk assessment forms.
   a. ____Family interaction
   b. ____Strength of the family support system
   c. ____History of abuse and neglect
   d. ____Presence of parent substitute in home
   e. ____Environmental conditions of home

V. CASE CHARACTERISTICS RID_____

A. Prior History-Index Child

1. ____Number of previous referrals/contracts related to **Family**
   (if "0", go to Section C)

2. ____Number of previous out-of-home episodes of care for **Index Child**

B. Referral-Current Episode *(if court case, see blue petition documents under court tabs.)*

Type of alleged abuse/neglect at referral-index child

____*1. Source/Report* [1=Law enforcement, 2=School, 3=Relative/Neighbor, 4=Medical professional, 5=Social service professional, 6=Self/Parent, 7=Daycare, 8=Anonymous, 9=Other

2. Type of alleged abuse/neglect-index child. If index child not abused, answer for abused sibling. If Yes for type of A/N, indicate alleged perpetrator(s).

2a. Type of abuse: [0=No, 1=yes, 2=Protective issue]	**2b. Perpetrator** [1=Mother, 2=Father, 3=Stepmother, 4=Stepfather, 5=Parent's girlfriend, 6=Parent's boyfriend, 7=Other relative, 8=Other]
____ a. Sexual abuse	
____ b. Physical abuse	
____ c. General neglect	
____ d. Severe neglect (positive tox)	
____ e. Emotional abuse	
____ f. Exploitation	
____ g. Caretaker absence/Incapacity	
____ h. Failure to protect	

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3. ____ Social workers overall rating of risk. See risk assessment form. (77=insufficient information/unknown, 1=low, 2=moderate, 3=high risk, 0=no risk)

4. Severity/frequency code from risk assessment (low, medium, high) for abuse____. For neglect____. If more than one type of abuse code for all applicable.

V. SERVICES

RID_____

Services provided [0=No, 1=Yes, 99=N/A, 77=Unk]	**2. Provided for who?** [1=Parent/Guardian, 2=Child, 3=Family, 4=Sibling, 5=Other, 99=N/A, 77=Unk] If more than 1, separate by comma.	**3. Used/Utilization** [1=Yes, 2=No, 3=Referral only, 77=Unk, 99=N/A]	**4. Initiated by?** [1=Court, 2=Voluntary plan, 3=CSB, 4=Client request, 77=Unk, 99=N/A]
__1a. Travel related			
__1b. Client advocacy			
__1c. Family therapy/counseling			
__1d. Psychiatric evaluation			
__1e. Psychological evaluation			
__1f. Individual counseling/therapy			
__1g. Domestic violence services			
__1h. Substance abuse treatment/ evaluation			
__1i. Alcohol abuse treatment/ evaluation			
__1j. Day treatment			
__1k. Parent support group			
__1l. Parent training			
__1m. Teen/child support group			
__1n. Recreation			
__1m. Employment/training/ education for adult			
__1n. Financial/budgeting			
__1o. Income support/public assistance			
__1p. Homemaker			
__1q. Childcare			
__1u. Parent/child conflict management			
__1r. Educational/child			
__1s. Medical/dental			
__1t. Family planning			
__1u. Emergency shelter			

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Services provided [0=No, 1=Yes, 99=N/A, 77=Unk]	**2. Provided for who?** [1=Parent/Guardian, 2=Child, 3=Family, 4=Sibling, 5=Other, 99=N/A, 77=Unk] If more than 1, separate by comma.	**3. Used/Utilization** [1=Yes, 2=No, 3=Referral only, 77=Unk, 99=N/A]	**4. Initiated by?** [1=Court, 2=Voluntary plan, 3=CSB, 4=Client request, 77=Unk, 99=N/A]
__1v. Housing			
__1w. Clothing, furniture, car repair			
__1x. Independent living			
__1y. Legal services			
__1z. Big brothers/sisters			
__1aa. Food			
__1bb. Parents Anon			
__1cc. NA/AA			
__1dd. Group counseling			
__1ee. Residential			
__1ff. Other. Specify: _____			
__1gg. Other. Specify: _____			

Reason client utilization below level.

Service # and letter. Code all that were coded as a 2=No.	**Code for underutilization. [1=Services unavailable, 2=No money, 3=No transportation, 4=Waiting list, 5=Client ill, 6=Client refused, 7=Client drug & alcohol, 8=Social worker did not comply, 77=Unknown, 10=Other, specify in block]**

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2. Family Agency Interaction. From Risk Assessment Form

	A	B	C	D	Highest
2a. Cooperation with staff					
2b. Progress in treatment					

VII. SOCIAL WORKER CONTACTS

RID #_____

1a. Date of contact	**1b. Type of contact** [1=Phone, 2=Office visit, 3=Field visit, 4=Home visit, 77=Unknown, 99=Not applicable]	**1c. With who?** [1=parent/guardian, 2=index child, 3=sibling, 4=Other family member, 5=Service provider, 6=Friend/Neighbor, 7=Other] Code all that apply.
1.		
2.		
3.		
4.		
5.		
6.		
7.		
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24.		
25.		

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VIII. CONDITIONS FOR CARETAKERS

Who? [1=Mother, 2=Father, 3=Both, 4=Guardian]	**By?** [1=Court, 2=Involuntary plan, 3=CSB, 4=Prison/Parole]	**What?** [1=Household, 2=No corporal punishment, 3=No drugs/alcohol, 4=Stay in contact with social worker, 5=No/Restricted contact with perp, 6=Treatment, 7=Other	**Met/Unmet** [1=Yes, 2=No]
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

IX. SOCIAL WORKER INFORMATION RID# _____

1. Identify all social workers who have signed court reports or narratives.

1. SWID	**1b. Highest degree** [6=Dr., 5=LCSW, 4=MSW, 3=MFCC, 2=Other MA, 1=BSW, 0=Other	**1d. Date case received**	**1e. IVE?** [1=Yes, 0=No] Check list.

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X. FAMILY AND SOCIAL CHANGES

Type of change [1=Yes, 0=No]. Except for italicized events, you are only interested in events that have occurred while receiving service or in the prior year to receiving services.	**When?** [1=While receiving services, 2=Within 1 year before case became active, 3=Over a year before case became active, 4=Not known]
___1=Separation	
___2=Divorce	
___3=Marriage	
___4=Pregnancy	
___5=Addition to household other than pregnancy	
___6=Death of child in nuclear family	
___7=Death of parent in nuclear family	
___8=Death in extended family	
___9=Loss of job, mother	
___10=Loss of job, father	
___11=Change of job, mother	
___12=Change of job, father	
___13=New job after unemployment, mother	
___14=New job after unemployment, father	
___15=Eviction/Homeless	
___16=Moved to worse housing	
___17=Housing move, better house, neutral or unknown	
___18=Major injury/accident, mother	
___19=Major injury/accident, father	
___20=Major injury/accident, child	
___21=Major illness, mother	
___22=Major illness, father	
___23=Major illness, child	
___24=Criminal justice involvement, mother	
___25=Criminal justice involvement, father	
___27=Incarceration, mother	
___28=Incarceration, father	

XI. OUTCOME EVENTS RID#_____

(Rereferral/Re-entry/Child still in home at case closing)

1. _____Is child still at home at case closing [0=No, 1=Yes]? If No, indicate where child is: _____

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Abstractor Note: Questions here refer to rereferral.

2. _____ Number of rereferrals [if "0", go to next section].

2a. _____ Number of those rereferrals that came within 6 months of case closing.

3. _____ Was case reactivated (reentered)? [1=Yes, 2=No] If No, skip to next question.

3a. Date reentered _____.

Code for reentry only. Reentry means active case after case closure. Code for latest reentry. Code date for information below_____.

3. Source/Report [1=Law enforcement, 2=School, 3=Relative/Neighbor, 4=Medical professional, 5=Professional, 6=Self/Parent, 7=Daycare, 8=Anon., 9=Other: _____

Reason for Rereferrals [1=Sexual abuse, 2=Physical abuse, 3=Severe neglect, 4=General neglect, 5=Emotional abuse, 6=Exploitation, 7=Caretaker absence

Ref# Source:
4a. _____

Report Reason:
4b. _____

5. _____Child removed from the home? [0=No, 1=Yes]

XII. LEGAL PROCESS

RID#_____

1. _____ Is there evidence of a court action for the abusive episode in file? [0=No, 1=Yes, 99=N/A, 77=Unknown]. If No, stop.

2. _____ Was there a change in program designation? [0=No, 1=Yes]

2a. ____ If yes, what was the change_____?

3. _____ Discordance between CSB recommendation and court decision? [0=No, 1=Yes, 99=N/A, 77=Unknown] If No, go to 3.

4. Nature of discordance (specify, using verbatim text where possible and identify source) _____.

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5. How does the caretaker(s) respond to abuse allegation? _____

Response codes:	True finding? _____
1=Denies	0=No
2=Admits	1=Yes
3=Submits	99=N/A
4=Pleads no contest	
5=Other response (specify_____)	

6. Misc. comments _____

_____

_____

Revised 11/26/97

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APPENDIX B

CASE ABSTRACTION MANUAL

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CASE ABSTRACTION MANUAL

GENERAL DIRECTIONS:

Pick up your cases from Lynn Amabile. *Use request form in office for requests. Give her 5 days to get a case. Ask for about 7 or 8 at a time.*

When a case is done return to her immediately.

There are two types of cases that you will be abstracting. The major difference is that you will find court reports in the court-mandated cases. In the voluntary plan you will not ordinarily find a court report, but you will find cases narratives, case plans, and risk assessments. In voluntary cases, you will rely on narratives. With multiple files, the original social study is a good source of information. Voluntary cases are sometimes called DD for Dependency Diversion. In court cases, you will rely on court reports.

TIMELINE:

Data Collection Timeline

	1995												1996												1997		
	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M
Case entry window	---	---	---	---	---	---	---	---	---	---	---	---															
Case opened for service delivery	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---			
Case closings													---	---	---	---	---	---	---	---	---	---	---	---			
Follow-up period																									---	---	---

You want to abstract cases that entered the data window between January 1st and June 30th. If there were multiple entries during that period, pick the last case opening. You collect data about services only for the period after a case was opened in the data window. You continue to collect service data until the case is closed even if services are delivered after the case is closed. Cease collecting service data after case closure even if the case is reopened. If the case was reopened after that closure, do not collect any service data. You are then only interested if there were prior referrals/reentry data before the data window opened (or before January 1, 1995). You are collecting no other data for that period. You are interested in collecting data about referrals and reentries after case closure.

We will get some cases that have been opened prior to the window, but have been transferred, or there has been a brief investigation, and was then closed. I have added a code for these cases.

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Only code additional information for these cases if there is activity in the window. Case files of the oldest sibling have more data about the caretaker and family than the other siblings. When you are abstracting a younger sibling's file, make sure you fetch the oldest siblings. The oldest child always has an 11 code after the case number. The second child would be 12, the third 13, and so forth.

NOTE: CASE NO., DDS case number, and RID# are one and the same.

ABSTRACTOR: First and last name

ABSTRACT DATA: Date abstraction performed.

TIME TO COMPLETE ABSTRACT: Give in hours and minutes.

CASE OPEN DATE: Date child began receiving service from DSS. When the child is born positive tox, use the child's birthdate as the case open date. The date should be on the front of the file. Make sure you get the date appropriate to the data window. The date may also be found in the petition if filed, or under the tab filed intake or law enforcement.

CASE CLOSE DATE:_____

CODE TRANSFER DATE IF A TRANSFER WAS THE ONLY ACTIVITY IN WINDOW.

I. Characteristics of Child

DATE OF BIRTH, GENDER, AND RACE/ETHNICITY: See the Face Sheet in the case file and the ethnicity code sheet in the manual's appendix to code these items. H or S is sometimes used for Hispanic. Assume Mexican American unless there is some other designation for Hispanic.

GRADE IN SCHOOL: On Face Sheet and in the Social Study court report, under the court report tab (right side). Make sure to refer to the sheet having the date nearest the period that the child was receiving services. As a general rule on all documents, you want the latest one closest to the date services were received. If the child is on vacation from school and scheduled to enter a higher grade upon returning to school, code the higher grade as the child's grade. Code Special Education as 88=Other and specify, even if a particular grade is given. (Include grade information in the Other specification.)

SPECIAL CHARACTERISTICS: Special characteristics are identified in court reports and in medical, psychological, or psychiatric evaluations. Their location is under the medical records tab on the left side. Answer "yes" only if there is documented assessment by a

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qualified professional, school, or other appropriate agency (e.g., San Diego Regional Center diagnosis of a developmentally disabled child), or if the social worker makes reference to the existence of such documentation. Answer "no" if there is no mention of the problem in the case record. For all special characteristics answer "suspected" if an evaluation for the particular problem has been requested, the social worker indicates the possibility of the problem, or if a non-professional third party, or family member reports the existence of the problem. A coding of "suspected" for severe behavioral problems requires a request in the case plan for a formal evaluation. Where formal evaluations for special characteristics are performed and the findings are negative, one may then answer "no" for the characteristics.

Mark yes/no/suspected for every special characteristic that meets a "yes" or "suspected" manual definition of it. That is, do not attempt to designate one of the characteristics as primary and code it while not coding secondary characteristics. For example, you may have someone who is both DD and has behavioral problems.

Additional Help:

a) Code *Developmentally Delayed* for cognitive communication, social/emotional, fine motor, or gross motor areas. Code speech disorder, attention deficit disorder, or disorder and weakness in language development as types of developmental delay. In some cases, it may not be clear if the child is developmentally delayed and/or learning disabled. As a guideline in such instances, regard developmental delays a more severe condition than learning disabled; if one has DD, she or he is also learning disabled. On the other hand, a learning disabled person is not necessarily developmentally delayed. However, if a child is clearly identified as having DD, do not code him or her as also being learning disabled unless there is mention of LD in the case file.

b) *Diagnosed Mental Illness:* Answer "yes" to this question only if a documented mental health evaluation has been completed which identifies the child's problem areas and/or specific diagnosis. Answer "suspected" if child is to be evaluated by a professional or was in counseling. DSM III-IV CODES (CHILD): See psych evaluation. DSM III codes are usually given in five axes. The first three axes constitute the official diagnostic assessment. Each individual is evaluated on each of these axes. Axes IV and V provide information supplementing the official DSM III diagnosis; they are not always filled in. The principal diagnosis will be assumed to be on Axis I unless the Axis II diagnosis is followed by the qualifying phrase "principal diagnosis." When this occurs, check the principal diagnosis box by Axis II. Occasionally the evaluator will offer diagnoses in verbal rather than numerical form. Record verbatim in the margins or on the back.

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c) *Learning Disability:* Child diagnosed through appropriate testing by school or other qualified professional as having an impediment to learning. See school tabs on the left side.

d) *Physical Disability:* For the purposes of this study, the areas of orthopedically impaired, health impaired, hearing impaired, and visually impaired shall be included under this category.

g) *Substance Abuse/Addicted:* Answer "yes" if child uses alcohol or drugs or has been diagnosed as being substance addicted—even if the child has completed treatment and is not currently "using." (When coding the special characteristics of adults, an underlying assumption again will be: "Once addicted, always addicted.") See drug treatment tabs on the left side.

g) *Substance Addicted at Birth:* Answer "yes" if child was diagnosed as being addicted at birth or as having Fetal Alcohol Syndrome. Answer "suspected" if the mother was positive-tox at birth and addiction of the child was not confirmed. One may code "no" if the mother was positive-tox but a medical authority reported that the newborn child was not substance addicted.

h) *Severe Behavioral Problems:* Child diagnosed as being behaviorally disabled via a psychiatric or psychological evaluation, or through a special evaluation by the school system. An answer of "suspected" is appropriate for those cases that have a case plan requesting an evaluation.

i) *Medical Problems:* Answer "yes" if child has *serious medical* problems that require a lot of time *and energy* on the part of the caretaker, caseworker, or hospital staff. Do not code normal childhood illnesses such as colds or sore throats. You are looking for things like diabetes or asthma.

j) Code enuresis and encopresis as *Eating/Sleeping Disorders.*

k) *School Problems:* Child routinely has problems (physical, mental, emotional, behavioral, but not absenteeism) that affect his performance in school, as verified by a teacher, school principal, or school psychologist.

o) Use the *"Other"* slots for coding behaviors that might be problematic, but which are not covered by other categories.

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II. CHARACTERISTICS OF FAMILY/HOUSEHOLD (See Face Sheet)

1. All adults living in the home mentioned in the narrative should be included in the abstraction. Adults should consider the home where services were first delivered as their primary residence. Do not count foster homes. It is not unusual for children to move several times while the window is open. Count the first residence where they began receiving services. A boyfriend of the mother who stayed in the child's home on weekends, would not be coded as living in the home. If the family is homeless, count the shelter or wherever they happen to be living as home.

2. Number of Siblings. Indicate the total number of biological siblings the index child has. Then indicate the number of those siblings who are living **in the home at the time the family was receiving services.** In case of multiple moves, code the home where services were first received. Consult the Face Sheet. Only count stepsiblings if they live with the child.

3. Sibling Characteristics. Start with the oldest child and work down to the youngest.

4. Note family's living arrangement at time they began receiving services.

III. CHARACTERISTICS OF SIGNIFICANT ADULTS/FAMILY
B. Natural Mother, C. Natural Father, D. Other Caretaker

Over the next several pages of the abstract form, one will be coding demographic and special characteristics data for up to three **Significant Adults** per case. Generally, you can expect to find this information on the Face Sheet, court reports, or narratives. Significant Adult is defined as: 1) all adults **noted in the case file** who are biologically related to the index child—regardless of whether or not they have a social relationship with the child, and 2) all adults **noted in the case file** who are not biologically related to the child, but with whom a social relationship to the child exists or existed (e.g., parent's boyfriend, stepmother, etc.). Abstract data on stepparent, boyfriend/girlfriend, or grandparent living the home during the period of service delivery. Collect on one in order listed. Stepparent first.

CHARACTERISTICS OF SIGNIFICANT ADULTS:

You will always find more information on mothers than fathers. It is not unusual for there to be little if any information on significant adults. Even if only a couple of items are known from the case file on the third significant adult, go ahead and enter them, and code the other items as unknown.

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Special characteristics are identified in court reports and in medical, psychological, or psychiatric evaluations. Coding of Significant Adult special characteristics largely follows the conventions established in the Characteristics of Child section. Domestic violence is to be checked only if between adults. An example of the use the "Other" code would be: perhaps the person is a Significant Adult rape victim. Feel free to make liberal use of "Other" options.

Additional information:

Where a significant adult receives substantial attention in the court reports or narratives and there is no mention of him or her having a given special characteristic, answer "0=No" to the characteristic item. Where a significant adult is barely addressed in the court reports, answer "77=Unknown" to characteristic items for which there is no data. Entering "77" in items for which there is no data would also be appropriate when the adult in question is described in the court reports as refusing to provide personal information. Choosing between No and Unknown is problematic. "Unknown" is appropriate when the social worker says it is. "No" is appropriate when there is no mention of a problem in the file. Assume social workers would identify a problem if it existed. No mention of alcohol abuse would be coded a No. If the social worker said he/she did not know whether a client had an alcohol problem, it would be coded as Unknown. Throughout the instrument use "77" for Unknown, even when an item does not have a code for unknown. Use "99" for Not Applicable. Always code an item. Blank items will be treated as missing data.

Education: Take a close look at the court reports, narratives, and psychological evaluations to try to get data on highest grade/degree completed. For significant adults but not for index child, it is permissible to convert information such as "father dropped out of school at age 12" to grade equivalent.

The *Highest Grade Completed* items for significant adults elicits somewhat different data than the index child's Grade in School item. Take "Highest Grade Completed" for the adults literally. The highest grade completed of a significant adult in the middle of her or his 12^{th} grade studies is grade 11. If a significant adults gets his or her GED, code "12" as their highest grade completed and write "GED" to the side of the Highest Grade Completed item.

Income Source: The Face Sheet should indicate whether Significant Adults are employed. As before, make sure you are using the Face Sheet that was completed for the time the family was receiving services. The blue, handwritten Face Sheets frequently offer more detail on income source than the printed sheets, but defer to the printed ones if there is a conflict of information. See also court reports, especially the Social Study. Additional Income: Legal. Specify. (Do not code as employment any paid-for labor mandated under General Relief.) If the case file says that the adult is employed but offers no additional

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information on whether this is employment full or part time, code the employment as full time. You may see reference to illegal activities in the files such as drug dealing or prostitution. Code in illegal income item.

Occupation/Profession: Always specify type of work rather than employer when you can. Fill in also if at baseline the adult is unemployed from a certain type of work that he or she usually does for a living. If the adult is employed at baseline and also retired from a career, mention the career retired from on the Occupation/Profession line.

Economic Contributor to Child's Home: Assume a contribution if adult lives in the child's home and has any income. If adult does not live in the home, code as contributor, only if file indicates contribution.

Marital Status: Separated: Code the adult as separated if the SW's ct. reports, psych eval, other documents say she/he is separated. One needn't determine whether legal separation is involved. Common Law Marriage: Code as "Married" and specify Common Law in the margin.

III. Family Environment

1. *Situational Problems:* (This information is found on the court reports, narratives, and face sheets).

   Inadequate Housing and Unsafe House. Code Inadequate Housing for conditions of the house. Code Unsafe house for behavior of the residents of the house, which places the child at risk. *Unsafe neighborhood* refers to situations outside the house. The child's house could be safe, but the neighborhood could present a danger. Code any indications of deprivation of food and clothing.

1. and 3. *Social Support.* Is there any mention in files of family receiving support from any of the following? Support refers to the provision of concrete help (childcare, loan, food, etc.), and the provision of emotional support (advice, counseling, consoling, visitation). [1=Yes, 0=No]. One mention is enough to code yes.

IV. CASE CHARACTERISTICS

PRIOR HISTORY: (See Intake and Law Enforcement Tabs).

Prior CPS history data on both the index child specifically and her/his family should appear in the Social Study court report. Code whatever the Social Study mentions, whether or not

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the data pertains to residence in California (or Washington). In Number of Previous Referrals/Contacts Related to Family, we are looking for previous referrals regarding any child or combination of children in the family. If there is indication of previous involvement with agency but record is incomplete and/or missing information like specific intake information, code this “99” for unknown as opposed to “0” for no previous referrals.

Referral-Current Episode

TYPE OF ALLEGED ABUSE/NEGLECT/INDEX CHILD AT REFERRAL:

C. Current Episode: At the time the index child was receiving services, what were the types of abuse or neglect cited as reason for DSS involvement with the family, and who were the alleged perpetrators? Answer for siblings if index child not abused. There may be more than allegation. Consult the **blue** petition documents (at the bottom of the Court Orders section of the case file) that correspond with the child’s baseline data. (Under Court Tabs). Also, consult the Social Study court report. Perpetrator/caretaker gives a restatement of the petition and offers additional information on the episode, including on alleged perpetrators who are not parents or guardians. ***Read the petition and Social Study while having on hand the Referral/Rereferral/Removal code sheets.*** The Referral/Rereferral/Removal code sheets show that exposure to parent’s physical violence is a type of Emotional Abuse. In other words, begin with verbatim language of especially the petition, find out what type of abuse/neglect listed on the Referral/Rereferral/Removal sheets. Stick with the petition and Social Study for abstracting this section. Other documents (e.g., in the Placement/Financial and Intake/Law Enforcement sections) may give their own reasons for the removal that can be at odds with the petition and Social Study. ***Caution! Petitions usually contain boiler plate language or standard phrases regarding “physical harm and illness,” “physical safety” that should not get abstracted for.*** In particular, do not take such phrases on their own as grounds for coding for Physical Abuse. Boiler plate language is especially common at the beginning of the petition, prior to a colon. Example (boiler plate language in bold):

> **Said minor has suffered and there is a substantial risk that the minor will suffer serious physical harm and illness as follows:** On or about 9-6-90 to 10-16-90 said minor was exposed to violent confrontations in the family home between his mother and father, **that endangered said minor’s physical safety and said minor is in need of the protection of the Juvenile Court.**

The only type of abuse that should get abstracted for in the above example is Emotional Abuse.

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Follow the petition and Social Study in considering “Failure to Protect” a type of abuse/ neglect. When failure to protect occurs, there will be a 300(B) W & I code, and the party(ies) who failed to protect the child from the abuse/neglect directly perpetrated by another party(ies) should clearly be identified in the petition.

Protective Issue: If a 300(J) code appears on the index child’s petition, it usually indicates that he or she was pulled from the home at least in part due to the threat of experiencing some type of abuse/neglect that a sib, allegedly, did experience. For example, the index child might have been removed not because she was physically abuse, but because her sib was. One would then code “2” for Protective Issue by Physical Abuse under Type of Abuse on the index child’s instrument, and under Perpetrator(s), code for whom the petition alleges physically abused the sib. However, sometimes 300(J) appears on the index child’s petition for other reasons (e.g., to indicate that in addition to herself, a sib(s) also experienced abuse or neglect. In such cases, just code “1” for Yes under Type of Abuse on the index child’s instrument. “1” for alleged actual experience of A/N always overrides “2” for threat of experience.

If type of abuse is confirmed substance addiction at birth (pos. tox) (see item 6, p. 2), code 3, Severe Neglect.

Severity frequency code from risk assessment. If more than one type of abuse, code for all applicable.

VI. SERVICES

Court reports and case summaries provide a list of services provided the child, caretaker, and family. The service plans should be attached to the court report. Look for services in voluntary cases with the service plan. The worker will also comment on utilization. Reports and summaries in the court orders and court summaries, unless they are clearly identified as CSB-initiated or caretaker-requested.

Additional Information:

Initiated by: Court-ordered services will be clearly indicated in the files. CSB-initiated services will only be learned of by reading the court reports. The court order for the dispositional hearing frequently lists services and conditions. Date these services according to the date assigned to the court report document itself-even when, as is sometimes the case, the SW gives an exact initiation date.

Utilization/Use: Code as yes or no. If a parent completed a set of parenting classes, code yes even if there were indications at some point that the parent did not finish. If she/he

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started classes but never finished code as no. If you cannot find any evidence of anything other than a referral for service, code as such.

Social worker referrals for court-ordered services: If the court reports reveal that the social worker/DSS are providing referrals or taking other steps to assist a caretaker in complying with a service that earlier was ordered by the court, do not code these actions as CSB-initiated services. However, each time the court orders a service, code it.

Attorney/Caretaker request of services which the court then order: The court summaries especially give examples of parents or attorneys requesting services that the court then orders. Code these as court-ordered services.

Provided for Who? Code all services to family not just those given to the child. Sometimes court orders do not make explicit for whom services are being provided (i.e., for both the mother and father, one of the two, etc.). Usually the court report dated closest to the given court order says exactly who is getting the services. If after reading the court report it is still unclear who is receiving the services, code "Who" as 77=Unknown. Code for family when it is obvious it is for the whole family like family counseling or shelter care.

If court documents state that given services are for "minors" without specifying which minors, code the service as ordered for "2=child." If child clearly not one of the minors codes as "4=siblings."

As a general rule, code a service category once for each service. The one exception is with residential. A second code is sometimes appropriate. One can receive alcohol and drug treatment and be in residential care. Code residence at KIVA as Drug/Alcohol Testing/Treatment (i.e., apart from any services provided while the caretaker is in KIVA).

Domestic violence includes any service provided for domestic violence. If client is in a shelter, code residential also.

Neurological evaluation: Code as a medical service.

Progress in treatment can sometimes be found in the narrative.

VIII. SOCIAL WORKER CONTACTS (see narratives)

You will have to read narratives to get this information. Include only contacts between case opening and case closing. Home visit refers to the child's home. Field visits refers to schools, agency treatment programs, etc.

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With who? Use parent to include bio and stepparent. Use caretaker if person caring for child is not step or bio. Family member refers to anyone not covered by previous code (grandmother, uncle, etc.).

IX. CONDITIONS FOR CARETAKERS (see court documentation and service plans)

We are interested in court-ordered or CSB conditions for M/F/G/O.

Conditions Household: Includes keeping the home safe and clean, maintaining a stable residence, eliminating the threat posed to children's well-being by dangerous appliances and other objects in the home or yard, etc.

Conditions Personal: Identify conditions stipulated by court. Includes those conditions stipulated by Parole Services and Prison authorities. Any condition in voluntary contract ought to be identified.

Answer Conditions Met/Unmet as a dichotomous choice. However sporadic a party's meeting of conditions may have been, code for whether or not she/he ultimately did or did not meet these conditions.

X. SOCIAL WORKER INFORMATION

Workers would usually provide information after their signature on court documents and narratives. Consult your list in Appendix of IV-E worker. For the most part, social workers do not give evidence of their degree.

XI. FAMILY AND SOCIAL CHANGES IN FAMILY SINCE REMOVAL

Is there any reference in the records to any of the specified events? For italicized events, we are interested if they occurred at any time. Other events are coded if they occurred within one year of the case opening and the period until case closed.

> Separation, divorce, marriage, pregnancy, and addition to nuclear family apply only to parents/guardians.
>
> Where there is addition to nuclear family before the project close date, do not also code pregnancy. Code pregnancy but not addition to nuclear family when birth occurs after PCD.
>
> Code abortion or miscarriage as a pregnancy.

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If a person quits a job, code it as job loss. For whatever reason is recorded for person stopping work, code as a job loss.

If housing mover was to worse housing, code it as such. But if to better, no change, or unknown, code that category. If multiple moves in period, code only once.

XI. OUTCOME EVENTS (see cover of file)

We will code only for rerefferals that are dated after the index child's case was closed. Make sure you pay close attention to post 6 months of case closure. It is important that you note if the child was in the home at case closure since that is an outcome measure.

REENTRY: Means after case closed date was the case reopened? Note if the child was entered into out-of-home care at any time.

XII. LEGAL PROCESS

Indicate if there is any indication of court action in case. We are interested in any change in program designation, particularly with voluntary cases.

DISCORDANCE BETWEEN CSB RECOMMENDATION AND COURT DECISION?

Discordance refers to whether social worker and/or the judge agree on the type of plan given.

Discretion: The court orders and, especially, the court summaries frequently mention that at the hearing in question, the court is giving discretion to CSB or the assigned social worker regarding visitation, services, detention/placement, etc. To code, the discretion should clearly apply to CSB or the social worker. Note even if the discretion is conditional (e.g., upon the agreement of an attorney).

Revised 9/24/97

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TITLE IV-E GRADUATES EMPLOYED BY SAN DIEGO COUNTY

Class of '94
TOTAL: 11

Beck, Gina
Coronado, Alice
Dunford, Alison
Edwards, Virginia
Hofheins, Coreen
Jaime, Carmen
Luangviseth, Suzanne
Martin, Gale
Mori, Kimberly
Ozolins, Diane Parker
Ruegg, Paul

Class of '95
TOTAL: 11

Byrd, Courtland
DaSilva, Therese
Hanson, Lara
Hodom, Susan
Koch-Wenger, Jennifer
McGee, Cheryl (transferred to Contra Costa County)
Moua, Seng
Palafox, Martha
Supranovich, Ruth
Wilkins-Gjada, Paola
Yang, Pao

Class of '96
TOTAL: 17

Adam, Laurel
Broers, Esther E.
Crawford, Loretta
Cureil, Miriam
Donahue-Watson, Maureen
Edwards, Ronda K.
Gustavson, Jean
Kelly, Patricia
Marron, D'Alicia
Martinez, Julius
Nichols, Ann Marie
Peck, Karen M.
Sakahara, Karen
Schulte, Linda
Taylor, Nakima E. (former Esther Kiwanuka)
Winter, Leslie
Wojtach, Barbara

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CHOICES:

A CHILD WELFARE CURRICULUM MODULE ON VOLUNTARY SERVICES AND COURT-MANDATED SERVICES

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CHOICES:
A CHILD WELFARE CURRICULUM MODULE ON VOLUNTARY SERVICES AND COURT-ANDATED SERVICES

A. Purpose

Society has given Child Protective Services (CPS) an enormous obligation to protect children and preserve families. They carry out this task in the context of increasing reports of child maltreatment and at a time when society gives CPS fewer resources to protect those children. The decision by child welfare agencies to intervene with families has enormous implications for a democratic society. Errors by child welfare workers can threaten the integrity and privacy of families. Practice theory, social policies, and agency procedures have not provided a consensus on the criteria to make decisions about intervention with families (Gleeson, 1987; Knitzer, Allen, & McGowan, 1978). The lack of clear guidelines has resulted in the failure to protect children and families.

In the late 1950s the suggestion first emerged that research in child welfare ought to give great attention to the decision-making process. The purpose for doing so is that guidelines for decision-making can be developed (Wolins, 1959). Fanshel (1962) suggested that these research efforts should focus on the decision-making choice points found in child welfare.

The initial investigation and subsequent treatment in child maltreatment cases involve local law enforcement officers and social workers representing child protection agencies. These professionals are responsible for the initial decision-making stages, and

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the disposition of cases. One decision the worker makes is whether to leave the child in the home or remove him or her to out-of-home placement. Among children who have substantiated cases, but have been left in their homes, the social worker must decide whether to seek court intervention or develop a voluntary plan for services with the caretaker.

This module focuses on the decision to give a child's caretaker a court-mandated or voluntary service plan. CPS workers must decide, after substantiating a child abuse complaint, whether to request the court to mandate services with the caretaker, or to develop a voluntary plan. Court-ordered services are assumed to provide an element of social control that protects the child, and provides a stimulus that enhances the likelihood that families will get needed services. Proponents of voluntary plans assert that court intervention introduces an adversarial element into the worker-client relationship that works against the therapeutic change process (Wilk & McCarthy, 1986). Voluntary plans are assumed to be less intrusive and coercive, and thus reduce some social concerns about child protection.

B. Learning Objectives

Through this module, students will be able to:

- Discuss the pros and cons of voluntary versus court-mandated plans;
- Identify criteria for the selection of court-ordered or voluntary plans;
- Outline key research findings concerning the effects of court mandates on service utilization, case outcomes, and client worker-relationships;

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- Discuss differences among professions involved in child welfare regarding the choice of plan;
- Review the major limitations of the research studies in the area;
- Discuss practice differences with voluntary and court-mandated families;
- Evaluate the major ethical dilemmas of practice with court-mandated and voluntary plans;
- Identify factors which might increase positive outcomes with both voluntary and court-ordered plans; and
- Identify ways to engage non-voluntary clients

C. Background and Basis for Concern

In 1994, states reported 2.9 million cases of substantiated child abuse. In most of these cases voluntary services were offered to the families. Dependency petitions were filed in 3-21% of cases (Barth, 1996). However, a survey of 1,000 state, county, and regional administrators suggested only a little more than half thought in-home services should be voluntary (Berrick & Karski, 1995). Debates about the utility of the choice of court or voluntary plans can be found in the literature, but empirical data to aid decision-making is lacking.

Proponents of voluntary plans assert that court-mandated intervention might limit the number of families who might seek services voluntarily because they see the court as punitive, and fear legal consequences. DePanfilis (1982) claims that despite mandatory reporting laws, private agencies are equally concerned about referring their voluntary cases to a sometimes impersonal system of reporting and investigation. A voluntary option is

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assumed to increase the number of families receiving services, perhaps at earlier stages of risk, and thus preventing the need for more expensive “after the fact” services.

On the other hand, voluntary plans may place children at more risk due to lowered ability by the worker to see that a caretaker utilizes services. The court also provides the client protection against arbitrary and faulty decision making by workers as court cases are subject to judicial review. Voluntary plans may be more costly because if they do not work, child protective service (CPS) workers must still file for court intervention. Surprisingly, there is a paucity of empirical data utilizing child protective samples to help identify which choice would be the best option for social workers.

Voluntary programs are attractive because they support the family structure, limit state intervention in private family matters, and meet the requirements of P.L. 96-272. Some support these programs as a cost savings alternative to out-of-home care. Others remain skeptical on how effectively in-home services prevent child maltreatment (Schuerman, 1991). Wells & Biegel (1992) assert that the empirical evidence is mixed on the effectiveness of family preservation services that are delivered in-home.

Others suggest that voluntary plans are not really voluntary. The crisis nature of intake may force clients to make rapid decisions. Clients may feel coerced to acquiesce to voluntary plans for fear of the alternative.

An additional concern of court intervention is the cost involved. In San Diego County, more money is spent in the dependency system on legal services than is spent on treatment services (Davis, English, & Landsverk, 1993). Presumably, if voluntary plans

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were just as effective in reducing child maltreatment they would be the cost efficient choice between the two options.

D. The Empirical Evidence

Surprisingly, there is a paucity of direct empirical data utilizing child protective samples to help identify which choice would be the best for social workers to make. One study, which examined the difference between court intervention and voluntary treatment for abusive and neglectful parents, found that court involvement did not necessarily make someone less amenable to treatment (Iruesta-Montes & Montes, 1988). This study found the court-ordered group made comparable gains in parenting skills compared to those persons receiving services voluntarily. They argue that compliance can be gained from court-ordered mandates when the court spells out the nature of treatment, by whom, how frequently, what behavioral changes are demanded, and for how long the intervention is expected to last.

DePanfilis (1982), using data from a small quasi-experimental study utilizing a protective service sample, found that voluntary cases had lower placements rates, shorter stays in placement, and briefer periods of treatment. She suggests the two most important factors to decide who gets what type of plan are the motivation and self-awareness about the problem by the client. Wolfe, Aragona, Kaufman, and Sandler (1980) report that a court order was more likely to spur completion of a parenting skills program. However, they do not comment on whether treatment was effective. Other research examines child abuse prevention programs where the intervention is with families where abuse and neglect has

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not occurred at a level to sustain legal intervention, but families are considered high risk. Most of these programs struggle with engaging and maintaining voluntary involvement of target families (Larner, Halpern, & Harckavy, 1992; McCurdy, Hurvis, & Clark, 1996).

Other research is available from related fields of service that examined whether voluntary or court-ordered treatment is effective. The following are studies from domestic violence, substance abuse, and mental health. All of these are settings in which CPS clients are likely to be found, so they do have some relevance.

Rosenfeld (1992) reviewed 25 studies that collectively cast doubt on the assumption that mandatory psychotherapeutic treatments are effective in reducing incidents of violence between spouses. In many of the studies he reviewed, the choice was between court-ordered treatment versus arrest and incarceration. He asserts the differences in the reoccurrence of intimate partner violence between subjects receiving court-ordered treatment, those arrested, and persons who do not receive any treatment are small. Also, he reports many subjects withdraw from court-ordered treatment, indicating that legal system involvement does not motivate unwilling clients. On the other hand, Dutton (1986) used a quasi-experimental design to examine post-conviction rates of 50 men who completed a court-ordered treatment plan against those who received nothing at all. He found the treatment group had a 32% lower recidivism rate during a 3-year follow-up period. Dutton concludes that court orders improve the protection for women who remain in relationships with husbands who would not seek treatment voluntarily.

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A review of the history, development, and current status of drug control programs asserts that voluntary and coerced treatment show about equal effects in effectiveness (Inciardi, McBride, & Rivers, 1996). Brandsma, Maultsby, Welsh, and Heller (1977) report results that they assert are in accord with several other studies. They found that both voluntary and court-ordered subjects showed a similar unwillingness to complete treatment. In order to increase compliance with treatment, they introduced "intensive social work home visitation." Some researchers have suggested aggressive follow-up is needed to ensure client completion (McCurdy et al., 1996). This follow-up did not increase compliance but they did find that subjects were more likely to drop out of treatment for "physical" (moving, income, incarceration, etc.) reasons rather than "psychological ones" (disinterest and lack of motivation).

Inciardi et al. (1996) assert that many addicts would not seek treatment without court intervention, but admit that not all those mandated to attend treatment actually show up or remain engaged. Both of the above sets of researchers suggest that the severity of the sanction and the likelihood of it being imposed, are critical in determining whether people remain in treatment. They do concede that effective treatment alternatives to incarceration are cost effective.

Wells-Parker (1994) used meta-analysis to review the literature on drinking and driving programs and asserts that rehabilitation is more effective than coercive interventions like automobile license revocation. She argues for a combination of strategies such as sanctions combined with therapy, education, and monitoring. Schottenfeld (1989), in

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another review of the literature, finds involuntary treatment for substance abuse to be an impediment to treatment. The involuntarily treated tend to deny problems related to substance abuse. He notes that others define the presenting problem for involuntary clients. Voluntary clients are more likely to admit the problems of addiction and withdrawal. However, he does note it is possible to be court ordered to treatment but voluntarily accept services.

Lipsky (1980) suggests court-mandated clients can be engaged by attaching client-centered goals to the court-mandated goals. Mandated goals consist of things like drug/alcohol abstinence, gainful employment, and avoidance of criminal activities. Client-centered goals include providing for financial needs, help in taking care of dependents, providing concrete goods and services (e.g., disposable diapers, transportation, toys). These provisions provide an immediate tangible benefit for participants that encourage a person to give the intervention a chance (Barth, Hacking, & Ash, 1986). Identifying a number of shorter-term, easily achievable goals in the initial stages of work with a client may increase engagement with services. Such an approach may help foster a sense of accomplishment and establishes some positive experiences

Cournos, McKinnon, and Stanley (1991) compared the records of 51 involuntarily medicated and 51 voluntarily medicated patients in a psychiatric hospital. They found that forced medication did not return a patient to the community more quickly, or get the patient to eventually comply with medication. No differences were found between groups in

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discharge rates, compliance with staff, or relapse. However, initial improvements in the patient's mental health were noted.

The empirical studies suggest factors that are important in considering what type of plan: (a) client motivation to engage in treatment, (b) willingness to acknowledge a problem, and (c) court orders are useful to engage clients and protect victims, but unless motivation to engage in treatment does not develop at an early stage of intervention, the client is likely to withdraw from treatment. The non-empirical literature suggests motivation can be developed in non-voluntary clients by attending to client needs beyond the reason for the mandated intervention. The empirical studies also indicate mixed findings on the effectiveness of the use of court coercion to bring about change.

E. Different Professional Views of Choice of Plans

Studies suggest that there is a divergence of opinions on the utility of different types of plans based upon professional training/affiliation. Wilk and McCarthy (1986) find police officers are in favor of court mandates. They speculate that police officers view perpetrators as criminals in need of punitive treatment rather than social services. Fridell (1991) suggests police are suspicious of any diversion schemes such as voluntary plans, and would like to use the courts because they believe that would increase compliance with treatment. Fridell unexpectedly found that mental health professionals providing services to families favored court intervention, possibly because they see the advantage that a court order provides in assuring attendance at counseling sessions. Craft and Clarkson (1985) found lawyers were more likely to urge court intervention than child welfare workers.

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Lawyers are comfortable with the adversarial nature of the courtroom, and they see the courts as the best guarantor of the rights of all the involved parties. All of the above researchers found social workers to favor voluntary plans.

Finkelhor (1979) suggests social workers favor such plans because the treatment orientation of child welfare contains a belief in rehabilitation. Slonim-Nevo (1996) suggests that social workers find involuntary plans clash with the profession's core value of self-determination and social workers' view of themselves as change agents rather than as agents of social control. Social work practitioners have an education that stresses the limits of coercion in bringing about therapeutic change. Social workers would prefer a less adversarial approach than the court provides. They come from an atmosphere where there is a reliance on trust and cooperation. These workers find the adversarial process of the courts to be foreign, uncomfortable, and in some instances unproductive (Duquette, 1980).

Finkelhor (1979) notes that this paradigm may not protect children from sexual abuse. He recognizes that there is an alternative view of treating sexual abuse as a criminal act, and like any other assault, uses the full weight of the justice system to punish the act rather than try to rehabilitate.

F. Summary of the CalSWEC-Funded Research

The following is a summary of the CalSWEC-funded research and is meant as an addition to the empirical literature on court mandates versus voluntary services. The general objective of this research was to compare the relative effectiveness of court-mandated services versus voluntary service plans in preventing child maltreatment

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recidivism. Two groups were compared (a group given a mandated plan versus a group given a voluntary plan) on dependent variables derived from public policy notions of success in child protection. Four hundred and fifty children were selected at random from the 1,898 children for whom the Department of Social Services in San Diego (DSS) filed a petition or gave a voluntary plan for child maltreatment reasons between January 1 and June 30, 1995, and who initially received services in their homes. Eighteen cases were eliminated from the sample because a review of their case files indicated they were not study eligible.

Files of study children were reviewed to identify child, parent(s), and family characteristics, characteristics of the alleged abuse, history of prior CPS involvement, service delivery history, and outcome variables.

Findings

Situations that would suggest heightened risk warranted court-mandated plans. This finding is not surprising given the practice wisdom about court plans. Children in families who had received court plans exhibited more problem characteristics than children in families receiving voluntary plans. Significantly higher rates of severe behavior problems, mental illness, learning disabilities, developmental delay, runaway behavior, juvenile delinquency, and substance abuse were noted with this group. These problems may make it appear that parents need more intrusive and coercive supervision to deal with these issues. Parents and other significant adults of the children in the court-mandated group

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also had significantly more problems than the other parents did. They were more likely to be perpetrators, have substance abuse problems, criminal histories, and mental illness. These parents may need the added stimulus of court intervention in order to bring about change in the family.

Hispanic families were more likely to receive voluntary plans than other groups. White families were more likely to have court-mandated plans. Parents in families that received voluntary plans were more likely to be married to one another, which might suggest stability to social workers. Younger children in voluntary plan families were more likely to be in preschool or kindergarten than the court intervention families. This finding may suggest that children are getting supervision outside the family. Siblings were also more likely to be in the home of voluntary plans. It is possible that the siblings of children in court-mandated families are in out-of-home placements already, which is another sign of risk.

Court-mandated families were more likely to have been homeless and to have a death of a child at some point than families receiving a voluntary plan. Court-mandated families were also more likely to have lived in unsafe housing. Again, these factors suggest families that are at a greater risk than voluntary families.

Children from families who have had a previous history of involvement with DSS received court plans. It is possible that they received a voluntary plan in a previous contact with DSS, and it was determined because of the new referral that more intensive and

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coercive supervision was needed. Also, when failure to protect was an issue, and the mother was the perpetrator, families were more likely to receive court-ordered plans. Failure to protect results from situations where the caretaker is unable or unwilling to protect a child from an abusive situation. Added court intervention may be seen as needed to afford that protection. Finally, as expected, the higher the assessed risk by the social worker, the more likely the case will involve court intervention.

Court-mandated cases were open on average 16 months, and voluntary cases on average 6 months. Court-mandated cases received more clinical, substance abuse, and residential services. These findings are consistent with greater risk found in court-mandated cases. The longer length of time a case was open, and the greater number of services supplied this group relative to the voluntary plan cases, is a reflection of the need to address that risk. Court-mandated families were more likely to utilize the services they were provided than those with voluntary plans, which provides some evidence of the utility of court mandates. However, no differences were found between study groups on the completion of case plan conditions. Generally, court-mandated cases had more contacts with social workers. Social workers had more contact with collateral agencies and workers in court-mandated cases, and they had more contact with the friends and neighbors of voluntary cases.

The most important type of services in preventing recidivism were those that helped the parent(s) carry out a parental or family function, for example, parent training or

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homemaker services. Substance abuse or clinical services did not prevent recidivism. It may be that families that respond to family services are families whose major problem is a lack of competence that is addressed by family services. Substance abuse services go to families with more intractable problems. It is also the type of problem where relapse is expected.

The major finding of this research is that type of plan did not make a difference on case outcome. Children were more likely to remain in their homes at the end of the service delivery periods in families that received voluntary plans. This finding is not surprising given the higher level of risk identified earlier. However, when other factors are controlled, the advantage of a voluntary plan disappears. Moreover, similar rates of recidivism were noted between both types of plans after the case was closed. Outcomes were no worse in the court-mandated group where their high level of risk would suggest the opposite. The mothers' characteristics and level of functioning were strongly associated with case outcomes. One factor that was used in case assignment that can be discarded is the number of problem characteristics a child has. The findings of this research suggest it is the mothers' functioning, and ability to deal with the child's difficulties that is the more relevant issue. Fathers' characteristics were not associated with outcome. Study children were more likely to live with their mothers and fathers, which made the mother's functioning more important to the child. Only 36% of study children lived with their biological fathers, but 83% of the children lived with their biological mothers. However, if the father is the perpetrator of

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abuse a case is more likely to fail. Children who lived with their biological mothers fared better than children who did not. Fathers were also important in avoiding new referrals when they are married to the biological mother of the child. Marriage may be taken by social workers as an indicator of stability.

Drug and alcohol abuse on the part of the mother seemed to be the most important problem characteristic associated with case failure. Over one half of the mothers in the sample had a drug problem at some point in their lives. Recycling these families in and out of the system will not end until effective means of addressing drug problems is available for this population. Receiving public assistance (AFDC, General Relief, SSI, social security, or unemployment insurance) was associated with avoiding recidivism. These forms of public aid may have at least guaranteed a minimum level of resources. Most of the study children lived in families that experienced high levels of deprivation. These findings have implications for welfare reform. The loss of benefits could result in more referrals and children in care.

G. Empirical Generalizations From the Literature and CalSWEC Research

The following represents a summary of the research findings from the literature regarding the choice of voluntary or court-ordered plans. Generalizations represent consensus findings in the literature.

- Most studies, including the CalSWEC-funded research, report similar rates of attrition and outcomes despite the type of plan given. A greater use of voluntary plans is warranted since they represent a more cost-effective and less coercive

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intervention. The use of voluntary plans is a prudent course of action, which would free up resources to pursue more effective means of intervention.

- Court-ordered plans are appropriate if:
    - Client does not acknowledge the problem,
    - Considerable risks exist for victims, and
    - Client is not motivated to change.
- Outcomes can be improved with non-voluntary plans if:
    - The court spells out the nature of treatment (i.e., who does the treatment, how frequently intervention occurs, what behavioral changes are demanded, and how long the intervention is expected to last),
    - The court provides some opportunity for choice by clients in the above issues,
    - The worker provides concrete tangible benefits in the early phases of treatment,
    - The client has some input on case goal setting, and
    - The court specifies sanctions for non-compliance, and client believes those sanctions will be applied for failure to comply.
- Court orders may be useful to engage individuals in the early phases of treatment, but unless motivation to engage in treatment does not develop at an early stage of treatment, the client is likely to withdraw from treatment.
- Court-ordered plans may be useful in protecting victims (maltreated children or abused spouses), but are not necessarily effective in changing behavior such as alcohol or drug abuse, perpetrating domestic violence, or ensuring the use of mental health services.
- Voluntary plans would appear to be most appropriate with caretakers who acknowledge their problems and are willing to take steps to correct them.

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- Professional affiliation is a powerful determinant of a worker's choice of type of plan. This assertion from the literature suggests client needs may be secondary to worker needs in choosing a plan.

- Receiving a voluntary plan is no guarantee of client involvement or success in treatment.

- It appears that longer periods of treatment are needed with court-mandated cases given the number and severity of problems noted and the presumed lower level of motivation to engage in treatment.

H. Some Suggested Alternatives

Most of the Northern countries promote voluntary, confidential (which means limiting reporting requirements while in treatment), and non-punitive services to encourage families to seek help. Services are available to all families, and the comprehensive nature of services is assumed to be a lure to utilization (Barth, 1992). In Belgium, the focus is on treatment and not investigation. Investigations only occur if criminal activity or severe abuse is suspected. Structurally, services are separate from the court and investigations because it is believed that trust necessary to treat families develops best without the threat of judicial or social intervention. An interdisciplinary team provides services. Intervention decisions are made with the involvement and participation of the family. If the family and team cannot agree on a plan and the team suspects abuse, then the case is referred to court. The court also maintains jurisdiction over child maltreatment cases where criminal activity has occurred (Marneffe & Broos, 1997).

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I. Class Activities and Assignments

☞Activity #1: Case Study Discussion

After reading Major Content Areas, Summary of Research, attached readings, and classroom presentations, distribute case vignettes. See below. Have students read the vignettes. Answer and discuss the following questions:

1. Which type of plan would you give the families described in the vignettes?
2. Provide a rationale for why you choose a particular plan. Identify:
    - Level of risk to victim,
    - Parent motivation to change, and
    - Parent prognosis for change.
3. What could be done to engage client or improve the case outcome?
4. Based on their responses to the vignettes, can the class come up with a consensus on when to seek a court mandate or voluntary plan?

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PHYSICAL ABUSE
VIGNETTE #1

Carlos, age 2, was brought into the hospital ER by his mother and stepfather. The mother, Maria Jones, had noticed that Carlos refused to stand on one of his legs and that it appeared swollen. When the doctor examined Carlos, it was determined that Carlos had a spiral fracture of the femur. When the doctor asked the mother how the injury occurred, the mother stated that she had left Carlos in the care of his stepfather, Sam Jones, while she went shopping for food. Carlos was fine when she had left for the store. When she returned she had noticed Carlos was crying and did not want to stand on his leg. She had asked Sam how Carlos was injured and Sam had that Carlos had fallen off the couch. Sam was in the process of calling the doctor when Maria had returned from shopping. Maria decided that going to the hospital was faster. When the doctor told Maria and Sam that Carlos could not have sustained this type of fracture from falling off the couch, the stepfather became anxious and agitated and admitted to pulling and twisting Carlo's leg while trying to change his diaper. Sam stated that he was angry with Carlos for not lying still while changing his diaper. Sam said he did not mean to hurt Carlos, but was afraid to tell Maria because Maria had told Sam that she would leave him if he spanked Carlos.

Maria is 20 years old and recently married Sam. Sam is in the military and was recently transferred to Camp Pendleton. Both Maria and Sam's extended family live in South Carolina. There is no immediate family in the area. Maria is 3 months pregnant with Sam's child. Maria was very angry with Sam, but stated she did not have any alternatives at this time to live elsewhere.

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PHYSICAL ABUSE
VIGNETTE #2

Angela, age 6, was discovered by the schoolteacher to have bruising on the backs of her legs that appeared to be made by a belt. Upon further examination by the school nurse, Angela had some bruising on her buttock area but no other location on her body. When Angela was asked about the marks, she began to cry and said that her mother had given her a spanking for breaking a vase. Angela stated that her mother had warned her not to touch the vase, but she thought it was very pretty and wanted to put some flowers in it. In the process, Angela dropped the vase. When asked if Angela had been spanked before, Angela stated that she has been spanked "many times" with a belt before. She says she gets spanked for making noise and for lying. Angela says her mother spanks her 5-year-old brother Darren, too. The nurse examined Darren and no bruises were found. Darren said he has been spanked, but couldn't remember the last time he was spanked. Darren did say that he gets spanked with a belt.

Upon reporting Angela's injuries to the child abuse hotline, it was found that CPS had two previous referrals on Angela and Darren. Both referrals were for excessive discipline and neglect. The mother had been warned by previous social workers about injuring the children to the point of leaving bruises. The mother had stated on both occasions that she would not spank her children with a belt. The mother, Karen, was a single parent and had a minimum wage job. She worked long hours and had neighbors and an aunt help watch the children while she worked. The mother often used physical discipline as the only means of disciplining her children.

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SEXUAL ABUSE
VIGNETTE #1

Sheila, age 8, and Katie, age 4, where brought into the receiving home because Sheila had disclosed to her friend's mother that an uncle was touching her "private parts." Sheila told the social worker that she had never told her mother about Uncle Mason touching her. Sheila stated that Uncle Mason had started touching her about 2 months ago, when he began to babysit Sheila and Katie after school. Uncle Mason had told Sheila that she would get into trouble if she told her mother what he was doing. Today, Sheila had seen Uncle Mason touch Katie, and Sheila was afraid she couldn't protect Katie. Sheila told her friend and her friend's mother, while playing at her friend's house.

Uncle Mason, age 19, is the mother's younger brother. When informed of the allegations the mother was distraught and had some difficulty accepting that her brother would do these things to her daughters. The mother stated however, that she would do anything to ensure her daughters' safety and would not allow Mason to have contact with her daughters. Subsequently in a phone conversation with the maternal grandmother, Mary Smith, the grandmother stated that Mason wouldn't do those things and wondered why Sheila would make up such a story. Mason denies that he has done anything wrong.

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SEXUAL ABUSE
VIGNETTE #2

Jackie, age 13, has disclosed that her father, Larry, has molested her over a 3-year period. The molestation consisted of digital vaginal penetration, fondling, and oral sex. Jackie was afraid that her father might begin to have sexual intercourse with her and told her school counselor. Jackie stated that she had once tried to tell her mother about the abuse but her mother told her that her father would not hurt her. When the social worker interviewed the mother, Maxine, she stated that Jackie had never told her that Larry had molested her. Maxine did recall that Jackie had told her once that her father was bothering her but Jackie was not very specific and would not tell Maxine how Larry was bothering her. Maxine asked Larry what he was doing to Jackie, but Larry denied that he was “bothering” Jackie. The mother believed her daughter, and appeared to be angry with the father. The mother agreed that Jackie needed protection; however, the mother felt that she could protect Jackie while the father remained in the home and received counseling. Larry stated that his daughter really had no reason to lie, but he was mystified that Jackie would make up such a story about him. Larry did agree that the family needed counseling and wanted everyone to begin right away. Larry did not see any reason to leave the home, and wanted Jackie to come home immediately. The mother works as a medical receptionist and the father works at the local transit authority repairing buses. There is an older male sibling, Frank, age 16.

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EMOTIONAL ABUSE
VIGNETTE #1

Rita, age 4, was reported by a neighbor because the mother, Sally, was overheard screaming at Rita “all the time.” The neighbor stated that the mother constantly yells at Rita and calls her names like “fucking bitch" and “little asshole.” The screaming and name-calling goes on for hours and happens every day. Rita appears to be small for her age and never smiles. On several occasions, Rita has wet her pants while playing in the yard. Rita would become hysterical and did not want to enter the house. On one occasion, the mother put Rita in a diaper and told her to sit in the front yard, “because everyone will know you are still a baby who can’t keep her pants dry.” Lately, Rita has taken to hitting the family cat when she is allowed to play outside. The neighbor has tried on several occasions to talk to the mother, but the mother says she’s in a hurry and doesn’t have the time to talk. The neighbor has never seen the mother hit the child. The neighbor reports that there is a younger boy, Eric, age 2, but the neighbor never hears the mother screaming at him, or calling him names. The neighbor has tried to befriend Rita, but Rita told the neighbor, “I’ll get into trouble if I talk to anyone.” There has been one prior referral on Rita from a public health nurse when Rita was born. The nurse was concerned that Rita had a low birth weight and the mother expressed frustration that Rita was a fussy baby and was having a hard time with her. CPS and the PHN followed Rita for several months and Rita gained weight and the mother appeared less anxious in caring for her.

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EMOTIONAL ABUSE
VIGNETTE #2

Hector, age 8, and Jacob, age 6, were reported to CPS by the police due to a domestic violence incident between the father, Victor, and the mother, Gina. Hector had called 911, because his father “was beating my mother again.” When the police arrived, they found that the mother appeared to be battered about the face and her left wrist appeared to be broken or badly sprained. Hector was crying and was afraid that his father would kill his mother. Hector denied that he, or the father, or the mother ever hit Jacob. Hector stated that he has watched his father hit his mother for several years “ever since I can remember, but never this bad.” The mother and father have separated on three occasions, however the father swore he would not hit the mother again. Each time the children were left with the father because he refused to allow the mother to take them. The father had one previous arrest for hitting the mother, but the mother refused to press charges. The father was arrested, the mother was taken to the hospital and Hector and Jacob were taken to a maternal aunt who lived several miles away. When interviewed by the social worker, the mother stated that she was afraid to leave the father, as he had threatened to kill her. Lately, the mother has been concerned about Hector, because “Hector won’t mind me, he is yelling at me just like his father.” The mother is agreeable to entering a shelter for battered women. The mother has no support systems, outside of the maternal aunt, and is financially dependent on her husband. The mother has no employable skills, having married Victor when she was 16 years old.

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NEGLECT
VIGNETTE #1

Walter, age 5, and Suzie, age 4, were reported to the CPS hotline because of chronic neglect. The mother, Sandy, appeared to have some mental disability and while she loved the children, did not appear to understand some of the developmental needs of her children. Both Walter and Suzie appeared at the preschool dirty and their clothing often smelled of urine. Suzie continues to have "daytime bladder control problems." Both children appeared to be good-natured, but appeared to be delayed in the cognitive, verbal, and social skills. The children were very glad to see their mother every day and were reluctant to leave her at the start of each school morning. Lately, Walter has become more aggressive in hitting other children. When the mother was told this, the mother responded, "that is what boys are supposed to do, so they can protect themselves." The mother did not appear to understand the need for Walter to learn how to get along with his peers. Suzie appeared to need some dental care, as her baby teeth appeared rather gray. When the mother was asked about dental care for Suzie, the mother responded that Suzie didn't need any dental care. The preschool was unaware if a father or other relatives were in the picture. There have been two previous referrals for neglect, the last being 2 years ago. The mother was reported to be cooperative, but had difficulty understanding the long-term developmental needs of her children.

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NEGLECT
VIGNETTE #2

Bess, age 3 months, was brought to the doctor's office for a routine check up. Bess appeared to be below the 5TH percentile in height and weight. Bess had had two other check ups in which her weight had declined from the 50TH percentile to the 40TH; and her height had declined from the 60TH percentile to the 40TH. The parents, Bret (age 20) and Lisa (age 22) did not appear concerned about the baby's weight loss. Lisa reported that Bess appeared to be a good baby, rarely crying, and always seemed able to eat all the formula that was prepared for her. When asked how much formula the baby was getting, Lisa responded, "It's a couple of bottles a day, I think about 6 oz. each." Bess was subsequently hospitalized and made rapid weight gains in the hospital. The hospital staff noted that when the mother fed the baby, that there was no eye contact between the mother and Bess. The mother appeared uncomfortable holding the baby and did not attempt to verbally interact with the baby. There was no known medical reason for her failure to gain weight other than underfeeding. When the hospital social worker spoke to the parents about the failure to thrive diagnosis, the mother insisted that nothing had been wrong with Bess. "I am a good mother and I would never hurt her." Bret stated that he really didn't know much about raising a child and wasn't sure how much a child should be eating. He too appeared to be uncomfortable in holding the baby.

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☞ ACTIVITY #2: Discussion of Ethics and Values

Locate and distribute the Slonim-Nevo article (listed in the References). After reading, discuss issues such as:

1. Self-determination versus legal authority

    a) Definitions and limits of self-determination

    b) Conditions under which coercion is justifiable

        - When children are in need of protection because of their dependency status

        - When there is a need to force rehabilitation on those who have violated a social norm such as abuse in parenting

2. Forced rehabilitation creates a series of dilemmas for practitioners. Discuss possible options.

    a) Integrate the authority and service roles, and within the limitations imposed by the setting, try to expand opportunities for self-determination, or

    b) Services are offered only on a voluntary basis within a collaborative arrangement

3. Social control versus social change

    A dilemma faced by practitioners is whether they are agents of society who ought to control deviants, or whether they are supposed to bring about change. Discuss the CPS workers role within this context.

4. Discuss the limits of voluntary cases.

    a) What are the consequences of refusing services or change?

    b) How is service delivery limited by external policy, regulations, and resources? What opportunities exist to expand client decision making in service delivery?

5. Discuss how students' professional affiliation affects the choice of a plan.

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☞ ACTIVITY #3

Discuss ways to increase positive outcomes in engaging both voluntary and court-ordered cases. The following summarizes research findings from the literature, which suggests actions that would facilitate engagement.

- Parents are more likely to succeed if they perceive their child will benefit or if they have a specific need that can be met by the worker (Olds & Kitzman, 1993).

- Home-based services produce higher participation rates than center-based services (NCPCA, 1995). However, based upon culture, neighborhood, or family norms, some families may find home visits by workers to be aversive.

- The failure of a service provider to recognize and address immediate personal needs can cause a parent to withdraw from services (Larner et al., 1992; NCPCA, 1992b).

- A number of studies highlight the salience of the relationship between provider and participant as a primary determinant of program participation and progress. Elements of this relationship found to enhance participation include mutual agreement on the presenting problem (Epperson, Bushway, & Waxman, 1983; Tyron & Tyron, 1986) and perception of the provider as friendly (Powell, 1990).

- If a worker is unable to establish trust during the preliminary stages, families may decide to forgo additional preventative services.

- Such issues as lack of motivation or disinterest in services can be overcome if the worker can provide a concrete tangible benefit in the early stages of treatment (Lipsky, 1980; Olds & Kitzman, 1993).

- Identifying a number of short-term, easily achievable goals in the initial treatment stages, may increase engagement among clients (NCPCA, 1992a; Barth et al., 1986).

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