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Interventions

Over the years, many treatment options for abusing families have been explored. Interventions have included psychotherapy for maltreated children, psychotherapy for adult abusers, home aides, crisis nurseries, respite care, and self-help groups such as Parents Anonymous.

Some interventions have targeted skills training to ameliorate deficits in parent knowledge about child development and discipline techniques. These treatments include didactic training in basic parenting skills (Howing et al., 1989).

Other programs endeavor to assist families with factors felt to be indirectly related to child abuse. These interventions seek to remedy conditions such as social isolation, unemployment, substance abuse and economic deprivation (Howing et al., 1989).

In the early seventies, a residential program for abusive families was instituted at the National Center for the Prevention and Treatment of Child Abuse and Neglect in Denver. Conceptualized by the late C. Henry Kempe, it was seen as an alternative to separating children from their parents. The model was short-term, intensive residential treatment designed to meet specific needs of referred parents and children. Emphasis was placed upon improving parent-child interaction. Research suggests that this treatment was successful in meeting it’s goals (Alexandra, McQuiston, & Rodeheffer, 1976). However, the intervention is expensive and few similar programs have been developed.

Another less costly approach also emerged in the early seventies as a result of the permanency planning movement and a desire to preserve families. This approach, called “family preservation”, was an intensive in-home treatment designed to assess the characteristics of both the individuals and their microsystems in an effort to strengthen family deficits and build upon the strengths already present. Family preservation clinicians provide treatment and case management to assist in ameliorating stressors which lead to maltreatment and teach concrete skills for child and home management.

Treatments specific to each type of abuse have developed. A variety of behavioral and cognitive-behavioral approaches have been piloted with abusive and neglectful parents. The largest growth, perhaps, has been in treatments specific to sexual offenders. Programs for adult offenders, adolescent perpetrators and children who molest have been developed and refined.

This issue of VCPN will examine published literature addressing treatment outcomes for those who abuse, neglect, or sexually abuse children. Additionally, model programs in Virginia will be spotlighted.

Overall Treatment Outcomes

There is extensive literature that describes characteristics of abusive families and child victims. There are also an abundance of books and articles which describe treatment and prevention programs. Unfortunately, studies which evaluate treatment outcome are scarce.

In the late 1980’s, Cohen and Daro (1987) examined the findings of four major federally funded treatment evaluation studies of parents who abuse or neglect children. Findings were that one-third of the parents served continued to abuse and/or neglect their children while in treatment. Less than half the families were judged by workers to have a reduced abuse and/or neglect propensity after treatment (reported in Howing et al., 1989). The four studies encompassed 89 demonstration projects. These treatment

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Prevent Child Abuse, Virginia

Prevention Month Works to Celebrate Positive Thinking

Again this year, April will be proclaimed national Child Abuse Prevention Month. The Honorary Chairman of this year’s awareness campaign is NASCAR driver and Chesapeake native, Ricky Rudd. Ricky has taped public service ads for the Virginia Child Abuse Prevention Month Coalition. He and his wife Linda are parents of a toddler and are looking forward to helping other parents understand the need for positive parenting practices. Amber Medlin, Miss Virginia, is also helping out during April. Her platform is special needs children and the importance of good self-esteem for all children. She brings her message in presentations to elementary schools and parent-adolescent groups across Virginia.

A Prevention Month Packet will be sent to over 2000 individuals and organizations. Filled with ideas and camera-ready materials, the month of April will come to life because caring individuals are using the packet to initiate community-based prevention activities. At the center of the awareness effort is the blue ribbon, a symbol that has spread, in a few years, from the efforts of one heartbroken Virginia grandmother to a nationwide observance. Each year, hundreds of thousands of blue ribbons are distributed across the country by organizations who are interested in solving the problem of child abuse and neglect. We urge Virginians to don a blue ribbon this April and become a partner in prevention with us.

Healthy Baby Week

“Research indicates that the best way to promote healthy child development, to strengthen families, and to prevent child abuse is to provide parents with education and support beginning with the birth of their first baby, ideally by means of a voluntary program of home visits” (Starting Points: Meeting the Needs of Our Youngest Children, Carnegie Corporation of New York, April, 1994). To increase awareness of the need to begin supporting families when children are first born, Healthy Baby Week has been planned for April 7-14, 1996, during Child Abuse Prevention Month. Community organizations will call attention to early intervention and prevention programs by choosing one or more days on which to honor every newborn baby and its family in their locality.

Healthy Baby Week is sponsored by the Healthy Families Virginia initiative, a pioneering prevention and early intervention program that brings the incidence of child abuse and neglect to near zero in the population it serves. Since its inception in Fairfax, Virginia in 1991, eight Healthy Families programs have developed. Home visitors who serve as mentors have assisted 853 very stressed families. None of the 853 families has had a founded abuse or neglect complaint and there have been no abuse or neglect death cases among these families. Many positive outcomes are evident in these families as well. Nine more Healthy Families sites are currently in various stages of development.

Hospitals, businesses, pediatricians, local government and other groups are being asked to donate items for gift packs for new mothers. These packages may include flowers, booklets about child health or child safety and coupons for baby products, diaper service or a restaurant meal for new parents to tired to cook. Senior citizens’ clubs have been a source of hand-made baby items for the new arrivals. To help new parents, this years

Prevention Month packet has a “Hey Dad” booklet just for fathers, “Shh...Baby Sleeping” doorknob tags, the “Never Shake a Baby” brochure and a Parents’ Survival Tips brochure. Healthy Baby Week celebrations are hospital-based, so contact your local hospital administrator to see if other groups in your area have expressed interest in Healthy Baby Week, and so that you can help plan or participate in a community-wide celebration.

Freddie Mac Foundation Support

The Freddie Mac Foundation awarded Prevent Child Abuse, Virginia a three-year, $170,000 capacity-building grant to strengthen evaluation, resource development and strategic planning and to assist our affiliate network. Based on needs identified by our affiliates, the grant will enable us to help them with board/volunteer development, public relations, fundraising and evaluation of programs and public awareness activities. In the third year of the grant, three Virginia localities with few services for families will be targeted for community organization in order to establish affiliates in those areas.

The Freddie Mac Foundation, established in 1990, is dedicated to brightening the future for children and youth. The foundation fulfills this mission by supporting organizations working to strengthen the health, education and welfare of children and youth, and providing family and support services. In addition to funding, the foundation is a strong advocate for children, supporting policies and programs that focus attention on the needs of children and foster positive solutions to meeting child welfare needs.

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Kidwise

April is Child Abuse Prevention Month.
Wearing a blue ribbon shows your support for children and families.

Prevent Child Abuse, Virginia
programs were not typical of services offered by public agencies. Rather, the interventions studied received special resources that allowed for reduced caseloads and increased services. Thus, even the most comprehensive programs in the 1970’s and early 1980’s helped only a portion of those who abuse and neglect.

A comprehensive review of literature from 1983 to 1992 concerning treatment of physical abuse was undertaken by Oates and Bross (1995). Using a “modest standard of scientific rigor”, Oates and Bross searched for studies with more than 5 subjects and where 15 percent of subjects were known to be physically abused. Also, some method of comparison was needed (for example, pre- and post-tests or a treated versus a nontreated group). Only 12 articles meeting these criteria were found when the abusers were the focus of treatment (there were also 13 studies of treatment of child victims that met criteria).

The twelve studies identified by Oates and Bross utilize a variety of treatments, ranging in length from 4 weeks to 12 months. A wide range of outcome measures were used, making it impossible to compare the studies. All twelve indicated some degree of improvement due to treatment. However, follow-up periods were short, leaving open the question of long term benefit.

Individual Psychotherapy

The treatment efficacy of individual psychotherapy with abusive or neglectful parents has not been systematically evaluated. Daro (1988), in analyzing components of 19 federally funded demonstration programs for intervention with maltreating parents found that individual psychotherapy was less successful than either group or family therapy. Insight-oriented psychotherapy appears particularly ineffective (Wolfe, 1994).

Behavioral and cognitive-behavioral treatments appear to be the most effective approach for those engaged in individual interventions with families (Flaxer, 1995; Wolfe, 1994). These interventions target improvements in parenting skills, awareness and coping. Techniques include teaching parents practical skills such as tracking child behavior, how to reinforce positive behaviors, and use of non-physical consequences (such as timeout or withdrawal of privileges). Effective teaching techniques include modeling, verbal instruction, use of parent training materials, behavioral rehearsal, cognitive restructuring, stress inoculation, relaxation training, role playing and systematic desensitization.

Wolfe (1994) reviewed 11 studies of abusive and/or neglectful parents (mostly mothers) who were treated using cognitive/behavioral interventions. Wolfe concludes that the interventions show promise. Increases in positive behaviors and emotion between parent and child were noted, as were enhanced ability to control anger, reduce stress, empathize with children, and maintain appropriate expectations. Reductions in recidivism rates were shown in the studies with control groups.

Behavioral approaches tend to be narrow in focus. Child management training may equip a parent to handle isolated problem situations but fail to impart principles and skills for analyzing and responding to other problems not covered in training (Kelly, 1990). Thus, behavioral techniques should be employed in conjunction with a broader approach that addresses situational variables. The most effective combinations appear to be behavioral interventions and supportive services (Azar & Segil, 1990; Howing et al., 1988). Behavioral interventions, in general, appear to be a good match for abusive families. The strategies are concrete and problem-focused, and can be utilized by parents of all educational levels. The overall response to behavioral intervention is favorable, especially in contrast to treatment efforts aimed at personality change (Wolfe, 1994). However, it should be noted that these treatments do not change social or economic conditions which may be contributing to the maltreatment.

Group Treatments

Group treatments appear more effective than individual psychotherapy. Cohen & Daro (1987), evaluating 19 demonstration projects, found that those receiving group counseling were 27 percent less likely to show propensity for maltreatment compared to those who did not attend therapeutic groups. Self-help groups such as Parents Anonymous have promising results as well, but should be an adjunct to more formal intervention, rather than the sole or primary approach (Azar & Segil, 1990; Howing et al., 1988).

Parent training programs (such as the Nurturing Program featured in VCPN, volume 30) offer structured information about child development, discipline, stress management and anger reduction, using discussion, video, assignments, lecture, exercises and readings. Several large-scale studies have found parenting classes to be a component of successful client outcome for those parents who physically abuse children. However, some evidence suggests that in-home coaching is needed in order for abusive parents to actually implement and practice what they have learned (Howing et al., 1988).

Neglectful and economically disadvantaged parents are not promising candidates for parenting groups. Those with limited education skills have difficulty with a didactic approach. Also, parenting classes do not address the socioeconomic stressors which typically characterize neglectful families.

Factors Predicting Success or Failure

A number of factors appear to be related to treatment success or failure. These include: duration of therapy, number of kept appointments, high expectations, misperceptions of children, a history of prior abuse, and type of abuse.

Several studies have shown that a longer duration of treatment yields a better outcome (Cohn, 1979; Egeland & Erickson, 1990; Ferlger et al., 1988; Green et al., 1981). However Daro and McCurdy (1994) caution that duration alone is insufficient, rather the intensity of the service is a primary factor. None-the-less, these studies suggest caution in interpreting results of brief, short-term treatments.

The number of kept appointments

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has been shown to predict outcome (Ferleger et al., 1988; Green et al., 1981). Presumably, those parents who keep appointments are more motivated (and also receive more intervention) than those who cancel or fail to show.

In an early study of 1,724 clients, Cohn (1979) noted that the use of highly trained, experienced clinicians improved treatment effectiveness. Few studies include information about the training and background of those delivering services, yet it is well established that therapist variables are a major factor in treatment effectiveness.

While some studies have found no differences in response as a function of type of abuse (Ferleger et al., 1988), others have found that type of abuse is important. Herrenkohl and colleagues (1979) found families with physical abuse were the most likely to re-abuse followed by those reported for neglect, sexual abuse and emotional abuse. Chronic neglect appears to be especially resistant to treatment (Gaudin, 1993).

Type of abuse may interact to a degree with severity. The infliction of severe injury is a poor prognostic indicator (Ferleger et al., 1988; Green et al., 1981; Johnson, 1988), especially in cases where there is a history of prior abuse (Green et al., 1981).

Parent expectations and perceptions may be a valuable source of determining who is at risk to re-abuse. Those who maintained inappropriate expectations, even with therapy, were high risk for re-abuse (Green et al., 1981).

Marital relationships may also be important predictors. Egeland & Erickson (1990) note that most mothers who were able to break the cycle of abuse were in intact, stable and satisfying relationships. They were also likely to report that a foster parent or relative provided them with emotional support as a child or adolescent. Others (Wolfe, 1994) have found similar results concerning social isolation and lack of social support. Tray and Whittaker (1987) agree that social support makes a difference in an individual or family’s ability to cope effectively. However, they caution against simplistic measurement of social support and also note that much research on social support is correlational.

Parent pathology has been cited as a predictor. Personality disordered individuals, especially those with antisocial personality, are unlikely to respond well to treatment (Green et al., 1981; Murphy et al., 1991). Others have suggested that cases involving chronic substance abuse are not amenable to treatment (Schene, 1995). Psychotic parents also respond poorly to intervention (Murphy et al., 1991).

Employment status has also been cited as a predictor. Some who are unemployed and receiving AFDC or public assistance have not responded well to treatment (Ferleger et al., 1988; Ritter, 1994). In these cases children and families often lived under transient and unstable conditions.

The overall data suggests a profile of abusive parents who are likely to re-abuse, even with intervention and treatment. Abusive parents with a prior record of maltreatment who enter therapy involuntarily, who deny the abuse and other problems and who have inflicted severe injuries are high risk for recidivism. These individuals miss sessions and terminate therapy early, against medical advice. They maintain inappropriate expectations for their children and show impaired relationships with other adults. They may fit diagnostic criteria for psychosis, substance abuse and/or personality disorders. Often they have been unable or unwilling to maintain steady employment.

Interventions Specific to Neglect

While neglect is the most frequent category of reported maltreatment (approximately 50 percent of founded cases in Virginia and elsewhere), treatment of neglect has received little attention in research studies (DePanfilis, 1996; Wolfe, 1994). Often, families with problems of neglect are not separated from abusive families in data analysis, even though there is ample evidence that characteristics and needs of parents who abuse are different from those who neglect.

Neglectful parents are typically poor and lack access to resources. Case management of multiple services is frequently necessary. Also, neglectful parents generally lack maturity and are unable to put children’s needs first. Those with chronic neglect need intensive service over long periods of time. For example, neglect secondary to parent’s mental retardation requires intensive, in-home instruction and support to remedy knowledge and skills deficits. Denial and apathy further compound therapeutic intervention (Gaudin, 1993).

According to a review by Gaudin (1993), the overall results of interventions with families that neglect are not encouraging. Daro’s review (1988) of 19 demonstration programs from 1978 to 1982 shows five which specifically targeted neglectful families. Overall, 53 percent improved their level of functioning. In 66 percent, there were additional reports of neglect during treatment and 7 percent were judged likely to neglect after services terminated. Those with more severe problems and those with alcohol or drug involvement had less successful outcomes.

Behavioral techniques were the most successful interventions with neglectful families and the results appeared to endure. Clearly defined short-range goals were more successful than loosely defined “casework” or “counseling” activities. Contracting for specific changes was helpful. Because most chronically neglectful families are multi-problem, a broad range of concrete services from multiple sources that use a variety of intervention techniques are needed. Long-term treatment of at least 12 to 18 months is required. A combination of parenting groups and intensive individual in-home services were necessary. Improving informal social networks and remediation of daily living skill deficits appear to be components of successful treatment (Becker et al., 1995).

Still, neglectful families were significantly less successful than families referred for other types of maltreatment.
Traditional in-office, individual counseling was ineffective in changing neglectful patterns (Gaudin, 1993).

Families who present with non-chronic neglect associated with a life crisis have a better prognosis. These families are thought to respond to crisis intervention, stress management, support groups and family counseling. However, there is a lack of empirical data to support this conclusion (Gaudin, 1993).

**Family Preservation**

Data from 22 states show that over 68,000 children were placed in alternative care for some period of time during 1994. Approximately 14 percent of substantiated child victims were removed from their homes. This is lower than the 1993 figures which show that 17 percent of substantiated child victims were removed (Daro, 1995). In total, more than 600,000 children in America live apart from their families. American taxpayers spent more than $11 billion for foster care in 1992 (American Humane Association, 1995).

Removing children who have been victims of abuse and neglect has been the most effective intervention in immediately eliminating abusive behavior (Cohen & Daro, 1987). However, recent government initiatives have shifted federal policy from removal to the option of family preservation.

In 1993, Congress passed and President Clinton signed the Family Preservation and Support Services legislation. This bill provides federal monies to states and counties to establish, expand or operate family preservation services. The legislation provides $60 million for FY 1994 with the amount increasing each year until over $250 million is made available in FY 1998. (American Humane Association, 1995.)

As its name implies, family preservation programs focus on preserving the family by providing treatment and case management services in the family’s home. These services are designed to strengthen the family unit. Many models exist.

Models tend to share the following elements in common: 1) accepts families on the verge of having a child placed; 2) are crisis-oriented, seeing the family as soon after the referral as possible; 3) have twenty-four hours a day, seven days a week client access; 4) conducts intake and assessments that ensure that no child is left in danger; 5) deals with the family as a unit rather than focusing on either parents or children as the problem; 6) provides services in the client’s home, with workers visiting several times a week at times convenient to the family’s schedule; 7) treatment combines teaching skills to family members, helping the family obtain necessary resources and services, and counseling that is based upon an understanding of how each family functions as a system; 8) delivers services determined by family’s need rather than by pre-established categories 9) workers carry a small caseload (less than five families at any given time) with some programs using teams of two workers per family in order to provide support and ease the demands of the program schedules; 10) limits involvement with families to a short period, typically two to five months; 11) provides on-going in-service training and hires persons with social work degrees or with an extensive knowledge of the community; 12) families are collaborators with treatment, not recipients of treatment; 13) utilizes follow-up with families to assess progress and evaluate program success (Fraser & Haapala, 1988; Henggeler, 1995; Nelson, 1994; Palamountain, 1994).

Home-based, multi-systemic therapy provides a realistic in-depth view of the family. This approach obtains more accurate information for treatment than services based in an office. In addition, the approach emphasizes the continuous informal evaluation of treatment efficacy. Additionally, intense therapist involvement can assist the family in developing and moving toward more natural support systems. (Henggeler, 1995).

Family preservation programs provide a variety of services tailored to client needs. Some services are concrete such as transportation, assisting in obtaining housing, securing child care or developing recreational interests. Others are more complex treatment services such as developing a trusting relationship, enhancing problem solving, learning to reduce conflict, improving parent effectiveness, managing depression and stress, and modifying behaviors (Lewis, 1991; Nelson, 1994).

Lewis (1991) reviewed family preservation services provided to 435 families. Lewis suggests that the diversity of concrete services needed by these families is great. Approximately twenty-five concrete services were provided to the families, with transportation being used by 50 percent of all cases. The next most utilized concrete service was recreational services, used by 20 percent. Concrete services accounted for 25.6 percent of direct service time for those cases where concrete services were delivered and about 20 percent of direct service time overall.

In addition to concrete services, the study examined approximately 75 clinical services provided to the 435 families. Nine clinical services were provided to 70 percent of families. Four of the top nine were related to the therapeutic relationship: listening, offering support, relationship building and reframing. Two were related to technique-specific activities associated with behavioral treatment: use of reinforcement and use of natural consequences. Other than those, therapists tended to use a broad range of clinical skills according to the client’s specific needs.

Lastly, six family preservation goals were used with 70 percent of these families. The goals were: to increase parenting skills, to improve anger management, to increase communication, to increase child compliance with house rules, to establish trust, and to improve the child’s school performance. “Such goals reflect the client situations that bring many families to the child welfare system: child neglect, physical child abuse, and parent-adolescent conflict” (Lewis, 1991, p.105).

That is the family preservation model and its purpose. Now, how well does it work?

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Treatment Outcome
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Family Preservation Outcome Studies

It is difficult to find a measure of treatment success for family preservation programs. One typical measure is the percentage of cases where the family is able to avoid having the child placed in alternative care. However, keeping a child at home is a success only if the child is no longer abused. A relatively high rate of family preservation may reflect effective treatment. However, if there is also a high re-abuse rate, the interpretation is not positive. Many studies fail to collect follow-up data, and thus re-abuse rates after treatment are unknown. Readers should keep such limitations in mind while reading the results of family preservation efforts.

Regardless of the methodological problems, much can be learned from the body of research evaluating family preservation programs over the last decade. Several research projects show that a multi-service treatment model produces positive outcomes. In addition, there is evidence that home-based multi-systemic treatment is more effective than traditional interventions (Flerx, 1995) and/or that supplementary in-home services coupled with traditional outpatient approaches yield a better treatment response (Green et al., 1981).

For what percentage of families is Family Preservation an effective intervention? It is difficult to draw a single conclusion.

Some studies suggest a significant degree of effectiveness. Using placement as the outcome measure, Fraser, Pecora and Haapala (1991) report that 31 percent of their treatment group experienced at least one out-of-home placement during the year following treatment while 85 percent of those families referred but not treated resulted in out-of-home placement. In addition, Wells and Wittington (1993) found that 80 percent of the families served by Family Preservation avoided placement. However, these researchers note, "In this study 80 percent of the children were not placed, but 41 percent moved from the homes of their parents at least once. Placement stability of child's living situation should be treated as a separate concept in subsequent research" (p. 77).

A more modest, yet considerable degree of effectiveness was reported by Child Welfare League of America (1985). In summarizing the findings of 17 programs which contained intensive interventions designed to prevent foster care placement, researchers reported 34 percent of the children receiving services entered care while 46 percent of the control group did. In addition, in cases where entry could not be avoided, prevention services appeared to delay entry. The control group entered care in 4.5 months while the treatment group entered care in 12.6 months.

Evaluating family functioning as an outcome, Scannapieco (1993) found that 75 percent of the families served experienced positive gains in functioning. However, some children in families with improvements also experienced placement. In this context, placement was not interpreted as treatment failure.

Other studies resulted in no significant difference between treatment and control groups. (Magara, 1981; Rossi, 1992; Wells & Biegel, 1993). An Illinois statewide evaluation study of 1,677 maltreating families also failed to find significant differences between family preservation services and the usual social services. Families were randomly assigned to the two conditions and followed for one year. There were no differences in placement rates of children or rates of subsequent maltreatment (Rzetnicki et al., 1994 reported in Becker et al., 1995).

In a comprehensive program review by Wolfe (1994), family preservation programs showed positive outcome in several aspects. Success in avoiding placement of the child outside the home was high, with as many as 95 percent of families remaining intact. Wolfe found only four studies that addressed gains in family functioning and environmental conditions thought to contribute to abuse. All four studies reported modest to significant gains in factors such as marital functioning, family interactions, improved income, improvements in housing, improved social contracts, and increased use of community resources.

A comprehensive 5 year evaluation of Project 12-Ways, an ecobehavioral program in Illinois, offers promising results (Wesch and Lutzer, 1991). The study compared 232 maltreating families served by Project 12-Ways to a sample of 232 families served by the Illinois Department of Child and Family Services (IDCFS). The Project 12-Ways clients were more chronic and had not responded to IDCFS services. Both groups significantly benefited from services, as shown by pre-and post-tests and recidivism rates. An earlier study of Project 12-Ways (Lutzer & Rice, 1987) showed that the percentage of recidivism was consistently lower than or equal to comparison groups from July, 1979 to June, 1984.

Outcome research in family preservation also addresses which aspects of treatment are most beneficial. In addition, family, child and parent variables which affect success or failure of the intervention are beginning to emerge.

TREATMENT VARIABLES.

There are aspects of treatment that appear to affect the outcome of family preservation services. Using placement as a measure of success or failure, variables affecting outcome include:

1) The amount of time spent in the home. This appears to be an important variable, particularly with families determined to be at imminent risk (as opposed to general risk) of having a child placed. Families receiving more hours of service per week (some as many as 30 hours) were as likely to avoid placement as families who were at general risk and who received approximately 7 hours of service a week (Berry, 1993; Berry, 1991). The important variable is the time spent in the home which appears highly correlated to success. Families who received significant time in the home also gained useful skills such as positive discipline techniques and improved ability to care for a child's health needs. Fraser, Pecora and Lewis (1991) found that of the family preservation sites studied, the one with the highest failure rate had the lowest number of total client contact hours.
2) Worker commitment to placement prevention and family empowerment. Nelson, Landsman & Deutelbaum, (1990) found that all of the social workers in the eight programs studied agreed that a philosophy of and commitment to the child being better off in the home was an important component to effective family preservation services.

3) The amount of time elapsing between the family crisis/agency referral and in-home therapist response. The longer the lapse between referral and treatment the higher the likelihood of negative outcome (Spaid, Lewis and Pecora, 1991). Individuals and families appear to be more amenable to change when they are in a state of crisis and their coping patterns for dysfunctional situations are not working.

4) Therapist credentials. Fraser, Pecora, and Lewis (1991) found that therapist credentials were an important factor in program success. The site with the lowest failure rate had therapists who held, without exception, a master’s degree whereas the site of the highest failure rate had no master’s level therapists. In the latter site, one therapist held a graduate degree in social sciences while all others held bachelor’s degrees.

5) Length of service. Berry (1993) and Pecora et al. (1991) found that an average of 2.5 months of service at approximately 9 hours a week was effective in helping families at risk remain intact.

6) Concrete service. Another important treatment variable related to outcome appears to be the offering of concrete services. In some studies concrete service offerings were found to be one of the few variables that predicted avoidance of out-of-home placement (Barry, 1991; Fraser & Haapala, 1988; Fraser, Pecora & Lewis, 1991; Spaid, Lewis and Pecora, 1991).

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Spotlight: Family Trauma Services of Northern Virginia

Family Trauma Services of Northern Virginia offers several services to high-risk or adjudicated youth and their families who are referred by a variety of sources in Northern Virginia, including DSS, courts and mental health agencies. "Families and children referred to this agency are assigned to one of eight programs," explains Wayne Parks, Director. "These programs are the adolescent post-traumatic stress disorder program, the children's post-traumatic stress disorder program, the sex offender program, the conduct disorder/social skills program, the transition after-care program, and the ADHD program, the oppositional-defiant behavioral program and the Immediate Response Crisis Intervention program."

According to Parks, each program offers an range of services including individual therapy, a behavior specific group, intensive in-home therapeutic and case management services provided by a Master's level clinician, and a home-based family worker who serves as a role model, tutor, support and advocate. "The home-based worker is the one person who develops a strong one-on-one supportive, mentoring relationship with the identified client," notes Parks.

The staff have been conducting follow-up surveys with cases which were successfully discharged. Clients are surveyed at 90 days, 6 months and annually. Referring professionals are surveyed at the same intervals if they are still working with the client. The surveys are instruments developed by the agency and are designed to assess family functioning. According to Parks, the information gleaned is used for ongoing evaluation of each of the treatment programs and to provide case collaboration when necessary.

One piece of information was of particular significance to Parks. "My associate, Rod Baber and I have been providing treatment to our adolescent sex-offenders for over 7 years. Seventy youth have successfully completed the program, and there has been zero percent recidivism. We are proud of that."

Family Trauma Services is licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services. Fees are received primarily from contracts with the Department of Youth and Family Services and the Comprehensive Services Act.

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FAMILY VARIABLES

Several aspects of the family appear related to treatment success. These are:

1) Type of maltreatment. Various forms of maltreatment undoubtedly involve different causal mechanisms and different dynamics. Therefore, treatment goals and outcome measures will vary as a function of the type of abuse or neglect. Analysis of research findings suggests that treatment of physically abusive parents should focus upon improving parent-child interactions and on increasing parent flexibility in responding to child behavior. In contrast, treatment with neglectful families should center upon the provision of support services, development of family cohesion and increasing parental responsiveness (Howe et al., 1989).

Child neglect appears to show a significant relationship with negative treatment outcome. Some researchers found that neglectful families, compared to abusive families, were poorer, more reliant on public income, more likely to be headed by a single parent, had more children at imminent risk of placement, and were more likely to have medical, mental health, and/or substance abuse problems. After treatment, children from neglectful families were almost twice as likely to be placed than children from abusive families (Bath and Haapala, 1993; Berry, 1993; Berry, 1991; Gaudin, 1995; Yuan and Struckman-Jones, 1991). Another study found that children from families with multiple maltreatment (abuse and neglect) are more likely to be placed than children experiencing abuse only or neglect only (Bath and Haapala 1993; Gaudin, 1995).

2) Available supports. Several studies have found a correlation between lack of agency or social support and treatment failure (Barbiter & Verdieck, 1988; Barry, 1991; Reid, Kagen & Schlosberg, 1988; Spaid, Lewis & Pecora, 1991; Wells and Whittington, 1993). However, Barry (1991) found that the availability of friends and relatives increased the likelihood of placement, perhaps because of placement options with relatives known to the child and acceptable to the parent. Tracy and Whitaker (1981) voice concerns about the absence of experimental studies of social supports which give anything more than correlational data. While correlational data may be compelling, experimental studies which address well-defined and measured aspects of social support are needed.

3) Employment. Fraser, Pecora and Lewis (1991) made the curious finding that when parents were employed outside the home, children had a 65 percent higher risk of being placed. This suggests that work obligations complicate family preservation services. Possibly these parents are simply unable to monitor their children or provide adequate day care or after school care.

4) Parent attitudes. If parents prefer placement at intake or are not willing to engage with the services, the child is more likely to be placed (Fraser, Pecora & Lewis, 1991; Wells and Whittington, 1993). Green et al. (1981) found that families where parents came to treatment involuntarily and terminated against advice were more likely to have a child placed. However, Trueste-Monles and Monles (1988) maintain that a program clearly stating the kinds of behavioral changes expected from the parents and the conditions under which treatment can be terminated renders even highly resistant parents more amenable to treatment.

5) Movement toward goals. Families which set at least one treatment goal and displayed significant progress toward their goals were more likely to be successful in preventing their child’s placement (Fraser, Pecora, & Lewis, 1991; Green et al., 1981; Reid, Kagen & Schlosberg, 1988; Spaid, Lewis & Pecora, 1991; Swartz, AuClaire, & Harris, 1991). An interesting finding by Fraser, Pecora and Lewis (1991) suggested that parents whose homes had structural problems and were only marginally habitable showed a high degree of unresponsiveness to treatment.

6) Family functioning. Studies suggest that improvement in family functioning is a result of family preservation services and a positive predictor of treatment success (Scannapieco, 1993; Spaid, Fraser, & Lewis, 1991; Wolfe, 1994). According to Scannapieco (1993) seven important dimensions of family functioning include: the parent/child relationship, the child’s school behavior, the family’s problem solving abilities, the child’s behavior at home, parenting skills, family communication, and overall family functioning. Parents whose child management skills were reported as remaining low at the end of treatment continued to have children at high risk for placement (Fraser, Pecora, & Lewis, 1991). Wells and Whittington (1993) suggest, however, that family functioning post-discharge will depend upon how the family engaged in treatment, upon having resolved admission problems, and upon social support after treatment. While families in their sample were functioning at a lower level than the control group both at the end of treatment and at follow-up, families reported that their problems at admission were resolved and continued to show improvement at follow-up.

7) Demographics. Some family demographics related to treatment failure include minority status (Barry, 1991; Fraser, Pecora, & Lewis, 1991), parental history of maltreatment (Ferleger, Glenwich, Gaines, & Green, 1988; Green et al., 1981), mental illness of parent (Bath, Richey, and Haapala, 1992; Green et al., 1981; Spaid, Lewis and Pecora, 1991) and poverty (Barry 1991; Bath, Richey & Haapala, 1992; Daro, 1993; Reid, Kagen & Schlosberg, 1988; Spaid, Lewis & Pecora, 1991; Wolfe, 1994). In addition, one study found that homes with male caretakers were more likely to have children placed than homes without male caretakers (Fraser, Pecora, and Lewis, 1991).

CHILD FACTORS.

Several child characteristics appear correlated to treatment success or failure as well. These include:

1) History of placement. Several studies found that treatment success was correlated to the child’s previous placement status (Fraser, Pecora & Lewis, 1991; Nelson, 1991; Spaid, Lewis & Pecora, 1991; Unrau, Grinnell & Stephens, 1992; Yuan & Struckman-Johnson, 1991). Children with at least one prior placement or children who were not in the home at the time services began were more likely to be placed during or after services.

2) Child behaviors. A child’s behavior is closely correlated to treatment outcome. Spaid and Fraser (1991) found fam-
The Family Educator Program is housed at the Campbell County Department of Social Services. April Mela, Training Specialist, supervises the program. She is animated and excited when she talks about her work. “I can talk about this program all day!” she exclaims.

Campbell County’s home-based services began due to client need. The agency was able to hire a social worker, using short-term funds, to work with the families. As the funding approached it’s end, the agency realized how effective and how important home-based services were to the families. The position became permanent by certifying the social worker as a Homemaker. Thus began The Family Educator Program.

Soon thereafter, federal child abuse and neglect grant funds became available through the Virginia Department of Social Services Child Protective Services Unit and the Campbell County DSS seized the opportunity to expand the home-based services to more families. The grant award enabled the hiring of Mela. That was approximately three years ago.

Mela brought important experience and expertise to the agency. “In previous employment I developed a project which recruited and used parent aids to provide home-based services to CPS clients”, Mela explains. “I proposed using a similar model for Campbell County.”

Mela has recruited and trained approximately 30 home-based Family Educators. “We try to have between 10 and 15 trained educators available at any given time”, she explains.

Family Educators receive 40 hours of training using a curriculum developed by Mela. Once certified, the educators are assigned as needed to families with founded CPS dispositions.

Mela feels that intervention follows a progression of three phases. First there is a Dependency phase. The worker listens, observes, helps with linking the family to community resources, and develops goals, all the time building trust and rapport. Workers during this phase are in the home from 6 to 10 hours a week. During the Interdependency phase when family and the Family Educator are working jointly on goals, Educators might spend as much as 15 to 20 hours per week in the home. Then comes Achievement. It is during this time that the Educator “phases out”, spending less and less time with the family.

In addition to the in-home intervention, Campbell County’s program provides parenting classes. Classes are based upon a 22 hour curriculum covering child development, nurturing issues and discipline. “Another focus is to build the parents’ self-esteem”, says Mela. “And, we build practical skills.”

Mela has conducted pre-and post-services surveys each year. The surveys include a child risk assessment, consumer satisfaction, referral satisfaction, and agency social work satisfaction. In addition, family functioning before and after home-based services is rated.

Recent results of the surveys in Campbell County suggest overall satisfaction and positive impact on families. Of 35 community professionals involved with families being served by the clinicians (called Family Educators), 29 indicated positive changes in family functioning. Of 26 social services staff surveyed, 20 indicated specific improvements in family functioning. Finally, of 24 families completing the family survey, 21 reported the Family Educator program as helpful to the family.

Mela reports plans for improving both the instruments and the follow up procedures. “We are working with Raymond Kirk, a professor from the University of North Carolina School of Social Work who is interested in our project.”

In the second year of the grant, Mela developed a technical assistance manual in addition to supervising the program. During the upcoming grant year, the Virginia Department of Social Services Child Protective Services Unit will choose five agencies interested in developing this program. Those agencies will receive seed money to begin a local program as well as technical assistance from Mela and the manual.

For more information about the Family Educator Program, contact April Mela, Training Specialist, Campbell County Department of Social Services, P.O. Box 6, Rustburg, VA 24589, Phone: (804) 332-5161, Fax: (804) 332-1707.
Developmental age of the child has received little attention as a potential mediator of treatment outcome. One goal of future research efforts might be to determine which therapeutic techniques are most effective at each developmental level (Fiery, 1995).

4) Gender. A child's gender is another demographic related to placement. Werbach, (1992) found that girls, while a smaller percentage of the sample, were more likely to be placed out of the home. It appeared that this was related to several factors, especially the complexity of their problems as compared to boys. The girls were more likely to display suicidal gestures, have been sexually abused, have had psychiatric admissions and have a family history of sexual abuse and domestic violence. Bath, Richey and Haapala (1992) found that being male and between ages 10 and 17 was a predictor of placement as an outcome. Unrau, Grinnell and Stephenson (1992) found no gender differences in their study of family preservation outcomes.

Is Family Preservation Cost Effective?

An important factor in evaluating program effectiveness is treatment cost as compared to the cost of placement. Cost benefit analysis measures inputs and outcomes in monetary terms. For intensive in-home services, "costs" includes direct costs, supervision time, administrative overhead, community services, and other resources expended and invested during the intervention (Barnett, 1993; Pecora, et al., 1995). Although results are preliminary, studies indicate that family preservation programs have the potential for significant savings (Wolfe, 1994).

The Homebuilders program, mentioned earlier, saved $5-6 for every dollar invested. In 1992, in-home service was provided for an average cost of $2,800, compared to a cost of $7,400 to keep a child in foster care for 35 months (the state average). Approximately 80 percent of Homebuilders families were still intact after one year (Wolfe, 1994).

Michigan recently conducted a three year evaluation of Families First. During that time, 13,000 children were served, with 80 percent avoiding out-of-home placement a full year after the intervention. The state saw a decrease of children entering foster care by 7.7 percent, with the trend continuing into 1993. Was the intervention cost effective? "The evaluation concludes that during the first three years of the program (1988-1991) the state of Michigan saved as much as 55 million dollars in the 12 month period following the intervention by the Families First worker...During 1992, 3,300 more children were served, meaning that another 23 million can be added to the findings on the study" (Executive Summary, p.30).

Trends

What does the future hold for family preservation? Patricia Ronk, Home Based Therapist for Lutheran Family Services in Bedford, Virginia is willing to speculate. She has been watching the proposed federal welfare reform proposals closely. She notes that under current proposals, money will be turned over to the states in the form of block grants. The family preservation monies will be collapsed into these grants. Therefore, under this scenario, the availability of future monies for family preservation programs currently using federal monies will depend on each state's priorities for the block grants. Of course, with the possibility of federal Medicaid funds also being given to the states in block grants, the same concerns will be present for programs depending on Medicaid support for their programs.

"In Virginia there is strong support for family preservation, but I'm not sure how long it will last. We need strong advocates", says Ronk. "We also need to prove the worth of family preservation."

Summary

Much of the literature on family preservation efforts addresses placement rates as an indicator of treatment success or failure. Most reports discuss reasons for failure. Little emphasis is placed on reasons for success. However, a few variables related to success can be gleaned from available literature.

Spaid and Fraser (1991) suggest that comprehensive programs which focus on the broader network of influences on the family-school, courts, mental health, family, friends- are more likely to be successful. Success may be due to networking offering support to a family unit which strengthens the capacity of that family to

SUCCESSFUL TREATMENTS
- Are immediate and practical
- Are long term (6 to 18 months)
- Are court-mandated
- Involve male caretakers as well as mothers
- Emphasize early intervention with less severe problems

Continued on page 14
Spotlight on Tidewater

The In-Home Service Program of the Tidewater Regional Group Home Commission provides several services to the Tidewater region, with offices serving Isle of Wight and Southampton Counties, and the cities of Chesapeake, Franklin, Hampton, Newport News, Norfolk, Portsmouth, Suffolk, and Virginia Beach. One of the services is an intensive in-home family preservation service.

“Our program began in 1991,” explains Linda Filippi, director of this service. “Like most intensive, in-home projects, we provide extensive therapeutic and case management services to families deemed to be at-risk for a child being removed due to abuse, neglect, delinquency, substance abuse, or emotional and behavioral problems. We also serve children who are in transition back to their homes.”

This agency is licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services. The staff contracts with local Community Service Boards, which allows them to serve Medicaid recipients. They also receive funding from the Department of Youth and Family Services, and receive fees from the Comprehensive Services Act.

Recently the agency engaged in a review of sixty-seven closed records. “One of our staff members, Norman Stein, needed to complete a research project to complete his M.S.W.” says Filippi. “He decided to conduct a client satisfaction survey, with questions designed to assess responses of the families to our services. We wanted to know if the family problems were ameliorated and if so, were the effects lasting.”

Stein’s survey included sixty-seven families from four counties. All had terminated in-home services between August 1993 and August 1994. The children in these families were either at risk of removal or were being reintegrated into their home after having been removed.

Stein found that 82 percent of the youth surveyed were able to avoid out-of-home placement. Of those who experienced subsequent placement, the majority were youth who had been incarcerated one or more times previously. In addition, 84 percent of those families rated services either “very good” or “excellent.” In contrast, Stein found that only 24 percent of the same families reported satisfaction with services they had received from the community service system as a whole.

Two other programs available through this agency are 1) the Tidewater Juvenile Substance Abuse Program, a treatment program for juveniles experiencing problems due to their own substance abuse, and to substance abuse in their families; and 2) Parents and Children Together Against Violence, a program designed to work with families from Portsmouth with founded abuse to help them learn alternative means to solving problems.

For more information on the In-Home Service Program, contact: Linda Filippi, Director, 119-A Tilden Avenue, Chesapeake, VA 23320. Phone: 804-548-4197 or 804-548-9288. FAX: 804-548-8589.

Is “Family Preservation” Endangering Children?

The changes in child welfare policy from removal of children to family preservation is not without critics. While efforts to keep families together are laudable, some family situations are both highly dangerous and also not amenable to treatment. Leaving vulnerable children in such families because of an emphasis on family preservation can result in fatalities or further serious abuse.

Clinicians routinely raise concern about leaving children in seriously dysfunctionable families. Mary Holmon, Clinical Coordinator of the Division of Child Protection at Children’s Hospital Medical Center, presented an analysis of 36 cases of recidivism presenting to the hospital in the early 1980’s (Holmon, 1983). Parent dysfunction included drug and alcohol abuse, psychosis, teenage parents and prior conviction for adult homicide. Although children were allowed to remain with their family, less than one-third received follow-up services beyond the crisis intake interview.

Many studies have documented continued serious abuse in spite of lengthy, thorough interventions. For example, a Boston study of 206 court-referred cases found a third of the child victims had been reabused within a two-year period (Murphy, et al., 1991). This reabuse rate is typical of the early outcome studies and of studies where long-term, intensive and comprehensive services are lacking.

Family Preservation, with its emphasis on short-term intensive services may not be a suitable intervention for every family. The goal, rather, is to select cases where a family can benefit from intervention without leaving a child in danger.

Isaac Palmer, executive director of Montgomery County Children’s Services in Dayton, Ohio is one expert who is clear about the relationship of child protective services to family preservation. According to Palmer, child protection agencies protect children. States Palmer "...no public agency works under a mandate to preserve families. What is being referred to as family preservation is an agency's efforts to support the family so the family can protect its own children" (1994, p. 18).

Palmer sees family preservation as a treatment model that one can use when it is the best method for protecting children. He notes that the law stipulates that reasonable efforts be made to protect the child within the home. When agencies intervene in families, the intervention should be as minimal as possible consistent with protecting the child.

After assessment of a child’s condition and the circumstances in the home, the agency chooses a method to protect the child. “We are never called to choose between protecting the child and preserving the family...The choice is: Can we protect the child best by working with the family so the child can stay in the home, or by taking the child out of the home?” explains Palmer (1994, p. 18).

Virginia’s policy reflects the philosophy explained by Palmer. Family preservation is encouraged since children should stay, whenever possible, with their family. However, family preservation should not be undertaken if conditions are unsafe for children.

References Available Upon Request


In 1989 the American Public Welfare Association's (APWA) National Commission on Child Welfare and Family Preservation conducted a national survey of 60 state human service agencies that provide public child welfare services. The Factbook presents the findings.

The publication is divided into two major sections: services and staff. Aggregate and state-specific charts and tables on over 100 topics are presented. Descriptive summaries are provided of major findings.

The reader will discover findings that suggest state and national efforts to provide adequate services fall short of community standards. Frontline workers are extremely stretched. The 1980's appear to be a difficult time for the child welfare system.


Available from: Lawrence Erlbaum Associates, Inc., 10 Industrial Ave., Mahwah, NJ 07430-2262. Phone: (800) 926-8579. FAX: (201) 236-0072. EMAIL: orders@erbaum.com

This special supplement of the Journal of Clinical Child Psychology contains the reports of five different working groups. Diane Willis authors the first report "Psychological Impact of Child Abuse and Neglect." The second report is "Child Abuse Prevention: Knowledge and Priorities." A third report examines empirical research on child abuse treatment, and the fourth looks at child maltreatment and the law. Finally, recommendations are offered for education and training in child abuse and neglect from high school through post doctoral levels.


Available from: The Office of Communications, The Edna McConnell Clark Foundation, 250 Park Avenue, New York, NY 10177-0256. Telephone: (212) 551-9100, FAX: (212) 986-4558

A comprehensive information packet that explains how intensive family preservation services work and why they are needed. Please include a self-addressed mailing label with your request.


Available from: Margaret Konofal, MSN, PhD, Memorial Medical Center, Clinical Education Department, P.O. Box 23089, Savannah, GA 31404. Phone: (912) 350-3420 or (912) 350-7470, FAX (912) 350-8912. EMAIL: msh58a@prodigy.com

Resource Mother's Program is a monograph designed to guide others interested in reducing infant mortality through the use of lay visitors. Lay visitors assist at-risk pregnant teens throughout their pregnancy. They understand the pressures and obstacles facing a young mother. They know how to help her deal with the many tensions and concerns of daily life. Lay visitors look at the strengths and the possibilities of the teen and the situation.

The Resource Mother is trained to address the non-medical dimensions of pregnancy and child care. The Resource Mother is matched to the teen according to race and socioeconomic status. She encourages the teen to obtain consistent prenatal care, provides her and her family with practical help, and increases community awareness of infant mortality and teen pregnancy issues.

After the birth, the Resource Mother assists the teen mother in bonding with her infant. She supports the mother and her child through the first year of the child's life. She links the mother with appropriate services in the community. Details for program development are included.

Correction

A resource reviewed in our last issue, Second National Roundtable on Outcome Measures in Child Welfare Services: Proceedings, is also available for $20 from American Public Welfare Association Children's Division, 63 Inverness Drive East, Englewood CO 80112-5117, telephone (303) 792-9900, FAX: (303) 792-5333.
## GUIDE TO PAST ISSUES

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### New Resources from NCCAN

**NCCAN**

**ANNOTATED BIBLIOGRAPHY**

**Treatment Outcomes: Program Evaluations, May, 1994, 47 pages.**
Available from: National Clearinghouse on Child Abuse and Neglect Information, P.O. Box 1182, Washington, DC 20013
Phone: (703) 385-7565 or (800) FYI-3366.

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Available from: Kendall/Hunt Publishing Company, P.O. Box 1840, 4050 Westmark Dr., Dubuque, IA 52004-1840.

Barker, a clinician, was catapulted into the recognition of child maltreatment by a small hollow eyed child who clung to her neck saying, "Take me with you, my mommy doesn't want me anymore". This was the beginning of many experiences which led to the compiling of information for this book.

The text is divided into four interrelated sections containing chapters written by experts in the field. Section one examines the phenomenon of child abuse, neglect and sexual maltreatment. Section two focuses upon the interdisciplinary and community-based approach to treatment and prevention of abuse and neglect. Section three confronts practitioners with the realities of abuse and neglect with an emphasis on collaborative services for handling multiple-problem families. Section four examines policy and professional issues.

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When requesting an address change, please include a copy of your old mailing label.
The Harrisonburg-Rockingham Community Services Board in Harrisonburg has made efforts to serve families through non-traditional means for many years. For instance, the CSB successfully took parenting education classes to public housing projects in the early 80's in an effort to prevent parenting problems which lead to child abuse and neglect. So, it is not surprising that, upon learning about the Homebuilders model, the agency looked for funding in order to offer this program to the community. In 1989 monies became available. The idea was to provide intensive in-home services to families whose children were at risk of removal because of patterns of abuse or neglect. Services were to be concrete and therapeutic, focusing upon parent education, crisis stabilization and bolstering the family’s linkages with community resources.

"An intriguing aspect of this project was the establishment of a two-tiered interdisciplinary team process for screening referrals and for program management", explains Joe Sharrer, Executive Director of the CSB who came to the agency the year after funds were awarded. "The system is identical to the process adopted by the Comprehensive Services Act a few years later. It emphasizes community collaboration. We were ahead of the times."

The first tier in the system is staffed by line workers from the CSB, social services, schools, and courts. This group makes the clinical decisions and decides which services are most appropriate. The second tier is comprised of the management of the same four agencies. Management sets policy issues.

Harrisonburg's Family Preservation Program continues today with the same two-tiered system. The program is primarily supported by state general funds and medicaid. Three master's level clinicians maintain a caseload of 4 to 6 families each. Clinicians average 5 hours a week with each family, with a goal of completing services by the end of 26 weeks. "Some achieve their goals sooner, some later", Sharrer explains.

For the last two years, client satisfaction surveys have been conducted. "These surveys have become an integral part of our program" Sharrer says. The agency was able to contact 24 of the 85 families served. Eighty-five percent were satisfied with the services. The CSB also analyzed discharge information on 35 families served by Family Preservation in 1993. Of these, 32 children were in their home and 1 was in DeJarnette Hospital (inpatient program) when services began. At discharge, 31 children remained in the home, while 2 children were in foster care.

Sharrer is pleased that general satisfaction with services is very high (87.5 percent). However, the response rate is low. Sharrer comments, "We are exploring ways to increase our response rate. We are also adding a question regarding the child's placement at the time of contact, since this seems to be an outcome measure of interest. We want to gather the most useful outcome information within our resources."

Further information is available from: Charlotte McNulty, M.A., Harrisonburg-Rockingham Community Services Board, 1241 North Main Street, Harrisonburg, VA 22801, Phone (540) 434-1941, Fax (540) 434-1791.

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**Treatment Outcome**

Continued from page 10

maintain a difficult child at home.

The same authors, in evaluating the outcome literature for Homebuilders (one of the first nationally-known family preservation programs, located in the state of Washington), suggest that the program appears to be more successful for families with young children whose parents display poor supervisory skills. These problems, they report, were negatively associated with placement as compared to other, more difficult and ingrained problems in families with older children.

Szykula and Fleishman (1985) found similar results in their evaluation of family preservation treatment for abusive families. Families characterized as more stable, with less severe problems and where the abuse seemed an outgrowth of failure to manage the child in an authoritative and supportive non-abusive manner, benefited most from treatment.

When reviewing treatment effects on abuse-only, abuse/neglect and neglect-only groups, in-home family preservation treatment appears more effective with abuse-only groups. For example, Amundson (1989, cited in Wolfe, 1994) reports a decrease in the use of physical punishment of 95 percent.

Read the outcome results cautiously. As noted in VCPN, volume 46, there are many factors which lead to problems in the ability to generalize treatment results.

First and foremost is that programs across the country are different: more or less intensive, more or less therapeutic, more or less concrete in services provided. Secondly, many studies have been conducted without adhering to technical aspects of the scientific method. Others use questionable (in terms of validity or reliability) instruments for measuring change. Assumptions which may not be accurate are made when using placement as a sign of program success or failure. Finally, there is ongoing concern regarding small sample sizes for many studies.

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**THE NEXT ISSUE**

of VCPN, Volume 48, Summer, 1996 will review treatment outcome for sexually abused children and for sexual offenders.
Virginia's Picture

Virginia has family preservation programs located throughout the state. VCPN staff interviewed 16 programs across the state. The programs selected were a mixture of public and private programs. As is true nationally, implementation models vary. However, regardless of the model, most programs provide a combination of interventions such as family therapy, individual therapy, support groups, and concrete services, such as parent education, transportation and case management. All program clinicians are available 24 hours a day, 7 days a week for crisis management and stabilization.

Duration of services is becoming more and more driven by funding sources. In Virginia, medicaid requires an average of five hours of service to a child and his/her family and will fund the services for up to 6 months. Many clinicians begin services at a more intense level, possibly as much as ten hours a week. As family functioning improves, the number of hours of service decreases. Because of the intensity of involvement, caseloads remain low, with clinicians carrying from 4 to 6 cases at a time.

All programs receive a mixture of funds. Private agencies tend to be funded with Comprehensive Services Act funds (see VCPN, volume 38 for an explanation of the Comprehensive Services Act), grants, or contracts with organizations such as courts or departments of social services. Programs in public agencies (Community Services Boards or departments of social services) receive funds through the state general funds, medicaid, Comprehensive Services Act and grants.

VCPN staff were interested in how programs were structured as well as data regarding cost effectiveness and treatment outcomes.

When asked what determines whether a family is appropriate for services, a variety of responses were given. All agencies agreed that child safety, worker safety and parental motivation were among the most important criteria for implementation or continuation of services. Beyond that, however, there appeared to be fairly consistent differences between publicly funded and private agencies. Almost all public agencies used risk of removal, risk of child abuse and neglect and serious emotional disturbance of the child as selection criteria. Private agencies, on the other hand, accept most cases that are referred for an initial assessment. During that assessment, family motivation and compliance appear to be important.

VCPN asked what factors in the home seemed to predict failure of in-home intervention. Overwhelmingly, all interviewed named untreated alcohol and drug abuse as a primary cause of poor outcomes. Sharon Parker, acting Mental Health Director at Eastern Shore Community Mental Health summarized the sentiment when she said, “When there is active substance abuse in the family, we ask the abuser to seek services. If that doesn’t happen, there is little chance of impacting the family dynamics that resulted in a need for referral to our program.”

Other predictors of failure included unemployment, low SES, single parenting, previous experience with the social services system, chronic mental health problems, chronic truancy and demonstrated inability to provide a safe environment for the child.

Alternatively, VCPN staff wondered what factors appeared to predict success? Most clinicians agreed that an alliance of many resources was a primary factor in maintaining a family. “Establishing an ongoing network of support is essential”, says April Mela, Training Specialist with the Campbell County Department of Social Services (see Spotlight). “Parents need to reconnect with their natural supports in the community.”

Are Virginia’s family preservation programs cost-effective? “Absolutely!” was the resounding reply. However, few programs engage in formal cost-accounting and cost comparison methods, therefore, no specific data was available to support the opinions and clinical impressions.

Since most research studies use placement rates as an important outcome variable, VCPN wondered if program staff had data related to placement rates. No program had quantitative outcome data. Some, however, had some qualitative information. Campbell County provided the most qualitative information of the agencies we contacted. For instance, Mela related that only 2 of 58 children served by the Campbell County Family Educators Program were placed out-of-the-home. In addition, they conduct pre- and post-treatment surveys of professionals referring to their program, in-house professionals and the families who are served. The questions ask about client satisfaction as well as family functioning (see Spotlight, this issue).

The Harrisonburg-Rockingham CSB has conducted client-satisfaction surveys for the last two fiscal years. “Overall, family preservation clients who responded appear to be satisfied with services they received”, Joe Sharrer, Executive Director, remarks. “However, it is important to note that our response rate is small compared to the sample size, due to lack of phones or family members not being home when a personal call is made.” (for more information, see Spotlight, this issue).

Clearly, while clinical staff in all 16 programs are excited about their work and believe it to be effective, few are able to give quantitative outcome results. For those working in the field, scientific evaluation is riddled with implementation problems. In addition, evaluation is very expensive. Few can afford to use program funds to support rigorous studies. It is gratifying to note, however, that more and more program directors are aware of the need for outcome data, and are exploring methods to gather information documenting the effectiveness of services in which they take great pride.

Future Directions

Several possibilities exist for future studies. Overall, researchers agree that studies which are more methodologically sophisticated and which use a wider range of outcome measures are needed.

Secondly, most treatment efforts are directed at mothers, even when a history of violent male partners is evident (Egeleland & Erickson, 1990; Green et al. 1981; Wolfe, 1994). Treatment outreach must find ways to involve abusing men/fathers or treatment will be compromised.

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