Chapter Three

Child Welfare System & Public Assistance

Building a System of Care in Child Welfare

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Introduction

The System of Care being implemented by the Oregon State Office for Services to Children and Families (SOSCF) resulted from an agreement in 1995 between the Juvenile Rights Project and SOSCF developed to change the process by which services are delivered to families in the child welfare system throughout Oregon. The Regional Research Institute for Human Services at Portland State University, in collaboration with the Child Welfare Partnership, assumed responsibility for evaluating the implementation of the Strengths/Needs Based (S/NB) service delivery system, the critical practice component of the System of Care.

The evaluation has been carried out over a five-year period. During this time, areas for evaluation have included: 1) initial experiences with implementation of S/NB practice, 2) protective services and S/NB practice, 3) post-protective services and S/NB practice, and 4) a longitudinal study of children in these families over the period of a year. In the fourth year of the study the experiences of community partners with SOSCF were explored[1].

One of the central tenets of S/NB practice is to provide individualized, needs-based services. These services should emerge and be provided out of collaboration between the family, public child welfare and community partners, and any identified family resource providers. As SOSCF implemented the S/NB practice, questions arose concerning the perception of community partners who work closely with SOSCF staff and the families served by the agency. Obtaining the perspective of community partners would, it was thought, provide additional insight into the integration of this new practice model.

Sample recruitment and size

In order to identify an appropriate sample of community partners, SOSCF Branch Managers and/or Resource Developers were asked to provide the team with lists of community partners (individuals and agencies) with whom they had a close working relationship. This lists included private agencies (many of which were subcontractors), public agencies, and private individuals, only some of whom were subcontractors. The list was supplemented with the knowledge of the research team interviewers. Beginning with this list, a snowball sampling technique was used to identify respondents. Of 75 potential respondents contacted for an interview, only seven did not complete an interview. Sixty-eight community partners from five Oregon counties were interviewed. Both rural and urban counties were included in the study. Table 1 displays the range in types of community partners that participated.

Methodology

Data collection

Community partners of SOSCF were contacted by telephone. Verbal informed consent was obtained. In this process, partners were told about the evaluation of S/NB and were advised that we wanted to interview community partners to obtain their perspectives on the relationship between their agency and SOSCF. Subjects were told that their participation would be kept confidential and that their comments would become part of a summative report that would not attribute comments to individuals or to individual agencies.

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[1] *Details on all parts of the evaluation are available in comprehensive reports located at: http://www.cwp.pdx.edu/SOC/pgSOCHome.shtml*

Table 1
Types and Numbers of Providers Contacted

Provider type	*Number*
Legal: Attorneys, Victim Advocates, Trial Assistants, CRB, CASA, Juvenile Corrections, Referee, LEA, Adult Corrections	16
Domestic Violence Services-Shelter, Support for Survivors, Treatment for Offenders	3
Private Contractors for Therapy and Drug/Alcohol Treatment Programs	11
Family Resource Centers/Level 7 Shelters/Tribal Facilities/Churches/AFS	11
Public Mental Health/ Public Health	6
Parenting Education/Teen Parent Program	9
Schools	5
Juvenile Outpatient/Residential Treatment	7
Total:	68

Questions asked were oriented to components of the S/NB model. The questions were open-ended and intended to elicit expansive comments from the participants, followed with a prompting or probing question if needed. There were two interviewers, each of whom took detailed notes of interview responses. Questions asked were:

1. Describe what you understand about the practice or service model that SOSCF is asking its workers and partners to use on a daily basis.
2. How do your current services and capacities accommodate this model? Probes: How does your agency individualize services? Have flexible funds been used in the creation of services, and how?
3. As this service delivery model has been more fully integrated into the agency, how would you describe its benefits or limitations for the families with whom you have had service contact?
4. What strategies, if any, within SOSCF's service delivery system, would significantly increase your ability as a "community partner" to work within the current practice model that is used at SOSCF?

Data Analysis

The data were analyzed using a grounded theory approach. After 25 interviews were completed, interviewers independently analyzed responses in order to identify themes. Interviewers compared individual question responses and found a high degree of similarity of responses and of interpretation of meaning. From these responses, themes were developed and then organized into tentative categories. These themes were reviewed with the S/NB research team and with the project's Research Advisory Board. On the advice of the Research Advisory Board, the snowball sampling technique was modified to ask those interviewed for referrals of community partners who it was thought might have a different perspective. This was done, but the content of the interviews continued to reflect previously identified themes. Interviews continued until no new themes emerged, resulting in a total of 68 interviews. These interviews were analyzed by the interviewers, who extracted themes within these interviews, and compared the initial with the latter findings. In order to validate the emergent themes, findings were organized into key points and presented to two separate representative community groups. The community groups verified the findings as representative of their own experiences as community partners with SOSCF.

Findings

- Successful service collaboration depends on the caseworker; community partners' experiences vary.
- SOSCF has become a stronger community collaborator with the implementation of the S/NB model, becoming more willing to share responsibility for, and information about, cases.
- Community partners have questions about aspects of the S/NB model and about inconsistencies in the use of flexible funds. They would like to have more information to advocate for clients.
- Partners would like to see increased training for workers and improved staff performance. They would also like to see decreased workloads and decreased staff turnover, as well as greater consistency from branch to branch.
- Family decision meetings (at which community partners, family and extended family plan with the caseworker) are well liked as a forum for collaboration, but community partners also observed that collaborative efforts at the "front end" of a case are not always continued due to workload and personnel issues in the public child welfare setting.

Discussion

Though there was a wide range of perceptions about the S/NB model and its applications, many community partners commented positively on the overall changes that SOSCF continues to make. Most partners believe that the job of an SCF caseworker is a difficult one. It is also clear from the interviews that partners had experienced some excellent casework, and that, in general, community partners are noticing the efforts that SOSCF is making to become more strengths-based. As reflected in the many comments about practice, community partners speak to a need for improved retention, training, and supervision to strengthen service staff's ability to be solid SN/B practitioners.

Among the 68 community partners that were interviewed there appears to be general agreement that implementation of the S/NB practice model is uneven. Although participants reported that SOSCF is more collaborative, and family decision meetings are seen as a powerful tool for collaboration, community partners suggested that outcomes from those meetings were directly impacted by variable follow-through by SOSCF staff.

At its heart, S/NB practice is based on collaborative relationships with families and community partners. These relationships are centered around meeting the needs of children by building upon the strengths of a family, drawing on the perspective of community partners and crafting individualized services to meet those needs. Although the model highlights a team approach, field implementation of this model currently appears to pivot upon the ability of, and the system support for, caseworkers to coordinate efforts and/or to respond to the plan established by the team.

Implications

SOSCF began to implement Strengths/Needs Based practice almost five years ago. State permanency legislation and the Adoption and Safe Families Act (ASFA) have been integrated into SOSCF while SN/B has matured. At the same time, community partners report their observations that SOSCF is experiencing personnel instability in the form of turnover, case transfer and an influx of new and temporary workers. These changes in the work force, amidst the constant change associated with system reforms, may noticeably affect service delivery. It is the caseworker who is the ambassador for SOSCF, and with whom families and community partners have the most contact. It is not surprising then, that community partners' experiences with S/NB practice are most reflected in the phrase "it depends on the worker."

In light of SOSCF's heavy investment in this model, and with its key ingredient being an open, trusting and collaborative relationship between caseworker, family, and community partner, the hiring, development and retention of a skilled work force at the casework level is a fundamental step to successful outcomes for children.

In addition, SOSCF, along with its community partners, needs to develop and maintain consistent strategies for workers to access funds and services in a timely manner in order to support caseworkers' service delivery efforts. This will create a climate of consistent and uniform service delivery, which in turn forms the cornerstone of collaboration.

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Evaluation of Oregon's Title IV-E Waiver: Contextually Driven Decisions

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Introduction

Oregon's Title IV-E Waiver demonstration project has evolved over the course of three years, and provides flexible funding for local child welfare programs to collaborate with community partners in designing innovative approaches to serving children who are abused or neglected and their families. Presenters discussed the complexities of evaluating a statewide child welfare effort, designed within the context of local project design and implementation.

Background

Enactment of the Adoption and Safe Families Act (ASFA) occurred as Oregon's child welfare practice evolved toward a system of care approach. This juxtaposition of policy implementation and evolution of child welfare practice appeared to impact state and local decisions regarding how Waiver flexible dollars were utilized. This paper summarizes preliminary findings and their relationship to evaluative challenges encountered while measuring child and family outcomes when multiple innovative services were implemented at the local level, within a dynamic and complex state administered system. Evaluators raised the concern that child welfare outcomes as defined by the federal government may limit the ability of state and local child welfare services to examine the effectiveness of current practices that impact child well being in a very real, case-by-case way.

Context for the Evaluation

Oregon was one of the initial ten states to be awarded a Title IV-E Waiver by the U.S. Department of Health and Human Services, Administration for Children and Youth, under section 1130 of the Social Security Act. Oregon's Waiver demonstration project was implemented in July of 1997. The goal of the Waiver is to prevent out of home placement, shorten lengths of stay in substitute care, and improve child and family well being. The objectives include: (a) serving more children in their homes, (b) resolving the original caretaker's issues as soon as possible, (c) reducing the time it takes to arrive at an alternative permanency plan, and (d) lowering the rate of re-abuse and neglect. The state child welfare administrator and operations team intended that the Waiver both support and compliment the statewide child welfare System of Care Initiative (SOC), by encouraging local branches to collaborate with community partners to develop and implement strategies that bolstered SOC development.

The additional flexible funds, provided as a result of the Waiver agreement, were utilized in three ways: (a) one-time payments for foster care prevention, (b) expansion and enhancement of existing services, and (c) implementation of innovative approaches to service provision. Local child welfare agencies, in collaboration with community partners, submitted Waiver plans to the state agency. With state approval, the plans were implemented. The evaluation included process, impact, and cost-benefit components, and an overview of those processes and impact components are included here. The State agency has the responsibility to conduct cost benefit analyses.

Process Evaluation

Method

The process evaluation explored how the project progressed over time and provided possible interpretations for why the activities evolved as observed. Information was organized within three areas: (a) organizational, (b) service, and (c) contextual. Three data collection methods were used to answer each question within each category: (a) document/policy review, (b) exploratory group and individual interviews, and (c) site visit observational and field notes.

Results

Process findings suggested that specific local and state factors appeared to affect the capacity of local branches to develop and implement innovative approaches to supporting children and families, within the parameters of federal Waiver cost neutrality requirements and the state agency's procedures. These factors included: (a) branch history of collaboration with other community agencies (e.g., county drug and alcohol services, community mental health and family service agencies); (b) branch enduring success in maintaining or reducing numbers of paid out-of home placements; (c) accessibility to community services, both formal and informal; and 4) progressive leadership at the regional and local level, both within and outside the child welfare agency.

State and local administrative pressure to fulfill ASFA requirements and state legislation related to Family Decision Meetings (FDM's) appeared to exert an increasingly stronger influence on how Waiver flexible funds were utilized. For example, the number of local Waiver plans that provided greater numbers of FDM's that fulfilled the requirements of state enacted legislation were increasing as the next legislative session drew near. Moreover, state administrator interest in the Waiver as a viable source of flexible funds appeared to be more evident as the ASFA reporting system disseminated state child welfare outcomes to a broad audience, with limited explanation of what each outcome meant, beyond the quantitative "report card."

Impact Evaluation

The impact evaluation employed a quasi-experimental design to measure differences in outcomes between children who received Waiver services and those who received typical child welfare services. The following research questions provide examples of the outcome questions addressed in the evaluation.

1. To what extent did Waiver services contribute to preventing the placement of children in substitute care and promoting children's return home?
2. Were there differences in establishment of permanent placements for children between those whose families received Waiver services and those whose families received typical services only?

Results

With regard to question 1, preliminary findings suggested that two innovative services may contribute to maintaining children in their homes. These are the Drug and Alcohol Facilitator service and the Housing Specialist service. Preliminary analysis of child placement data indicated that the majority of children whose parents received these timely and tangible supports remained at home at three and six months after initiation of services. Comparative analysis between the group of children whose families received these services and an equivalent comparison group is not yet completed.

With regard to question 2, when measuring overall differences between Waiver and non-Waiver groups, without controlling for types of services received, differences in the time it took to establish permanency were not statistically significant. However, evaluators have not yet been able to more closely examine subgroups of children. For example, during the next year, differences in the time it takes to establish permanency will be examined between the subgroup of children whose families received Therapeutic Visitation services and an equivalent group of children whose families received typical visitation services. In addition, an analysis of child placements that occurred within one year of target date will be conducted to compare differences in proportions of children placed with relatives, re-placed in substitute care, and experiencing multiple placements, controlling for level of child and family difficulty and demographic characteristics.

Discussion

Preliminary findings provide information about how a state directed, locally managed child welfare system makes adjustments as it integrates a demonstration project that supports program practice changes during a period of federal and state shifts toward more rigid mandates and accountability. One possible result of facing the complexities that arise appears to be an increased capacity for state and local fiscal and program administrators to collaboratively plan and make decisions. In addition, a number of training needs have surfaced. For example, as evaluators began exploring the length of time cases were open, the question that arose was "What is the criteria for closing a case?" The answer to this question varied widely from branch to branch and caseworker to caseworker, with no apparent strategy for determining how and when to close or "transition" a case from child welfare agency monitoring to community support and monitoring.

The impact evaluation addresses outcomes agreed upon by the federal and state entities. However, these outcomes may not be appropriate within the limitations of how the Waiver is actually implemented. During the next year, data for Waiver and non-Waiver children that were collected through in-depth case reading will be analyzed and compared to determine differences in outcomes between groups who received innovative services (e.g., drug and alcohol facilitation, housing specialist, enhanced visitation, in-home parenting, family decision meetings) and those who received typical services only. Process findings will be utilized to explain the context within which these results occurred.

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Readiness for Change in Home-Based Services in Child Welfare: Validity and Prediction

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Introduction

Background

Prior research on home-based services in child welfare has focused on the outcomes of short-term, intensive, in-home services for families of abused and neglected children. Often called family preservation services (FPS), most of these programs bear some resemblance to the Homebuilders model (Kinney, Haapala, & Booth, 1991). Previous studies have examined the effects of FPS on out-of-home placements, subsequent child maltreatment, and family functioning; and some studies have looked at relationships between program or case characteristics and outcomes. FPS have not produced hoped-for reductions in out-of-home placements or the recurrence of maltreatment. Important questions about the proper goals, target population, structures, and processes of these programs remain (see Littell & Schuerman, 1995).

In Philadelphia County, where the current study was located, in-home services are provided by private child welfare agencies (under contracts with the Department of Human Services) to primary caregivers (usually mothers) of abused and neglected children. These services aim to improve parent and family functioning and reduce the risk of further child maltreatment. FPS programs provide 5 to 10 hours of in-person contact with family members each week for three months. Less intensive Services for Children in their Own Homes (SCOH) provide 1 to 3 hours of contact per week for up to nine months. Compared with SCOH, FPS caseworkers have smaller caseloads (up to 5 families per full-time caseworker vs. 8 to 14 families), FPS are initiated more quickly (within a few days vs. 6 to 8 weeks after referral), and provide more concrete services (material aid) to families.

Many FPS caseworkers think it is unrealistic to expect dramatic (or even measurable) improvements in parent or family functioning over a three month period, particularly in cases with serious substance abuse problems. Instead, caseworkers have suggested that measures of program "success" should focus on progress, including: 1) increased awareness on the part of the caregiver of the impact of substance abuse and maltreatment on her children and 2) greater readiness for change. Caseworkers have different expectations for caregivers depending, in part, on their perception of the caregiver's readiness for change. For caregivers who appear to be ready to change at the outset, program goals of improving child, parent, and family functioning are thought to be more realistic. Hence, our study examined caregiver readiness for change as an outcome and as a mediator of other outcomes related to family functioning and subsequent child maltreatment.

Readiness for Change

While there are many ways to conceptualize readiness for change (RFC), at present, the most popular view comes from the Transtheoretical Model of Behavior Change (Prochaska & DiClemente, 1984). According to this model, behavioral change occurs in a series of discrete stages. Whether within or outside of formal treatment and in relation to virtually any problem behavior, people are thought to move from precontemplation (not thinking about change) to contemplation (thinking about change) to action (behavioral change), and then maintenance. The "stages of change" are considered discrete and mutually exclusive, and individuals "pass *through* each stage" in an orderly fashion (Prochaska, DiClemente, Velicer, & Rossi, 1992, p. 825). This progression can be characterized as movement from cognitive to behavioral change, although progress is not always linear. There are a number of variations on the stage model; for example, some authors include a preparation stage between contemplation and action.

The stages of change have been widely used in health psychology and psychotherapy research and with Caucasian, voluntary, middle-class samples. Over the last decade, the model has been used in studies of a wide range of problem behaviors and in diverse samples (for a review, see Littell & Girvin, in press). At present, there are no published studies of the stages of change in relation to parenting behaviors, including child maltreatment.

Methods

Our study was nested in the national evaluation of family preservation and reunification services, which replicated and extended previous research on the outcomes of in-home services for families of abused and neglected children (Westat, Inc., 2001). The national evaluation was conducted in five sites; our study took place in one of them (Philadelphia County).

For purposes of the national evaluation, 362 cases were randomly assigned to family preservation services (FPS) or Services to Children in their Own Homes (SCOH) in Philadelphia County between March 1997 and July 1999. Families eligible for the study had substantiated reports of child abuse or neglect and children were thought to be at moderate risk of future harm.

Repeated interviews with primary caregivers were conducted in their homes at 2-3 weeks (Time 1), 12-14 weeks (Time 2), and one year (Time 3) after random assignment. The FPS or SCOH caseworker assigned to the case was interviewed by telephone at Time 1 and Time 2. Administrative data on case events (e.g., child maltreatment, out-of-home placement) were available through December 1999. Caseworker demographics and attitudinal data were gathered in a survey of FPS and SCOH caseworkers.

Sample Characteristics

At Time 1, caregivers were predominantly unemployed (83%), African American (81%) women (95%) whose ages ranged from 19 to 78 (*M* = 32, *SD* = 9). Almost all (90%) were unmarried and slightly more than half (53%) were the only adult in their household. Half (52%) had not completed high school and 70% were receiving TANF at Time 1. One-third had lived at their current address for less than a year.

Thirty-seven percent of the caregivers reported that they had been abused or neglected as a child. Their mean score on the SCL-90-R depression subscale fell between norms for outpatient clinical and nonclinical samples of adult women. Eleven percent reported that they had a substance abuse problem and 18% reported substance abuse in their household at Time 1. In contrast, FPS/SCOH caseworkers reported substance abuse in 38% of the households and intake (CPS) workers identified it in 52% of the caregivers. These figures are lower than previous estimates (of 90%).

On average, caregivers had slightly more than three children (*M* = 3.4, *SD* = 1.7, range 1 to 10). Children's ages ranged from newborn to 18. One-fifth of the caregivers had one or more children under 18 living outside the home at Time 1 (this includes both formal and informal placements).

Demographic data are available on 62 caseworkers who provided direct services to FPS or SCOH cases. Most (69%) were women. Two-thirds identified themselves as African American, 26% Caucasian (not Latino/a), 5% Latino/a, and 3% "other." Half of the caseworkers had a bachelor's degree, 23% had taken some graduate courses, and 26% had a Master's degree. On average, they had 8.6 years of experience in social work (*SD* = 8.4, range = 0 to 40) and 5.9 years in child welfare (*SD* =5.6, range = 0 to 26). Although we do not have data on caseworker turnover, at the time of the survey, 40% of the caseworkers reported that they wanted to change jobs, were looking for work elsewhere, or had already taken another job.

Measures

To assess caregivers' readiness for change, we used an 18-item version of the University of Rhode Island Change Assessment (URICA) Scale (McConnaughy, Prochaska, & Velicer, 1983, McConnaughy, DiClemente, Prochaska, & Velicer 1989; Carbonari, DiClemente, Addy, & Pollack, 1996). We modified the stem, so that the questions referred to "parenting problems," and dropped the maintenance subscale because these items were not applicable in our sample. Three subscales were retained with six items per subscale. This instrument was added to the data collection protocol for the national evaluation in Philadelphia County. Caregivers were asked to rate each item on a 5-point scale (from strongly disagree to strongly agree). Sample items are shown below.

Precontemplation (PC):

- I'm not the problem one. It doesn't make much sense for me to consider changing.
- Trying to change is pretty much a waste of time for me because the problem doesn't have to do with me.

Contemplation (C):

- I've been thinking that I might want to change something about myself.
- I have a problem and I really think I should work on it.

Action (A):

- I am really working hard to change.
- I am actively working on my problems.

We also used a short version of the Marlowe-Crowne Social Desirability Scale (Reynolds, 1982) and had access to data collected for the national evaluation including longitudinal data on child, parent, and family functioning; social support; life events; and administrative data on service history, child maltreatment, and of-home placements.

Statistical analysis

We used Pearson's product-moment correlation coefficient, principal axis factor analysis with varimax rotation, and K-means cluster analysis to examine the construct validity of the URICA subscales. To assess the predictive validity of URICA-based measures, we used multilevel, piecewise linear growth models (a form of HLM) to handle repeated measures of readiness for change and various indicators of parent and family functioning. Piecewise models make no apriori assumptions about the overall direction or rate of change over the observation period. We modeled change in two segments: from Time 1 (T1) to Time 2 (T2) and T2 to Time 3 (T3). Our analysis includes 600 observations on 242 cases.

We used Cox proportional hazard models and logistic regression in analysis of outcomes derived from administrative data on the timing of case events (e.g., subsequent reports of maltreatment, out-of-home placement) through 1999. In this analysis, the observation period ranges from 6.3 months (for cases enrolled in the study at the end) to 33.6 months (for those enrolled at the beginning).

Our growth models, hazard models, and logistic regressions include controls for social desirability bias, other case characteristics, and service group (FPS/SCOH).

Results

Construct Validity

Instead of three discrete stages, we find two dimensions (scales) that represent Precontemplation (PC) and Contemplation/Action (CA). Contemplation (C) and Action (A) scores are positively and significantly correlated at all points in time ($r > .57$). In principal axis factor analysis, most PC items load on one factor, while two factors represent different combinations of C and A items. K-means cluster analysis does not produce subgroups that clearly represent the three stages.

Predictive Validity

Greater problem admission (i.e., lower PC scores) is positively associated with the number of negative life events and greater caregiver depression at all points in time. Greater problem admission at Time 1 is predictive of:

- significant reductions in reports of corporal punishment between T2 and T3,
- use of more positive parenting practices over all points in time,
- less increase in economic problems from T2 to T3 (compared with cases with high PC scores),
- significant increases in network support from T2 to T3 (greater problem admission was associated with lower network support at T1), and
- a higher risk of out-of-home placement at 18 months (but not at 12 months) post random assignment

Higher CA scores are associated with greater caregiver depression at all points in time. Higher CA at T1 scores predict:

- increases in positive life events from T2 to T3,
- increases in network support from T2 to T3,
- greater perceived improvements in family life,
- lower risk of subsequent reports of maltreatment at 12 (but not 18) months,
- lower risk of substantiated reports of maltreatment at all points in time, and
- lower risk of out-of-home placement at 18 (but not 12) months.

Other outcomes that were not predicted by PC or CA scores were: positive child behaviors, housing problems, negative life events, and network size.

Discussion

Caregiver readiness for change may be important in relation to intervention processes and outcomes. Readiness can be assessed, albeit imperfectly. The performance of the URICA subscales in our sample is similar to their performance in other samples. That is, contrary to many published reports, most of the research on the stages of change does not fully support the stage model (Littell & Girvin, in press). There may be different dimensions of readiness for change, rather than discrete stages. We identified two distinct dimensions, precontemplation and contemplation/action. It may be particularly difficult to distinguish contemplation from action in relation to complex problem behaviors, such as child maltreatment.

Our measures of readiness for change predict some outcomes, but these predictions are not strong (i.e., they account for less than 4% of the variance in dependent measures) and underlying mechanisms are not clear.

Implications

More work is needed to develop better conceptualizations and measures of readiness for change. Future research should examine the construct (meanings) of readiness, and its components and underlying dimensions in different samples. It may be useful to examine client and caseworker views of the client's readiness for change, because they may not agree and the latter may be more influential in case planning. Distinctions should also be made between a client's readiness for change and readiness to participate in a particular intervention. With better understanding of the phenomenon of readiness, it should be possible to explore its relationships to intervention processes (e.g., alliance formation), outcomes, and other factors.

The stages of change may have some heuristic value for caseworkers, because they portray change as a gradual, somewhat unpredictable process. However, in our view, it is too early to base program design, child welfare policy, or major case decisions (e.g., out-of-home placement) on measures or judgments of clients' stage or readiness for change, since these assessments may not be valid.

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The Evaluation of Treatment Foster Care: Ecosystemic Conceptualizations

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Introduction

Treatment foster care (TFC) is a family-based, out-of-home intervention that has emerged as a viable alternative to more restrictive settings for children and adolescents with serious emotional and behavioral disturbances (SED). The last two decades have witnessed a proliferation of TFC programs, with 88% of programs surveyed having been established since 1979 (Hudson, Nutter, & Galaway, 1992, 1994a; Nutter, Hudson, & Galaway, 1989). Cross-sectional data suggest that approximately 11% of children with SED in out-of-home care are living in TFC (Foster Family-based Treatment Association [FFTA], 1995).

Among out-of-home services for these children, TFC is considered to be the least restrictive treatment-based setting (Hawkins, Almeida, Fabry, & Reitz, 1992). It combines a structured therapeutic approach with the benefits of a more normative family-based milieu (Meadowcroft, Thomlison, & Chamberlain, 1994). TFC family providers are carefully selected and trained to provide specialized care, receive additional support and assistance from human service professionals who carry a limited case load, are viewed as members of a professional treatment team, and are reimbursed at higher rates than traditional foster parents (Hawkins, Meadowcroft, Trout, & Luster, 1985; Hudson et al., 1994a).

Research on outcomes for children in TFC is not extensive. Early evaluations, that were mostly naturalistic, suggested that TFC was more effective and less expensive than more restrictive settings (Meadowcroft et al., 1994; Reddy & Pfeiffer, 1997). Recent randomized trials have generally supported these findings (Chamberlain & Reid, 1991,1998; Chamberlain, Ray, & Moore, 1996; also see review articles of Hudson, Nutter & Galaway, 1994b; Kutash & Rivera, 1996).

TFC Domains

To further advance our knowledge of TFC, we will have to know what works, for whom, and under which conditions. Figure 1 attempts to articulate the various domains that need to be explored if a fuller understanding of the impact of TFC is to be attained.

This summary synthesizes the state of knowledge in each of the three domains depicted in Figure 1, and discusses how this ecosystemic framework can advance our knowledge of TFC programs and their impacts.

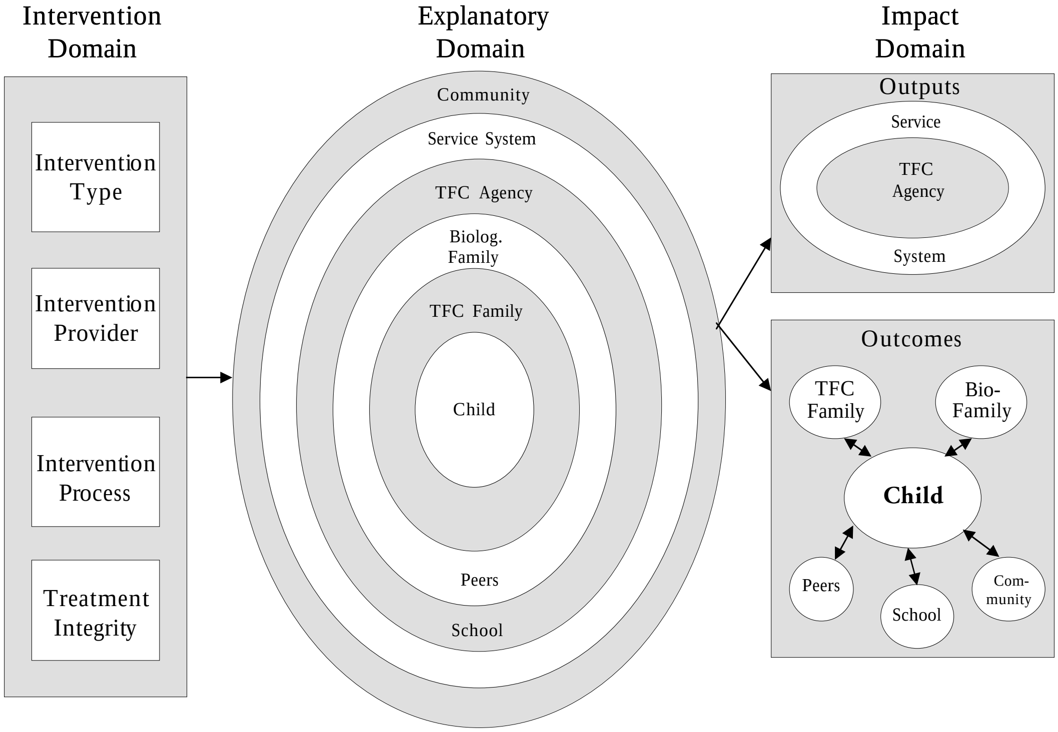
Intervention Domain

The intervention domain in Figure 1 delineates the types of information needed to unlock the “black box” of the intervention. Through this column, attention is drawn to various dimensions of the intervention, including the type of intervention applied, the characteristics of the service providers, the therapeutic processes employed, and the consistency with which the treatment is delivered. Each of these dimensions can influence the impact of services.

Explanatory Domain

Through the use of ecological contextual models, service success can be conceptualized as being impacted by factors other than the intervention itself (Cicchetti & Aber, 1998). In keeping with this more complex understanding of the determinants of outcomes, children in TFC should be visualized as being nested within larger systems that vary in proximity to them (see the Explanatory Domain in Figure 1). These nested mediators might explain program effects, and include the characteristics of the children, the adults with whom they interact, the other children in their lives, and the systems

Figure 1
An Ecosystemic Evaluation Framework Applied to Treatment Foster Care



responsible for their care. This section reviews what is known about salient variables within each of these ecological levels. While all potential variables at each of these levels cannot be addressed, those covered are illustrative of factors that might confound the attainment of program goals.

Impact Domain

Reddy and Pfeiffer's (1997) analysis of TFC effectiveness across studies indicated that: 1) there is no consensus in the TFC literature on what constitutes successful outcomes; 2) the majority of studies have taken a narrow approach to assessing effectiveness; and 3) one of the most studied outcome variables, discharge status, did not have a strong relationship to the intervention provided. They concluded that "treatment outcomes are best conceptualized as multidimensional and multidirectional" (p.587).

Building on these conclusions, it seems fruitful to also address program impacts from an ecosystemic perspective. An important "implication of the ecological perspective is that we are not just measuring single systems…but nested systems…" (Pecora, Fraser, Nelson, McCroskey, & Meezan, 1995, p.122) and interactions. The impact domain captures a number of areas that might be influenced by the program. It distinguishes between two types of program impacts∇outputs which are defined as status changes within the program or the service delivery system, and outcomes which describe changes in behavior and functioning (Jones, 1991). While the primary outcome variables studied should address the program's impact on the child, one might also look at the impact of TFC programs on the biological family and the TFC family. One would also consider the interactions between child and biological family, child and TFC family, child and peers, and child and larger community systems including school and neighborhood as potential TFC outcomes (see the Impact Domain, Figure 1). This section presents the major findings regarding the outcomes of TFC, and discusses additional variables that ought to be studied in future investigations to better understand the full impact of these programs.

Discussion

TFC is a complex multidimensional intervention that confronts the field with many challenges. This paper proposed an ecosystemic evaluation framework to forward knowledge building activities in the field, and has supplied information as to what is currently known when it is applied. Addressing current limitations in the three domains will not be an easy task. Based on this discussion, several conclusions can be drawn.

First, to further an understanding of the intervention, it will become necessary to clearly specify “the what, by whom and how” of the intervention. The current level of variability within and between programs prevents any definite conclusions about the generalizability of effects. The existence of standards of care for TFC programs (FFTA, 1995) puts this service in a unique position for more rigorous evaluations, which will advance knowledge about it. These standards provide a structured way to assess treatment integrity, and will allow the field to address whether differences in adherence to a single treatment model, or different treatment models, lead to differences in program effects.

Second, there are many variables in the child’s ecology that might explain, and can potentially confound, the effects of the intervention. While little is known about the children and families most likely to benefit from TFC (Meadowcroft et al., 1994), even less information is available about the program and system characteristics that would promote service success (Galaway, Nutter, & Hudson, 1995). As has been demonstrated in other fields of practice (Weiss & Jacobs, 1988), this review shows that as one moves further away from the child’s immediate living context, less and less is known about the variables influencing the experiences and outcomes of children in TFC.

Testing the significance of all potentially confounding variables may seem like an impossible feat. However, there are examples in the literature indicating that research can progress to include variables from more distal ecological milieus. In the child maltreatment and child mental health literature, for instance, recent studies have increasingly examined the influence of neighborhood and community factors (Aneshensel & Sucoff, 1996; Garbarino & Kostelny, 1992; Korbin, Coulton, Chard, Platt-Houston, & Su, 1998; Lynch & Cicchetti, 1998). In order to advance our understanding of TFC, we need to gather extensive descriptive data on the children and families under study and relate these different characteristics to program impacts. Focus should then be directed on investigating variables that are located between the child and the service system context. These variables could then be tested to determine their mediating or moderating function.

Third, program impacts have been defined narrowly and have focused primarily on easy-to-count “status” variables, such as placement permanency and discharge status. There is need to explore the broader impacts of these programs, including their effects on child functioning, biological and foster family functioning, child-caregiver interactions, and the child’s community integration (Reddy & Pfeiffer, 1997).

Expanding definitions of program success beyond outputs will not be an easy task for a number of reasons: a) the variety of potential outcomes across ecological systems; b) the multiple and often competing goals of many programs even within a single ecological level; c) the poor quality of many measures at a variety of ecological levels; and d) our limited ability to measure relational variables (Bloom, Fischer, & Orme, 1999; Jones, 1991; Pecora et al., 1995; Weiss & Jacobs, 1988), which hinders our efforts to capture these outcomes. Finally, we must face the fact that social work often borrows its measures from other disciplines, and is thus unable to capture the constructs of most interest to the field. To use measures that are reliable but not valid, and to make judgements about programs and how to improve them based on these measures, leaves us particularly vulnerable to criticisms (McCroskey, Sladen, & Meezan, 1997; Meezan, 2000).

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Failure in Treatment Foster Care: The Whys and Wherefores

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Introduction

Treatment foster care (sometimes called therapeutic or specialized foster care) is a form of out-of-home care of children that came into its own during the 1970s as an alternative to more intensive forms of residential care such as psychiatric hospitalization or incarceration of youthful offenders (Hudson, Nutter, & Galaway, 1994). During this period, agencies began placing children who would normally have been served in some form of residential program into specially designed foster homes. Treatment foster care combined the stability of the home environment with intensive case management services and therapeutic interventions carried out by trained foster parents. Encouraged by the federal CASSP initiative which saw this specialized foster care as a key component in its continuum of children's mental health services (Morissette, 1992), treatment foster care use increased greatly through the 1980s. In the late 1980s, the North American Foster Family-based Treatment Association was established. Two years later this organization promulgated a set of standards for treatment foster care that provided a set of criteria for developing and evaluating this form of care.

As treatment foster care has evolved over the past 30 years, it has become an important placement option in the three major child serving systems of juvenile justice, mental health, and child welfare. However, treatment foster care takes different forms and serves somewhat different needs in each of these systems. Although research touting the clear superiority of treatment foster care over residential care may be overly optimistic (Reddy & Pfeifer, 1997), there is reason to believe that treatment foster care programs provide quantifiable benefits, including reduction in problematic behaviors, improved academic performance, and fewer post-treatment days spent in more restrictive settings (Chamberlain, 1994; Meadowcroft, Thomlinson, & Chamberlain, 1994; Reddy & Pfeifer, 1997). However, as Meadowcroft and her colleagues (1994) point out, past research focused primarily on whether treatment foster care works as a treatment modality; little is known of the specific elements within this modality associated with optimal outcomes.

The research reported in this summary focuses on one particular element that other studies and clinical observations suggest is critical to the success of treatment foster care: placement stability. Prior research on traditional foster care found a strong relationship between difficult child behavior and multiple foster home placements. It is difficult to know which comes first, the child's behavior problems, or the instability in his or her living situation, but it seems clear that each problem area contributes to an increase in the other. The more a child is moved from home to home, the less likely he or she is to form important attachments that can serve as stabilizing factors and provide the necessary environment for social and emotional development. One of the key elements in treatment foster care is the selection and training of foster parents who are thought to have special qualities that enable them to manage very difficult child behavior. These parents are paid at a higher rate than traditional foster parents, commensurate with their training and qualifications.

Despite recognition of the importance of stability in the lives of vulnerable children, and efforts to minimize factors that may contribute to placement instability when such youngsters experience out of home care, placement breakdown can occur. This breakdown was the focus of the research conducted here to describe the constellation of events that may lead to the removal of a child from a treatment foster home. Research also sought to identify patterns or characteristics of foster parents, foster youth, and placement agencies and their workers, all of which may interact to disrupt placement. By identifying these factors and their interactions, we have developed recommendations for policies and practice that could decrease the numbers of disrupted placements.

Casey Family Services

The study was carried out at Casey Family Services (CFS), a multi-site voluntary child welfare agency offering a continuum of programs for vulnerable children and families. CFS has seven divisions located throughout New England that house treatment foster care programs. These programs serve children and youth with histories of severe behavioral, emotional, developmental, and/or academic problems. Indeed, one of the criteria for entry into a CFS treatment foster care program is that the child has exhausted other, less-intensive services. Most of the children accepted into CFS treatment foster care have histories of multiple placements through their state child welfare agencies. Even preschoolers coming into the CFS program have been in six, seven, eight, or more foster homes, and have been removed at the foster parents' request because their behavior could not be managed in the foster home. Many admitted children have also had in-patient psychiatric placements as well as extended stays in residential treatment centers. One eleven-year-old in our study had been in residential treatment for 5.5 years, beginning at the age of five. These are children who, in times past, would have experienced long-term psychiatric hospital stays.

Methodology

Each CFS division was asked to contribute four cases to the study, i.e., two in which they felt the child benefited from the program, and two in which the child was unable to benefit from this form of care. A total of 28 cases were studied.

This was a qualitative study using narrative analysis to review and extract meaning from the voluminous case records kept by CFS social workers on each child. Each record contained extensive documentation, such as: 1) intake assessments, referral summaries, previous psychiatric and psychological evaluations, court documents, and 2) psychosocial evaluations, case notes, monthly case reviews, foster parents' weekly written commentaries, educational assessments, and other materials. The case material was rich and provided for cross checking of data across multiple sources. All the case materials were read by two researchers who used constant comparative analysis to reach agreement on findings gleaned from the case material. The following questions guided the analyses:

- What were the precipitating factors surrounding each placement breakdown?
- How did these factors interact to result in a move to a different placement?
- What actions by key players could have prevented this event?"

Results and Discussion

Our study of the factors which precipitated placement breakdown led us to look not only at placement failures after the child came into CFS treatment foster care, but also at the early histories of these children that contributed so dramatically to their difficulties in psychosocial functioning in the present. These children had been multiply wounded psychologically in egregious ways through severe abuse and neglect by their earliest caregivers, and then repeatedly by a public child welfare system that compounded their difficulties by failing to respond to their needs for safety and security. As noted previously, we were struck by the number of out-of-home placements experienced by three, four and five year olds.

One child had eight foster home placements and two psychiatric hospitalizations in 14 months, all between the ages of four and five and a half. During the first four years of this boy's life, he had lived with his mother in a series of homeless shelters and with different, usually violent men. His mother was an alcoholic who had a long history of mental illness, stretching back into her own adolescence when she spent three years in a residential treatment center. The state agency had received repeated reports of her neglect and possible abuse of this child but had made only half-hearted attempts to locate this transient family. The mother voluntarily turned her son over to Child Protective Services when she could no longer manage his behavior; he was four years old. This child, who had no experience of safety and stability in his young life, was then subjected to a succession of failed foster home placements by the state, culminating in placement in residential treatment at five years old.

We found that for all of the children who were referred to CFS treatment foster care, they had already equated family life with rejection and failure. They had few lasting attachments to others and little experience of supportive, nurturing caregiving. Demands for the give and take of normal family life in a foster home were overwhelming and met with regression to primitive levels of expression such as spitting, biting, smearing, injuring animals and people. Any perceived threat of rejection or loss (including even the most innocuous change in structure or the environment) triggered intense anxiety in these children with resulting behavioral expression. If this behavior triggered a negative reaction from foster parents, and if the clinical staff failed to intervene early in this sequence of events, the cycle of reactivity threatened to spiral out of control, resulting in the demand for the child's removal from the home.

Implications for the field drawn from our findings include:

1. The immediate need for earlier, more responsive intervention in these children's lives, before the extensive psychological damage we found occurs;
2. Earlier recognition of the trauma suffered by these children and more responsive actions on the part of public child welfare agencies to insure treatment and stability, even in the toddler and preschool years;
3. Greater attention to the selection and training of treatment foster parents to insure that they understand the behavioral sequelae of severe child maltreatment and have a repertoire of skills to manage this behavior.

We also identified a significant need for additional research on the processes of treatment foster care, not only on outcomes, to further develop our understanding of how this form of out-of-home care can better serve the needs of the very vulnerable children it serves.

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The Match Team: A Collaborative Process to Strengthen Adoptive Families

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Introduction

The Tampa Bay community has a tradition of commitment to children who have been abused, neglected, or abandoned, many of whom have been removed from the custody of their parents. Often, these children have spent years in foster care. They are described as having special needs because they are older, members of sibling groups, of minority status, and/or present physical, emotional or behavioral challenges. One of the community organizations that has been instrumental in helping these children is the Adoption Council of Tampa Bay. Established in 1992 and incorporated in 1996, the Council's membership includes adoption agencies, community programs, and adoptive parents. The Council's mission is to *increase the number of adoptive placements of children with special needs.* The Council has striven to accomplish this goal in a number of ways, through a number of activities, involving people from the general community as well as from agencies.

In 1996, the Adoption Council of Tampa Bay developed the Match Team, a public-private collaboration designed to improve adoptive placements through a process of selection of families whose strengths best match the special needs of the children available for adoption. Members of the Match Team include representatives of licensed child-placing agencies, including: the Children's Home, Children's Home Society, Family Enrichment Center, Catholic Charities, Everyday Blessings and the Department of Children and Families (DCF). A Guardian ad Litem, the Banyan Family Center, and an adoptive parent (from the Council) also attend meetings. The goals of the Match process are to: 1) increase the pool of families to be selected for waiting children, and 2) to objectify the selection process through the inclusion of multiple perspectives from knowledgeable individuals not immediately involved with a particular child or family.

The Match Team meets twice a month. Prior to each meeting information about the children to be discussed is distributed to the private agencies. During meetings, information about the waiting children is presented, emphasizing their specific needs; home studies of approved families are presented by the child-placing agencies. Following those presentations, the Team reaches consensus regarding the family whose attributes and strengths, in the judgement of the group, best meet the needs of the child. When more than one family offers similar strengths, there may be a ranking and/or the child's counselor (and the Guardian ad Litem when appropriate) may meet and interview the families recommended prior to making a decision. Sometimes a family that was not the "first" choice becomes the family that actually adopts a child.

The purpose of this study, which was funded by the USF Collaborative for Children, Families, and Communities, was to explore the Match process, its effectiveness in fulfilling its mission of matching families' strengths with children's needs, and its potential value as a model for other communities.

Methodology

The study used primarily qualitative methods in examining the experiences and responses of the following individuals involved in adoption and/or the match process: 1) counselors and supervisors from the Department of Children and Families, 2) members of the Match steering committee (representatives of community agencies), and 3) adoptive parents. These methodologies included focus groups and interviews. Two focus groups of adoption professionals were conducted; one of six DCF counselors, and one of eight members of the Match steering committee. There was one focus group of four Non-Matched parents; these individuals had received their adopted children without the Match process. As it was not possible to arrange a focus group of Match parents, nine one-on-one semi-structured interviews were conducted with these participants. For the purpose of this study, Match parents were defined as having been selected through the Match process to be adoptive parents of their children

Demographic information was collected on all the above-named groups. In addition quantitative data were collected from the Department of Children and Families regarding the children presented at Match and—to the extent possible given limitations in accessing available data—compared with demographics of the available children in the county. Information available on outcomes of Match was also examined.

Findings

Quantitative data

Quantitative data regarding Match is not readily available, as there is no data collection system utilized for this purpose within the Department of Children and Families. Therefore the following information was collected ex post facto, from DCF supervisors.

During the six months included in this study, from July 1999 to January 2000, 46 children were presented at Match meetings; eleven of them were placed in adoptive homes selected through Match; six remained in foster/ adopt placements. No families were found through Match for 25 of these children. No information was available on outcomes for four of the children presented.

Demographically, seven African-American children were presented at Match and one was placed with an adoptive family; three biracial children were presented and two placed; of five Hispanic children, one was adopted, and thirty-one Caucasian children were presented, with seven placed in adoptive families. Although a small sample, these data support the notion that the children served through the Match process are not representative of the cohort of children awaiting adoption in this county, 52% of whom are African American while 42% are Caucasian. The average age of those children involved in the Match process was about five years old, while the predominant age group of children needing adoptive homes is 6 through 12.

Qualitative data

Qualitative data involved protocols for focus groups and interviews. Sets of open-ended questions were designed for the parent interviews and focus group as well as for both the steering committee and the DCF counselor focus groups. Questions for the parents covered topics including: reasons for adopting, experiences with the adoption, most challenging period (after placement), effectiveness of process in matching strengths to needs, ways to improve process, and indicators of successful adoption. The questioning route for the professional focus groups were similar, excluding topics related to the adoption experience.

- ***Professionals:*** Generally, counselors were less positive about the Match Team than were members of the Match steering committee. Some counselors stated that staffing is a “waste of time” because they know the child’s needs best; therefore they should be making those decisions. They also felt that the workload in preparing for meetings was on them, and often there were no positive outcomes for the children (i.e., no families). The steering committee viewed the Match process positively as a way to objectify the selection process and to assure that the focus remained on the “best interests of the child.”

  Both groups felt the collaboration of the different agencies was important and could lead to better decision-making. They felt that Match has improved relationships, outside of the meetings. Both groups also emphasized the need for “full disclosure” of information about the child, and the families, in order to make informed selections; and the need for uniform home studies, as formats and requirements for home studies vary among agencies.

- ***Parents:*** The Non-Match parents naturally had little or no information about the Match process, and had rarely even heard of it. They generally had known the children they had adopted or had met the children, and their motivations for adoption were that they wanted these particular children to be with them. Their children were somewhat older when adopted than were those of the Match parents. The Non-Match parents described less difficulty with the whole adoption process than did the Match parents.

  The views of the Match parents depended upon their individual experiences with the Match and the adoption process. They had knowledge of Match through orientation and the classes; however, none of them had directly experienced the process as parents to be presented do not attend the meetings. Therefore, those parents who had not been initially selected or who had had negative outcomes were critical of the process. Of the nine parents interviewed, six spoke positively in a general way, while three felt decisions of the group could be arbitrary and unfair.

  Virtually all of the Match parents “had always wanted to adopt,” and they had not known their children prior to placement. Most of them also had experienced considerable difficulty during the early weeks and months after their child arrived. Some sought counseling or some type of support, while others had not known that such services were available.

- ***Consensus:*** Several themes and areas of agreement among all groups emerged from the interviews and focus groups. Some kind of matching of children with families is a good thing, e.g., a way to systematize and formalize the process.

  1) The Match Team has been successful in promoting collaboration among agencies, which has not only been useful for adoptive placements, but generally.

  2) Information about the children should be available and shared, with the counselors and with the families, so that there are as few “surprises” as possible. Information should also be shared about services and resources in the community.

  3) The amount of *time* it takes to secure permanency for children is a huge problem. This issue involves the time from removal of the child to termination of parental rights; to locating, studying and approving families; to finding homes for these children and placing them there; and to finalizing the adoption.

  4) There is a need for adoptive families to receive counseling, especially in the early weeks and months following an adoption.

Successful Adoptions

Counselors and other professionals answered the question “how do you know when an adoption is successful?” pragmatically, with answers such as: “when our phone doesn’t ring,” or “when we don’t hear from them.” Basically, counselors don’t know what happens to these families unless there is a problem There were, however, other answers: “when they go home for Thanksgiving, and they have children of their own, that’s where they go.”

The Non-Match and Match parents viewed success somewhat differently, perhaps due to their degree of familiarity with the children. The Non-Match parents described success in terms of their children’s future achievement and character; the Matched in terms of the attachment and relationship they develop with the adopted child. “We would never give her up…she’s very attached to us.”

Conclusions

The Match team has limitations as presently constituted, especially as a strategy for placing those children who are over represented in the child welfare system; i.e., primarily male, African-American children between the ages of 6 and 12. As there rarely are two or more families seeking to adopt these children, the Team process is inappropriate for them. In addition, there is a need to track the outcomes for the children presented at Match to document areas of need and of success.

Nonetheless, Match is an innovative process that has demonstrated adaptability. Match has a worthy mission and a solid, collaborative structure; and it has considerable potential, especially as the areas of foster care and adoption move into community-based care.

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Evaluating Child Welfare Consumer Satisfaction among Children, Parents and Professional Collaterals

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Introduction

Customer satisfaction surveys proliferate in mental health and child welfare systems, founded in a desire for client direction and quality improvement, and buoyed by apparent face validity and relatively convenient data collection (Harris & Poertner, 1999). The same motivating values direct agencies to survey the professional collateral consumers of their services (e.g., educators, mental health service providers, judges, etc.). In contrast to the literature available on the perceptions of adult and child consumers of mental health and child welfare services (e.g., Godley, Fiedler & Funk, 1998; Wilson & Conroy, 1999), professional collaterals' voices are less often heard in the consumer satisfaction chorus.

There are many potential benefits for including collateral input. For instance, referral sources' input regarding what they seek, and what they perceive as most and least helpful inform agency efforts to make services more available and attractive to consumers. Therapists, evaluators, educators, and other treatment team members' ratings of key agency performance characteristics can highlight specific areas for improvement and assist in monitoring the success of change efforts. External experts bring their unique perspective and this input can facilitate triangulation on difficult to measure constructs.

This paper examines one child welfare agency's Continuous Quality Improvement Team's (CQI) effort to employ consumer survey data from foster parents, foster youth and professional collaterals to enhance service delivery. Parallel forms of a brief questionnaire examined general perceptions of three areas of primary interest to the agency, including Service Quality, Multicultural Sensitivity, and Service Outcomes. However, previous efforts to develop scales that measure independent subscales have met with mixed success in the arena of mental health (c.f., Brannan, Sonnichsen & Heflinger, 1996), and there is little guidance in the child welfare literature (c.f., Wilson & Conroy, 1999). In order to advance to more sophisticated analyses of between-group differences and similarities, scale integrity needed review for each respondent group.

Method

Setting and Participants: Casey Family Services employs child-centered, family-based casework models in their long-term and treatment foster care services. In September 2000, parent surveys were mailed to all parents, including foster parents, in families served by any Casey program at any time during the previous 12 months. All foster children 13 and older who were served in any of the foster care programs during the last 12 months were targeted for telephone interviews. Service divisions identified external members of their treatment teams and referral sources for the professional collateral mailed survey. Information concerning the foster care programs was eventually collected from 165 foster parents (41% response rate), 158 foster children (68%) and 190 collaterals (32%; the collateral response rate is based on surveys distributed to professional colleagues with experience of both foster care and non-foster care programs). Few youth who were contacted declined to participate, as most incomplete interviews were the result of busy lives and scheduling conflicts that prevented contact during the study period. Overall, the response rates were consistent with previous administrations of this survey.

Respondents included a wide variety of children and parents as well as professional colleagues. Foster parent responses came mostly from foster mothers (only 13% came from foster fathers). Foster youth respondents were more evenly divided among males and females. Collaterals who responded were predominantly female (73%). Almost half of the responding collaterals were from child welfare agencies (e.g., state child protective services), while about one third were from mental health service providers. Most respondents were parents (77%), youth (72%), and Caucasian (80%).

Measures: In developing the initial survey, available measures were considered (e.g., Attkisson & Greenfield, 1996; Shapiro, Welker & Jacobson, 1997; Wilder Foundation, 1997). However, none of these measures addressed local needs fully (e.g., the agency's multicultural sensitivity initiative). Additional items had been developed in 1998 to augment a brief mailed survey tailored to address the agency priorities and context (Notter & Anand, personal communication, May 19, 2000). The survey was expanded to include a parallel foster child telephone interview in 1999 and professional collateral mailed survey in 2000. Each format asked respondents to rate several key service characteristics along a 5 point scale, ranging from 1 ("poor") to 5 ("excellent"). While minor adjustments were made across forms, they consisted of three theoretically derived subscales: Service Quality (e.g., timeliness of agency response), Multicultural Sensitivity (e.g., respect for cultural beliefs), and Outcomes (e.g., progress on goals).

Analyses: Measures of the items' central tendency and the observed distribution provide a first indication of the overlap and divergence of perspectives, as well as of the consistency of using these parallel gauges. Subscale integrity was examined using both variance explained and coefficient alpha indices of internal consistency for each of the theoretically derived subscales. Factor analyses with all of the subscales' items then examined the empirical and theoretical factor structure. Examination of the rating scale data concluded with a look at the relative ranking of several critical items in order to consider convergence and contrast in different respondent groups and to measure these against agency-set benchmarks.

Results

The means and medians, most of which met or exceeded the 4.0 threshold ("Very Good") indicated the clear complimentary tone of the respondent groups. There was some apparent variation in the item means among the respondent groups. As is typical of consumer satisfaction data, the distributions are narrow and negatively skewed.

Subscale analyses summarized in the first row of Table 1 explained most of the variance among the constituent items. For instance, parent subscales explain 72.8% of the variance among the Service Quality subscale items and 68.7% on the Multicultural Sensitivity Subscale. Parent subscales' coefficient alphas ranging from .92 to .84, reflected internal consistency. While the collaterals' results resembled those of the parents, the youth subscales were somewhat less effective in explaining the variance among their constituent items (range 48.7% to 58.7%), and less internally consistent (range alpha .55 to .78). Thus, individual factor analyses suggest that the subscales were generally consistent across the parent and collateral respondent groups, though slightly less stable in the youth sample.

Like most satisfaction scaling research, the items were expected to share so much variance that the rationale for composing separate subscales would be primarily theoretical. Considerable association among the scales underscored the possibility that all of the scales reflected a single global satisfaction construct. For instance, the mean scale intercorrelations for parents, youth and collaterals were .72, .57 and .76.

The second row of Table 1 illustrates the empirical factors extracted in a principal components factor analysis when items comprising all three theoretical factors were examined together. Consistent with theoretical predictions, three empirical factors emerged in the parent respondent data. In contrast, the youth data supported only two factors and the collateral data supported only a single empirical factor.

Table 1
Summary of Service Quality, Multicultural Sensitivity and Outcomes Scale Analyses

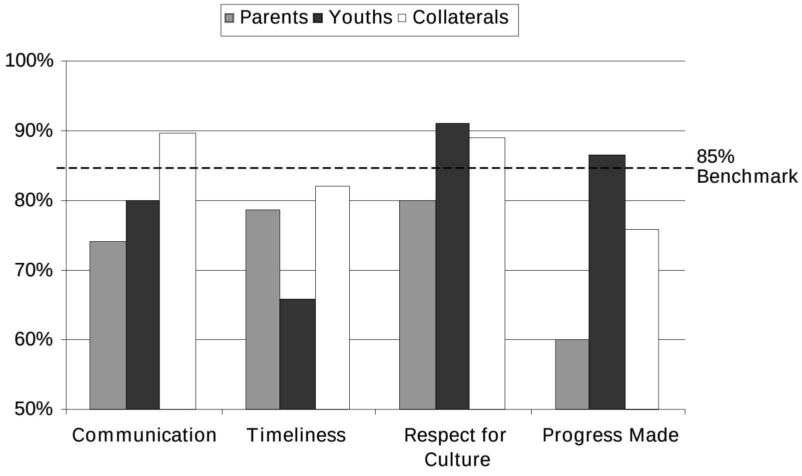
	Parent	*Youth*	*Collateral*
Variance explained in scale (Cronbach alpha)			
Service Quality	72.8% (.92)	48.7% (.78)	70.7% (.93)
Multicultural Sensitivity	68.7% (.91)	58.7% (.63)	78.2% (.86)
Outcomes	75.8% (.84)	53.5% (.55)	84.5% (.91)
Empirical factors extracted [1]	3	2	1
Theoretical factor loadings			
Service Quality-SQ			
Understands particular needs	.89	.74	[MS .70]
Recognize strengths	.85	.61	[MS .74]
Timely response	.82	.79	.86
Clear communication	.91	.63	.71
Welcome & Comfort	[MS .58]	[MS .80]	.90
Overall quality direct service	.48 [MS .44]	.65	.70
Overall quality collateral service	–	–	.76
Multicultural Sensitivity-MS			
Understand & serve culture	[SQ .83]	[SQ .60]	.89
Respects cultural beliefs	[SQ .83]	.69	.98
Effective outreach	.42	–	[SQ .58]
Representation in literature	.66	–	–
Access staff same culture	.67	–	–
Availability of staff like you	.86	[SQ .50]	–
Outcomes-O			
Progress on goals	.75	.43 [SQ .63]	.92
Improved coping, problems	.41 [SQ .58]	.34	.71
How things going now	.90	.92	.48 [SQ .43]

– Item not on instrument
[Brackets] indicate unpredicted or complex loading (item loads > .40).
[1] Minimum eigenvalue of 1 was used to determine number of empirical factors, although three theoretical factors were rotated.

The lower portion of Table 1 provides a summary of the factor analyses results when all items were entered simultaneously. When three factors were extracted for oblique rotation, the item loadings corresponded in part to the theorized pattern. While somewhat consistent across respondent forms, the presence of several complex, low and unpredicted loadings reflected substantial factorial variance.

Nevertheless, the CQI team was able to glean helpful information from the item-level data through measurement against agency benchmarks and the correspondence of rater group concerns. For example, the percentage of respondents rating agency timeliness as either “Excellent” or “Very Good” in all three groups fell below the agency benchmark (85%). This convergence, illustrated in Figure 1, triggered an agency-wide initiative to better understand consumers’ concerns and to develop action plans to address them. In contrast, collaterals ranked communication near the top, but parents ranked it near the bottom. These divergences underscore the value of breaking grouping homogeneous informants, and recognizing that these informant groups may have different experiences of, relationships with, and expectations for the agency.

Figure 1
Benchmarking to Promote Improvement in Critical Areas
Foster Parents, Youth and Collaterals
Rating “Excellent” or “Very Good”



Note: Minimum eigenvalue of 1 was used to determine number of empirical factors, although three theoretical factors were rotated.

Discussion

These preliminary results highlight the complexities of parallel measurement and triangulation. The goal of collecting information from multiple sources to get the best representation of a complex reality is worthy, but deceptively complicated. The scales generally behaved similarly and there was considerable overlap between the parent, child and collateral ratings of agency performance. Simplistic adoption of parallel scales and the assumption of validity based on appearance is unwarranted.

Still, these results highlight the potential value of these albeit imperfect data applied to a specific agency setting. Even in light of metric inconsistency and lack of factorial invariance, such data can inform and energize CQI efforts to enhance services and build capacity for further data use. These activities have contributed to ongoing efforts to improve services through the setting of benchmarks in priority areas. When results fell short of benchmarks, CQI developed action plans to better understand the roots of the problem, and to address these causes and enhance overall quality. The practice of examining relative ranks assigned by different respondent groups, and considering actual performance relative to established benchmarks can help transcend concerns about respondent groups’ unique use of scales.

Another valuable strategy that also controls for the negative skew commonly observed in Satisfaction survey data is to focus on understanding and addressing the concerns identified by the most dissatisfied consumers. Agency efforts have also focused on developing a better understanding of these outliers, especially through the identification of themes in their open-ended responses.

The use of multiple perspectives can facilitate an agency’s self-understanding, but the hope for reliable and exact parallel forms remains unrealized. However, the experience with this data, even with its flaws, can enrich and build CQI capacity. With each data collection iteration, the questions asked have improved and the readiness to use the data has grown beyond the cadre of CQI champions and activists. The commitment to consumer input and direction clearly embodies a value underlying many current service models. Still, these results do not suggest that methodological vulnerabilities should be ignored. Increased dependency on market forces and the competition metaphor in system reform suggest that these information needs will not soon vanish.

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Symposium Overview: Health Care Reform Tracking Project: Findings from the 2000 State Survey

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Introduction

The early 1990s witnessed a rapid expansion of managed care from the private health care field to the public sector. For example, while only 9.53% of Medicaid enrollees were enrolled in managed care arrangements in 1991, as of June 1998 that figure had risen to just under 54% of the 31 million Medicaid recipients, according to data from the federal Health Care Financing Administration (1998).

With the sharp increase in enrollment in managed care plans that has occurred in the past decade, children with emotional problems and their families are increasingly being served through managed care arrangements directed at containing costs and controlling service utilization. At the same time that managed care reforms have occurred, reforms in the children's mental health field have focused on the development of community-based systems of care. The Health Care Reform Tracking Project was initiated in 1995 to track and analyze the impact of public sector managed care reforms on children and adolescents with serious emotional problems and their families and on the systems of care that serve them.

Methodology

The Tracking Project uses a mixed method approach for the research design. It involves three major components — surveys of all states, for which quantitative, descriptive statistics are used; in-depth impact analyses, using qualitative case studies, of states that have experience with Medicaid managed care reforms; and a study of promising strategies and approaches for children's behavioral health services in publicly financed managed care systems. An initial baseline state survey was conducted in 1995 to identify and describe state health care reforms. The all-state survey was repeated in 1997-98 and again in 2000 in order to document changes resulting from the continuing implementation and refinement of managed care systems. In addition to updating descriptive information and tracking changes on publicly financed managed care reforms affecting children's mental health services, the 2000 State Survey incorporated a new feature — identifying and collecting preliminary information on promising approaches within managed care arrangements for children with behavioral health disorders and their families.

The 2000 State Survey was mailed to state children's mental health directors in all 50 states and the District of Columbia. Respondents were given the options of responding electronically, by telephone or by mail. Questions from the previous all-state surveys were retained as appropriate so that trends and changes could continue to be tracked over time; additional items were added to clarify findings from previous Tracking Project activities and to identify promising approaches and features of managed care systems. A highly systematic and structured approach to survey follow-up resulted in a 100% response rate. Data analysis was conducted on the reforms for which respondents provided sufficiently detailed information.

Findings from the 2000 State Survey

Throughout its activities, the Tracking Project has examined the differential effects of *carve out designs*, defined as arrangements where behavioral health services are financed and administered separately from physical health services, and *integrated designs*, defined as arrangements in which the financing and administration of physical and behavioral health services are integrated (even if the management of behavioral health services is subcontracted). The data analysis from the 2000 State Survey compared findings for carve outs and for managed care systems with integrated designs.

As noted, all 50 states and the District of Columbia responded to the survey. Most states (42) reported involvement in publicly financed managed care activity affecting behavioral health services for children and their families. In addition, 8 states reported termination of managed care activities since the last survey, and 3 states reported new reforms underway, suggesting continuing experimentation in states with managed care approaches. Respondents to the 2000 survey provided detailed data on 35 reforms in 34 states, including 27 carve outs and 8 integrated approaches. The findings that follow pertain to this sample of 35 reforms.

As was true in 1997-98, State Medicaid agencies are the lead agency in more than half of the reforms (55%). In 2000, most reforms (71%) were in late stages of implementation, defined as implemented for a period of 3 or more years.

Key Stakeholder Involvement. Continuing a trend identified in 1997-98, stakeholder (i.e., families, child-serving systems, providers) involvement in planning, implementation, and refinement of managed care reforms has increased over the past few years. However, significant involvement for most stakeholder groups still occurs in fewer than half of the reforms. For example, juvenile justice staff reportedly has significant involvement in only 23% of reforms, despite the increased enrollment of juvenile justice populations in managed care. Families have significant involvement in less than half (48%) of reforms—all carve outs—in spite of national attention to the need to increase the consumer and family voice in managed care systems.

Covered Populations. The 2000 survey results suggest acceleration of a trend noted in 1997-98, the coverage of more Medicaid populations in managed care, including those with more serious and costly needs. Half of the reforms reportedly cover all Medicaid subpopulations. Carve outs (62%) are more likely to cover the total Medicaid population than integrated reforms (12%). There has been a 23% increase in reforms covering the Supplementary Security Income (SSI) population, a 22% increase in reforms covering the child welfare population, and a 42% increase in reforms covering the juvenile justice population.

Planning for special-need populations also has increased in managed care systems. Since 1997-98 there has been a 44% increase in the percentage of reforms that include special provisions for children with serious and complex needs, such as intensive case management, an enhanced benefit package, or interagency coordination requirements. However, only 20% of reforms reportedly include risk-adjusted rates for these populations, suggesting that resources to support these special provisions may be lacking.

Managed Care Financing. As in 1997-98, Medicaid and mental health agencies are the primary sources of financing for managed care systems, with Medicaid contributing to 91% of reforms and mental health agencies contributing to 76% of reforms. There has been a 15% increase since 1997-98 in the percentage of reforms in which both the Medicaid and behavioral health agencies contribute to the financing arrangement. However, the 2000 survey reports declines in the financial participation of other child serving agencies, and the level of participation of these agencies remains low. SCHIP funds are contributing to both carve out (50%) and integrated reforms (44%). Almost all reforms (91%) leave some Medicaid dollars for children's behavioral health services outside of the managed care system in other child-serving systems-schools, with child welfare and developmental disabilities systems being the most frequently cited.

Cost Shifting. Cost shifting is reportedly occurring in over two-thirds of reforms. In the integrated reforms, there were more reports of cost shifting from the managed care system to other child serving systems (71%). In carve outs, cost shifting is reportedly more likely to occur from child serving systems to the managed care system (52%). Reports of cost shifting are largely anecdotal as only 16% of reforms reportedly are tracking and monitoring cost shifting.

Services Covered. Reportedly, there has been an 18% increase since 1997-98 in managed care systems that cover a broad array of services, with carve outs far more likely to cover a broad service array than integrated reforms (70% versus 13%). The services most likely to be covered are assessment and diagnosis, outpatient, crisis services, medical management, day treatment, and inpatient care. The services least likely to be covered are transportation, therapeutic foster care, respite, therapeutic group care, and residential treatment. While carve outs are more likely than integrated reforms to expand coverage of home and community-based services (63% versus 38%), findings indicate that these services also continue to be provided outside of the managed care system by other child serving systems in most states.

Service Capacity. Significant expansion of service capacity occurred in only about one-third of the reforms (all carve-outs). Nearly half of the reforms (42%) reported either very little or no expansion of service capacity as a result of managed care. Lack of service capacity, a problem that pre-dated managed care, remains an issue in almost all states. Respondents for only 31% of carve outs and none of the integrated reforms reported that the behavioral health service capacity in general was highly developed or close to highly developed in their states. In addition, respondents also reported a 16% decline in the percentage of reforms that require reinvestment of savings to expand service capacity.

Access. Initial access to behavioral health services reportedly has improved in 76% of carve outs but in only half of the integrated reforms. Access is more likely to be improved in carve outs (better in 76%, worse in 10%), and less likely to be improved in integrated systems (better in 50%, worse in 33%). Access to extended care reportedly has improved in 39% of carve outs, but in only 20% of integrated reforms, with reports of worse access in 60% of integrated reforms, but in only 4% of the carve outs.

Initial access to inpatient care reportedly is not considered more difficult in most reforms (80%) but shorter lengths of inpatient stay were reported in 63% (56% of carve outs and 88% of integrated reforms). Resulting problems include premature discharge before stabilization, children discharged without needed aftercare services, and placement of children in community programs without appropriate clinical capacity. A major concern is the inappropriate use of child welfare placements (8% of carve outs and 43% of integrated reforms) and juvenile justice facilities (13% of carve outs and 29% of integrated reforms).

Family Involvement. Over two-thirds of the carve out reforms reportedly incorporate various strategies to include families at the system and service levels, such as using family advocates, covering family support services, requiring family involvement on system advisory bodies, and requiring family involvement in service planning. In contrast, nearly 70% of integrated reforms reportedly have no strategies for involving families who have children with behavioral health needs. The 2000 State Survey found, much like previous Tracking Project studies, that managed care reforms reportedly have had no impact on the practice of families having to relinquish custody to obtain behavioral health services.

Cultural Competence. Specific strategies for enhancing cultural competence were reported with greater frequency for carve outs than for integrated reforms. For example, almost half of the carve outs include special services needed by culturally diverse populations, in addition to translation/ interpretation services, compared to none of the integrated reforms. Nearly half of the carve outs reportedly track utilization and outcomes by culturally diverse groups, in comparison with none of the integrated reforms.

Provider Issues. Provider reimbursement rates reportedly are higher under managed care than under the previous fee-for-service system in less than a quarter of the reforms, mostly carve outs. Rates are lower in 57% of the integrated reforms, but in only 25% of the carve-outs. Administrative burden reportedly has increased in nearly two-thirds of reforms, regardless of design. Lower rates, coupled with increased administrative burden, suggest that providers may be struggling financially under managed care arrangements. The majority of reforms include culturally diverse providers, certified addictions counselors, and school-based providers in their provider networks. The use of family members as providers was reported for 42% of the carve-outs, but for none of the integrated reforms.

Accountability. The majority of reforms (71%) reportedly incorporate child-specific quality measures, although this represents a 17% decrease from 1997-98. More than half of the integrated reforms and over a third of the carve outs reportedly do not have adequate data for behavioral health decision making, attributed to inadequate management information systems, lack of encounter data, and lack of staff capacity for data analysis. Continuing a trend noted in 1997-98, more reforms (two-thirds) reportedly measure clinical and functional outcomes, although nearly half of these are in early stages of development, and few results currently are available. In 41-46% of reforms, the impact of managed care reforms on penetration rates for children behavioral health care, service utilization, quality, cost and family satisfaction was unknown, and in 63%, impact on clinical and functional outcomes was unknown. In the very small sample in which results were known, most were in a positive direction, with the exception of cost, where results were mixed. Decreased aggregate costs were reported in 19% of reforms, increased costs in 25%, and no change in 16%.

State Child Health Insurance Program (SCHIP). About half of states reportedly have implemented SCHIP as a Medicaid expansion, and about half as a separate program. SCHIP behavioral health benefits were more likely to be broad within Medicaid expansions and limited within separate SCHIP programs. Where SCHIP was implemented as a separate program, a high level of coordination was reported between SCHIP and Medicaid systems. However, less than half (43%) of the separate SCHIP programs incorporate strategies to identify and refer children with behavioral health needs.

Child Welfare Special Analysis. A specific focus on children in the child welfare system has been incorporated into all phases of the Tracking Project. Most reforms in the 2000 State Survey (82%) include children in the child welfare system in their behavioral health managed care system; representing an increase from only 45% of reforms in 1995. Progress in meeting the needs of this population was noted in 2000. Most reforms reportedly have special provisions for children in child welfare systems (87%), most provide training for the child welfare system about managed care (72%), and most reforms are able to track the use of behavioral health services by children in the child welfare system (74%). A number of concerns were also identified. For example, in 54% of the reforms, the child welfare system is not significantly involved in planning and implementing the behavioral health managed care system; only 11% of reforms reported have an enhanced capitation or case rate for children in the child welfare system; and child welfare providers are not included in provider networks in 47% of reforms.

Discussion

Publicly financed behavioral health managed care continues to present challenges and opportunities for children with emotional problems and their families and for systems of care. States and local entities are becoming more experienced in the role of designers and purchasers, and, particularly in carve out reforms, often include specifications that would seem to benefit children needing behavioral health services and their families. However, managed care implementation continues to lag behind policy intentions. For example, broad benefit designs are hampered by lack of service capacity and/or inadequate capitation and/or case rates.

Through the efforts of family members, advocates, and researchers, states are beginning to examine more closely how this population experiences managed care and at approaches that may be more effective. The Health Care Reform Tracking Project, while it will continue to identify and track managed care developments, also is moving to a new phase of identifying promising approaches and features of managed care systems. The 2000 State Survey respondents identified a number of promising approaches which the Tracking Project will be studying and reporting on in future activities.

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Findings from the Supplemental Security Income (SSI) Family Impact Study

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Introduction

Recently, a major focus of research and evaluation activities has been to increase the understanding of the impact of policies on services and outcomes for children with serious emotional disturbances (SED) and their families so that policies and policy implementation can be strengthened. It is believed that one important source of input about the impact of policies are the families whom the policies are intended to impact. This is particularly the case since the perspective of children and families on mental health and related services is not always the same as the perspective of service providers, administrators, and policy makers (Friedman, 1997; Unger & Powell, 1991). Moreover, the inclusion of a family perspective has been found to improve the quality and effectiveness of service delivery (Friesen, Koren, & Korolof, 1992; McNaughton, 1994; Reimers, Wacker, Derby, & Cooper, 1995).

The SSI Family Impact Study was designed to meet the need for information from family perspectives about the general impact of the new regulations on families and children whose SED had previously qualified them to receive SSI disability benefits, and for whom the continuation of this benefit was in question or had already been lost. Social Security Administration (SSA) indicated that most of the children losing SSI disability benefits—78,600 of the 95,180—had "mental disorders," representing about 85% of all the cases for whom eligibility for SSI disability benefits were re-determined.

At the individual and family level, this is a study in coping, decision-making, and resilience in response to major changes in an important formal support system. At the macro level, the study has implications for federal, state and local policy-makers, evaluators and the family support movement. This study also highlights the importance of the qualitative methodology and longitudinal approach to gathering information as identified by Maxwell (1990):

- Identify unanticipated factors influencing situations and issues;
- Provide further insight into experimental and survey designs;
- Enable the study of the complexities of life experiences;
- Give a holistic picture of the phenomenon studied; and,
- Incorporate the perspectives of the people studied.

Method

The SSI Family Impact Study utilized a qualitative, multi-site, longitudinal approach. The study method was designed to examine the short-term effects of the new regulations, as well as effects over time. It is a useful, thorough, and systematic method to describe what happens to families, and helps to provide an understanding of the subtleties and complexities of the families' experiences. This study compliments more quantitatively designed studies through its in-depth focus on a limited sample of families, thereby adding a "human face" to other studies examining the impact of this legislation.

The study utilized one form of a case study methodology, which derived its findings from interviews conducted over time and with multiple sources, including the primary caregivers and other individuals identified as providing support to their families. This process began with in-depth, in-person interviews and was followed up with telephone interviews every three months thereafter with the primary caregiver. The purpose of the prospective, longitudinal design of the interview was to gather information on changes in the family's status during the period studied. Special focus was placed on decisions that the family had made in response to their situation, and how these decisions had affected them. In addition, the study utilized a series of focus groups with parents to expand and confirm an understanding of how families have been impacted by the legislative changes.

Eligibility for the study was based on the families' receipt of a letter from the SSA giving notice that their children's eligibility for SSI benefits was slated for reevaluation, and that their child was receiving SSI benefits for a serious emotional disability. Forty families, between twelve to fifteen from each of three sites, (southeastern Kansas; Bronx and Brooklyn, New York; and, Hillsborough County, Florida) were selected to participate in the study.

Initial interviews were conducted between February and June 1998. All families were interviewed in-depth and in-person, and then re-contacted every three months by telephone. The last in-person interview was conducted during the final phase of the study between February and June 2000. Participants were paid $25 for the first and last in-person interviews, and $10 for each telephone interview. Focus group participants were paid $20.

Findings

At the time of the initial interview and throughout the two-year study period, all families were in various stages of the process for the legislated SSI review of benefits. All had received a letter from the SSA in the spring or summer of 1997 notifying them that their child's eligibility was being reviewed. Based on that review, many families who were denied benefits for their children chose to appeal the SSA decision. These families were in various stages of appealing, with a few already having received notification that their child's benefits would or would not continue. Key Findings are presented below.

Characteristics of the Children and Families

- These were children with severe emotional and behavioral disorders and the change in eligibility and loss of SSI did not change their need for services.
- Most children were enrolled in special education classes throughout the study.
- Children's behavior was highly variable but no new diagnosis had been given.
- These were families in which not just the one child, but adults and siblings had major health or mental health problems as well.
- Most families were single parent homes, where the primary caregiver was the child's biological mother.
- These families were experiencing consistently high stress with co-occurring negative events and challenging existing circumstances.

The Importance of the SSI Benefit to Families

- The SSI cash benefit represented an average of 41% of the families' total income.
- Families typically used the SSI cash benefit as part of the household income, to meet basic needs, pay bills and cover expenses.
- SSI was important as a stable source of income.

Impact of the SSI Changes and Process on Families

- SSI policy changes affected multiple dimensions of families' lives in ways that went beyond families' obvious financial need.
- Families experienced increased levels of stress as a result of the review process.
- Continuity of mental health care was disrupted for many families, especially those without formal supports.
- Families experienced a loss of ability to provide "normalizing" supports.
- Parental anxiety increased over their child's behavior in school and at home.

- Although the worst fears of child and family advocates—that children would be placed outside their homes—was not realized, there was an increase in turbulence and crises leading to negative outcomes and changes in the families' quality of life.
- Few families changed residences during the course of the study.
- Families that retained the benefits reported having greater peace of mind, due to the assurance that their child had medical coverage.

Medicaid and Health Care Coverage

- Health care coverage was tenuous for many of the families.
- Most families appealed because of the potential loss of Medicaid.
- Many parents were without health care coverage of any kind.

Coping Mechanisms of Families

- Families were not passive in response to the loss of SSI, making numerous decisions and weighing costs and benefits.
- Families became better navigators of public supports.
- Informal and formal helpers were major sources of support.
- Support from some informal and formal sources was provided inconsistently.
- Insights were gained by families, confirming their own strengths and validating their resiliency.
- Most families adapted to the loss of SSI with heroic efforts *and* with consistently high levels of stress.

The SSI Process

- Families were taken by surprise and distressed when notified that their child's SSI eligibility was to be reviewed.
- The decision to appeal/not appeal was made for a variety of reasons.
- Families were faced with a choice of whether or not to continue receiving the SSI cash benefits during their appeal.
- The SSI review/appeal process was lengthy, with outcomes that extended beyond the review period.
- The SSI process required a lot of "waiting and wondering," which caused increased family stress.
- Experiences with the review/appeal process and the state SSA office generally proved confusing and difficult for parents, prompting some to seek assistance from schools, friends, or their local SSA office.
- Paperwork required for the appeal was overwhelming and time consuming and parents had little help from the SSA.
- There was a general feeling of distrust among families for the ability of the SSA to make an accurate determination of eligibility.
- Parents perceived the SSA as "talking down" to them.
- There was a pervasive belief that SSA was not very knowledgeable about the connection between the SSI cash benefits and Medicaid.
- Very few families sought and received legal help with the process.

Implications

The SSI Family Impact Study examines the impact of a major policy change in a program designed to provide economic assistance to low-income families with children who have a serious emotional or behavioral disorder. Study findings have implications that are equally applicable for federal, state and local policymakers, evaluators and the family advocacy support movement.

Importance of understanding the inter-relatedness of supports. It became evident throughout the study that SSI is part of a larger, complex system of support for families with low incomes with children who have mental health needs. When SSI was removed, other areas of support were affected as well, such as Medicaid. The changes in SSI were part of a major reform effort in welfare. Welfare reform had direct effects on employment through TANF work requirements, on child care, and on access to health care as the reform legislation de-linked Medicaid (medical assistance) and TANF (financial assistance).

Importance of services and supports for children with emotional/behavioral disorders. The SSI changes were a policy decision, not a diagnostic one. The change in eligibility or SSI status for these children *did not* change their need for services. While the study did not involve direct assessment of the children, these children appeared to be those with significant emotional disturbances Thus, while savings may have accrued to the SSA as a result of the SSI changes, these children and families continued to use other public services and supports, such as special education.

Importance of communicating policy changes. Many of the findings of the study reflect the importance of an effective process for communicating legislated program changes. According to families, programs were unable to provide them with accurate and complete information. Misleading, inaccurate or lack of information caused many families to miss deadlines for appeal and also created problems for families as they attempted to maintain current supports and services or qualify for new ones. Families were either not informed about or did not understand the linking or de-linking of other benefits. This lack of information or misinformation had a negative impact on their ability to make informed decisions or plan for the future. States must identify those family support agencies where families seek information, (e.g., schools, pediatrician offices, mental health centers, neighborhoods) and work to provide them with the relevant information to be passed on to the front-line workers who have direct contact with families. Local supports and services should be aware of where families are most comfortable going for information, and whom they ask for help (e.g., teacher, therapist, doctor, natural helper in the neighborhood) and then systematically equip them with the knowledge to be helpful.

Importance of the policy change process. While the policy change for SSI occurred in August 1996, it took a number of years for many families to complete the process. The resulting impact on the children and families the legislation targeted will take even longer to fully understand. The impact of the SSI policy change process was most evident when looking at the experience families had with the appeal process. The appeal process placed families in a difficult situation, being able to retain their benefits during the appeal, but putting themselves at risk of paying back their cash benefits should they lose their appeal. If appeals are decided in a timely manner, the financial consequences of allowing families to retain their money during the appeal process would be minimal.

Importance of physical and behavioral health care coverage. Related findings consistently suggest the importance of physical and behavioral health care coverage, an especially critical benefit in families with children who have a serious behavioral or emotional disability. Many families viewed the loss of medical benefits as being more devastating than loss of income, with most families reporting that the most important motivator for their (almost universal) decision to appeal was financial need in health care areas and their fear of losing Medicaid.

Importance of a basic minimum income for the well-being of children and families. The findings of this study suggest the importance of a basic minimum income for the well-being of families. For most families in the study, the SSI cash benefit played a large role in total family income. Families' reported that as a result of changes in their children's SSI status, a portion of their household income was eliminated, creating many financial difficulties and changes in essential areas of living and in areas of "normalization" for their children. Families also reported that the stress of the financial loss had an impact on family relationships and mental and physical health. The families in the study exist at or near poverty level. Feeling they will never "get ahead," many families experienced one catastrophic situation after another.

Importance of the family as a complex system within a system. It is important to recognize that one of the basic assumptions of systems theory is that a change in part of the system (the child) leads to changes in other parts of the system (the family). The SSI Family Impact Study identifies a *cascade effect* of the family's experiences. The loss of income as a result of a policy change (i.e., SSI) in one area of support had a comprehensive and, as described by one parent, "downward spiraling" effect. The loss of income for a family with a child who has mental illness is complicated and comprehensive in effect, especially with the complex array of services a family may have for support. The decision and choices these families face are equally complex and the effect of those choices can be the difference between providing health care for one child or a roof over the head for the family. While it is difficult to tease out the cause and effect in many of the families' stories, they aptly illustrate an important sequence of events.

Importance that the primary caregiver remain the sole provider of daily care for the child. Most families in the study consisted of children with a single mother. While the supports were important, families reported that it was critical that the primary caregiver remain in the home to care for the child with the disability. The primary care-giver, most often the sole provider of daily care for the child, realized that without money from SSI they would have to seek employment; this action would seriously reduce the amount of time the caregiver spends with the child, leading to issues around continuity of care.

Importance of the families' strong commitment to keeping their children at home. Most of the families in the study did not lose their children to out of home placement—not because the system 'made up for' the loss of SSI and wrapped other supports around them—but because these families exhibited enormous resilience and commitment to their children. This study found families making heroic efforts to keep their children at home

Importance of informal supports. Our findings suggest the importance of formal and natural, informal supports and services. While families wanted practical information, little formal support was identified by families in obtaining SSI or in the review or appeal processes. However, tangible support in meeting basic living needs and emotional/spiritual support was viewed as very important with most of this help coming from informal sources. For families in Kansas, the mix of support from the informal and formal supports proved to be very helpful. Upon closer examination of the entire group of families over the seven waves of data collection, it appears that families made an effort to draw on informal supports when formal supports declined.

Two major policy implications related to this finding suggest that when eligibility criteria is being changed or benefits are being eliminated, policy makers can help to identify and shore up those natural systems of support, and systematically look at ways to beef up the natural supports. Policymakers must understand the fragility of the social support networks, recognizing that these informal support networks cannot take the place of necessary formal services.

Importance of strategic intervention. A goal of the study was to look at how people make real-world decisions. This information can help to identify the specific decision-making criteria used by the individuals experiencing a policy change in order that policy makers and frontline practitioners might intervene at different points in the decision-making process with new policies designed to make life better for families. For example, an impact on mental health frontline practitioners might be the ability to anticipate the needs of families as they experience a policy change. Identifying strategic areas of intervention and support might help to mitigate the negative effects of larger policy changes. While a relatively consistent picture of families experiencing the effects of the SSI changes emerges, the individual experiences of each family create opportunities for service providers to intervene strategically.

Conclusion

A comprehensive picture is critical when we see poor families or families experiencing consistent instability being criticized for being poor decision-makers. The effects of their total experience, added to the system's ineffectiveness in providing accurate information, sets the family up to fail. Families need to be able to make decisions from a position of strength and be viewed and evaluated in that light. It has become too common to place blame on parents for children's problems or to place the blame on children for their families' difficulties. Operating from a systems perspective, a longitudinal study can eliminate blame and be more respectful of the families participating in research.

The SSI Family Impact Study supports the "breadth of research findings now emerging largely as a result of welfare reform, suggesting that a substantial subset of families will need episodic or sustained help much longer than TANF time limits will allow, from a broader array of providers than TANF agencies consistently or effectively interact with, and that some may need help from outside the TANF system entirely." (Kramer, 2000).

What is evident in this study is that behind most of the children, thre are one or more parents struggling to keep up their sense of hope and their emotional and physical energy, while searching for solutions to meet the needs of their children. Most families adapted to the loss of SSI (i.e., loss of income) and to other changes resulting from the new legislation with heroic efforts *and* with consistently high levels of stress.

The family voices contributing to the SSI Family Impact Study expressed their experience of the changes of SSI, not as an ultimate outcome issue, but as a quality of life issue. This qualitative shift in examining the impact of external intervention on children and families, whether in policy or mental health and substance abuse treatment, is the challenge and responsibility of evaluators.

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Job Training Activities and Opportunities and Transportation Among WAGES Participants

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Introduction

The Catholic Charities Diocese of St. Petersburg, Florida, in partnership with the University of South Florida's Center for Urban Transportation Research (CUTR) and the Louis de la Parte Florida Mental Health Institute (FMHI) collaborated to conduct part two of a welfare reform study. Part one was conducted between June of 1998 and June of 1999. The interest for both studies arose out of the Catholic Charities' desire to objectively assess the degree to which the current "safety net" of services is sufficient for families impacted by welfare reform, specifically those attempting to transition from public assistance to self-sufficiency though the Work and Gain Economic Self-sufficiency Act (WAGES).

Part two builds upon the initial study effort with a purpose that is two-fold:

1. To describe the job training opportunities available from the perspective of the WAGES participants and providers in Hillsborough, Pasco and Pinellas counties; and
2. To describe participants' access to, use of, and need for transportation for all daily activities and the role transportation plays in recipients' access to job training activities or their ability to obtain and maintain gainful employment.

This study specifically seeks to obtain candid and in-depth information to:

- Identify and describe job training opportunities in Hillsborough, Pinellas and Pasco counties;
- Examine the successes and continuing needs of families in job training programs or who have graduated;
- Identify patterns and needs concerning participants' use of transportation;
- Identify and describe any assistance received for transportation needs; and
- Examine employment opportunities in the three counties studied.

Florida was an early adapter of welfare reform measures and therefore the proposed project has having implications for statewide and national welfare reform. Service gap analyses for these program participants may improve services, assisting participants to achieve economic self-sufficiency.

Methodology

Key Informants for the study included current and former recipients of WAGES sponsored job training programs, and staff from provider agencies. Eligible participants were selected based on purposeful sampling techniques, which are homogeneous and criterion based.

In total, six focus groups were conducted with WAGES recipients in three counties in the Tampa Bay area: Two each in Hillsborough, Pinellas, and Pasco counties. One of these groups consisted of entirely Spanish speaking participants. In addition, four focus groups were conducted with staff members representing WAGES' contracted job training service providers in the same three counties. All participants completed a pre-focus group survey, with WAGES participants also completing a trip diary, detailing their need for and use of transportation. CUTR and FMHI were responsible for study design, instrument development, focus group moderator training, and data analysis, while participant recruitment and data collection was conducted by Catholic Charities.

Data analysis was based primarily on what is typically referred to as qualitative or ethnographic summary, with a heavy reliance on direct quotation of group discussions rather than on numerical descriptions of the data that are possible with full content analysis.

The topic guide served as the "practical structure for organizing the topic-by-topic analysis of the discussions." (Morgan, 1988, 66). During the focus group, the guide organizes each group's discussion around the same set of topics and in the same order. This method is therefore an effective tool for organizing and comparing findings across groups during the process of analysis. Initially, co-moderators identified and clarified the major themes during the groups, with further analyses by FMHI, in which information was extracted from those notes and tape recordings.

Responses were then clustered by topic across subgroups in an effort to determine the presence or absence of certain themes and the level of agreement or disagreement on those themes.

Data collected from the transportation trip diaries were analyzed separately by CUTR and combined with the findings from the focus groups.

Results

WAGES Recipient Demographics

The average age of participating WAGES recipients was 32 years, with 44% being African American, 33% Caucasian, 17% Hispanic, and less than 2% Asian, multi-racial, or biracial. The vast majority (80%) of these participants reported renting their home, with 19% being homeowners. Participants reported caring for an average of 2.2 children.

Sixty percent (60%) of participants were not receiving welfare checks, while the other 40% were receiving these benefits. The length of time respondents have been on welfare or were on welfare ranged from as briefly as one month to up to 10 years on and off. Of those who had been on it consistently in recent months and years, the average length of time reported was 12 months. Nearly three-fourths (74%) of participants reported that they were not employed.

Table 1 details the various job training programs participants reported attending and the frequency of those responses. Sixty-two percent (62%) reported completing their job training program, while 17% did not (19% of respondents did not answer this question, while 3% reported that they were currently enrolled in the program). Those who did not complete the program indicated attending the training for a few as three days to as long as six months.

Table 2 illustrated types of transportation reported by participants. More than half (55%) of participants indicated that lack of transportation posed a barrier to finding and keeping a job. Thirty-six participants reported relying on a personal vehicle for transportation, with 22 relying on the bus, 21 on getting rides from friends, neighbors or family and 18 using a friend's or relative's vehicle. Fewer reported using taxis or other non-motorized transportation (e.g., riding a bicycle).

Summary of Findings—WAGES Recipients Focus Groups

WAGES recipients reported that the primary sources of information about job training were highly variable, with direct referrals from a WAGES case worker being the most consistent, along with word of mouth. Their interest in job training typically arose out of the need to train for a new type of job after an injury, an interest in a specific career path, or simply the need for benefits to continue. These participants expected that they would learn a new trade, gain the skills to have a career, earn more money, and receive benefits such as paid vacation and health insurance.

Participants reported that the job training programs offered the opportunity to gain computer skills, technical skills for a trade, medical skills (e.g., x-ray or ultrasound technician), and office skills (e.g., billing, customer service). Many also reported gaining employability skills, such as resume development, interviewing, and tips on "dressing for success." Respondents reported that these programs did not devote adequate time and opportunity for computer training or computer equipment, and that transportation, childcare assistance, and clothing vouchers were not adequate to meet their needs.

Table 1
Job Training Programs Attended

*Hillsborough County (n=23)**	*Pinellas County (n=29)*	*Pasco County (n=13)*
Centre for Women (*n*=6)	Ultimate Medical Academy (*n*=11)	Career Central (*n*=6)
WAGES (*n*=5)	"WAGES Program" (*n*=8)	No answer (*n*=3)
Share program	WIA (*n*=3)	WAGES (*n*=2)
Immigration Service	Advantage Training Systems (*n*=2)	JTPA (*n*=2)
Hispanic Needs Council	"My own"	
Florida One Stop Center	One stop Center	
S.H.I.P.	Voc rehab	
EST class – James Har Building	Pinellas Works – Lockheed	
DACCO – welfare to work	Program for senior citizens	
ACTS		
Job training		
DCF – University Leaney Technical Center – Customer Service Academy		
No answer (*n*=2)		

*Two respondents gave multiple answers.
WAGES: Work and Gain Economic Self-Sufficiency
WIA: Workforce Investment Act
DCF: Department of Children and Families
JTPA: Job Training Partnership Act

Table 2
Types of Transportation Available

	Hillsborough # of mentions	*Pinellas # of mentions*	*Pasco # of mentions*	*Overall # of mentions*
Personal vehicle (car or motorcycle)	13	16	7	36
Bus	10	12	--	22
Getting rides from friends/neighbors/family	4	11	6	21
Friend's/relative's vehicle (car or motorcycle)	4	9	5	18
Taxi	--	3	2	5
Bicycle or other non-motorized transportation	1	--	3	4

Note: multiple responses are allowed.

Participants identified a variety of barriers to obtaining employment, mentioning lack of reliable transportation most frequently, followed by child care (i.e., access, cost, reliability). They also did not receive comprehensive information about available job training programs. Others reported that lack of health insurance for their children, lack of time (in general), and an inability to deal with tragic and stressful life events, were barriers to obtaining employment.

Participants specifically described the public transportation system as lacking in availability, reliability, and therefore requiring too much advanced time/travel time to reach their destination. Others needed more information about how to take the bus or to interpret bus schedules. Physical disabilities and childcare responsibilities also made using public transportation more difficult.

Summary of Travel Diaries

Travel diaries were returned by more than half (52%) of WAGES recipients participating in the focus groups. These individuals logged a total of 1,226 trips, with 22% reported as work-related, followed by childcare (21%), business (18%), and social (14%). The most common modes of transportation were a family/friend/neighbor's car (15%), a personal vehicle (57%), and walking (16%), with only 6% taking the bus.

Summary of Findings—Job Training Providers

A total of 30 providers participated in the focus groups in the three counties, representing a wide variety of job training programs. The majority of providers (n = 19) reported holding either a bachelors or master degree, although not necessarily in a field directly relating to job training.

Providers reported that individuals participating in job training programs can be referred from a wide variety of agencies, including Worknet, the Area Agency on Aging, one-stop centers, WAGES, and other community-based service organizations. For most programs, the criteria for eligibility for job was receipt of cash assistance and/or low to moderate income, which individual programs defined somewhat differently depending on their affiliation or sponsorship.

Providers perceived job training enrollees as needing basic or remedial education in reading and grammar, computer skills, basic office skills (e.g., answering phones and customer service), and "soft skills" relating to employability, such as work ethic, attitude, communication, and personal hygiene. They also saw a need to provide additional support in the form of mentors and to address concurrent issues, including mental health, substance abuse, and spousal abuse.

Job training programs varied in the actual skills they were teaching, with some focusing on training participants for a medical career, including x-ray or ultrasound technician, medical or dental assistant, or Certified Nurses Aid and phlebotomist. Others taught more general skills, including computer training, customer service, and business administration. These programs also offered classes relating to employability, in which trainees are taught how to fill out an application, develop a resume, participate in an interview, conduct a job search, and to "dress for success." Although not widespread, a few programs also worked to build trainees' self-confidence and to empower trainees to help themselves. Only in rare instances were programs offering job placement assistance.

Most providers agreed that there is a need for job training programs to emphasize the "soft skills" necessary for obtaining and maintaining employment. These included self-sufficiency, personal responsibility, addressing a poor attitude or the fear of success, and generally coping with and managing the everyday demands of employment. Although some trainees needed help with mental health issues, medical issues, or overcoming a criminal background, providers reported that their programs were not specifically designed to address these needs.

Barriers to employment were identified by providers as including the trainee's inability to transition from a cycle of dependency to a life of independence. Specifically, trainees did not believe their benefits would be cut off if they did not obtain employment, they were unable to manage a budget based on employment income, were inexperienced with time management and goal setting, and lacked the self-esteem and the appropriate attitude to succeed in the workplace. Other practical barriers included a lack of job training slots for the working poor, lack of employment offering livable wages and affordable health insurance, limited time with caseworkers resulting in a lack of individual attention, and long waiting lists for mental health services, transportation options, and unmet childcare needs.

Providers specifically noted that trainees struggled with a lack of transportation, describing the public transportation as failing to meet the needs of riders in terms of the actual routes and the time of day buses were running. For this reason, the amount of time required to drop off children at childcare and then travel to job training or work was extraordinary, placing a great burden on those relying on public transportation. Even those with their own cars struggled with the unreliability of their transportation and limitations in the help they received from WAGES to keep their cars running or insured. In addition to a great deal of stress, these barriers resulted in trainees missing classes and being sanctioned for lack of attendance.

Conclusion

This report represents a summary of the findings from a small sample of WAGES recipients and job training providers from the represented counties. As with all qualitative research, the findings are not intended to provide conclusive data, but rather explore the depth of experience of those impacted by the legislative changes. Qualitative methodologies provide a unique opportunity to obtain information from families and lend a voice to those who may otherwise not be heard. These findings represent likely patterns for individuals affected by welfare reform and raise new questions, which warrant further study.

This study does not offer confirmatory findings concerning the factors that correlate most highly with WAGES recipients' degree of success in completing job training programs or moving from welfare to work. Rather, it focuses on participants' perspectives of what is currently being offered, what additional programs or program features may be helpful in promoting success, and identifying other barriers to this success. In sharing their perspectives, participants may or may not have accurately identified the issues that a statistical analysis would find as most predictive of positive outcomes.

The findings of this study describe several key features of current job training and transportation resources in the Tampa Bay area. They are: training access, trainee assessment, training offerings, transportation, and collateral supports. Based on the current offerings and needs, recommendations are provided in the hopes of guiding policymakers and service providers to better meet the needs of WAGES recipients and assist them in overcoming the barriers they face to self-sufficiency.

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The Effect of Mothers' and Children's Health on Exits from AFDC

David S. Mandell

Introduction

It is quite likely that mothers who have health problems, or who are raising a child with health problems, will have more difficulty leaving welfare than other women. Certainly, health-related problems create a demand that competes with work activities (Acs & Loprest, 1999). Yet women who move to work from welfare consistently are not provided with enough paid leave or job flexibility to attend to their or their children's health needs (Cook, 1978; Heymann & Earle, 1999).

Mothers of children with chronic health problems have more difficulty than other mothers in finding employment (Breslau, Salkever, & Staruch, 1982; Salkever, 1982). Much of the difficulty in obtaining and maintaining employment is due to the fact that, much more than other children, these children require a high volume and intensity of health services and home care (Newacheck & Halfon, 1998). The additional burden placed on mothers comes mostly in the form of increased childcare demands, including children's greater dependence on others for care and mobility, mothers' time spent on obtaining health-related services, and the limited availability of childcare for disabled children (Breslau et al., 1982).

Between 15% and 40% of women on welfare are raising a child with chronic physical or mental health problems (Heymann & Earle, 1999; Loprest & Acs, 1996; Meyers, Lukemeyer, & Smeeding, 1996). These rates are much higher than those found among poor women who are not on welfare (Heymann & Earle, 1999); however, the few prospective studies in this area have shown at best a marginal relationship between either mother or child-related disability and leaving welfare (Hutchins, 1981; O'Neill Wolf, Bassi, & Hannan, 1984; Plotnick, 1983; Blank and Ruggles, 1992; Acs & Loprest, 1999).

This study uses large administrative data sets to identify welfare receipt and chronic physical and mental health conditions as measured by service utilization and diagnoses. The hypothesis of this study is that families in which mothers have, or are raising children with chronic physical or mental health conditions will leave welfare more slowly than other families.

Methods

Sample

Single-mother families receiving AFDC in July 1993 in Philadelphia, Pennsylvania and enrolled in Medicaid fee-for-service in this city ($N = 33{,}609$) were identified with the use of a probabilistic algorithm.

Measures

Health Service Utilization was derived from the Medicaid Management Information System, which contains paid claims data for mental health, general health and substance abuse treatment provided to Medicaid-eligible Pennsylvania residents.

Chronic health conditions were described both by specific diagnoses and cost of services used. Diagnoses for chronic illness were based on condition lists (Gleeson, 1974), prevalence in this population, and disabling features of the condition. The following diagnoses for physical health

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conditions were coded: asthma, diabetes, epilepsy, hypertension (mother only), migraine (mother only), otitis media (chronic), sickle cell anemia (child only), and spina bifida (child only). The following psychiatric diagnoses were used: adjustment disorder, affective disorder, attention deficit disorder, autism, conduct disorder, and schizophrenia.

Based on findings from previous studies (McFarland, Freeborn, Mullooly, & Pope, 1985; Johansen, Nair, & Bond, 1994; Jerrell, 1998), those who were in the top 20% of service users by cost in a given six month period also were coded as having a chronic health condition. Diagnoses associated with hospital stays were included in the definition of chronic illness, but costs were limited to ambulatory care costs.

Analyses

Service utilization was aggregated within each of the six, discrete 6-month windows of the study. Individuals were coded as welfare recipients in a given 6-month period if they received welfare for at least one month during that period.

Cox proportional hazards models with time-dependent covariates were used to determine the effect of children's health on welfare leaving (Cox, 1972; Cox & Oakes, 1984). Families were treated as censored observations (Cox & Oakes, 1984) if the following occurred during the study: 1) they enrolled in an HMO; 2) the mother switched welfare program status from AFDC to Supplemental Security Income (SSI); or 3) the youngest child in the family turned 18 during the study.

Results

Table 1 provides descriptive information for families in the sample. Table 2 provides the results of the Cox model with time until first 6-month break from welfare regressed onto mothers' and children's chronic physical and mental health variables. Families in which the mother had a chronic physical health condition as measured by cost of service utilization or had any contact with the specialty mental health system were 2.3 times more likely to remain on welfare. Families in which children had a chronic physical health condition were 1.7 times more likely to remain on welfare. Families of children who had any contact with the specialty mental health sector were 1.3 times as likely to remain on welfare.

Neither specific diagnoses for physical or mental health nor volume of mental health services as measured by number of visits or cost were predictive of welfare leaving when entered into the model with the cost of general health services or the presence of a specialty mental health contact.

Table 1
Demographic Information on Study Mothers

Race	*N*	*Avg. Age of Mother (SD)*	*Avg. Number of Children (SD)*	*Children born 7/93 to 6/96 (SD)*	*Months on AFDC pre-7/93 (SD)*	*Months on AFDC/TANF 7/93 to 6/96*
African-American	22,343	30.6 (6.5)	2.5 (1.3)	0.14 (0.02)	31.0 (9.0)	32.2 (7.9)
Asian	641	32.3 (7.4)	2.7 (1.5)	0.15 (0.14)	27.2 (11.5)	31.7 (9.3)
Hispanic	5,238	30.4 (6.7)	2.7 (1.4)	0.16 (0.05)	29.1 (10.6)	31.4 (9.2)
White	5,025	30.7 (6.6)	2.2 (1.3)	0.11 (0.05)	28.1 (11.1)	30.3 (9.6)
Other	321	29.8 (8.1)	2.4 (0.9)	0.16 (0.22)	26.2 (11.9)	31.4 (8.8)
Missing	41	30.5 (6.1)	1.8 (1.01)	0.12 (0.33)	16.6 (14.2)	25.6 (10.7)
Total	33,609	31.9 (8.4)	2.5 (1.48)	0.14 (0.37)	30.1 (9.8)	31.8 (8.4)

Table 2
Effect of Children's and Mothers' Health on Welfare-Leaving*

Variable	*Odds of remaining on Welfare*	*P value*	*R*
Top 20% of service users (children)	1.67	< 0.001	-0.03
Had MH contact (children)	1.27	0.007	-0.01
Top 20% of service users (mother)	2.33	< 0.001	-0.05
Had MH contact (mother)	2.27	< 0.001	-0.02
Mothers' age (years)	0.98	< 0.001	0.03
Number of children	1.12	< 0.001	-0.03
Newborn during study	1.32	0.027	-0.01
Asian	0.96	0.757	0.00
Hispanic	0.66	< 0.001	0.03
White	0.65	< 0.001	0.04
Other	0.95	0.740	0.00
Months on welfare pre-study	1.04	< 0.001	-0.09

* Reference category consists of African-American families with one child.

Discussion

By merging administrative datasets for a large sample and using different measures of disability, this study provided evidence that mothers experiencing chronic physical or mental health conditions are more than two times less likely to leave welfare than other mothers. Contrary to the other published study in this area (Acs & Loprest, 1999), the results from this study also suggest that raising a child with a disabling health condition creates an additional burden on mothers separate from any burden imposed by their own health conditions.

It is important to note that mothers' psychiatric disorders were as predictive of remaining on welfare as chronic physical health conditions. Children's psychiatric disorders also independently predicted that families would remain on welfare. Studies that examine the effects of health on welfare tenure and labor force participation, as well as programs designed to assist these families, must take into account the effects of mental as well as physical health.

Implications

There are at least three reasons why both maternal and child illness make it more difficult for families to move off welfare: 1) families with considerable health service needs are less likely to leave welfare because of concerns about losing health care benefits; 2) quantity of treatment is a proxy for severity; and/or 3) the treatments mothers and children are receiving are inappropriate or ineffective. These possibilities are discussed below.

Concerns about Insurance. The administrative complexity involved in enrolling in other programs, confusion about eligibility, as well as inadequate outreach may encourage families to remain on welfare even when other options are available (Shi, Oliver, & Huang, 2000). Moffitt and Slade (1997) found that only 7% of mothers and 17% of children remained on Medicaid after leaving welfare; 45% of mothers and 12% of children had no insurance. These low proportions suggest that families were not aware of their continued eligibility. Since families in which mothers or children have greater health needs may see insurance as having greater value, they may be more likely to remain on welfare.

Treatment as a Proxy for Severity. It may be that there are mothers whose disabling condition is not recognized by either their caseworker or physician as qualifying them for disability status. While some states have made efforts to improve caseworkers' recognition of disabilities, some conditions are often missed (Kramer, 1999). It may also be that these women have disabling conditions, but their condition is not considered a disability under SSI regulations. The same may be true of their children, who perhaps should be receiving SSI payments but are not. Having a child on SSI significantly increases cash assistance and may also open the doors for additional services that make it easier for mothers to find and maintain employment (Meyers et al., 1996).

Effectiveness of Services. In actual practice, a variety of health conditions that are not disabling when correctly treated are often treated using nonindicated treatments and subtherapeutic doses. These conditions include asthma and respiratory infections (Mainous & Hueston, 1998; Mendenhall & Tsien, 2000), diabetes (Kenny et al., 1993; McClellan, Knight, Harp, & Brown, 1997; Streja & Rabkin, 1999), depression (Hirschfeld et al., 1997; Druss, Bradford, Rosenheck, Radnor, & Crumholtz, 1999), and other psychiatric disorders (Holloway, 1988; Zito et al., 1999; Walkup et al., 2000). Ineffective treatment may result in a prolonged course of illness and increased disability.

Many welfare programs have recognized the need to offer special assistance to women with physical and behavioral health problems who are making the transition from welfare to work. Fewer programs provide services to mothers raising children with chronic health conditions. In order to help women make the transition from welfare to work, programs must contain components to help women balance the needs of the workplace and their children. This may include specialized daycare, more flexible access to medical services, and parenting classes specific to the needs of parents of children with chronic physical and mental health conditions.

Federal legislation allows states to exempt up to 20% of their welfare caseloads from the time limits imposed by the Personal Responsibility and Work Opportunity Act. As of February 2001, no states have published exemption guidelines. The results of this study suggests that both women with chronic physical and mental health problems as well as those raising children with chronic health conditions are important groups to consider.

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